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Division of
Clinical Psychology

The Power Threat Meaning Framework

Towards the identification of patterns in emotional distress,
unusual experiences and troubled or troubling behaviour,
as an alternative to functional psychiatric diagnosis

January 2018

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Document summary

In 2013, the Division of Clinical Psychology (DCP) of the British Psychological Society (BPS) published a Position Statement entitled *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift*. Recommendation 3 of the position paper is: ‘To support work, in conjunction with service users, on developing a multi-factorial and contextual approach, which incorporates social, psychological and biological factors’ (p.9). This document is the result of a DCP-funded project for work towards fulfilling this aim.

The framework described here, the Power Threat Meaning Framework, is an over-arching structure for identifying patterns in emotional distress, unusual experiences and troubling behaviour, as an alternative to psychiatric diagnosis and classification. The document sets out the conceptual and empirical basis of such a system and is intended as a foundational intellectual resource. It is important to note that the framework is not tied to a particular level of explanation (social, psychological or biological) or to a specific theoretical orientation such as cognitive, behavioural or systemic. Thus while we suggest it can be used as it stands, it can also be seen as a meta-framework within which many existing models and bodies of evidence can be accommodated, and which can be used to inform future projects translating the framework into practice.

Chapter 1 examines the problems of medicalisation and psychiatric diagnosis, using comparisons with medical diagnosis to show why a very different approach is needed. It is argued that medical diagnosis is fundamentally an attempt to make sense of problems by drawing on research into patterns/regularities in bodily structure, function and dysfunction, and that while this is appropriate and productive for many bodily problems, psychiatric diagnosis is inherently limited in its capacity to make sense of emotional/psychological distress. This is because it largely draws on theoretical models designed for understanding bodies rather than people’s thoughts, feelings and behaviour.

Since all human experiences are mediated by our biology, highlighting these limitations does not imply a mind-body split. However it does mean that alternatives to psychiatric diagnosis need to be based on very different theoretical models, which are likely to lead to the identification of very different kinds of patterns and regularities.

Chapter 2 addresses some philosophical and conceptual issues raised by the need to account for the behaviour and experiences of embodied persons in cultural, social and relational environments. Abandoning what the authors have called the ‘DSM mindset’ is not easy, since it is deeply embedded in fundamental Western philosophical assumptions including, but not limited to, the separation of mind from body, thought from feeling, the individual from the social group, and human beings from the natural world; the privileging of ‘rationality’ over emotion; and a belief in objectivity, or the possibility of partialling out values, ethics and power interests from theory and practice in human systems. These influential but not universal worldviews underpin what can broadly be described as positivism, which tends to promote a view of human beings as objects acted on by causal forces rather than agents who have reasons for their actions. Although this paradigm has led to major advances in medicine, science and technology, it is not well suited to understanding human emotional distress and troubled or troubling behaviour.

It is this philosophical basis, not just psychiatric diagnosis and medicalisation as such, which needs to be fundamentally re-thought if we are not to end up with variations on the same unsatisfactory system. Modified versions such as the ‘vulnerability-stress’ or ‘biopsychosocial’ models still position social and relational factors as secondary to underlying biological causal malfunctions, and thus do not fully theorise distress as a meaningful, functional and understandable response to life circumstances.

Drawing on relevant theoretical approaches, principles and practices are presented which allow us to see humans as active, purposeful agents, creating meaning and making choices in their lives, while at the same time subject to very real enabling and limiting factors, bodily, material, social and ideological. This has implications for service user/survivor and carer voices and views, for culturally appropriate perspectives on manifestations of distress, and more widely, for ethics, values and social justice. In relation to the aims of the project, the implication is that patterns underpinning individual and group experiences of distress will be inseparable from their material, environmental, socio-economic and cultural contexts, and that alternatives to diagnosis need to recognise the centrality of meaning, narrative, agency and subjective experience.

Chapter 3 picks up these themes by examining meaning and narrative in more detail. Personal meanings are shaped by social and cultural discourses, which themselves arise within wider social structures and socioeconomic contexts. These in turn are based on particular assumptions about human nature and behaviour. Judgements about who is deemed to be ‘mad’ are inevitably, to some extent, based on implicit norms about what are acceptable ways of thinking, feeling and behaving in a given society. This includes norms about gender roles, class and ‘race’, such that those whose behaviour and experiences do not fit the implicit parameters – either by falling short of expectations, or by over-fulfilling them – are more likely to attract a diagnosis. Further, it is suggested that lived experiences of distress, particularly in industrialised societies, are shaped by the more deep-rooted assumptions we have outlined above. Most profound of all are our core assumptions about personhood – what we mean by the ‘self’, and the relationship between self, others and the material and natural world. One implication is that, as cross cultural studies show, there are not, and cannot be, universal categories of emotional distress.

A central aim of the project is therefore to restore the multi-levelled layers of meaning in madness and distress that are obscured by the process of psychiatric diagnosis, in order to open up space to identify different kinds of patterns in distress. This requires a sophisticated understanding of ‘meaning’ as a complex and multi-layered achievement, variously constituted from linguistic, material, social, bodily and psychological elements that combine to generate a lived, dynamic sense of intentionality and selfhood. Meaning is not simply personal, since it draws upon shared resources and discourses, and nor is it straightforwardly under our control; rather, it is something that we both ‘make and find’. Our own narratives, the stories we tell about our lives in order to make sense of our experiences, are derived from wider cultural narratives in which some ways of understanding are more available and socially sanctioned than others.

In making sense of our experiences of distress, we are invited to compare ourselves against prevailing social discourses, resulting in social shame when we fail to attain these ideals. We may also be met by diagnostic narratives of difference and individual deficit. Narratives can also, in various forms across cultures, be experienced as helpful and healing. They have the potential to provide a common language about the emergence, experience and expression of distress,

thus restoring the central role of meaning and providing a foundation for positive change.

Chapter 4 uses these conceptual discussions as a starting point for an analysis of the empirical evidence about the social contexts of distress, with a particular focus on childhood adversity, gender, 'race' and ethnicity and social class and poverty. It summarises a very large and growing body of evidence for the causal impact of a whole range of relational and social adversities in all mental health presentations (and other behavioural and social outcomes), in marked contrast to the ongoing failure to provide evidence for primary biological factors. These can collectively be seen as demonstrating the operation of various kinds of power including: coercive; legal; economic and material; biological/embodied; interpersonal; and ideological. Ideological power is one of the least visible forms, but is fundamental to how we identify, understand and experience emotional and psychological distress, individually and collectively.

The recent trend for investigating links between particular psychosocial events and circumstances (such as institutional care or sexual abuse) and particular outcomes (such as suspicious thoughts or hearing voices) is examined, with the conclusion that existing attempts to outline alternative causal patterns, whether biological or psychological, have all foundered on what the authors have called the 'everything's' problem: *Everything causes everything*: a whole range of adversities is implicated in almost every presentation of distress. *Everyone has experienced everything*: few people in mental health (or other welfare/criminal justice) settings have had single social disadvantages or adversities. *Everyone suffers from everything*: in diagnostic terms, this is known as co-morbidity, and typically leads to the application of multiple diagnoses over time.

In summary, all types of adverse event and circumstance appear to raise the risk for all types of mental health presentations (as well as for criminal and offending behaviour, physical health problems, and a range of other problematic social outcomes). This appears to be mediated, for better or for worse, by all types of attachment relationships, and by all kinds of social support, biological mechanisms and emotional and cognitive styles. This is in keeping with the earlier contention that specific causal pathways of the kind that relate to some forms of bodily malfunctioning do not, and cannot, exist in relation to human thoughts, feelings and behaviours. The relevant causal factors are generally multiple, complex, highly interactive and overdetermined and, moreover, shaped by personal meaning and agency. This does not mean there are no regularities, but it strongly reinforces the need for a fundamentally different approach to pattern-identification in relation to emotional and behavioural distress and difficulties.

Chapter 5 discusses the role of biology, making a strong distinction between biology as a primary cause, and biology as mediator and enabler of all human experience. Reviewing a wide range of studies, it concludes that there are no consistent associations between functional psychiatric diagnoses and any biological pathology or impairment, and nor have any biomarkers been identified. This leads to the conclusion that while all human experience is reflected in some way in the activities of our brains and bodies, we need a much more sophisticated account of how these aspects arise out of each other, one that is not based on assumptions about illness, disorder or disease. This will also help to avoid attempts to assimilate findings about the impact of social and relational adversities back into the existing paradigm.

The 'lifelines' model acknowledges the multi-directional and continuous interaction of

biology, experience and the environment within complex processes that are at once, and equally, psychological, biological and social. This is consistent with evidence about the impact of adversity on attachment relationships and on evolved bodily threat responses. These emerging bodies of evidence are a promising start in developing comprehensive, sophisticated accounts of emotional distress that integrate meaning into a model of embodied, socially situated, agentic persons.

Chapter 6 draws together the principles and evidence discussed in previous chapters in order to suggest a new meta-framework based on the core assumption that emotional distress and troubling behaviour are intelligible responses to social and relational adversities and their cultural and ideological meanings. It is entitled the Power Threat Meaning Framework, and its main features and purposes are as follows:

- It allows provisional identification of general patterns and regularities in the expression and experience of distress and troubled or troubling behaviour, as opposed to specific biological or psychological causal mechanisms linked to discrete disorder categories;
- It shows how these response patterns are evident to varying degrees and in varying circumstances for all individuals across the lifespan;
- It does not assume ‘pathology’; rather, it describes coping and survival mechanisms which may be more or less functional as an adaptation to particular conflicts and adversities in both the past and present
- It integrates the influence of biological/genetic and epigenetic/evolutionary factors in mediating and enabling these response patterns;
- It integrates relational, social, cultural and material factors as shaping the emergence, persistence, experience and expression of these patterns;
- It accounts for cultural differences in the experience and expression of distress;
- It assigns a central role to personal meaning, emerging out of social and cultural discourses and belief systems, material conditions and bodily potentialities;
- It assigns a central role to personal agency, or the ability to exercise influence within inevitable psychosocial, biological and material constraints;
- It acknowledges the centrality of the relational/social/political context in decisions about what counts as a ‘mental health’ need or crisis in any given situation;
- It provides an evidence base for drawing on general patterns of coping and survival responses to inform individual/family/group narratives;
- It offers alternative ways of fulfilling the service-related, administrative and research functions of diagnosis;
- It suggests alternative language uses, while arguing that there can be no one-to-one replacements for current diagnostic terms;
- It includes meanings and implications for action in a wider community/social policy/political context.

This broad framework can be used for the identification of patterns in emotional distress, which are comprised of the following interrelated aspects:

1. The operation of **POWER** (biological/embodied; coercive; legal; economic/material; ideological, both proximal and distal; social/cultural; and interpersonal, with impacts that are moderated by our available resources). This includes possible re-traumatisation by mental health services themselves.

2. The kinds of **THREAT** that the negative operation of power may pose to the individual, the group and the community, with particular reference to emotional distress, and the ways in which this is mediated by our biology.
3. The central role of **MEANING** (as produced within social and cultural discourses, and primed by evolved and acquired bodily responses) in shaping the operation, experience and expression of power, threat, and our responses to threat.
4. In response to all the above, the learned and evolved **THREAT RESPONSES** that an individual (or family, group or community) may need to draw upon in order to ensure emotional, physical, relational and social survival. These range from largely automatic biological reactions to linguistically-based or consciously selected responses such as holding suspicious thoughts, self-blame, shame, rage, self-harm and controlling our eating. The latter are likely to appear later in developmental terms, to be more open to shaping by local meanings, and hence to be more culture-specific.

There are fundamental differences between this and the more traditional biopsychosocial model of mental distress, in that there is no assumption of pathology. The ‘biological’ aspects are not privileged, but constitute one level of explanation, inextricably linked to all the others. Equally important, although a tripartite model is a convenient heuristic, the three elements are not independent, but evolve out of each other. The individual does not exist, and cannot be understood, separately from his/her relationships, community and culture; meaning only arises when social, cultural and biological elements combine; and biological capacities cannot be separated from the social and interpersonal environment. Within this, ‘meaning’ is intrinsic to the expression and experience of all forms of emotional distress, giving unique shape to the individual’s personal responses.

In summary, this framework for the origins and maintenance of distress replaces the question at the heart of medicalisation, ‘What is wrong with you?’ with four others:

- ‘What has happened to you?’ (How has **Power** operated in your life?)
- ‘How did it affect you?’ (What kind of **Threats** does this pose?)
- ‘What sense did you make of it?’ (What is the **Meaning** of these situations and experiences to you?)
- ‘What did you have to do to survive?’ (What kinds of **Threat Response** are you using?)

The Power Threat Meaning (PTM) Framework can be used for the provisional identification of evidence-based patterns which are highly probabilistic, with influences operating contingently and synergistically. Such patterns will always be culture and time bound, and thus to an extent local to time and place. However, this does not mean that no regularities exist. Rather, it implies that these regularities are not, as in medicine, fundamentally patterns in biology, but patterns of embodied, meaning-based threat responses to the negative operation of power.

The PTM Framework provides a new perspective on the dilemma about the application of Western psychiatric classification systems to non-Western cultures and expressions of distress, both within the UK and around the world, since it predicts and allows for the existence of widely varying cultural experiences and expressions of distress without positioning them as bizarre, primitive, less valid, or as exotic variations of the dominant diagnostic paradigm. Viewed as a meta-framework that is based on universal evolved

human capabilities and threat responses, the core principles of PTM apply across time and across cultures. Within this, open-ended lists of threat responses and functions allow for an indefinite number of locally and historically specific expressions of distress, all shaped by prevailing cultural meanings.

The PTM Framework can be used to identify broad, provisional, evidence-based **patterns of meaning-based threat responses to the negative operation of power**, which provide a context for the co-construction of individual narratives, as well as suggesting alternatives to diagnosis for clustering/administrative/legal/ service planning/research purposes. These patterns operate at various levels, starting with the 'Foundational Pattern in Mental Distress and other behavioural, health and social outcomes'.

An elaboration of the various types of power, threat, meaning and threat response sets the scene for the identification of seven Provisional General Patterns which emerge from within the Foundational Pattern.

These Provisional General Patterns fulfil one of the main aims of the PTM Framework, which is to restore the links between meaning-based threats and meaning-based threat responses. Restoring these links demonstrates that threat responses are most usefully considered not as discrete 'symptoms' or complaints, but in terms of the functions they serve. These strategies arise out of core human needs to be protected, valued, find a place in the social group, and so on, and represent people's attempts, conscious and otherwise, to survive the negative impacts of power by using the resources available to them. They cut across diagnoses, across specialties, and across the boundaries of what is usually considered 'normal' versus 'pathological.'

One purpose of the Provisional General Patterns is to inform the construction, or co-construction, of personal narratives. More specifically, the General Patterns are a basis for more effectively fulfilling some of the claimed functions of diagnosis, such as providing an explanation, having distress validated, facilitating contact with others in similar circumstances, relief from shame and guilt, suggesting a way forward, and conveying hope for recovery. They also provide an evidence-base for one particular kind of narrative, psychological formulation.

Chapter 7 reports on the views of the consultancy group of service users and carers who gave feedback on the framework as it developed.

Chapter 8 discusses the practical implications of adopting a non-medicalised, non-diagnostic approach to distress, unusual experiences and some kinds of troubled or troubling behaviour in the areas of service commissioning, design and delivery, therapeutic practice, research, legal practice, access to welfare and other benefits, and in relation to society as a whole in terms of social policy, equality and social justice. It also illustrates some of the ways in which non-diagnostic practice has already been successfully adopted.

This document therefore offers an in-depth understanding of the context, principles, research and practice from which the PTM Framework emerged. There is also a shorter publication, available in print as well as online formats (www.bps.org.uk/PTM-Overview) and entitled *The Power Threat Meaning Framework: Overview*. This version offers a brief summary of the principles and evidence from which the PTM Framework emerged, but

its main focus is on the PTM Framework itself and the General Patterns derived from it. It thus approximates to Chapter 6 of the longer publication. It also includes guidelines on how the PTM Framework might be used in service, peer support or self-help settings as well as 13 appendices which extensively illustrate some of the ways in which non-diagnostic practice has already been successfully adopted both within and beyond services.

Both this publication and the Overview are envisaged as the outcomes of the first stage of a larger ongoing project. Much further work will be needed in order to translate their principles into action. One of the primary aims of this work will be to produce or co-produce materials for diverse audiences including service users/survivors, carers, students and trainees, professionals, researchers, commissioners, policy makers and the general public.

The Overview publication is available from: www.bps.org.uk/PTM-Overview

Reference

Division of Clinical Psychology (2013). *Classification of behaviour and experience in relation to functional psychiatric diagnosis: Time for a paradigm shift*. Leicester: British Psychological Society.

Introduction

Background

In 2013, the British Psychological Society's Division of Clinical Psychology (DCP) issued a position statement entitled *Classification of behaviour and experience in relation to functional psychiatric diagnosis: Time for a paradigm shift*. The summary is:

The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and ICD, in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations. Consequently, there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a 'disease' model (DCP, 2013, p.1).

In the same year, the publication of the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM-5, 2013)* was accompanied by explicit admissions of fundamental difficulties in the diagnostic system. For example, Dr David Kupfer, Chair of the *DSM-5* task force, noted that: 'In the future, we hope to be able to identify disorders using biological and genetic markers that provide precise diagnoses that can be delivered with complete reliability and validity. Yet this promise, which we have anticipated since the 1970s, remains disappointingly distant. We've been telling patients for several decades that we are waiting for biomarkers. We're still waiting' (Kupfer, 2013). Former Chair of the US National Institute of Mental Health (NIMH) Dr Steven Hyman, described *DSM-5* as 'totally wrong, an absolute scientific nightmare' (Hyman, quoted in Belluck & Carey, 2013), while the then NIMH Chair Dr Thomas Insel declared that 'Patients deserve better...the weakness is [the *DSM*'s] lack of validity' and announced that NIMH would be 're-orienting its research away from *DSM* categories' (Insel, 2013).

Echoes of the controversy have also been felt in the UK. Paul Bebbington predicted that 'If it becomes apparent that the information obtained by testing disease theories is incoherent, we may eventually jettison particular disease constructs...The disease constructs in psychiatry may be approaching this point' (Bebbington, 2015, p.1119). The Critical Psychiatry Network (2013) asserted that 'The *DSM* is incapable of capturing the full range of experiences of distress in the way that narrative formulation can'. These criticisms came from within the psychiatric profession. Other concerns about *DSM-5* and about diagnosis more generally, focused on the widening scope of what is considered to be 'mental disorder' (Frances, 2013) and the role of financial interests (Cosgrove & Krimsky, 2012). Service users challenged the ethics of diagnosis (<http://www.mindfreedom.org/DSM9>) and the Hearing Voices Network England's position statement registered their '... serious concerns about the way we currently understand, categorise and respond to mental distress' (Hearing Voices Network, 2013). The DCP and the BPS have since published a number of documents aimed at opening up the debate about diagnosis and models of distress, including the widely-disseminated *Understanding Psychosis and Schizophrenia* (BPS, 2014.) A recent report from the United Nations Human Rights Council (2017) reinforced these concerns arguing that '...many of the concepts supporting the biomedical model

have failed to be confirmed by further research and that ‘(w)e have been sold a myth that the best solutions for addressing mental health challenges are medications and other biomedical interventions (pp.5–6). The report also argued that ‘the crisis in mental health should be managed not as a crisis of individual conditions but as a crisis of social obstacles which hinders individual rights’ (p.19).

There is, then, widespread concern that the difficulties facing diagnostic systems (including the psychiatric chapter of the World Health Organisation’s International Classification – the *ICD*) are of a nature which makes them unlikely to be resolved by continuing to follow the same approach. In recognition of this, and of long-standing critiques of diagnostic systems, recommendation 3 arising out of the DCP position paper is: ‘To support work, in conjunction with service users, on developing a multi-factorial and contextual approach, which incorporates social, psychological and biological factors’ (p.9). This document is the result of a DCP-funded project for work towards fulfilling this aim.

Aims of the project

There are, and have always been, alternatives to diagnosis on an individual, one-to-one basis, such as problem descriptions (e.g. hearing voices; self-harming; panic) or formulations. What we have so far lacked is a supporting conceptual framework which works at a broader clustering and pattern-identification level. Our aim was therefore to produce a foundational document which sets out the conceptual and empirical basis for such a framework and describes how it can serve as a conceptual alternative to psychiatric classification and diagnosis. The document suggests how this may be achieved by:

- Drawing on assumptions, theoretical frameworks and evidence that are appropriate to understanding the behaviour and experience of embodied persons within their social and relational environments, rather than the (mal)functioning of bodies.
- Based on the above, identifying broad, provisional, probabilistic and evidence-based patterns that offer an understanding of emotional distress and troubled or troubling behaviour from a non-diagnostic perspective.
- Demonstrating how these patterns can be used to support the construction of narratives of various kinds and at various levels, in both service and self-help settings.
- Illustrating the potential of this framework for more effectively fulfilling the other purposes that diagnosis claims to serve, including indicating interventions, making decisions about access to benefits and services, guiding service commissioning and design, making legal judgements, providing a basis for research, and informing social and public health policy.

It is important to emphasise that the framework is not tied to any specific theoretical orientation or set of practices, such as behavioural, cognitive, psychodynamic or systemic, since it draws from a whole range of theoretical positions. Instead, we offer it as a first step in opening up new ways of conceptualising emotional and behavioural difficulties, one that can both enrich existing models and suggest new perspectives. In the longer term we hope it will lead to additional projects and initiatives to develop it further and translate it into practice.

In the final chapter, we provide a discussion and overview of non-diagnostic practice, both as

it currently operates within the parameters of existing systems, and as it might operate in the future. None of the illustrative examples is presented as an ideal, complete or unproblematic solution. Rather, the overview reflects a recognition that we need to promote a whole range of ways of moving towards theory and practice that is not based on psychiatric diagnosis.

Scope of the document

The document mainly focuses on the field of what is sometimes called ‘functional psychiatric diagnoses’, i.e. groupings of thoughts, feelings and behaviours for which no organic cause has been identified. This is not to suggest that these problems never have organic components, or that the distinction between functional and organic is a fixed one. Survivors of childhood abuse and domestic violence, for example, may sustain neurological difficulties which can act as one of the maintaining factors for subsequent emotional or behavioural problems. More generally, brain injuries however acquired have psychological and emotional consequences and meanings along with physiological effects. Thus, our arguments are relevant to the psychological distress that may accompany medical, developmental or neurological conditions, whether as a result of coping with them or as the consequence of associated experiences of adversity. Similarly, there are implications for people with physical health conditions, since these are so often related to and accompanied by other adverse life experiences, as well as being distressing in their own right. We will also indicate ways our arguments may be relevant to problematic forms of behaviour such as those seen in the fields of addictions and criminal justice.

However, our arguments are not intended to apply to the direct effects of conditions like dementia, intellectual disabilities, neurological or neurodegenerative disorders and the consequences of stroke, brain injury, infections in older adults, and so on. We also exclude problems arising from the immediate effects of street drugs. We have not considered autism as a specific diagnosis, and instead refer readers to the excellent debates on this topic at the Exeter University ‘Exploring Diagnosis’ project (<http://blogs.exeter.ac.uk/exploringdiagnosis/>). We are also aware that physical health problems can sometimes present as, or be wrongly identified as, mental health conditions. The wide and not always recognised range of possibilities includes hormonal imbalances, vitamin deficiencies, viral infections, autoimmune diseases, and so on. These conditions need detection and appropriate medical treatment, and are not part of our argument.

We make these distinctions because we will be arguing throughout the document that there are important differences between forms of distress and troubling behaviour that are enabled and influenced by our biology – as all human experience is – as opposed to bodily and other problems where there is evidence for a primary causal role for biological disease processes or impairments in the major aspects of the difficulties. We would argue that this distinction is sufficiently valid to require different theoretical frameworks for each as well as to inform research programmes and practice. There will inevitably be grey areas which seem to fit neither conventional medical patterns nor the kind of framework being proposed here. These are a matter for further research but do not affect our arguments about the problems of psychiatric diagnosis and the need for alternatives.

There is a large and growing literature on the potentially damaging effects, both mental and physical, of psychiatric drugs of all kinds (see Chapter 8). Professionals should be very

aware of the possibility that these drugs may be causing or exacerbating emotional distress and physical disability. This too is beyond the scope of our argument, except in so far as adherence to the principles of the framework would be likely to lead to much reduced levels of prescribing.

The document acknowledges the intrinsic difficulty of devising a conceptual system that is applicable across ethnic groups and cultures. While we argue that some of the same general principles would still hold, we recognise that the experience, expression and understanding of distress and troubling behaviour vary widely across cultures and that it is very unlikely that there could ever be a 'global psychology' or 'global psychiatry'.

Terminology

We have followed the DCP *Guidelines on Language in Relation to Functional Diagnosis* (2015). However, there is no entirely satisfactory substitute for terms like 'mental illness' or 'mental health', not least because they carry so many implicit assumptions about the behaviours and experiences they refer to. This is partly because what are called mental health problems or mental disorders are usually first identified, by the person themselves (Thoits, 1985) or others around them (Coulter, 1973), as social rule transgressions and/or role 'failures' in everyday life. The decision about who is to be labelled as 'mentally ill' thus takes place within a network of social discourses and relationships, based on ordinary layperson judgements about what are considered to be 'reasonable' ways of thinking, feeling and behaving within a particular context. These judgements may then be officially sanctioned by applying a psychiatric label (Pilgrim & Tomasini, 2012).

The fact that roles and rules are context-bound means that it is hard to come up with satisfactory overarching descriptions of what is labelled 'psychiatric illness' or 'mental disorder'. Equally, the term 'distress' may not do justice to the degree of suffering, and does not capture personal and interpersonal complexity. Moreover, not everyone who is psychiatrically labelled is in a state of distress, although their actions and behaviour may be disturbing to others. This raises questions about who has the problem in any given situation; who is distressed and about what? Finally, some people see their unusual experiences as valuable and enriching rather than distressing, perhaps from a mystical or spiritual perspective.

For all these reasons, we have used a variety of general terms interchangeably, while acknowledging that each has its limitations. The *Language Guidelines* offer 'emotional distress, mental distress, severe mental distress, extreme state, psychological distress'. Our synonyms also include emotional/psychological distress, problems, emotional difficulties, and unusual experiences, as well as descriptive or semi-descriptive terms such as 'hearing voices' or 'very low mood'. We have also referred to 'troubling or troubled behaviour' to indicate some of the ways people may react to extreme distress. While it would be preferable to reserve the term 'psychosis' for the states of mind that result directly from medical, organic or drug-induced conditions (as in 'drug-induced psychosis'), we acknowledge that 'psychosis' is often used in the research we draw on, and more widely, to mean experiences outside of generally shared reality and which others often find difficult to understand; we will sometimes use the term in that way. All of this is in keeping with one service user's comment that rather than a 'new dogma' we need 'sensitive diversity in language' (Beresford et al., 2016, p.27).

Similarly, there is no perfect alternative to ‘patient’ for people who have received mental health interventions. We have mainly employed ‘service user’, but we acknowledge that this could imply voluntary use of services, which is not always the case. ‘Carers’ refers to the family members or friends who may be supporting them. We have used the term ‘service user/survivor’ when describing activists and campaigners. ‘Mental health systems/services’ is used to refer to the system as a whole, its theory and practices, and all the professions who work within it, in which diagnostic assumptions and practices are usually dominant. We have used ‘Psychology’ and ‘Psychiatry’ to refer to disciplines/professions, with lower case spelling for all other uses, for example, ‘the psychology of gender’ or ‘psychiatric research’.

Multiple perspectives on psychiatric diagnosis

We recognise that there is a range of service user perspectives on psychiatric diagnosis, and their views and experiences are central to the arguments and to the project. Some service users, offered an alternative way of conceptualising their difficulties, see it as a turning point in their recovery. Others report that diagnosis brought relief, and validation of their suffering (Johnstone, 2014). Themes associated with recovery have been summarised as connectedness (including support from others and feeling part of the community); hope and optimism about the future (including belief that recovery is possible); identity (including overcoming stigma); finding meaning in life (including the experience of ‘mental illness’); and empowerment (including taking personal responsibility, focusing on strengths, and taking control of one’s life) (Leamy et al., 2011). For some people, diagnosis is a step towards this. For others, it is the diagnosis itself that has created or compounded feelings of hopelessness, exclusion and disempowerment; they report that it was a profound assault on their identity, accompanied by overwhelming feelings of shame, fear, invalidation, damage and despair (Johnstone, 2014).

It is not surprising, then, that questioning the validity of diagnosis can arouse strong feelings. The arguments are sometimes heard as denying the reality of people’s distress and difficulties – a position we strongly reject – rather than as questioning certain ways of understanding and responding to them. Debates are also sometimes heard as an attribution of guilt or blame, an accusation of malingering or a requirement to ‘pull yourself together.’ We reject this equally strongly.

One clue to understanding these often very heated debates can be found in an analysis of social discourses and assumptions about what is referred to as ‘mental illness’. There is a lack of an alternative position between a medical one (you are a sick person and it is an illness) and a moral one (you are a bad person and it is your fault; Harper, 2013; Lafrance, 2009; Pitt et al., 2009). This has been characterised as the ‘brain or blame’ dichotomy (Boyle, 2013). In other words, ‘As a society, we seem to find it hard to find a middle ground between “You have a physical illness, and therefore your distress is real and no one is to blame for it” and “Your difficulties are imaginary and/or your or someone else’s fault, and you ought to pull yourself together”’ (Johnstone, 2014, p.2). Faced with this apparently stark choice, people may understandably opt for the one that confers a ‘sick role’ since, by definition, this includes the assumption that ‘you are not responsible for your condition and can’t help it’ (Parsons, 1951). In this way people may defend themselves against attributions of shame and guilt by self or others, but at the high price of taking on a devalued identity that positions them as flawed, inadequate or defective, as well

making them vulnerable to discrimination and social exclusion. Psychiatric diagnosis may therefore represent both ‘salvation and damnation’ (Leeming et al., 2009).

These unhelpful polarisations are often mirrored within mental health services. The ‘sick role’ or ‘not responsible’ messages that are conferred by a psychiatric diagnosis can quickly lead to frustration on the part of professionals who may see service users apparently waiting to be ‘made better’ without sufficient effort or motivation (Johnstone, 2000). This can lead to rapid switches between a Rescuing position (‘They’re ill and can’t help it’) and Persecuting (‘They are lazy and unmotivated’). In other words, ‘Simultaneously, the messages received by the patient include that they are helpless, out of control, unable to manage without being (forcibly if necessary) detained and drugged, while being asked to explain their behaviour, take responsibility for their actions and “get better”’ (Kennedy, 2008, p.42). Both staff and service users can become stuck in these conceptual contradictions.

Arguably this socially embedded polarised thinking, along with the conflation of description and evaluation and a limited view of causality, can serve the useful functions of ascribing undesirable behaviour (e.g. criminality) to individual responsibility; the consequences of social policy (e.g. unemployment) to a personal lack of effort; and the impact of social injustice to ‘illness.’ The person who is labelled is left struggling to protect their identity within these external forces. The rhetoric is all the more convincing because it fits with the individualistic messages of the mainly Western cultures where diagnostic models dominate. This is despite the fact that national (Read et al., 2013) and international (Lasalvia et al., 2015; Seeman et al., 2016) research confirms that ‘the notion that mental disorders are simply “brain diseases”...that exist as such in nature... is responsible for unwanted and destructive pessimism about recovery... (It) results in stigmatisation and rejection from the outside, and self-attribution and self-blame from the inside’ (Lasalvia et al., 2015, p.512).

Diagnosis also serves other purposes. In the words of one service user: ‘Those of us with mental health issues represent some of the most frightening aspects of being human. We literally embody things people fear at a profound level – unreason, challenge to social contract, highlighting issues people can’t tolerate such as the futility of living, familial abuse, vulnerability to violence and mortality. What better way to wipe away these fears than by locating them in a “broken” person rather than by acknowledging them as consistent, frightening features of society?’ (service user quoted in Beresford et al., 2016, p.19).

The philosophical position outlined in this document suggests a more sophisticated view of human beings and human emotional distress, within which we are active agents in our lives at the same time as facing many very real limits and barriers to the changes we can bring about. Those limitations may be material (money, food, transport) biological (physical disability) psychological (fear, anxiety, self-doubt) and/or social (gender expectations, isolation, discrimination.) More subtly but perhaps most damagingly, they may take the form of the meanings, beliefs, expectations, norms and values that we absorb, often unconsciously, from wider society.

Our framework offers a way of constructing a non-diagnostic, non-blaming, de-mystifying story about strength and survival, with the potential to re-integrate many behaviours and experiences which would currently be diagnosed as symptoms of mental disorder back into

the range of universal human experience. The overall message is: *'You are experiencing a normal reaction to abnormal circumstances. Anyone else who had been through the same events might well have ended up reacting in the same way. However, these survival strategies may no longer be needed or useful. With the right kind of support, you may be able to leave them behind.'* This position offers a way out of the conceptual trap by recognising and making sense of the very real struggles people have faced and continue to face, while also conveying the message that within some unavoidable limitations, they can be supported to reclaim a greater degree of responsibility and control over their lives.

In the short and medium term, psychiatric diagnoses will still be required for people to access services, benefits and so on. These rights must be protected. Equally, we all have a right to describe our experiences in the way that makes most sense to us. This right has not always been accorded to service users, who may be seen as 'lacking in insight' if they query their diagnosis. However, it is our hope that the framework offered here will, in the longer term, encourage and allow all of us to let go of diagnostic thinking.

Chapter 1: Problems of psychiatric diagnosis and the need for a different approach

Introduction

In Western countries, and increasingly around the world, mental and emotional distress and various forms of unusual or unintelligible behaviour, are routinely presented as if they were the same kind of phenomena as physical problems like cancer, measles or diabetes. It is this claimed similarity between bodies and behaviour, involving the application of the theories and practices of medicine to people's actions, thoughts and feelings, that is often referred to as the 'medical model' or 'medicalisation'. Medicalisation operates through medical language (e.g. symptoms, disorders, illness, treatment), through practice (e.g. diagnosis, hospitalisation, administration of drugs) and through research which tries to discover genetic and biological causes of 'mental disorders'.

Diagnosis is fundamental to this way of thinking about and responding to people's difficulties. The process is codified in the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)* and in the Mental and Behavioural Disorders chapter of the World Health Organisation's *Classification of Diseases and Related Health Problems (ICD)*. The *DSM* and the *ICD* chapter group what are said to be symptoms of mental disorder into discrete, named categories such as schizophrenia, major depressive disorder, attention deficit hyperactivity disorder, and so on. During the process of diagnosis, a person's thoughts, feelings, and behaviour are compared to these groupings so as to assign them to a particular category of 'mental disorder'. The first edition of the *DSM* was published in 1952 and the fifth in 2013. The most recent psychiatric section is included in the 10th revision of the *ICD* (1992; 1993, currently being revised).

In spite of the widespread acceptance and influence of medicalisation and psychiatric diagnosis, it would be difficult to find any professional enterprise of the 19th, 20th and 21st centuries which has been more subject to criticism and controversy. Many who have been given diagnoses have testified to the negative impact on their lives and identities. Critics have also focused on the low levels of agreement amongst clinicians making diagnoses (unreliability) and on the lack of validity or usefulness of diagnostic categories within their own conceptual terms, including their failure to produce successful research on the assumed biological causes of 'mental disorders' or to predict effective treatments, as well as the fact that they generate extensive 'comorbidity', so that people might fit several categories simultaneously (Bentall, 2003; Boyle, 2002a; Kirk et al., 2013; Moncrieff, 2008). And, as we saw in the Introduction, forthright criticism has come most recently from those directly involved in the development of diagnostic systems and *DSM-5* in particular, while the intractable dilemmas faced by the systems are discussed in a growing number of articles (e.g. Phillips et al., 2012a,b,c; *World Psychiatry*, 2016, Vol. 15(1)).

There have been many attempts to improve psychiatric diagnostic systems. A great deal of effort has been put into trying to make diagnostic judgements more reliable – to increase agreement amongst clinicians – and into making diagnostic categories more specific, often involving the creation of more and more subtypes. An apparently more radical suggestion

for change has recently come from the US National Institute of Mental Health's project on Research Domain Criteria (Insel, 2013; Insel et al., 2010, and see also Chapter 2). We will return to this project later following a detailed discussion of diagnosis but, briefly, a major problem with attempts at improvement is that they are just that: attempts to improve diagnostic systems, to deal with problems such as unreliability or comorbidity but without querying the systems' most basic assumptions. This is partly because the major belief underlying the *DSM* – that various kinds of mental distress and apparently unintelligible behaviour are symptoms of mental disorders, with a physical basis, just as bodily complaints may be symptoms of physical disease – is strongly held to the point where it may not be recognized as a belief but simply taken for granted as fact. Indeed the *DSM* presents itself as adopting a descriptive or atheoretical approach, as if its contents involved no underlying assumptions but were simply read off from nature. This is far from the case. We will be arguing in this document that what is needed is a completely different way of thinking about emotional distress and various forms of troubling and apparently unintelligible behaviour. Most of the document will be concerned with describing this way of thinking, the evidence which supports it and its implications for practice and service delivery.

In this first Chapter, however, we will look more closely at the problems of psychiatric diagnosis. There are several reasons for this. First, the *DSM*'s claim to be a descriptive, atheoretical approach can make it more difficult for us to understand the very close connection between the development of diagnostic systems – both medical and psychiatric – and particular theories or assumptions about people's bodies or behaviour. Second, psychiatric diagnosis gains much of its credibility from its apparent similarity to the more successful practice of medical diagnosis – both use medical language such as symptoms and syndromes, both talk about identifying disorders and finding out what is wrong with people and both involve assigning people to particular groupings or clusters. All of this can make it seem reasonable to carry on as before but simply try and improve things – provide more reliable and accurate descriptions of mental disorders, perhaps take more account of a person's cultural background in deciding whether to apply a particular diagnosis. This conservative approach is reinforced by the relative lack of discussion of how psychiatric diagnosis came to be in its current difficult situation, why previous attempts at revision have failed even in their own terms or of why diagnosis has proved so persistent in spite of the lack of evidence to support it.

To try and better understand why psychiatric diagnosis has been the subject of so much criticism and debate and why a new approach is needed, we will start by briefly describing what happens during *medical* diagnosis before discussing how this is different from psychiatric diagnosis, how these differences came about, why they matter and how they can inform the development of alternatives.

What is medical diagnosis?

The popular language of medical diagnosis – finding out what's wrong with someone, what disease or illness they're suffering from – can be misleading and tell us very little about what is going on when doctors make diagnoses. This language can also hide important differences between medical and psychiatric diagnosis. Medical diagnosis is instead perhaps best described as a process of pattern matching where doctors try to find a match between patterns of bodily problems already identified by researchers and the complaints

(symptoms) and other abnormalities shown by a particular patient. 'Patterns' in this sense means bodily characteristics which cluster above chance level, possibly because they are 'held together' by particular biological processes. It follows that the usefulness of diagnosis depends on the success of this earlier research work. If researchers suggested clusters which actually weren't meaningful patterns (as has happened in the history of medicine, for example 'wasting diseases' or 'general paresis') then clinicians might try to match their patients to them – 'make a diagnosis' – but nothing very useful could follow, for example understanding how the problem came about, might progress or how it should be treated.

Diagnosis happens semi-publicly, between doctors and patients; by contrast, the first part of the process, where researchers try to identify patterns in the huge array of bodily problems we can experience, has usually happened over long time periods and more privately, for example in laboratories, and been discussed in meetings among professionals or in specialist publications. This means that the importance of this research, how it relates to diagnosis, the rules governing it and the many difficulties involved, may not be widely understood or appreciated. Yet, as we will see, it is problems with this part of the process as it has been applied to people's thoughts, feelings and behaviour, which are responsible for many of the difficulties faced by psychiatric diagnosis. We will therefore look at how the process works in Medicine so as to clarify why it has been so problematic when applied in Psychiatry.

In trying to identify valid clusters or patterns – clusters that will be useful in understanding causes or treatments – a major question faced by medical researchers is: how can we know that an apparent cluster of bodily problems or characteristics is meaningful in the sense that it is not just chance co-occurrence or several patterns mixed together? Over several centuries, medical researchers have developed various rules and methods to address this problem. Two of the most important are, first, do not rely on symptoms (i.e. subjective complaints) to identify valid clusters. This is partly because symptoms – pain, nausea, tiredness, thirst etc. are subjective and will mean different things to different people. But they are also extremely common and have many causes. This means that symptoms do often cluster by chance, may mean very little or indicate several different patterns. Medical researchers have therefore emphasised the importance of linking apparent clusters of symptoms to other bodily characteristics or processes which can be observed or measured more objectively. These are known as signs and include levels of various blood chemicals, types of organ damage, particular cell structures, antibodies and so on. Not only can signs be measured more objectively, they also have fewer causes than symptoms, and so provide more guidance on where to look next. Crucially, there should be evidence that the sign came first – is an antecedent of the symptoms and is playing some causal role in them. It is these two characteristics – that the sign(s) can be measured objectively and that they seem to be implicated in causing the symptoms – which give researchers some confidence that they have identified a meaningful pattern and not just a chance co-occurrence of symptoms.

The second rule in trying to identify meaningful patterns is to be guided by evidence-based theory. This not only helps researchers know where in the body to look in identifying patterns but also, once patterns are proposed, provides a justification, i.e. the cluster makes theoretical sense and therefore allows us to have more confidence in its validity. One of the reasons why modern researchers may identify patterns more quickly than, say, a century

ago, for example, as in Legionnaires Disease and AIDS, is because they have far more access to evidence-based theories of body functioning.

When researchers have identified what they think is a basic pattern, their aim is to find yet another bodily process or characteristic associated with it in a backward causal chain so as to better understand how signs and symptoms come about. A good example was the discoveries that symptoms including strong thirst and tiredness could be associated with glucose in the urine and that this cluster could be associated with abnormalities in insulin production. Researchers tend to denote these patterns by abstract names, for example, diabetes or cystic fibrosis, and sometimes by the name of the person who first described the cluster, for example, Cushing's syndrome.

Using these and other rules, and especially since the late 19th century, medical researchers have been very successful at identifying what seem to be meaningful clusters of bodily problems. Some clusters, of course, are more complex and elaborated than others. Some may be abandoned completely, for example, 'wasting diseases' or encompass what is later shown to be two or more patterns, for example, 'diabetes mellitus' and 'diabetes insipidus'. The idea of backward causal chains, though often very useful, may also be inadequate where there are complex interacting processes. All clusters, however, are provisional, and developments in theory and technology over the next decades are likely to result in new clusters being proposed and existing ones rearranged or abandoned although this does not detract from the fact that many existing medical clusters may have very good evidence for their validity. But this constant process of change can be hidden not just because unsuccessful clusters may be remembered only by historians, but because everyday language tends to reify the abstract names given to the clusters (or, more correctly, the concepts inferred from them), that is, we talk as if these abstract names were descriptions of things, for example 'He *has* cystic fibrosis'. This can give diagnostic concepts – both medical and psychiatric – an impression of solidity and permanence quite inappropriate to their abstract status. This is another factor which can make it difficult to see psychiatric concepts – which have borrowed these linguistic habits – as dependent on particular ways of thinking and not descriptions of things that are actually present in nature.

How does this process of pattern identification relate to medical diagnosis? When researchers have described what they think is a meaningful pattern of bodily characteristics, then the elements of this pattern become the diagnostic criteria and 'the diagnosis' given to the patient is the (abstract) name which denotes the pattern, for example, rheumatoid arthritis or multiple sclerosis. Diagnostic criteria change over time as researchers successfully move backwards along the causal chain from, or otherwise elaborate their initial pattern. For example, 'Down's Syndrome' used to be diagnosed by developmental delay and certain visible physical features but is now diagnosed by chromosomal abnormalities, hence the change to the diagnostic term 'trisomy 21'. How much people can be told about their problems will depend on how far researchers have moved along the backward causal chain and how much they understand the biological processes involved, including how they might be changed or 'treated'. Medical diagnosis, then, is not so much about 'discovering what disease someone is suffering from' or 'what illness they have' as it is about trying to understand how their initial problems (symptoms) have come about. As we've seen, this is done by trying to match a patient's complaints or symptoms and what gradually becomes known about them through history taking and

investigations, with a pattern of causal relationships previously described by researchers. Of course, different patterns contain different amounts of causal information. For some it is quite a lot, for example those patterns denoted by ‘diabetes mellitus’ or ‘tuberculosis’, for others, little or none, for example, ‘essential hypertension’ or ‘irritable bowel syndrome’. But even matches to very restricted patterns like these can convey important negative information such as ‘Your signs and symptoms don’t match the patterns for kidney failure or colon cancer’. Medical diagnosis, then, is far from a process of ‘reading off’ from bodily complaints to specific diseases. Although sometimes straightforward, it can involve speculation, dead ends, mistakes and uncertainty but always based on trying to match people’s subjective complaints and bodily signs with previously identified patterns, in the hope of answering the questions ‘How have this person’s complaints come about?’ and ‘What can be done about them?’

We can see that the research which tries to describe patterns of bodily problems, and the process of diagnosis are completely interdependent. Researchers provide the templates or patterns to which clinicians match their patients, while diagnosed patients can become participants in research designed to elaborate researchers’ patterns. The overall aim of research and diagnosis is to identify meaningful similarities and differences between people with bodily problems. Meaningful in this sense refers to the usefulness of particular groupings and separations in helping researchers find out more about particular problems, especially how they have come about and how they might be treated and prevented.

How does diagnosis relate to classification?

Diagnostic categories refer to (assumed) meaningful clusters of bodily or psychological/behavioural problems. Classification systems refer to groupings of these clusters into higher-order clusters with (assumed) important shared features – ‘important’ in this context includes the assumption that these shared features may denote other, as yet unknown, factors which may increase our understanding of these problems. The medical *ICD*’s higher-order groupings include, ‘Endocrine, nutritional and metabolic diseases’, ‘Certain conditions originating in the perinatal period’ and ‘External causes of morbidity and mortality’. This is not an advanced classification system and the groupings, which are based on many different criteria, are very provisional. Many of the ‘sub patterns’ denoted by individual diagnostic categories, however, may have good claims to validity. The *DSM* and the psychiatric chapter of the *ICD* have followed the medical practice of grouping diagnostic clusters into higher-order categories, including ‘Depressive disorders’, ‘Disruptive, impulse – control and conduct disorders’ and ‘Personality disorders’.

How is psychiatric diagnosis different from medical diagnosis?

The most obvious difference between psychiatric and medical diagnosis is that while medical diagnosis focuses on bodily problems, psychiatric diagnosis focuses on people’s beliefs, thoughts, feelings and actions. A second difference is that, with a few exceptions which overlap with neurology, such as some dementias, or severe or moderate learning disabilities, psychiatric diagnosis is based entirely on what in medicine would be called symptoms, i.e. subjective complaints made by the person themselves or others, such as low mood, feeling anxious or expressing very unusual beliefs. This is because, in contrast

with medical researchers, psychiatric researchers have not been able to identify any 'signs' – objective bodily characteristics which are reliably associated with these subjective complaints and which might reasonably be thought to be causing them. As a result, and in spite of being presented as similar to medical diagnosis, the diagnostic criteria in the *DSM* and in the psychiatric chapter of the *ICD*, do not refer to the kind of meaningful clusters of signs and symptoms identified by medical researchers. A major and related difference is that the medical chapters of the *ICD* do not include any diagnostic criteria because it is not intended as a diagnostic manual; it is assumed that clinicians are familiar with these criteria from their medical education and research knowledge. It was the lack of this shared research knowledge in relation to psychiatric diagnosis, and the resulting diagnostic disarray, which led to the development of 'official' committee generated diagnostic criteria first used in *DSM-III* in 1980 and now also a feature of the psychiatric chapter of the *ICD*. Inevitably, then, these criteria are lists of subjective complaints about behaviour and feelings, devised by committees using processes very different from those used by medical researchers (Boyle, 2002a). This means that these lists are very unlikely to represent valid patterns. It also means that the matching task which results in a psychiatric diagnosis is unlikely to be meaningful or useful.

A further difference between medical and psychiatric diagnosis is that because psychiatric diagnosis is based on complaints about what people think, feel and do, clinicians have to rely almost entirely on subjective judgements and social norms both in devising diagnostic criteria and in trying to match people's feelings and behaviour to them. For example, assessments of criteria such as 'excessive guilt', 'irritable mood', 'deficient sexual fantasies', 'inappropriate affect', 'unusual perceptual experiences' or 'marked impairment in role functioning' are not only very subjective, they also depend on social judgements about how people ought to feel or behave in certain circumstances. In fact, nearly every *DSM/ICD* criterion is ultimately based on this kind of subjective judgement.

This is not to say that subjective or social judgements never happen in medicine. Research data do not speak for themselves but are given voice and purpose by others (Kirk & Kutchins, 1992). Bodily malfunctions do not come labelled as 'cancer' or 'pneumonia' with instructions for their use – these are abstract terms developed by medical researchers. Terms such as disease and sickness are also subject to social judgement as are decisions about whether and when to intervene (Kennedy, 1983; Rosenberg, 2002; Treasure, 2016). But there is a great difference between a diagnostic system with social elements but also much that can be independently validated, and a system of functional diagnoses more or less entirely based on subjective social judgements.

Emphasising its reliance on social judgement, the *DSM* requires that people's feelings or actions should not be counted as symptoms of a mental disorder if they are normal, expected and culturally sanctioned responses to a particular event, hence the frequent use in manuals of terms such as usual, appropriate or excessive. In other words, to count as a symptom, what people feel or do should not be intelligible or understandable in their particular personal, social and cultural context; their feelings or behaviour might instead be described by those around them as extreme, irrational or bizarre. It is this claimed lack of intelligibility which is said to justify treating these feelings or behaviour as qualitatively different from 'normal' actions or feelings and to justify applying a medical framework. But what is seen as appropriate, excessive, culturally sanctioned or understandable varies

with time and place and may tell us more about people's limited knowledge, imagination or empathy than about the causes of feelings and behaviour. Lack of intelligibility certainly cannot be taken to indicate that someone's behaviour is symptomatic of a medical-like disorder. For example, for much of the 19th and 20th centuries, Western married women, especially middle-class women, were expected to be psychologically fulfilled by home, husband and children. The extreme misery of a woman with a 'good' husband, well-behaved children and nice home was therefore not readily understandable and many such women were diagnosed as mentally ill. Of course, many of these women knew that the problem lay in their enforced domesticity, which raises the question of whose culture is sanctioned in the *DSM* and highlights the role of power in the application of diagnostic criteria. More recently, strong evidence has emerged that even the most extreme kinds of distress, often labelled as 'psychosis', can be seen as intelligible responses to very adverse life experiences. We will return to these important issues later in the document.

How have the differences between medical and psychiatric diagnosis come about?

As described above, two major differences between medical and psychiatric diagnosis whose origins need explaining are, first, the difference in subject matter – bodily problems versus thoughts, feelings and behaviour – and, second, the fact that psychiatric diagnosis is based more or less entirely on subjective judgements of people's complaints about themselves or others, the equivalent, in medicine, of symptoms, rather than on more objectively observable signs. These two differences make a third difference – an extensive reliance in psychiatric diagnoses on social norms – inevitable.

Another way of putting the question of how these differences have arisen is to focus on the second difference and to ask why, in spite of more than a century of effort by psychiatric researchers, they have been unable to move beyond the level of subjective complaints, why only medical researchers have been able to describe patterns which include more objectively observable or measurable bodily signs which help explain how the symptoms came about. A major part of the answer lies in the theories which have guided the search. Both groups have used theoretical frameworks developed for studying bodies although only one of the groups was actually trying to explain bodily problems. The widespread adoption, from the late 19th century, of a medical approach to certain feelings, thoughts and behaviour – the idea that they were symptomatic of a disease process – is often seen as representing scientific progress but there is no evidence to support this. Instead, there is a great deal of evidence that the use of a medical approach was highly controversial and came about for a variety of social, political, economic, theological and professional reasons (Boyle, 2002a; Scull, 1979). The lack of evidence was partly obscured by the optimism engendered by medicine's rapid progress in the late 19th and early 20th centuries, when it was wrongly assumed that similar progress in understanding 'abnormal' mental states and behaviour would soon follow if a similar theoretical framework was applied. Because of all this, the medical approach to problematic feelings and behaviour has always been insecure. This is perhaps not surprising. Our body parts, after all, don't have language, make relationships, reminisce about the past or plan the future. Nor do they create symbols, stories or social hierarchies, feel love, hate, loneliness or despair. They do not attribute meaning to their experiences, influenced by a culture they themselves have created. It

seems unlikely, then, that people's thoughts, feelings and actions, even when distressing, troubling and very difficult to understand, will show the same kinds of patterns or follow the same 'rules' as malfunctioning body parts.

This lack of fit between what psychiatric researchers were trying to make sense of and the theoretical frameworks they used inevitably created many problems for psychiatric diagnosis. Researchers were unable to identify patterns analogous to medical patterns of symptoms, signs and bodily pathology which could act as valid templates for psychiatric diagnosis. But the belief persisted that discrete mental disorders must exist and that they followed the same rules as medical disorders. The result was a difficult situation where 'disorders' were named in advance of the evidence, different researchers proposed different patterns for supposedly the same disorder, or similar patterns for supposedly different disorders, and clinicians chose which disorders and which diagnostic criteria to favour according to their personal preferences. The criteria varied in different parts of the country and across countries. The inevitable result, by the 1970s, was what has been called a crisis of legitimacy for psychiatric diagnosis.

One response to the crisis could have been to adopt theoretical frameworks more suited to understanding people's actions, thoughts and feelings and to accept that the kinds of patterns likely to be found amongst these would be very different from the type of patterns found in bodily problems. Instead, the medical framework and a belief in the 'existence' of certain mental disorders was retained and panels appointed to agree a single set of diagnostic criteria – i.e. a single 'pattern' – for each 'disorder' as a way of stemming what threatened to be diagnostic chaos. The result was *DSM-III*, published in 1980. Inevitably, given researchers' failure to delineate medical-type patterns, the *DSM* panels could not go beyond the level of people's complaints or 'symptoms' and had no way of knowing whether the clusters they suggested as diagnostic templates or the disorders they were said to indicate, were actually valid (Boyle, 1999, 2002a). This problematic situation has not changed with the publication of the fourth and fifth editions of the *DSM* and, indeed, has been compounded by concerns that each new edition should be not too different from the last for fear of compromising 'clinical utility' or 'user-friendliness', a concern difficult to reconcile with attention to evidence (Bentall, 2003; Boyle, 2002a; Frances, 2014; Greenberg, 2013; Kirk et al., 2013). Essentially, rather than being developed and validated through a scientific process of pattern identification, informed by appropriate evidence-based theory, psychiatric 'disorders' and the criteria used to diagnose them, are voted into existence by committees, informed by theories which lack empirical support.

What happens when psychiatric diagnoses are applied?

Reliance on subjective social judgements means that psychiatric diagnoses have faced serious problems of reliability – agreement between people diagnosing the same person – which seem to have worsened or at least not improved in *DSM-5* (Clarke et al., 2013; Kirk, et al., 2013; Narrow et al., 2013; Regier et al., 2013). There is no objective way of resolving these disagreements. This does not mean that entirely 'objective' understandings of human distress are possible; as we will see in later chapters, this is unlikely. But psychiatric diagnosis creates an impression of objectivity, for example through analogies with medical categories which do involve more objective judgements, or through the use of numerical

criteria such as ‘six months of symptoms’ or ‘three or more of the following symptoms’; an impression of objectivity is also created by the presentation of diagnosis as a process where experts identify discrete disorders that exist separately from the person (‘mental disorders that people have’) and whose identification does not require the agreement of the person being diagnosed. As well as this, reliance on an inappropriate theoretical framework and on committees to decide whether a disorder ‘exists’ and what cluster of complaints justifies it, has led to even more serious problems of validity or usefulness. For example, people given the same diagnosis may have little or nothing in common while people given different diagnoses may share many characteristics with no indication of whether these similarities and differences are meaningful, for example that they are based on similarities and differences in underlying biological processes. It is not surprising, then, that people given one diagnosis also often meet the criteria for at least one other, known as comorbidity. This ‘comorbidity’ can be extensive, to the point where the large majority of people given a diagnosis of general anxiety disorder will also meet the criteria for a ‘mood disorder’ (Brown & Barlow, 2009) and where people may at various times be given several different diagnoses (BPS, 2010). Again, this does not imply that human distress should be expected to fall into discrete, nonoverlapping clusters. But within the theoretical framework on which psychiatric diagnosis is based, this kind of extensive ‘comorbidity’ suggests serious problems. It is also not surprising that statistical studies which apply various clustering techniques to the problems people present to psychiatric services, have found that the resulting clusters do not match *DSM* categories. In other words, people’s own reports of their problems do not follow the kinds of ‘patterns’ set out in the *DSM*. And, as we will discuss in Chapter 5 on biology, decades of research have failed to find reliable associations between the *DSM*’s clusters and any biological abnormality which would qualify as a ‘sign’; there is also little evidence that *DSM* diagnoses predict which treatments will work in spite of the use of disorder-specific names such as antidepressants, antipsychotics, mood stabilisers or anxiolytics (Bentall, 2003, 2010; Deacon, 2013; Kirk et al., 2013; Moncrieff, 2008). In other words, diagnostic categories have failed to fulfil three of their major purposes: to create groups who share important characteristics, to increase our understanding of the causes and outcomes of particular problems and to inform decisions about effective interventions. It follows that receiving a psychiatric diagnosis does not help someone understand how their problems might have come about or how they might best be helped, although it is often presented as if it does do this, for example through the naming of drugs as if they were disorder-specific or using a diagnosis to explain feelings or behaviour (‘You feel like this because you are suffering from depression’).

However, the implications go further. Although, as we saw in the Introduction, some people may welcome a diagnosis and find it helpful, there is much evidence and service user testimony that medicalisation and diagnosis can have serious negative consequences especially for those who experience distress but also for those who are disturbed by others’ unusual behaviour, and for society as a whole. Some of the main problems are outlined below.

What are the consequences of medicalisation and diagnoses?

- Once diagnostic categories are in place, there is a strong tendency to ‘diagnostic bracket creep’ where thresholds for inclusion are lowered and ‘new’ behaviours or feelings are described as symptoms, meaning that many more people may fit a

diagnostic category as, for example, in child and adult ‘attention deficit hyperactivity disorder’ and ‘childhood bipolar disorder’ (Frances, 2014). There is no evidence that this process follows any recognised scientific procedure.

- Using diagnostic categories is potentially wasteful of research time and money. Searching for the causes of, for example, ‘schizophrenia’ or ‘bipolar disorder’ is unlikely to be successful without evidence that these are valid categories. Moreover, persisting with a theoretical framework with a very weak evidence base has greatly hampered programmes of primary prevention whose effectiveness often depends on well-evidenced theories of how problems are caused.
- Research priorities, funding, evaluation and media reporting are often biased in favour of reductionist biological and genetic research in spite of the fact that this research has failed to produce well-replicated evidence on causes or inform constructive developments in intervention (Bentall & Varese, 2012; Read et al., 2009). This bias reinforces the lack of visibility of more productive research on social and psychological causes and interventions, where the evidence is much stronger and the potential for change greater. The biological bias also hinders our understanding of the subtle, complex and reciprocal ways the social, psychological and biological interact in producing and maintaining distress.
- By presenting emotional and behavioural problems as symptoms of mental disorder, by locating problems primarily in people’s brains and bodies, medicalisation and diagnosis help obscure the well-evidenced causal role of social and interpersonal factors in distress and make it much more difficult to understand people’s problems in the context of their lives and relationships. It can also make it easier to minimise or ignore the harmful psychological impact of social and economic policy. All of this creates particular problems for those living in oppressive circumstances.
- Psychiatric diagnosis inevitably involves subjective social judgements, influenced by dominant cultural norms and values – in this case often those held by higher class white Western men – about how people ought to think, feel and behave. Presenting these as objective, or at least authoritative, quasi-medical categories is problematic for everyone, but it can make diagnosis especially discriminatory and damaging for those from subordinated or minority cultures, who have least say in the creation of dominant social norms, for example, women, people from minority ethnic groups, children and people of low socio-economic status.
- Medicalisation privileges drugs as the default mode of treatment for most people in psychiatric services and diagnosis can set the scene for their misuse and overuse. Used carefully, drugs may bring some relief for their tranquilising, sedative or stimulant properties but there is no evidence that they are ‘treatments’ for particular ‘disorders’ or that they target an underlying biological process responsible for the person’s problems. They may also carry serious health risks unlikely to be as widely accepted in the treatment of physical problems (Horwood, 2016). People may also not be given adequate information about the physical and psychological costs and benefits of drugs or offered alternative forms of treatment (Moncrieff, 2008, 2013, and see Chapter 8). This includes the risk that drugs may, over the longterm, increase rather than reduce distress and disability (Whitaker, 2010).
- There is no evidence that campaigns based on the ‘mental illness is an illness like any other’ model reduce stigma and discrimination against people given psychiatric

diagnoses. On the contrary, this model and campaigns based on it appear actually to increase stigma and discrimination by inadvertently supporting stereotypes of difference, unpredictability and dangerousness (Angermeyer et al., 2011; Kvaale et al., 2013; Read et al., 2006). Medicalisation can also mystify the nature and causes of problems, potentially increasing fear both for the person themselves and those around them.

- Perhaps most importantly, psychiatric diagnoses change what people feel and do into something they have (e.g. ‘schizophrenia’) or are (e.g. a damaged or defective kind of personality.) Diagnosis can also remove meaning and intelligibility from thoughts, feelings and actions, and create an identity which can be very difficult to resist or change. Receiving a diagnosis may be the first step in the creation of a ‘psychiatric career’ and the reported positive aspects of receiving a diagnosis are often outweighed by a sense of stigma, shame, fear, invalidation, damage, hopelessness, exclusion, and disempowerment.

We will return to many of these issues later in the document.

Why do medicalisation and psychiatric diagnosis persist?

In spite of their weak theoretical and empirical basis, and their negative consequences, medicalisation and diagnosis persist and remain the basis of most psychiatric services. There are many reasons why this has happened – cultural, social, psychological, economic and professional. We noted some of these earlier, but they, and others, are worth summarising here:

- Psychiatric diagnosis often seems to provide an explanation for people’s problems. This is partly because of a cultural confusion between naming and explaining where we assume that simply labelling phenomena gives us more information than it actually does; this is especially likely when technical or Latin or Greek terms are used. And psychiatric diagnoses are often explicitly used as explanations. But the impression of explanation is false and the reasoning behind it is illogical. People may be told they have schizophrenia on the basis of their unusual thoughts, feelings and behaviour but if they then ask why they are having these unusual experiences, they are told that it is because they have schizophrenia. This circular argument results from diagnoses being based on the same subjective complaints they then try to explain. This kind of circularity can happen in medicine, for example, ‘the redness of your skin is caused by dermatitis’ but it is avoided in the many diagnostic categories involving signs, when some kind of explanation can be given: ‘You feel thirsty most of the time because your body is trying to excrete excessive sugar which results from a lack of insulin’.
- Diagnosis can seem to legitimise someone’s distress, make it appear ‘real’ by giving it a name, and provide hope that something can be done. Being given a diagnosis can also protect people from negative identities such as ‘weak willed’ or ‘malingerer’. Diagnosis and a biological ‘explanation’ can also seem to remove blame or responsibility from everyone involved. As we noted in the Introduction, this is very important in a society where mad or bad, brain or blame dichotomies are very powerful or where parents or people themselves might otherwise be held responsible for their children’s or their own difficulties.

- The *DSM's* false claim that its approach is descriptive or atheoretical, combined with our tendency to reify diagnostic concepts, can lead to responses such as 'You are denying that people hear voices' or 'You are ignoring people's suffering', when psychiatric diagnosis is criticised. This results from a confusion between descriptions of people's difficulties (he hears abusive voices) and the inferences we make from them (he is suffering from a brain disease called schizophrenia). In other words, what we are questioning is the way these experiences are conceptualised, the assumptions that are made about them, rather than the experiences themselves or the reality of people's suffering.
- We underestimate the difficulty of describing patterns in people's behavioural or bodily problems and often 'see' associations which are not there (known as the illusory correlation). This is why medical researchers have developed the kind of rules we discussed earlier to try to ensure that the bodily patterns they describe are 'real' and not illusory. The combination of limited public understanding of diagnostic procedures and overconfidence in judgements of patterns, can confer credibility on psychiatric categories which is not justified by the evidence. This process is encouraged by a strong belief, at least in Western societies, about the kinds of patterns we can expect to find amongst the many forms of distress and troubling behaviour, i.e. clusters of behaviours and psychological characteristics, held together by biological or psychological 'defects' or 'dysfunctions'.
- The existence of particular categories can influence how people's experiences are interpreted and how they express their distress. Aided by the illusory correlation, diagnostic categories can then become self-fulfilling prophecies, conferring further credibility as growing numbers of people seem to match them. And, especially if people do not have access to non-medical, non-blaming explanations, the process can become self-perpetuating as people increasingly request confirmation of self-diagnoses of 'bipolar disorder' or 'ADHD' and so on.
- Medicalisation and diagnosis have developed a strong narrative of progress, couched in a discourse of faith and optimism, disseminated through the media and professional literature, which often misrepresents evidence and gives the false impression of imminent breakthroughs in genetic and biological understanding of 'mental disorders'. Medicalisation and diagnosis also use the specialised language of science and medicine which confers credibility and makes it difficult for people to question or criticise (Boyle, 2002a; Deacon, 2013; James, 2015). The fact that Western society is highly individualised can also make it seem natural to turn to a medical and biological discourse which locates explanations for problematic feelings or behaviour in the individual's brain or mind. All of this creates powerful obstacles to understanding the problems these explanations present.
- There is an increasingly interdependent relationship between the devisers and supporters of diagnostic concepts, and pharmaceutical companies in that diagnoses seem more plausible if there seems to be a specific drug to treat 'a disorder', while drug marketing is strengthened if there appears to be a specific disorder that a drug can target. Almost 70 per cent of *DSM-5's* Task Force members had financial links to drug companies. One effect of this is to create a shared worldview of the importance of drug treatments and of the categories of 'disorder' which justify them (Cosgrove & Wheeler, 2013). The continuing failure to identify biological markers which might

validate diagnostic categories also means that drug companies now play a crucial role in providing apparent scientific legitimacy to medicalisation and diagnosis. They do this, for example, through dissemination of un-evidenced chemical imbalance theories in advertising to professionals and the public and through the renaming of non-specific drugs as ‘disease-specifics’, for example, ‘antipsychotics’ and ‘antidepressants’ (Kirk et al., 2013; Lynch, 2015; Moncrieff, 2008).

- Professionals are quickly socialised into particular ways of thinking which may be very difficult to change, especially if they have limited exposure to alternatives or if change involves loss of professional credibility or status (Ross & Pam, 1995; Whitaker, 2010).
- Diagnostic thinking is deeply embedded in administrative systems for services and in society as a whole, for example, in record-keeping, service planning, outcome measures, reimbursement and welfare systems, and the legal system. This can create the impression that diagnostic categories are necessary for these systems to function.
- People diagnosed with mental disorders who disagree with professional accounts of their problems may be labelled as lacking in insight because they have a mental disorder. It can therefore be difficult for them to challenge or change dominant theories.
- Medicalisation and diagnosis can create an impression of providing humane and scientific answers to complex social and moral questions which may be difficult for society to face – who should qualify for help? What should we do about people whose behaviour we find troubling? Should people be ‘treated’ or detained without their consent? What is the real impact of inequality, unemployment, violence, discrimination and abuse on people’s lives? These issues may then be removed from public debate and their social, political and ethical elements hidden. Equally, there may be strong resistance to bringing them to the fore.
- As we will discuss further in the next chapter, medicalisation itself arises out of very deeply embedded philosophical traditions and beliefs which pervade every aspect of our lives in modern Western societies, with consequences that are often helpful but can also be limiting. Thus, in offering a fundamentally different framework, we need to identify and interrogate ways of thinking that may be largely unquestioned – indeed, may not even be recognised as assumptions rather than unquestioned realities or truths. Without a different set of conceptual tools, we will be unable to bring about the shift of perspective that is necessary. But even with them, the perpetuating factors summarised above are likely to ensure that alternatives will face active misrepresentation and invalidation.

What are the implications for alternatives to medicalisation and diagnosis?

We have argued that two major aims of medical and psychiatric diagnosis are to use research-based patterns to help understand how someone’s presenting problems have come about and to use the groups created by diagnosis to carry out further research, to elaborate these patterns and add to our understanding of people’s problems, especially of their causes and alleviation. Of course, this research may result in major adjustments to some patterns or abandoning them. All of this should be guided by empirically supported theory.

We have also argued that, in contrast to medical diagnosis, functional psychiatric diagnosis – based on judgements of behaviour and psychological experience – has failed to meet these two aims. It does not help us understand how someone’s troubling or troublesome thoughts, feelings or behaviour have come about, because the ‘patterns’ these diagnoses are based on contain no information apart from a list of those problems. And, because the large majority of diagnostic categories are not based on research-derived patterns, they have struggled to increase our understanding of causes and helpful interventions.

Most importantly, we have argued that it is the adoption of an inappropriate theoretical framework, designed for understanding bodies and not persons, which is largely responsible for the problems which have beset psychiatric diagnosis and the *DSM* since their beginnings, including a lack of fit between *DSM* categories and people’s actual problems and a failure to discover biological causes of ‘mental disorders’. Another effect of the *DSM*’s medicalised framework has been to marginalise the very large amount of research showing close links between social and personal adversity and mental distress. But above all, the *DSM* removes meaning and intelligibility from an increasingly wide range of human thoughts, feelings and actions, by treating them as ‘symptoms’ often fundamentally explicable in terms of genes and biology, using the theoretical frameworks of medicine. Yet as we have seen, there is no reliable evidence to justify this approach – as the *DSM* itself admits. Instead, there is abundant evidence – presented later in this document – that actions, thoughts and feelings said to be symptoms of ‘mental disorder’, including those said to be symptoms of ‘schizophrenia’ and other ‘psychoses’, are intelligible in terms of people’s contexts and life experiences. And, if we want to understand people’s problems and offer effective help then it is vital to take account of this relationship.

It follows from all of this that alternatives to psychiatric diagnosis and the *DSM* must go much further than suggesting a different set of diagnostic categories or different clusters of ‘symptoms’ for, say, ‘bipolar disorder’ or ‘schizophrenia’ and so on. Nor can they consist simply of a manual from which categories of problem can be ‘read off’. But alternatives will share the (unfulfilled) aims of psychiatric diagnosis – to use research-based patterns, which, as in medicine, will be more or less robust, to try and understand how someone’s problems have come about and might best be helped, and to elaborate these patterns using evidence-based theory. These alternatives, however, will involve a fundamentally and irreconcilably different way of thinking from that adopted by the *DSM*, a way of thinking which sees people’s distress and (apparently) unintelligible actions not as symptomatic of ‘mental disorder’ but, unless there is good evidence to the contrary, as meaningful responses to their life experiences. This is not the same as saying that life events may trigger a ‘mental illness’ in a predisposed person. It is to say that people’s responses to situations or events are inseparable from the meanings these situations have for them and that these meanings are shaped by, for example, culture, gender, age, ethnicity, and past experience. It is also to say that what are seen as symptoms of ‘mental disorder’ are often purposeful and functional strategies for reducing or managing distress, maintaining relationships or for simply surviving adversity. There are many reasons why someone’s emotions and actions may seem unintelligible or meaningless, including that they are expressing distress indirectly, perhaps symbolically or metaphorically, as, for example, when a woman who has been sexually abused as a child

reports that her body is being invaded by aliens; or it may be because we do not know enough about what has happened to them, for example, a history of loss and rejection, or because we are part of a culture which does not always acknowledge the potentially damaging effects of everyday cultural practices such as women's traditional family role or a strong focus on academic attainment.

This fundamental shift in thinking has four further features. First, we assume, unless there is strong evidence against, that so-called abnormal behaviour and experience exist on a continuum with 'normal' behaviour and are subject to similar 'rules' of understanding and interpretation. And, even if extreme circumstances produce qualitatively different responses, there is no reason to suppose that this justifies a switch to a medical framework. Second, we recognize that people's distress, unusual experiences, and at times, seemingly unintelligible actions, will show patterns that might helpfully be labelled. But these will not be clusters of 'symptoms' of discrete 'mental disorders'; they are much more likely to be patterns of relationships amongst descriptions (e.g. hears hostile voices) and social contexts, life experiences, biological processes and personal meanings, patterns likely to look very different from those in the *DSM*. Third, we will adopt a view of causality and influence more suited to persons-in-context than that embodied in the *DSM*'s more reductionist model. This includes a recognition that human distress and associated reactions involve brains and bodies in a complex and reciprocal relationship with emotion, behaviour and society. Finally, we recognise that realigning problems away from brains or minds and towards social contexts, raises some difficult questions, ethical as well as theoretical and empirical: for example, how should we talk about extreme distress and seemingly unintelligible actions if not as symptoms? What should we do if the person themselves is not troubled by their 'abnormal' experiences but those around them are? How does someone's position in the social hierarchy influence how their behaviour is assessed?

As we will see, then, this is far from a straightforward process. Medicalisation and diagnosis have persisted, in spite of their poor evidence base, not least because they fulfil important social and psychological functions. This, together with the fact that our thoughts, feelings and actions need quite different frameworks of understanding than do our body parts, means that alternatives to medicalisation and diagnosis are unlikely to look anything like either medical or psychiatric diagnostic systems; they are also likely to reveal some of the difficult issues obscured by the present system.

Before proceeding, we will address some further common responses to suggestions that we find alternatives to psychiatric diagnosis. First, it has long been argued that classification and diagnosis are a necessary part of a scientific approach to distress, if we are to make any progress with research and avoid disarray (Kendell, 1975; Parsons & Armstrong, 2000; Shepherd, 1976). The hidden assumption in these arguments, however, is that the only patterns in distress we can expect to find are within a medicalised, diagnostic framework, so that we should keep working within the systems to improve them. But progress is very unlikely with classification and diagnostic systems based on invalid patterns and inappropriate theoretical frameworks. If, instead, we see diagnostic systems simply as one example of the much more general scientific activity of pattern description, an example that has enjoyed some success in medicine, then it is easier to see that we can pursue this goal in relation to psychological and emotional distress outside of a medical framework.

A second common response is that diagnosis aids communication. But it is difficult to see how a system which can place two people with little or nothing in common in the same category while placing others with a great deal in common in different categories, can support accurate and useful communication. Third, diagnosis is said to be important for administration, record keeping, access to services and benefits, and so on. We will address this issue in Chapter 8 but again, it is difficult to see why an invalid system should dominate theory, research and practice for bureaucratic reasons.

Psychiatric diagnosis is also defended on the basis that some of the features highlighted by critics may also apply to medical diagnosis (e.g. both can be unreliable; both can involve social judgements; both systems change over time; some medical diagnoses such as high blood pressure are not ‘diseases’ and are on a spectrum, and so on). The problem with these arguments is that they ignore crucial *differences* between medical and psychiatric systems. They also ignore the fact that, as philosopher of science Alan Chalmers has emphasised, theoretical systems and the concepts they generate must be tailored to their subject matter and be judged on their own merits; functional psychiatric diagnoses cannot borrow credibility from medical categories on the basis of superficial similarities.

Finally, it is sometimes argued that practitioners no longer use a narrow medicalised framework in understanding distress, or perhaps never have done. The vulnerability-stress and closely related biopsychosocial models are often cited as broader versions than a purely biomedical one and as ensuring the inclusion of psychological and social factors. While welcome in some ways, these models bring their own problems. Both remain very dependent on diagnosis and its underlying medical framework – diagnosable mental disorders are presented as the medicalised end point of the interaction of a number of factors; in the case of vulnerability-stress, people are assumed to be born with or acquire a ‘vulnerability’ to mental disorders which can be evoked by later ‘life events’ or ‘stressors’ such as sexual abuse, poverty or unemployment, in much the same way as lung cancer may be triggered by smoking or Type II diabetes by particular diets. A second and perhaps inevitable problem is that in practice, both frameworks are often used in a way that privileges biology. Thus, the reasonable need to include biology is used to smuggle in the assumption that it is the primary causal mechanism, often in the form of un-evidenced claims about genes or ‘biochemical imbalances’ (Boyle, 2002a; Pilgrim, 2015a; Read, 2005).

All of this can have the effect of reducing social or psychological factors such as abuse, poverty and so on to ‘triggers’ of a putative underlying disease process, in an individual who has a biological defect. The implicit message to the individual is: ‘It is unfortunate that you were bullied/assaulted/sacked from your job, but others without this biological vulnerability would have been able to cope.’ This can excuse us from examining too closely either the events themselves or their meaning to the ‘vulnerable’ person (Boyle, 2002b).

A third approach, the differential susceptibility model, focuses on interaction effects suggesting that what seems like ‘vulnerability’ may actually reflect heightened susceptibility to the negative effects of risky environments and to the beneficial effects of supportive environments (Belsky, 2013; Roisman et al., 2012). This approach, however, also defines ‘the environment’ in rather limited ways (see Chapter 2) and appears to accept diagnosis and its medical framework. There is also an emphasis on supposed genetic susceptibility,

reliant on research whose methods and results have been questioned (see Chapter 5, on biology).

Practitioners who work within versions of the biopsychosocial or vulnerability-stress models which implicitly privilege the causal role of biology (the differential susceptibility model has not yet been so influential) are doing so in good faith, and are typically very concerned not to exclude the 'psycho' and 'social' aspects. Nevertheless, at a broader level, the rise of these conceptually limited models can be seen as acting to preserve the status quo of medicalisation by a process of assimilation of opposing views (Boyle, 2013).

The well-publicised US National Institute of Mental Health's Research Domain Criteria (RDoC) project, which aims to produce an alternative diagnostic system, lies firmly within this tradition. The project has arisen from acknowledgement of psychiatric researchers' failure to move beyond the level of subjective complaints, their failure to describe patterns that are more valid than committee-generated clusters of behavioural 'symptoms'. Instead, its aim is to produce a diagnostic system based on underlying neurobiological and biobehavioural mechanisms of 'mental disorders' that will eventually lead to definitive treatments (Kirmayer & Crafa, 2014, p.1). But rather than an alternative to medicalisation and diagnosis, the project represents a strengthening of this framework, an attempt to move closer to physical medicine. This is clear from some of the assumptions said to underlie the project, including that 'Mental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion or behaviour' and that 'Mapping the cognitive, [neural] circuit and genetic aspects of mental disorders will yield new and better targets for treatment'. It is also assumed that dysfunction of these hypothesised circuits can be identified with the tools of neuroscience such as neuroimaging and that this shift from *DSM*-based 'symptom' categories is a first step towards the kind of 'precision medicine' said to have transformed cancer diagnosis and treatment (Insel, 2013; Insel et al., 2010). By their own admission, however, the project leaders have as yet been unable to design a diagnostic system based on these principles because 'we lack the data'; the project is seen as a framework for collecting the data over at least the next 10 years.

In spite of its optimistic language, the RDoC project has been strongly criticised on several grounds. These include its assumption that diagnosable 'mental disorders' exist independent of species, time and place; its overestimation of the conceptual and methodological power of the 'tools of neuroscience' and of the data these have so far produced; its extremely limited conception and relative neglect of social context in favour of genetic and biological factors; its misunderstanding of the reciprocal and dependent relationship between brain functioning and the social world and, finally, the loss of distinctly human aspects of functioning such as language, metaphor, narrative and subjective experience (Kamens, 2013; Kirmayer & Crafa, 2014; Peterson, 2015). All of this suggests that the reasons for the failure of previous diagnostic systems, the reasons why researchers have not been able to imitate medicine and move beyond the level of subjective complaints, have not been properly understood. The hope remains that somehow more of the same will produce a different result. We would argue instead that we risk repeating the same mistakes, giving false hope, and potentially wasting large amounts of time and money.

The rest of the document will be concerned with the development of alternatives to

psychiatric diagnosis and their implications, taking account of why diagnostic systems have so consistently failed in their own terms. We begin in Chapter 2 with a discussion of some philosophical and conceptual issues and present a set of assumptions and principles which could inform alternatives.

Chapter 2: Philosophical and conceptual principles of alternatives to psychiatric diagnosis

Introduction

In Chapter 1 we argued that medicalised approaches to distress and troubling or troubled behaviour were designed for understanding bodies and not persons, and we pointed out that the assumptions underlying these approaches, and their inappropriateness for understanding behaviour and experience, are obscured by a false analogy between psychiatric diagnosis and the process of diagnosis in medicine. We emphasised that people who have been assigned one of the ‘functional’ psychiatric diagnostic categories certainly have real experiences of distress and may behave in ways that concern others. We argued, however, that understanding these experiences as symptoms of hypothetical disordered bodily mechanisms, modelled in universal causal terms and independent of context, is flawed on scientific and ethical grounds (Thomas & Longden, 2013). While this paradigm has led to significant progress in the field of general medicine, it has run into serious difficulties, as outlined in Chapter 1, when applied to many forms of personal distress, unusual experiences and behaviours, or recurring interpersonal difficulties.

We also emphasised that medical diagnosis is best seen not as ‘identifying diseases’ or ‘finding out what’s wrong with someone’ but as a process of using appropriate theory and research to try and understand how someone’s bodily complaints have come about and how they can best be alleviated. This is done largely by trying to match someone’s presenting problems with patterns already identified by medical researchers and drawing on that research to predict progress and develop interventions. Many of the difficulties psychiatric diagnosis has faced in trying to repeat this process in relation to people’s thoughts, feelings and behaviour, have arisen from its basis in inappropriate theory and research, and the problematic assumption that ‘abnormal’ behaviour and experience will fall into similar kinds of patterns of signs and symptoms as many bodily problems. In developing alternatives to psychiatric diagnosis, in trying to understand and respond constructively to personal distress and troubling behaviour, we therefore need to move away from the assumptions underlying medicalised approaches and address four major questions:

- What different assumptions should we make, what different theoretical frameworks can we draw on, in understanding *the behaviour and experience of persons within their social and relational environments*, rather than the (mal)functioning of bodies?
- At the broadest level, what patterns have researchers described that might be helpful in understanding and alleviating emotional distress, unusual experiences and troubled or troubling behaviour from a non-diagnostic perspective?
- How might these broad trends and relationships be used to delineate narrower, provisional, general patterns which can inform our understanding of the particular difficulties of an individual, family or other group?
- What are the implications – therapeutic, social, ethical, legal – arising from adopting these non-diagnostic approaches and how might we address them?

This and the next chapter will focus mainly but not entirely on the first question; the others will be addressed in detail in later chapters.

An immediate problem in describing what is different about a non-medicalised approach is that much psychiatric research within a medical tradition does not make its underlying assumptions explicit and, as a result, as we noted in Chapter 1, they are simply taken for granted. Our first aim, therefore, is to spell out these assumptions. We will then discuss some alternative philosophical and theoretical traditions in the human sciences and beyond. As well as highlighting the problems with psychiatric classificatory approaches, each tradition also offers ideas that may be useful in building non-medical ways of understanding distress. We will draw on these alternative perspectives both as a way of delineating and critiquing medicalised assumptions and as a resource in developing different ways of thinking.

We will then advance a number of alternative, non-medical working assumptions in order to develop more specific alternatives to diagnosis.

Starting with a basic philosophical check-up of psychiatric classification and diagnosis

The concerns about medicalisation and psychiatric diagnosis raised in Chapter 1 can be summarised under three basic and related philosophical questions relevant to any form of human science. First, how do we demonstrate what is real about human experience and behaviour or, what set of ‘things’ should be assumed to exist by our theories and systems of thought? Second, what form of knowledge is the most appropriate to describe, interpret or explain human experience and behaviour? Third, which values should be applied to the investigation of the first two activities in human science? The first activity is referred to as *ontology*. The second activity relates to studying knowledge claims about experience and behaviour and their justifications, and is referred to as *epistemology*. The third activity relates to the role of moral assumptions and intentions in studies of both being and knowledge and is referred to as *ethics*. All forms of investigation in Psychology and Psychiatry and related fields like Sociology and Psychotherapy explicitly or, more often, implicitly, take a position in relation to these three areas.

In this document we adopt a different position on all three fronts from that taken in relation to psychiatric classification and diagnosis. First, we question the idea of ‘mental disorders’ which have an independent and universal existence across time and culture. More specifically, we question that the experiences this term refers to are analogous to physical disease processes.

Second, we question the epistemological validity of defining these hypothesised ‘disorders’ by a process of revising and refining editions of diagnostic manuals such as the *DSM* and *ICD*, and of directing the majority of research endeavours towards biology.

Third, in relation to the ethics of diagnosis, we note the requirement for the procedures and information offered to patients to have a sound epistemological basis. This ethical scenario is the case in all forms of medical and psychiatric diagnosis, but psychiatry has an additional mandate to operate under conditions which are sometimes involuntary. Ethical considerations also apply to the potential harms caused by the imposition of psychiatric diagnoses (<http://psychdiagnosis.weebly.com>), and to the misuse or over-use of medical

treatments and other interventions that a diagnosis may seem to justify (Whitaker, 2010) as well as its role in obscuring the importance of social factors as causes of distress.

Criticisms of psychiatric classification and diagnosis have all included one or more of the above considerations. Some critics query the ontological validity and epistemological status of functional psychiatric diagnoses such as 'schizophrenia' or 'depression' as descriptions of an aspect of universal reality, discovered by objective research. Some have critiqued the assumption that those assumed invariant aspects of reality have biological causes. Some have disputed the conceptual coherence of diagnostic categories and the procedures by which they are developed and some, from an ethical position, have described the damage caused to people by diagnosis and the social injustice it can facilitate.

Positivism and the roots of psychiatric classification and diagnosis

The ontological and epistemological assumptions we have described in relation to psychiatric classification and diagnosis, are not simply drawn from medicine but are part of a wider and extremely influential philosophical tradition known as positivism (sometimes also known as naïve realism). Positivist ideas are not the sole province of any particular discipline or profession, but have had a widespread influence on Western thought over the last 200 years. There are different versions of positivism, and some, such as logical positivism, are no longer in vogue, but its most general assumptions are traceable back through Plato and Socrates to Parmenides, who argued that the world exists before us in detailed but fixed complexity offered by the gods. He contended that these stable, objective arrangements were lawfully related and that those laws could be understood by human exploration and discovery. These ideas were developed further in Western Europe by philosophers such as Descartes, Locke, Berkeley and Hume, Bacon, Voltaire, Rousseau and Kant. They were leading figures in the Enlightenment, a European movement of the 17th and 18th centuries which (in brief) took reason and scientific progress as its source of authority, rather than church and state.

The success of the natural sciences through empirical methods led Auguste Comte (who coined the term 'positivism') to argue in the 19th century that natural science methods should be extended from studying the physical world to studying human affairs; indeed that these should only be investigated using methods developed for studying the physical world. Comte's argument should be seen in a context where natural science methods were (and still are) not only extremely successful in understanding the physical world but where metaphysical beliefs about the world were still popular.

The influence of these ideas on Western worldviews on matters well beyond the physical world cannot be overstated. Those brought up within this tradition may find it hard to question the idea that humans exist essentially as separate, individual selves, disconnected from the social and natural world, with our minds floating in some disembodied sense above our brains. It may also seem natural to employ analogies which essentially conceptualise humans as machines, acted on by external forces and liable to biological (and psychological) malfunctions which need technological fixes. However, this worldview has limitations as well as advantages, especially in relation to the understanding of our main subject matter, human behaviour and human emotional distress. Nevertheless, the idea that the world, including human behaviour and experience, is characterised by features and processes which can be objectively described in universal causal terms across

time and place, remains very influential (Bhaskar, 2011; Harding, 1991). Within this viewpoint, it is the job of science to discover these presumed regularities, to experimentally manipulate the world in order to demonstrate their nature, and to make predictions and explanations.

In Psychology, Psychiatry and some types of psychological therapy, the influence of these ideas is often apparent in their dependence on experimentation, quantification and measurement. These methods are not uniquely 'scientific' but they have proved productive in nonhuman sciences, and Psychology and Psychiatry have taken seriously Comte's injunction that the study of human affairs should imitate them. This imitation is more subtly but just as strongly evident in two related assumptions. First, that human characteristics, behaviour and experience – including problematic forms of emotional distress, behaviour and relationships – can be represented as a series of discrete, measurable variables and, second, that the nature and interactions of these variables, and how they relate to 'mental disorders' can be described independently of particular historical and social contexts. One example of this is the very popular vulnerability-stress hypothesis in which, as described in Chapter 1, 'disorders' are seen as resulting from an interaction between an initial vulnerability (often biological) and 'amounts of' environmental 'stressors' or 'life events', not dissimilar to the way that the molecules of two different compounds will interact in a test-tube or an objectively quantifiable weight will cause a table to collapse.

So, the influence of positivism on psychiatric classification and diagnosis is twofold. First, in its underlying principles and use of natural science methods, outlined above and, second, in its basis in the specific example of a positivist framework offered by Western medicine (Ingleby, 1981). Clarifying this double influence is important because suggested alternatives to current systems of classification and diagnosis take a variety of positions in relation to these frameworks but often without making their particular position clear. For example, some, like the RDoC project mentioned in Chapter 1, maintain both a highly medicalised and positivist framework (and see also the HiTOP classification, Kotov et al., 2017); some appear to adopt a partly medical, positivist approach (e.g. Borsboom, 2017; Brown & Barlow, 2009; Mineka et al., 1998) and some non-medical alternatives such as the psychological study of 'individual' experiences of hearing voices, extreme moods or unusual beliefs, are largely based on a positivist framework. This does not make them without value, but it may raise unacknowledged ontological, epistemological and ethical dilemmas, and limit the extent to which they offer genuine alternatives.

Positivist ideas, and more specifically the privileging of natural science research methods, have been questioned on several grounds in relation to their influence in Psychology and Psychiatry. The most relevant to our understanding of emotional distress, unusual experiences and troubled or troubling behaviour are:

- *A limited and misleading depiction of the social world and the relations between it and psychological experience* – The social world is often presented as a kind of backdrop to people's actions and experiences, a rather passive and unchanging thing 'out there', with an existence separate from the individual themselves (Riatt & Zeedyck, 2000; Sampson, 1981; Stoppard, 2000; Ussher, 2011). There is little appreciation that we are fundamentally and always social beings, whose minds, brains, bodies and behaviour develop and are shaped in interaction with our caregivers and others not just in our

very early years but throughout our lives (Bretherton, 1992; Schore, 2001; and see below and Chapters 4 and 5). Similarly, ‘society’ is seen as affording a series of discrete independent variables such as class or gender, whose influence is mainly quantitative. Little attention is paid to the broader social context beyond the immediate circumstances of people’s lives, or to its symbolic and historically and culturally contingent nature. Nor is much attention paid to forms of social organisation and power relations which bring ‘stressors’ into people’s lives in the first place, and powerfully shape their experience of them.

- *A limited and misleading depiction of the body and relations between it, the social world and psychological experience* – This can partly be traced back to Cartesian dualism and the consequent unresolvable philosophical conundrums about how mind and body relate to each other. Such a position stands in contrast to many non-Western traditions – for example, African worldviews are typically framed in terms of the dynamic interplay of all elements of reality (Mbaegbu, 2016). One enduring consequence is the presentation of biology as an independent source of behaviour and emotional distress (‘the biological basis of behaviour’; ‘mental disorders’ as brain diseases) rather than as an aspect of our being which is continuously shaped by social action, and is inseparable from thoughts, emotions and meanings. In practical terms, this means that approaches to mental distress tend to err on the sides of ‘all brain’ or ‘all mind’; a situation that more recent developments in psychotherapy attempt to address (see Chapter 8). Most commonly, it facilitates a narrow focus on the hypothesised ‘illness’ via medication and monitoring of ‘symptoms’, rather than attention to the lived experience of the whole person. Another consequence is a relative neglect of symbolic and discursive aspects of the body, its functions and dysfunctions (Stam, 2000; Stoppard, 2000; Yardley, 1997). Yet another consequence – ironic, given the core subject matter of Psychiatry and Psychology – is a limited and misleading understanding of feelings and their relationship to all the above aspects of our lives. John Cromby (2015) has argued that embodied feeling – typically conceptualised within positivist traditions as discrete, personal and quantifiable – can only be fully understood as constituted through ‘history, culture, social relations and materiality’ (p.17). One of the consequences of recognising that ‘feelings are enabled by the living body, and that body is always in the social and material world...the feelings it supplies are infused with social and relational influence’ (p.61) is to make the operation of power more visible in our analysis of extreme states of distress. In line with all of this, Cromby has argued for ‘an embodied psychology: one that takes seriously the observation that absolutely all our experience depends on our living bodies for its very character, as well as its mere possibility (2015, p.7).
- *The transformation or reification of aspects of the social world into universal individual characteristics* – For example, and similarly to feeling, human thinking is often depicted as a highly personal activity, in this case inside the head of an individual rather than, as Edward Sampson has put it, ‘a social and historical product of collective endeavour’ (1981, p.732), in which social practices and relations constitute the form and content of what we think of as ‘cognitions’. Others have made similar points: Michael Billig (1991) has argued that our private thoughts have the structure of public arguments while Julian Henriques and colleagues (1998) have criticised the idea of individuals as ‘unitary, rational subjects’ whose brains and cognitive processes can be understood

with little reference to changing cultural and social context. Similarly, John Shotter (1993) has suggested that individual responses to particular situations should be thought of as the ‘marking off’ of aspects of collective debate and communal thinking, and, he might have added, communal experience, reified as personal attributes ‘possessed’ by individuals. These include personality traits, cognitive styles, a whole range of dysfunctions, biases and deficits and, of course, specific ‘mental disorders’, seen as causing people to think, feel and behave in certain ways. It is a short step from this to seeing these attributes as natural targets for intervention independent of any social context.

- *Limited attention to ‘point of view’* – The idea of objectivity is central to traditional scientific discourse and is reflected in the frequent removal of the human observer from research reports; for example ‘it was found that’ or ‘the data showed that’. ‘Objectivity’ implies a neutral, impartial observer whose opinions or values play no part in the research process. This representation of research and theory as a ‘view from nowhere’ has long been criticised by standpoint theorists such as the feminist philosopher of science Sandra Harding and many others (e.g. Allen, 1996; Collins, 1990; Harding, 1986, 1991; Hartsock, 1983; Prilleltensky, 1989, 1994; Sarason, 1981). These and other critics have argued that scientific enquiry always involves a ‘view from somewhere’, hence the term ‘standpoint’, or a mental position from which we observe and interpret the world; Harding has argued that these ideas apply to all sciences including physics, and they certainly apply to the life and human sciences with their tradition of sexism, heterosexism and racism (Bowers, 1990; Easlea, 1981; Fernando, 2010; Hager, 1997; Mercer, 1986; Ussher, 2011).

This is not about researchers’ personal values which, we might think, can be put aside through the use of objective research methods; it is about cultural and institutional values, a complex and usually unarticulated structure of beliefs and assumptions – a standpoint – that influences what is questioned and what is taken for granted; what counts as ‘scientific’ method, as evidence, as validity or even as ‘objectivity’. It is about which metaphors are used to model nature or people, to generate research questions and act as a filter for the interpretation of data (e.g. mental disorder; psychopathology; cognitive structures; the brain as a computer). These are human judgements made by people working in particular historical, social and political contexts. In both pre-modern and modern sciences, these judgements have largely been made by white men who are also members of the group who have historically attributed to their own minds those faculties of reason, judgement and logic said to be needed for impartial scientific enquiry and discovery of the laws of nature. Western male scientists have also worked within structures of power which validated their viewpoint. All of this has created a problematic and inferior relationship between socially legitimated knowledge and other groups, particularly women, people not of European ancestry, and, of course, those deemed mad.

All the above means that evidence, experience and testimony falling outside positivist parameters is frequently marginalised or actively dismissed and this certainly includes evidence from the standpoint of service users/survivors themselves. A specific example of this process is the hierarchy of knowledge within ‘evidence-based practice’ in which systematic reviews and randomised controlled trials count as the strongest, ‘gold standard’ Type 1 evidence, while ‘the opinion of service users and

carers' falls into weakest Type 5 category. This facilitates the rejection of service user/survivor testimony and lived experience as 'anecdotal evidence' which is trumped by 'objective' scientific findings (for example, in the case of reports of difficulty coming off medication, or memory damage after ECT, Read & Bentall, 2010). In fact, as psychologist Gail Hornstein has shown: '...for as long as psychiatry has existed, there has been a rival literature on madness written by people with firsthand experience' (Hornstein 2012, p.xv). This literature, almost entirely ignored in official textbooks, training programmes, public information and research, often strongly challenges the medicalisation of distress, documents the extensive damage it causes, and suggests very different models of understanding. The emerging field of Mad Studies is based on the simple but radical principle of supporting 'those of us deemed mad to formulate and advance our own understandings, theories, research, actions, practices and knowledges, each of which carries an inherently enhanced credibility because of direct experience' (LeFrançois, 2016, p.v). To put it another way, it is based, in the words of psychiatric survivor Peter Beresford, on a fundamental re-examination of the assumption that 'the greater the distance there is between direct experience and its interpretation, the more reliable the resulting knowledge' (Beresford, 2016, p.29). Sandra Harding (1991) has emphasised that standpoint theory is not an argument for relativism and that the identification of social causes for the production or acceptance of a theory does not exclude the possibility that it matches 'reality' in better ways than its competitors. But we can increase our chances of producing such theories by recognising that (apparent) empirical support for a theory can come not just from reality itself but also, more problematically, from the fact that taken for granted theoretical concepts, research methods and standards of evidence, fit very well with prevailing cultural interests and values. We can also increase our chances of creating 'good' theory by broadening the range of standpoints involved in producing both theories and evidence, and criteria for their evaluation.

- *Limited attention to the impact of method and measurement on the outcomes of research* – This is a more specific instance of the point we've just made, that research methods are not neutral, objective ways of discovering facts about the world but always involve theoretical preconceptions and assumptions about the nature of what is being studied. As we noted, this is unavoidable but it brings with it the danger, as Kurt Danziger has put it, of a methodological circle where 'methods based on assumptions about the nature of the subject matter only produce observations which must confirm these assumptions' (1985, p.1). If we assume that human functioning can be represented in terms of discrete, universal variables, then researchers will present their observations in these terms. If we define these variables with limited or no reference to social context, then the social world will come to seem unimportant in understanding our behaviour. If we assume that human misery and social 'deviance' will follow the same patterns as bodily dysfunction, then we will observe and categorise 'symptoms' and find 'disorders' 'in' people. And, when quantification and measurement are used, research methods must produce data that can be handled by statistical techniques. As Danziger emphasises, quantification involves much more than numerical labelling of people's thoughts, feelings or behaviour; it means assuming that the structure of the numerical system represents the structure of these thoughts, feelings or behaviour. An example of this is when researchers add up responses to a scale or questionnaire

to describe the ‘amount’ of an assumed personal characteristic such as ‘schizotypy’, ‘depression’ or ‘self-esteem’. All of this means that research methods tend to produce ‘findings’ in their own image, with the possibility of mistaking artefacts of method and measurement for statements about the nature of people and the world.

- *An inappropriate model of causality* – All of the above contributes to a model of causality which is inappropriate for the study of human thoughts, feelings and behaviours, and specifically for those that are subsumed under the criteria of ‘functional’ psychiatric diagnoses. Causality in the natural sciences is modelled on Hume’s definition of any antecedent factor from which an event is highly predictable (assuming a third factor is not responsible for both). While this has limitations even in the physical sciences, it has very significant limitations in relation to the experiences and expressions of emotional distress that are described as ‘mental illness’. Reifying these into ‘symptoms’ arising from dysfunctions within individual minds, brains and bodies strips them of the contexts and meanings which make them intelligible. Instead it promotes a view of human beings as objects acted on by causal forces (Ingleby, 1981), or, as David Jacobs and David Cohen (2010) have noted, presents the person as having become, ‘through no intention or action of his or her own... the setting for the operation of impersonal, harmful cause-effect processes’ (p.312). This causal model can lead to reductionism – the view that complex human experiences can be explained at their simplest, usually biological, level such as ‘chemical imbalances’. It can also imply determinism – the notion that particular events will inevitably produce particular outcomes, whether expressed in biological (‘Excess dopamine causes schizophrenia’), psychological (‘Sexual abuse causes voice-hearing’) or social (‘Poverty causes depression’) versions. A contrasting position is that human beings are agents whose behaviour has not only antecedent causal influences but also purposes and functions – we act in anticipation of future outcomes (Ingleby, 1981). Moreover, the factors which contribute to any aspect of human behaviour, and their outcomes, are generally multiple, complex, highly interactive and overdetermined. Causality in relation to behaviour and experience and certainly to distress and troubling behaviour, is best understood as highly probabilistic – that is, it has an ‘on average’ character and it will never be possible to predict the precise impact. Causal influences also operates contingently – which means that the effects of any one factor are always mediated by (contingent upon) others; and synergistically, in that influences can magnify each others’ effects. For example, while domestic violence and poverty both increase the likelihood of distress taken separately, poverty is likely to exacerbate the impact of abuse through factors such as reducing opportunities to escape one’s abuser, although the specific effects and outcomes for any given individual are not predictable or inevitable. This is partly because personal meaning mediates the impact of any given situation or event. This does not mean that no regularities exist. However, rather than searching for universal causal laws in human behaviour, it makes more sense to look for trends, associations, their directions of influence and for processes that might underlie them. The notion of ‘generative mechanisms’ allows for causes and meanings to co-exist in human action, such that meanings (shaped by social and cultural norms) can become causes (see discussion below of process philosophy). At the same time, we are often unaware of intimate, sub-personal (biological), distal (social) and even proximal environmental influences on our behaviour but over which we have little, or no,

control (Archer, 2000; Nisbett & Wilson, 1977; Smail, 2005). This means that there will never be simple answers to causal questions in distress, but it also allows for hope. Even the most damaging series of life events need not determine our future, as the testimony of many former service users shows.

The implication of all of the above arguments is that human beings are active agents in their lives, both determined and determining beings, rather than objects acted upon by external forces. As human agents we both conform to the reality we encounter and seek to transform it. We do this through our capacity for meaning making, and for reflecting on and learning from our experiences. Social and cultural influences do not simply provide backgrounds and constraints; they are the conditions out of which meaning, agency, feeling and action arise (Cromby et al., 2013, Chapter 6). Alternative frameworks for distress must be built on these foundations.

Some of the discussion so far may seem rather abstract, so before we consider possible alternative frameworks we will provide a very concrete illustration of the fact that theories of human behaviour do not arise or become propagated in a historical, political or ethical vacuum.

Medicalisation, individualisation and the political economy

As we have argued, using frameworks from the natural sciences and the study of the body to understand our behaviour and experience will always limit the extent to which the social world can be taken into account. An obvious reason for this is that theories of social relationships, language and so on are not called for in the study of non-sentient objects. However, Psychiatry and Psychology have always acknowledged the social world to some extent even if this has not amounted to the widespread use of theoretical and research paradigms specifically for the study of human relationships and human emotional distress.

From the late 1970s, however, there have been significant changes in Psychology's and Psychiatry's relationship to 'the social'. In Psychology this was marked by the 'cognitive turn' and a far greater emphasis on autonomous individual minds – 'individualism' (Sampson, 1981, 1988). In Psychiatry, the change was marked by the publication of *DSM-III* in 1980. It was based on earlier Kraepelinian 'disease' models – that certain thoughts feelings and behaviours would cluster into discrete entities with specific (biological) causes and outcomes. In this and in its unsupported claims to scientific objectivity through precise lists of 'symptoms', *DSM-III* made a break with more socially and psychoanalytically influenced previous editions of the *DSM* (Lewis, 2006). Coincidentally or not, these changes have been closely paralleled by profound cultural changes in political and economic policy in the UK, USA and some other Western countries, marked by the rise of what is sometimes referred to as neoliberalism. The meaning of this term has changed since it was coined in the 1930s and its precise definition and relationship to related terms such as monetarism and neoconservatism is still debated (Boas & Gans-Morse, 2009). However, the term is often used as a shorthand description for a set of interconnected economic and social theories and practices based on the work of economists such as Friedrich Hayek, Milton Friedman and the Chicago School. Although originally seen as a means of avoiding totalitarian control, by the 1980s the emphasis was on individual freedom, autonomy, choice, self-sufficiency and responsibility, as exemplified in the 1980s by the eras of Margaret Thatcher in the UK and Ronald Reagan in the USA. These aims

were used to justify free-market economic policies such as privatisation, deregulation, low taxation, flexible labour markets and free trade along with a lesser role for the state and consequent reductions in welfare spending.

Although neoliberalism involves a set of economic policies, like all economic systems it also makes strong assumptions about human behaviour as well as requiring people to behave in certain ways and believe certain things about themselves in order to cooperate with the system. The interdependence between the political economy of neoliberalism and Psychology and Psychiatry involves several processes. The first is placing a high value on hypothesised intrapsychic attributes – rather than social institutions or structures – said to be necessary and even sufficient for success, such as aspiration, motivation, internal locus of control, self-esteem, character and resilience. People may then be required to demonstrate or develop these and similar attributes to be eligible for welfare benefits (All-Party Parliamentary Group on Social Mobility, 2014; Deary, 2014; Friedli & Stearn, 2015). Similarly, the public may be encouraged to believe that many people receiving welfare benefits almost wilfully lack some of the psychological attributes required for success and therefore do not deserve state support (Shildrick & MacDonald, 2013).

Second, people may be encouraged to find meaning in life through consumption and to measure their personal success through income and material possessions. Critiques of the psychological impact of consumerism predate the rise of modern neoliberalism; for example, from the 1950s psychoanalyst Erich Fromm wrote extensively about the despair that results from encouragement to find meaning through consumption (e.g. Fromm, 1962, 1976). Fromm was influenced by Marxist critiques which argued that modern alienation and the consequent commodification of material products, which we are encouraged to desire in order to restore a lost sense of creativity, community and connection, are intrinsic to capitalist systems (see Tweedy, 2017, for an overview). More recent analyses, however, suggest that materialist attitudes and their negative psychological effects have increased over the last 30 years (Barber, 2007; James, 2008; Kasser, 2002). Third, the damaging effects of economic systems are hidden by being individualised and pathologised. Neoliberal policies, in the West and globally, have been associated not just with materialist attitudes but also with greatly increased inequality, fragmentation of communities, and damage to the environment (Chomsky & McChesney, 2011; Klein, 2008; Sayer, 2016). Inequality itself is associated with increased levels of emotional and behavioural problems at all levels of society, even the most privileged, while in the UK the austerity measures said to be essential for economic growth and recovery have been accompanied by steep rises in reported rates of distress, suicide and prescriptions of psychiatric medication (Barr et al., 2015; Psychologists Against Austerity, 2015; Stuckler & Basu, 2014; Wilkinson & Pickett, 2009). These outcomes are then seen as the responsibility of ‘mental health services’.

A further process which links neoliberalism with Psychology and Psychiatry is the use of diagnosis, individualised therapy, self-management and medication to return people to or prepare them for the labour market and reduce the claims they make on the state. This political agenda is particularly explicit in the Improved Access to Psychological Therapy (IAPT) programme (Layard & Clark, 2014; LSE Centre for Economic Performance, Mental Health Policy Group, 2006). As Lynne Friedli and Robert Stearn (2015) have noted, people on government workfare programmes are increasingly required to engage with interventions which involve ‘labour on the self’ intended to modify attitudes, beliefs

and personality, notably ‘through the imposition of positive affect’ (p.40), often in very negative personal circumstances. Similarly, personal responsibility for recovery from or management of physical and mental problems is increasingly encouraged, again often in the service of return to the labour market. It has been argued more widely that the concept of mental health ‘recovery’ itself, a central theme of UK mental health policy and the impetus for a network of ‘recovery colleges’, has been co-opted to support these ends (Beresford, 2015; McWade, 2016).

However, it is not often acknowledged that all of this may involve competing for work which is scarce, insecure, poorly paid and stressful (Beresford, 2015; Deary, 2014; Speed & Taggart, 2012). The rhetoric of rational independent persons making choices about their self-management or care provision within a complex welfare market, while misrepresenting all of us, may have particularly unfortunate consequences for people from vulnerable groups such as those with intellectual disabilities (Fryson & Cromby, 2012). It has also been argued that diagnosis and medication, with their focus on unsupported claims about biological abnormalities, may function to neutralise discontent or disruption arising from economic circumstances, as, for example, in the enormous rise of prescriptions for ‘antidepressants’ and psychoactive drugs for children said to have ‘attention deficit hyperactivity disorder’ and other ‘conduct disorders’ (Moncrieff, 2008, 2010; Timimi, 2008). Finally, providing conceptual and related practical support within neoliberal economic systems can be extremely profitable as, for example, in the provision of diagnostic systems and psychoactive drugs, individual therapy and psychological aspects of workfare programmes.

These recent criticisms of neoliberalism and its relationship to Psychology and Psychiatry stand in a long tradition of writers who have linked the medicalisation and individualisation of distress and ‘deviance’ to social control and social injustice (e.g. Cooper, 1971; Foucault, 1967; Ingleby, 1981; Laing, 1967; Rose, 1985; Scheff, 1966; Szasz, 1974). Foucault traces this process to the mid 17th century Enlightenment period, when institutions for the mad began to appear across Europe. He argues that this mass confinement of those who were deemed to have lost their reason was driven by the need to regulate wages and employment as part of the move away from a primarily agrarian society. This set the scene for those on the margins of society to be seen as not just indigent but ‘ill’, a process that has also been described by Andrew Scull (1979). More recently, Richard Warner (2004) has provided a detailed illustration of the links between psychiatric theory and the political economy, in his analysis of recovery rates from ‘schizophrenia’. He argues that ‘psychiatric ideology may be influenced by changes in the economy – a notion which implies a rejection of the conventional concept of scientific progress inherent in mainstream medical history... Ideology and practice in psychiatry, to a significant extent are at the mercy of material conditions’ (pp.134, 146). Specifically, he demonstrates that at times of high employment, theories of social causation predominate and are associated with higher recovery rates whereas when jobs are scarcer, biological and genetic theories predominate and ‘the primary emphasis will be one of social control’ (p.145).

We can see, then, that particular economic and political interests can be facilitated and reinforced by models of human behaviour and distress which focus on individual minds and brains and locate responsibility for breakdown and recovery within individuals who are assumed to be dysfunctional at a biological, cognitive and/or emotional level. As Derek Summerfield has put it, ‘The political and economic order benefits when distress or

dysfunction that may connect with its policies and practices is relocated from socio-political space, a public and collective problem, to mental space, a private and individual problem' (2012, p.3). Indeed, these interests have shaped our very notion of what it is to be a person. This, as will be discussed further in the next chapter, in turn has had implications for our mental wellbeing, both in terms of what we define as 'normal' and in terms of how so-called 'abnormality' is experienced and expressed. Psychology and Psychiatry's claims to scientific status are central to these processes. And social acceptance of these claims is arguably strengthened by recognisable similarities, such as quantification and experimentation, to the methods of natural sciences.

There is no suggestion that such a process is deliberately or consciously enacted by clinicians, researchers policymakers or anyone else; on the contrary, they may often be motivated by a genuine desire to relieve suffering. However, at a level above personal motivation, yet another limitation of the natural science perspective on mental distress and troubling behaviour is that it can facilitate the operation of social injustice while obscuring its impact on people's lives.

Summary and conclusions

The discussion so far has been about issues raised by positivism's general influence on the study of human behaviour and experience. But as we have emphasised, for psychiatric classification and diagnosis the issues are compounded by medicalisation: assumptions and methods from the natural sciences and more specifically, the study of bodily problems, have been transferred to the study of emotional distress and troubling behaviour.

This might be less of a problem if the theoretical framework and methods underlying psychiatric classification and diagnosis had produced positive and well replicated results but, as we saw in Chapter 1, this is far from the case: as many critics have shown, the approach has comprehensively failed in its own terms.

It is the combination of this failure, and evidence of the mismatch between the theoretical/methodological framework and its subject matter, that justifies the search for alternative conceptualisations of emotional distress and troubling behaviour. The search is also justified by the ethical issues raised, including the potential harm from diagnosis and physical interventions, as outlined in Chapter 1; the marginalisation of many groups in the production of theories about themselves; the need for a strong basis in evidence for what people are told about themselves and their problems; the impact on public policy of focusing on individual minds and brains rather than social context; and, arising out of all this, the implications of exporting these theories and practices across the globe (see below). As we have tried to show, the theoretical positions underpinning medicalisation and psychiatric diagnosis have profound implications for real life policy and practice, whether these positions are held and promoted purposefully or (more commonly) arise out of unquestioned assumptions and discourses which are rarely challenged or even consciously identified.

The 'qualitative revolution' in the social sciences has opened up a whole range of new research methods and practices which do question many of these assumptions and have a commitment 'to understand the world from the point of view of the acting subject' (Harper & Thompson, 2011; Wertz, 2011, p.84). However, we are not arguing that research within the positivist or quantitative tradition has no place. On the contrary, some strong evidence against

medicalisation and evidence for the importance of social context, has emerged from within that tradition. And, as we noted earlier, some research on alternatives, for example the study of ‘individual’ experiences such as hearing voices, extreme mood states or unusual beliefs, has also come from a positivist tradition. We will therefore draw on this research, especially in Chapters 4 and 6, but as one of a range of potentially useful research traditions and keeping in mind the problems we discussed. We will be arguing that alternatives to psychiatric classification and diagnosis not only need to move away from a medical framework but to draw on a range of philosophical traditions, standpoints and theoretical/research frameworks that acknowledge aspects of human functioning that have so far been marginalised.

The next part of this section will be a general discussion about theoretical frameworks, philosophical assumptions and ways of thinking which might inform non-medicalised, non-diagnostic approaches to understanding distress. The discussion is aimed at addressing the first question we posed at the beginning of the chapter:

- What different assumptions should we make, what different theoretical frameworks can we draw on, in understanding *the behaviour and experience of persons within their social and relational environments* rather than the (mal)functioning of bodies?

The approaches and perspectives we will discuss are not of one voice, which is not necessarily a disadvantage in such a complex and contested area. They also have different status – some include theoretical models which underlie a body of empirical work and practice; others are more general philosophical stances. The approaches differ in how far they acknowledge the importance of particular human aspects of the world, such as the operation of power or social justice; they also vary in their ‘distance’ from positivism and even in their stance on diagnosis. But there is also a good deal of overlap, perhaps more than is apparent from their different headings. One thing the approaches have in common is a view of humans as active agents and meaning makers, and a respect for personal meanings arising out of our interdependence with our social worlds.

It is not our aim here to provide a detailed description or critical evaluation of alternative frameworks but to describe briefly some approaches to understanding human behaviour and experience, with an emphasis on those aspects most relevant to understanding and responding to distress and some (apparently) unintelligible behaviour. Drawing on these, we will then put forward a number of alternative working assumptions designed to avoid the problems associated with medicalised approaches and which can inform the development of alternatives to psychiatric classification and diagnosis.

Towards alternatives to medicalisation – consideration of ideas from different traditions

1. Cognitive approaches

We will look here mainly at cognitive approaches to distress, rather than cognitivism within Psychology as a whole. Personal meaning is central to these approaches as they focus on how people appraise and interpret their experiences, and the assumptions they make about them, about themselves and about the (social) world in general. The theories propose generally that our appraisals and interpretations of events are crucial determinants of our emotional responses to them. More specifically, they propose that

'dysfunctional' beliefs and assumptions about self, others and the world, developed as a result of (usually) childhood experiences, are later activated by 'critical incidents', ranging from the apparently minor such as a colleague's remark on our work, to the major such as a relationship breakdown or a bereavement. These events are appraised through the lens of this dysfunctional assumptive framework ('schema') resulting in a complex of 'negative automatic thoughts', distressing emotional responses such as anxiety, panic or very low mood, and protective or coping behaviour. These responses in turn can elicit appraisals which may intensify them. Some of this can take place outside conscious awareness so that we may be puzzled or distressed by thoughts, feelings or behaviour we do not understand. Cognitive approaches have also been extensively applied to 'psychotic' experiences, often focusing on 'beliefs about beliefs' in the case of 'delusions' and beliefs about voices in the case of voice hearing (Beck, 1976, 2016; Bentall, 2003; Birchwood et al., 2000; Chadwick, et al., 1996; Leahy, 2004; Thomas, et al. 2014).

Cognitive approaches, however, especially when applied to therapy, are far from unitary in their own underlying assumptions, often characterising themselves as 'pragmatic' or 'a family of theoretically affiliated approaches' (Strong et al., 2008, p.156) or, more critically, '(a) multistranded (and) arguably incompatible mixture' (Moloney & Kelly, 2008, p.279). There is certainly diversity. On the one hand, there are approaches that seem strongly to share the epistemological assumptions of positivist science as applied to the study of cognition, involving a mix of empiricism and rationalism (Bracken & Thomas, 2008; Slife, 2004). Here, cognition is presented as discrete components and mechanisms, with distress linked to faulty internal mental mechanisms. Other features of these realist approaches include a focus on the workings of individual minds; the separation and privileging of thought over emotion; a belief in the power of reason to bring about positive change; and the adoption of a correspondence theory of truth where distressed people's interpretations of their experience can be compared to an objectively known reality (Boyle, 2002a; Hemmings, 2008; Nelson, 1997; Strong et al., 2008). This stance tends to be associated with approaches to therapy which reflect values of rationalism and objectivity, for example, the use of procedures which have been 'tested' through randomised controlled trials; definition and assessment of relevant variables; the breakdown of therapy into component tasks; and measurement of specific outcomes.

Contrasting with this are approaches, sometimes called 'dialogical', which are closer to social constructionism (see later). These focus on the relational and social character of cognitive processing and content, which not only reflect dialogues and relationships with others but which can only 'happen' via whatever discourses and frameworks of thought are culturally available (Safran & Muran, 2000; Strong et al., 2008). 'Cognitive styles' or 'biases' or 'negative automatic thoughts' are therefore not seen as stable properties of individual minds but as ongoing constructions of self and world arising from social relationships in particular cultural contexts. Between these poles are many shades of theory and practice. Schema therapy, for example, draws on theory and practice of mainstream cognitive behaviour therapy, psychoanalytic object relations theory and gestalt therapy (Farrell et al., 2009; Kellogg & Young, 2008); cognitive analytic therapy (CAT) and mindfulness-based cognitive therapy also combine ideas from some of the approaches we will discuss here. But, overall, cognitive approaches tend to take a positivist and realist stance. Perhaps reflecting this, they are closely linked to psychiatric diagnosis (Shafran et al., 2009).

Specific ‘mental disorders’ or ‘symptoms’ are taken to be outcomes of certain cognitive processes, and people are often separated into diagnostic groups for therapy or evaluation of therapeutic techniques. Given the validity problems of diagnostic categories, this can limit research, lead to conceptual difficulties and, potentially, problems in the therapeutic relationship (Boyle, 2002a; Hallam, 2015; Hemmings, 2008; Proctor, 2008). Yet there is nothing in cognitive approaches to meaning making and its links to distress which requires the use of psychiatric diagnosis as distinct from the use of these ideas in non-diagnostic formulations (Clarke, 2015; Hallam, 2013, 2015; Harvey et al., 2004; Mansell, 2008). Unfortunately, this is sometimes referred to as a ‘transdiagnostic’ approach suggesting a reluctance to move away from diagnosis even when it does not seem particularly useful.

The role of social context is another long-standing and continuing controversy in relation to cognitive approaches. This arises from their focus – more apparent in some versions than others – on individual minds and on language such as ‘cognitive distortions’ or ‘maladaptive beliefs’, implying that people’s problems arise from their interpretation of current ‘reality’ and not from more objective features of reality itself such as poverty, racism, poor housing, or domestic violence. Teresa Hagan and Jenny Donnison (1999), for example, highlight the problematic distinction made between the ‘personal or private meaning’ of events and their ‘objective or public meaning’ (Alford & Beck, 1997, and see Chapter 3), a distinction that arguably makes it easier to label the individual’s meanings as ‘distorted’ or ‘maladaptive’. Given that these ‘private’, ‘maladaptive’ beliefs may also be highly functional, even life preserving, the distinction also creates the danger of ‘assuming that *it is possible for the [person] to act/believe otherwise in [their] situation*, i.e. it attributes to the [person] power(s) that he/she simply does not have’ (Hagan & Donnison, 1999, p.129, emphasis in original). These and other commentators (e.g. Hughes, 1997; Moloney & Kelly, 2008) have also highlighted the challenges of applying cognitive approaches in areas of disadvantage; that criticism could, of course, apply to other forms of individual therapy. However, although social adversity is at times acknowledged within cognitive approaches, this has not yet amounted to a comprehensive account of the relationship between distress and the social world, social power, and the cognitive processes which are so central to this approach.

2. Radical behaviourism

There are several versions of behaviourism in Psychology that are sometimes confused with each other. For radical behaviourism, associated with B.F. Skinner, ‘behaviour’ is everything humans do, including private acts and experiences such as thinking or feeling. But radical behaviourism rejects the idea of ‘cognitions’ as internal, private representations of objects and events in the external world and the use of hypothesised mental entities or structures such as attitudes, schemas, thoughts, cognitive deficits or mental disorders as explanations of people’s behaviour. It also rejects positivism’s assumption that we can know or discover the world objectively, although there may be a real world out there. In this sense, it is ontologically neutral. And, although Skinner advocated the use of natural science methods in the study of human behaviour, radical behaviourism views science as a process of invention or social construction, even if a highly specialised one, open to a similar kind of contextual analysis as any other human activity; it is a way of devising or formulating ways of talking about the world that are useful for certain purposes (Barnes-Holmes, 2000; Brown & Gillard, 2015; Hayes et al., 2011; Hayes & Follette, 1992; Skinner, 1974).

As a form of learning theory, radical behaviourism is concerned with how our behaviour

develops, persists and changes through interactions with our environment. Learning, here, is a process of adaptation to the environment mainly through our evolved sensitivity to consequences. These are usually grouped into: (i) punishing consequences, likely to suppress any behaviour they follow; (ii) positive reinforcement – consequences which increase the likelihood of any behaviours they follow by providing pleasant and rewarding experiences; and (iii) negative reinforcement – consequences which also increase the likelihood of any actions they follow but because these actions lessen or stop aversive experiences. People do not respond automatically to these outcomes but actively behave in ways that are goal seeking, purposive and functional; the term ‘operant learning’ refers to these kinds of actions as distinct from autonomic or more involuntary reactions or ‘conditioned responses’. However, the distinction is not clear cut because the latter, for example an initial experience of panic or voice hearing, may later be influenced by environmental consequences. In radical behaviourism, meaning arises from our interactions with the environment, from our ‘learning history’. Although there will be commonalities from our shared culture and biology, meaning is also personal and subjective since no two of us have the same history. This can make some actions difficult for others to understand. But what seems unintelligible to an observer becomes understandable the more we know of the environment and consequences which have shaped someone’s behaviour. The actions of someone whose life has been dominated by punishment and negative reinforcement or by switches between reward and punishment (for example, in an abusive relationship) are especially likely to be incomprehensible to others who may see the person as inconsistent or self-defeating, or as unwilling to make positive changes. All of this may also be perplexing or distressing to the person themselves because radical behaviourism, like cognitive approaches, assumes that meaning making can happen outside of conscious awareness.

The role of cognition in radical behaviourism is complex. Verbal reports (I think, I feel, I believe...) may be a source of information about private events but can never be seen as representing internal processes or structures in any straightforward way. The causal relationships between thoughts, feelings and behaviour are seen as context dependent and variable – for example, negative thoughts may happen before, after or at the same time as actions or feelings and be more or less in line with our behaviour in different situations. Private events and verbal reports of them are seen as inseparable from social contexts and subject to similar ‘rules’ as our public actions (Blackman, 1991). For example, beliefs, including highly unusual beliefs called ‘delusions’ serve important functions in people’s lives, and, like any actions, can be seen as adaptations to particular environments (Roberts, 1991). Again stressing the social nature of cognition, Robert Kohlenberg and colleagues (1993) have argued that some aspects of our everyday interactions and social learning can encourage unhelpful or distressing patterns of influence amongst thoughts, feelings and behaviour. These include: (i) *literality*, where someone may think ‘This is awful’...then act as if he or she is in an awful situation, not in a situation in which they have the thought ‘this is awful’ (585); (ii) *reason giving* – we are often expected to account for our actions and Western culture readily accepts thoughts and feelings as satisfactory reasons for them, reinforcing people for providing, believing in and acting on this kind of rationale; and (iii) *learning from our culture* that cognitive and emotional control can and should be achieved as a means to successful living.

All of this means that radical behaviourism has commonalities with social constructionism, although with less explicit attention to power (see later) and with dialogical approaches in cognitive theory. It has less in common with more positivist and realist versions of cognitive theory (Blackman, 1991). Radical behaviourist ideas inform a number of approaches to intervention including acceptance and commitment therapy (Hayes et al., 2011); dialectical behaviour therapy (Robins & Chapman, 2004) and positive behaviour support (Gore et al., 2013; Johnston et al., 2006).

3. The interpretative or hermeneutic approach

The interpretative or hermeneutic approach assumes that human experience and behaviour has to be understood in fundamentally different ways from rules and processes governing the movement of physical objects, or, in the case of psychiatric classification and diagnosis, the operation of bodily parts. In essence, with the exception of behaviours that result from an identified biological dysfunction, such as head injury or late stage syphilis (and not always even then), human activity has purpose, meaning and agency. Otherwise, ‘the meaningful activity of agents (‘praxis’) is described as if it were simply the outcome of an interplay of causal forces (‘process’) (Ingleby, 1981, p.41). Human beings do not inevitably respond to the ‘same’ event in the same way, and their response will be influenced by what sense they make of the event – its meaning to them will be shaped by their personal histories and by their social and cultural context. From this perspective, transforming behaviour and experience into universal, discrete, measurable variables, and especially into diagnostic categories, is a significant limitation on understanding.

When some of the so-called ‘anti-psychiatrists’ (a term that most of them rejected) attempted to render the ‘symptoms’ of ‘schizophrenia’ as intelligible and meaningful, they were adopting a hermeneutic rather than diagnostic approach. Thus, Laing did not argue that ‘families cause schizophrenia’ as is often alleged. He asked instead whether *‘the experience and behaviour that psychiatrists take as symptoms and signs of schizophrenia are more socially intelligible than has come to be supposed?’* (Laing & Esterson, 1964, p.12).

Two broad theoretical approaches within the hermeneutic tradition have attempted to focus on the meanings of an individual’s subjective experience of the world: psychoanalysis and phenomenology.

As Stephen Frosh (2012) puts it, because psychoanalysts have a shared belief that there is an unconscious dimension to mental life, they argue that we cannot take what people say or do at face value. Rather, in addition to the manifest meaning of an event there are likely to be other more latent meanings, which can only be understood through an examination of a person’s ‘inner’ emotional life, hopes, fears, dreams and nightmares. Psychoanalytic interpretation in psychotherapy aims to bring out these more latent meanings. While both cognitive and radical behaviourist approaches would agree that meanings of the actions and events of a person’s life are not always transparent or immediately obvious to them, psychoanalytic theory offers accounts of the structure and functions of unconscious processes and the ways in which ‘surface’ actions may be distorted by and relate to, unconscious needs, wishes, fears and so on. Some of these processes are described as defence mechanisms, such as denial, repression and projection, whose function is to protect the person from unacceptable or intolerable emotion or awareness.

Psychoanalysis has a complex relationship to psychiatric diagnostic categories. As

early editions of the *DSM* were heavily influenced by psychoanalytic concepts, many psychoanalysts used them relatively uncritically (e.g. in discussing ‘borderline’ or ‘schizoid’ personality presentations). However, *DSM-III* published in 1980 was designed to be free of psychoanalytic assumptions, and claimed to offer atheoretical descriptive categories instead (though, as we argue, they are not atheoretical in practice). As a result, psychoanalysts have become more critical of the *DSM*, though they tend to argue that the categories are not sufficiently grounded in psychoanalytic conceptualisations rather than disputing the categorical project itself. Despite these limitations, psychoanalysis and related approaches have given rise to an extensive tradition of therapeutic approaches in which meaning is placed at the centre of understanding distress. The list is too lengthy to expand on here, but includes the ideas of Carl Jung, Melanie Klein, Karen Horney, Harry Stack Sullivan, Jacques Lacan Alfred Adler, Erich Fromm and David Malan (for an overview, see Frosh, 2012).

Phenomenology is concerned with the subjective meaning of personal experience. The aim is to develop an insider’s perspective – a personal account which tells their truth rather than one which attempts to judge truth in a more objective sense. There is no space for a detailed description of this rich and influential tradition, which can be traced back to existential philosophers such as Kierkegaard and Nietzsche and their characteristic emphasis on freedom, choice and responsibility. Edmund Husserl subsequently developed phenomenology as a more appropriate method of describing and understanding human experience than the subject/object dualism of the natural sciences, while Martin Heidegger advocated hermeneutics as a way of understanding a person’s direct, unmediated experience of ‘being-in-the-world’, as opposed to natural science methods or the (sometimes pathologising) interpretations of psychoanalysis. These ideas were further developed by Merleau-Ponty and Sartre among many others (for a fuller account, see Aho, 2014, and Wertz, 2015).

These philosophers have been particularly influential in the humanistic and existentialist therapeutic traditions, which encompass Abraham Maslow’s developmental theory, Carl Rogers’ person-centred therapy, Eric Berne’s transactional analysis, Fritz Perls’ Gestalt therapy, and Harvey Jackins’ co-counselling. Viktor Frankl’s logotherapy and the work of Rollo May, Irvin Yalom, and Emmy van Deurzen is more in the existentialist tradition. (See van Deurzen, 2002, for a fuller account of all these therapies). Psychiatrist R.D. Laing drew heavily on these philosophical perspectives in his accounts of the subjective experience of people diagnosed with ‘schizophrenia’ in *The Divided Self* (1960/2010) and *Sanity, Madness and the Family* (Laing & Esterson, 1964). Rather than being diagnostically-based, these related and overlapping approaches emphasise relationships, choice and personal growth. Existential therapies have a central concern with finding meaning within the givens of human existence and the human condition. The emphasis within therapy is on ‘being with’ rather than ‘doing to’, or in the words of philosopher Martin Buber (1923/1996), the transformative potential of an ‘I-thou’ rather than an ‘I-it’ relationship. This highlights the limitations of positivism and places relationships, meaning and agency at the centre of our concerns.

Despite this, phenomenology has been limited by its generally uncritical stance towards diagnostic categories – thus many phenomenological investigations take a particular category as an a priori given before then describing the experiences associated with it.

Karl Jaspers, an influential phenomenologically-oriented psychiatrist, acknowledged the importance of focusing on patients' biographies, but he also saw the form of a 'symptom' as diagnostically more important than its content: 'Form must be kept distinct from content which may change from time to time... it is only the form that interests us' (1913/1963, pp.58–59) – what George Berrios (1988) refers to as an 'anatomical clinical view'. Jaspers, for example, saw 'delusions' as inherently un-understandable, with the consequence that the content of unusual beliefs has been de-emphasised.

4. Constructivist approaches

Constructivism in Psychology focuses on the way an individual imposes meaning on the world, tracing its origins to Piaget (1978) and is thus influential in education and other fields. George Kelly's Personal Construct Theory (Kelly, 1955/1991), is the basis of a therapeutic approach within this tradition in which people are seen as constantly developing and testing hypotheses about the world through discovery and experiment, and thus refining their constructs, or ways of making sense of their lives. In other words, we are all involved in creating systems of meaning (Winter & Proctor, 2013). Within personal construct psychotherapy, there is no room for diagnostic perspectives on mental health difficulties; rather, these are seen as a consequence of familiar constructs becoming blocked, and now longer helpful. People may then resort to swinging rapidly from one pole of a construct to the other, or else their construct systems may become very loose or overly tight and inflexible. The central assumption that human beings are above all concerned with making meaning has much in common with humanistic and existential approaches. Constructivist and phenomenological approaches have been linked through the method of qualitative research known as interpretative phenomenological analysis (Smith et al., 2009).

5. Social constructionism

Social constructionism is the name given to a body of work in the social sciences which grapples with the implications of the work of post-structuralist scholars like Michel Foucault and Jacques Derrida (Burr, 2015). The term social constructionism is used mainly within Psychology – in the rest of the social sciences scholars tend to refer to 'post-Structuralism'. Interpretative and hermeneutic, and constructivist approaches all focus on the individual's constructions of the world, but for social constructionists, these constructions are drawn from a wide range of culturally available options. Moreover, some constructions have more power by virtue of being associated with high status or powerful groups or institutions; they are more likely to be seen as fact rather than opinion, to be taken up by more people, to lead to what are likely to be seen as 'reasonable' actions, and to be imposed by such means as the framing of research questions, legal statutes or public policy.

American psychologist Ken Gergen (1985) has identified four key assumptions of social constructionist work, each of which can be used to generate a critique of psychiatric diagnosis. Firstly, social constructionists question the taken-for-grantedness of many of the concepts we use in everyday life, and adopt a questioning approach to realism. From this perspective, psychiatric classification and diagnosis is seen as naively realist in that it assumes that these categories, and research underlying them, map directly onto the world. Instead, diagnostic categories are seen as linguistic constructions developed by

social groups rather than examples of nature ‘carved at the joints’. Social constructionists are attentive to the assumptions implied in linguistic constructions, and thus they draw attention to the implicit essentialism and structuralism of traditional psychiatric diagnostic categories. Essentialism refers to the way in which diagnostic categories are seen as referring to coherent, stable and universal essences – for example, the implication that the diagnostic category of ‘schizophrenia’ refers to a brain or neurodevelopmental disorder. Structuralism refers to the way in which phenomena are described in structural terms, often hierarchical in nature – thus, within a medicalised approach, presenting problems are seen as symptoms that in turn are seen as the surface representation of a pathological process, operating at a deeper level within the individual. Cartesian dualism – the way in which the mind and body have been seen as separate entities in Western philosophical thought – is another example of structuralism.

A second assumption within social constructionism is that knowledge in the human sciences is historically, socially and culturally specific. Traditionally, psychiatric diagnostic categories have been seen as ahistorical and the regular revisions of diagnostic manuals to accommodate changes in categories are seen as progressive moves towards an objectively true representation of reality – indeed, we sometimes see examples of retrospective diagnosis of historical figures such as Joan of Arc. In contrast, social constructionists argue that diagnostic categories are very much rooted in a particular historical period and subject to changes in social norms. Thus, the hearing of voices might have been conceptualised primarily in religious terms in the West a few centuries ago whereas a medical conceptualisation, no less subject to social norms, predominates now. Hysteria was a common diagnosis in the 19th century but it is rarely heard of today. Changes in social norms about sexuality and the rise of civil rights campaigns about sexuality led to the removal of homosexuality from the *DSM* in 1973. Of course, social norms not only vary from one historical period to the next but from culture to culture, as will be discussed in more detail below.

A third assumption is that knowledge is not fundamentally dependent on empirical validity but is rather sustained by social processes. As we have seen, radical behaviourism and the standpoint theories we discussed earlier share the view of science as a social process; but, along with less relativist social constructionists (see below) they do not see this as negating the idea that some theories and concepts are more empirically valid than others. In the case of psychiatric diagnosis, however, social processes appear to dominate. For example, the American Psychiatric Association’s *DSM* working groups vote on whether to change diagnostic categories and, during the debate about whether to remove homosexuality from the *DSM*, the APA even conducted a nationwide membership survey (Kirk & Kutchins, 1997). And, as we noted earlier, this dependence on social processes rather than empirical evidence is evident across the functional diagnostic categories. Moreover, social constructionists might point to the way in which diagnostic categories gain credibility and apparent validity through social processes. For example, UK NICE guidelines use diagnostic categories even though the introductions to those guidelines often note problems with the reliability and validity of the categories. This in turn is said to be justified because the categories are used by researchers (Cromby et al., 2013). Yet researchers often use those categories because high impact factor psychiatric journals require them. We end up with a circle where diagnostic categories are sustained by such social processes.

A fourth and final assumption, echoing our earlier discussion of epistemology and ethics, is that descriptions and explanations of phenomena are not socially neutral. Moreover, as we noted earlier, there is also a relationship between social constructions of distress and the operation of power – some constructions are more dominant in society, opening up certain ways of seeing the world, making them seem reasonable and obvious whilst others are closed down. As Ethan Watters (2011) and Ian Hacking (2002) argue, once these categories have been produced, they create new ways of being in the world, which tend to produce the very forms of behaviour they define. This might help to explain the rapid spread of some previously rare expressions of distress, such as self-starvation. These particular ways of describing things have social effects. For example, if distress and troubling behaviour is constructed as resulting from dysfunction within individuals, solutions tend to be offered at the level of the individual – psychiatric medication if the problem is seen in biomedical terms or psychological therapy if it is seen in psychological terms. This individualization tends to obscure other potential descriptions and explanations – for example, the notion that distress may be understood at a societal level. But, as we saw in our earlier discussion of neoliberalism, one of the social effects may be that of ‘re-designat(ing) social problems as medical ones’ (Moncrieff, 2010, p.381) and encouraging policymakers to focus on solutions at an individual level.

Social constructionism has also been concerned with the relationship between the (constructed) social world and individual experience, for example of identity, feeling and desire, and with how these may be subjectively experienced as personal attributes independent of the social world (Burr, 2015; Davies & Harré, 1990; Lafrance, 2009; O’Grady, 2005). Researchers have broadened this to include the body, especially the female body, its functions and dysfunctions (Stoppard, 2000; Ussher, 1997, 2011; Yardley, 1997), along with other gendered aspects of emotional and behavioural problems.

Carla Willig notes that social constructionist research varies in how strongly relativist it is. Radical (i.e. more relativist) constructionist research focuses primarily on how language is used in specific local contexts whereas more moderate (i.e. less relativist) constructionist research seeks to ground the study of discourse ‘in social, cultural, economic and material structures’ invoking ‘a reality which pre-exists and indeed shapes the ways in which individuals construct meaning within particular contexts’ (2012, p.12). From a moderate constructionist point of view, then, we can expect similarities and regularities in our experience and expression of distress, since we all occupy the same planet and belong to the same species. We share embodied capacities to learn, remember, use language and symbols, to feel sad when abandoned, to feel angry when insulted, and so on (Cromby & Harper, 2009). In other words, there are real biological features and social circumstances that shape the experience of distress, quite apart from language. This avoids the danger that the impact of the material realities of people’s lives (poverty, poor housing and so on) are simply seen as additional discourses to be deconstructed, rather than addressed in their own right as making a significant contribution to distress. As Willig (2012) notes, there is a great degree of overlap between moderate social constructionism and the theoretical perspective of critical realism, to which we turn next.

6. Critical realism

Critical realism is a form of weak, not strong, constructionism. Critical realism prioritises ontological realism – in other words, it accepts that there is a ‘real world’ out there – but

accepts there are competing views of the world across time and space (epistemological relativism). It assumes that human beings take both into account and then exercise 'judgmental rationality' in order to decide what is fair and true about the world they inhabit (Bhaskar, 1986).

Critical realism thus treads a middle philosophical path between positivism on one side and radical constructionism on the other. It accepts positivism's view of an external mind-independent reality but rejects the idea that universal lawful relationships will be discovered in human science, because human life is an open not a closed system. While the roots of positivism may be traced back to the Greek philosopher Parmenides (see above) critical realism reflects the rather different tradition originating with Heraclitus, who argued that the world and everything in it are indeed real but that 'a man cannot step into the same river twice for fresh waters ever arise about him' (*Stanford Encyclopaedia of Philosophy*, 2015, np). In this view, reality is characterised by change and flow *but* the river does have a shaping bed to it. This implies the need to explore reality cautiously, asking, for example what happens contingently rather than universally; what underlying structures might account for this happening and not that; and what made the man of Heraclitus' example step into the river then and not another time. The implication is that human agency is also part of reality. Critical realism also rejects positivism's attempts separate facts from values, arguing instead that all human activity, including scientific activity, is interest driven; there is no neutral or 'disinterested' bird's eye view in psychology or any other human science.

Terms like 'schizophrenia' or 'depression' are rejected by critical realists as being ontologically and empirically unfounded. Nonetheless it is accepted that some people do hear voices, hold ideas that make no sense to others or are profoundly sad. In other words the 'reality' we try to understand here is not a 'mental disorder' called 'schizophrenia' or 'depression', but the specific experiences that are considered odd by others or are distressing to the self (Boyle, 2002a; Pilgrim, 2015b; Pilgrim & Bentall, 1999). However, this does not imply a straightforward acceptance of 'abnormality' because in relation to what is or is not problematic, critical realism concurs with more radical constructionists. In the example of hearing voices, an alternative to seeing it as a symptom of a 'mental disorder' would be to see humans as having a widely distributed capacity to experience imaginary events as real; to see the expression of this capacity as shaped by experiences, particularly ones that are extreme or traumatic, and also by social and cultural context; to see whether it is personally distressing as a matter of subjective meaning for a voice hearer shaped by social context, and to see whether it is disturbing to others and what they do about it, again as a matter of meaning and social context. All of this highlights complex, interacting processes – universal, contextual and personal – in our attempts to understand causes and meanings.

Critical realism has much in common with the perspective known as material-discursive (Lafrance, 2009; Stoppard, 2000; Ussher, 2011; Yardley, 1997) which emphasises the inextricable links amongst the social, political, material and discursive aspects of our lives. Both approaches assume that through using varied methods of research, we can build up a picture of the real world and its impact on us, albeit tentatively and always giving due weight to contingent causes and discursively produced meanings (Pilgrim, 2015b).

7. Process philosophy

Ideas from process philosophy offer a perspective on how the causal influences which are acknowledged from a critical realist, and other, positions, can contribute to emotional distress and the meanings associated with it. Process philosophy is the general term for a range of perspectives that emphasise how our world actually consists of constant change and instability. Process philosophers such as Alfred North Whitehead (1929/1978), Suzanne Langer (1967) and Gilles Deleuze (Deleuze & Guattari, 1984) emphasise the dynamic, ceaselessly evolving character of being. They argue that we should be concerned more with what is occurring, than with the seemingly stable entities we encounter. After all, even the largest and most solid things – mountains, say – are slowly changing and eroding, and some millennia from now will no longer exist. For most practical purposes the process character of mountains might be considered largely irrelevant, but a process perspective is clearly relevant to Psychology. Humans are intrinsically developing creatures: over time we live, change, grow and die, and our experiences are continuously shaped both by our changing psychological capacities and by the constantly unfurling possibilities we encounter and create. Debates have often emphasised the differences between critical realism and process philosophy, for example with respect to their ability to include emotions and feelings or their possible dependence upon mathematical ‘laws’ (Lawson, 2003; Nelson, 2003). At the same time, both philosophies can be seen as useful ways of ‘fleshing out’ some social constructionist approaches, because they both go beyond language and discourse in order to include material and physical influences.

Both philosophies rely upon notions of emergence in their attempts to understand the associations between material and psychological phenomena. Emergence describes how the properties of a higher order system cannot simply be derived from those of a lower order system (Chalmers, 2006), or – in everyday language – how the whole is greater than the sum of its parts. Cultures, for example, have properties such as languages and behavioural norms that are not simply properties of individuals, and that cannot be adequately understood in solely individual terms. Hence, these are called emergent properties: they emerge when the individuals that make up a culture come together in the conduct of everyday life.

From a critical realist perspective, Margaret Archer (2000) proposes that mind, consciousness, selfhood, identity and agency are all emergent properties. She argues that these psychological phenomena emerge from intertwined neurological, interpersonal and societal processes. From a process philosophical perspective, similarly, Suzanne Langer (1967) proposes that the entire psychological realm is a ‘phase’ of organic matter that emerges when its multiple processes (physiological, behavioural, etc.) cross a certain threshold of intensity. She uses the example of an iron bar, which when heated will glow red. The redness of the iron is not an extra quality that came from somewhere else: it is simply a phase of the iron that emerges when it is sufficiently heated. In a similar fashion, Langer argues, psychological phenomena emerge when the multiple processes of human bodies become sufficiently active. More recently, the relevance of process philosophy to psychological phenomena has also been recognised within neuroscience (Brown, 1998; Weber & Weekes, 2009).

Critical realism also describes how individuals in their everyday actions reproduce available social structures and cultural resources – and, in the process, sometimes more-or-less subtly

transform them. Margaret Archer (1995) offers the example of banking: most people who enter a bank simply queue to deposit or withdraw money, and this reproduces 'banking' as a cultural phenomenon. However, a very small minority commit bank robberies, and instead of simply reproducing 'banking', this activity de-stabilises and transforms it. Yet it is mostly impossible for banks to know, in advance, which of their customers will attempt a robbery and which will simply use their services. This is because the many different relevant processes involved (material, cultural, social, economic moral, ethical, psychological, biological and so on) come together in ways that – due to their enormous complexity and dynamic variability– simply cannot be entirely predicted in advance. This complexity is why there are broad epidemiological patterns of causality in relation to emotional and behavioural difficulties, but also why it is impossible to absolutely foretell the future effects of these causal patterns upon specific individuals.

The understanding that humans are creatures whose psychological experiences and characteristics are continuously in process challenges the relatively static models and divisions used in much thinking about distress. The neat distinctions frequently drawn between biological, psychological and social influences, for example, are revealed as overly simplistic. This is because – over time, as these various processes mutually entrain and intersect with each other – the psychological, biological and social become inseparably entangled. From a process perspective, what matters is not some retrospective reckoning of their presumed separable contributions. Rather, we should be more concerned with how their ongoing entanglements always come together, in different ways, to produce the various possibilities and constraints that shape our experience and behaviour in all its forms.

So an emphasis on process recognises how multiple, shifting combinations of influences dynamically produce different patterns of meaning and, therefore, different responses. But these responses, in their turn, immediately contribute to the newly emerging pattern of meaning that will shape the next response. Simply put, what we and others do now will shape what both we and they do next. Meanings in distress and troubling behaviour emerge from multiple, complex processes where threats are experienced within relations of power. At the same time, these meanings are themselves shaped by prior meanings. As we will show later, this process orientation allows us to include what is known about the possible effects of early adversity. At the same time, it can also include the possible effects of current factors (including the person's own responses) that can have the effect of maintaining the circumstances which produce their distress and behavioural difficulties.

While there are important differences between critical realism and process philosophy, there are also similarities. For our purposes, the two are linked by their insistence on the connections between psychology and material reality and by their focus on emergent properties. In practice, they converge on a similar notion of human beings continuously embedded within dynamic social structures and relations. The precepts of process philosophy have sometimes been compared to those of Buddhism, Hinduism and other non-Western traditions (Abe, 1975; Brown, 1998; Mesle, 2008), suggesting that it also has potential to incorporate cross-cultural influences within psychological thinking about distress. With its emphasis on 'becoming rather than being', and process rather than substance, it has been claimed that this perspective allows for the reintroduction of meanings, values and subjectivity into philosophical and scientific endeavours.

8. Systemic approaches

Systemic or family approaches broaden focus from the individual to the family or social group, on the basis that problems are located within the interactions between people and may serve purposes for the whole system. Disruptions or difficulties may be particularly common at times of transition, for example, when children leave home. They may also be linked to transgenerational patterns of relating. Contemporary theory and practice has been influenced by social constructionism and the ways that language and dominant social discourses shape the nature and understanding of difficulties. Thus, therapists may be interested in exploring what it means to be a ‘good mother’ or to have a ‘happy marriage’, and how these dominant cultural ideas are reproduced within particular families or systems. They will also want to take into account the impact and meanings of other contextual factors such as poverty and discrimination, and the ways in which service interventions may relieve or compound the difficulties. Making these influences more explicit offers an opportunity to open up other meanings, narratives and ways of relating. In this way, a bridge can be formed between families and their wider social and cultural contexts, although the extent to which the stress of external demands on the family system can be resolved is open to question. Systemic theorists and therapists do not typically use psychiatric diagnosis, although they are interested in exploring the impact and function of this kind of conceptualisation of people’s problems. The emphasis is on open and shared exploration of meanings, rather than on expert-derived theories and judgements (Dallos & Stedmon, 2014). Some versions of systemic theory and practice have been influenced by feminist and multicultural perspectives (McGoldrick & Vardy, 2008).

9. Spiritual perspectives

Spiritual or religious perspectives on unusual experiences are common in non-industrialised countries and are also held within the West, especially within the tradition of transpersonal psychology which integrates present-day psychological theory with spiritual wisdom. From this perspective, a mental health crisis may be seen as a ‘spiritual emergency’ (Grof & Grof, 1991) which is an opportunity for growth and healing, given the right support. Transformation of a person’s meanings, values, goals and beliefs may be the result, as illustrated in the life of Carl Jung among others (Jung, 1963). Some people report that the spiritual dimension of experience offers a wider containment, a sense of relationship with the whole and a reaching beyond individuality that can offer a way forward (Brett 2010; Jackson 2010).

The preoccupation with spirituality and religion among some people with a diagnosis of psychosis has led to parallels being drawn with the experiences reported by mystics and spiritual leaders. Research suggests that the ability to access these dimensions has both benefits – such as creativity – and downsides (Claridge, 2010). Viewed in this way, such experiences are a potentially positive navigation of the path of life rather than an illness (Clarke, 2010, 2013; PANUPS, 2011). The ‘Emerging Proud’ campaign, based in the UK but with links in a number of countries, is a grassroots social movement for the reframing of mental distress and extreme states, so that they are seen as a catalyst for breakthrough rather than breakdown. The campaign’s aim is to make it safe to speak about such experiences, which may have deep spiritual significance for the individual, without being pathologised. However, accessing this wider dimension can bring dangers, as the usual boundaries between and within people dissolve, the sense of safety and predictability is

lost and anomalous experiences become accessible. Organisations like the Spiritual Crisis Network (www.spiritualcrisisnetwork.uk) offer support for people who are not fully in touch with consensual reality, in order to help them negotiate their way safely through such experiences. Other cultures may have traditions of offering shamans and spirit guides to people in extreme distress, since in the shamanic view, such crises may signal the birth of a healer (Kakar, 1984).

Recent research suggests that respecting and supporting spiritual understandings may make the difference between an episode that someone can move on from, even learn from, and one from which it is much harder to emerge (e.g. Brett et al., 2014; Heriot-Maitland et al., 2012). Religious beliefs may help recovery through enhancing a sense of hope, purpose, self-belief and meaning (Heffernan et al., 2016).

10. Liberation and social justice approaches

In addition to these more philosophical traditions of thought about how we understand reality, there are other more practically oriented approaches (for example, ‘community psychology’) whose starting point is an explicit recognition of the role of social structures, interests and power in the production of knowledge and the practices it supports. They draw on a variety of theoretical positions but emphasise that the social patterning of those who contact mental health services or have those services imposed upon them is not random. Public information or media reports that mental health problems affect about one in four of the population can be misleading because it is not any one in four: that ratio is skewed by, for example, gender, ‘race’ and, especially, poverty. (We will discuss this evidence in detail in Chapter 4).

Community psychologists, intercultural therapists, feminist therapists and others who explicitly adopt a social justice or liberation psychology perspective have done much to highlight the impact of material conditions (Afuape & Hughes, 2016; Holland, 1995; Kagan et al., 2011; Kareem & Littlewood, 2000; McClelland, 2013; Midlands Psychology Group, 2013; Orford, 2008; Prilleltensky & Fox, 2007; Smail, 2001; Watson & Williams, 1992). They have also argued that medicalising and individualising distress creates serious ethical problems. One of their core assumptions is that because some groups within society are more privileged, and therefore more powerful, than others, they are likely to try and maintain that power and privilege by a variety of processes and practices that are to varying degrees unjust. In line with social constructionist approaches, these conflicts of interest are said to be concealed by particular uses of language – for example, describing members of disadvantaged groups as more at risk of having ‘mental illnesses’ rather than as suffering more from social injustice. This kind of medical language or ‘discourse’ is said to ensnare people further by confusing or mystifying them about the real causes of their distress. For this reason, liberation psychology places a strong emphasis on dialogue amongst diverse groups, reflecting critically on their personal experience, and through this process open up new ways of seeing ourselves and the world which can provide new possibilities for action. A key figure in liberation psychology and social justice approaches in general is Brazilian educationalist Paulo Friere. His ideas were taken up by Ignacio Martin Baro, the Latin American psychologist who argued that Psychology needed to be a force for transformation, not conformity. For these influential pioneers and others inspired by the same traditions, the links between personal distress and social oppression must be made explicit, and psychologists and

others must be committed to standing alongside those from marginalised groups, and to social action (Afuape & Hughes, 2016).

This perspective shares with some other approaches the assumption that what may be called ‘symptoms’ are intelligible responses to particular situations and experience. The emphasis here, however, as with many feminist and intercultural approaches, is on ‘symptoms’ as intelligible responses to inequalities of power and resources, as ways of trying to reduce the distress these create or to survive adversity. For example, hearing voices may bring comfort and encouragement; unusual beliefs may provide meaning in an otherwise meaningless life; anxiety and sensitivity to threat may keep you safe in a dangerous neighbourhood; legal and illegal drug use may dull emotional pain and make life bearable.

One obvious implication is that we need to work much more at a preventative, political and community action level, not just through one-to-one therapy; and that therapy must incorporate a ‘demystifying’ awareness of how power issues are played out in people’s lives, materially, relationally, and through social discourses. In the words of two community psychologists: ‘Community psychology is essentially concerned with the prevention of psychological distress. This requires the recognition of entrenched social injustices, the adverse impact of these on people’s wellbeing and health, and the need for organisational and social change. The means for community psychology to contribute to such change comes through the development of alliances with marginalised groups and community interests, so that collaborative work can redress power imbalance and abuse... Underpinning this endeavour are the principal values for community psychology of focusing on people’s strengths, taking a universalistic perspective on people’s experiences, working inclusively and devolving professional power’ (Bostock & Diamond, 2005, p.22).

11. Experience and expertise

This perspective has emerged as a result of various struggles of New Social Movements (NSMs), including campaigns against slavery, colonialism or in civil rights movements for black people, women, gay men and lesbians and disabled people. Standpoint theory and these social movements have been mutually influential in asking whose reality is being understood and who has the right to speak and theorise about others’ experiences in a context of unequal power. Obviously not all of those who belong to these groups have the same views and we draw here on those who have been critical of how their experiences have been understood by others. In the case of Psychiatry, the relevant NSM has been called, ‘the users’ movement’ or the ‘survivors’ movement’, meaning survivors of the psychiatric system (Beresford, 2010; Campbell et al., 2013; Chamberlin, 1988; Wallcraft, 2013; Wallcraft, et al., 2003). These groups, of course, are not separate from other NSMs, because those who are socially disadvantaged are overrepresented amongst service users.

As already noted, many criticisms from the service user and survivor movements relate to the top-down nature of knowledge production in Psychiatry and Psychology which emphasises objectivity, marginalises subjectivity and meaning, and often places strict limitations on what people can talk about, for example, through ‘symptom’ assessment schedules or preset questionnaire response categories. The medicalising approach has also traditionally been more interested in form (e.g. whether someone hears voices or feels persistently miserable) than content (e.g. exactly what voices say or what someone is miserable about (Boyle, 1996). These problems are compounded not only by the

transformation of people's experience and behaviour into symptoms of mental disorder but also by the historical conflation of madness and irrationality (Foucault, 1967), so that service users' reports of their experience can be seen as untrustworthy and as evidence of lack of insight. The problems are also, of course, compounded by the possibility of involuntary diagnosis and treatment.

A key question within service user and survivor movements, therefore, is who can speak about a person's experience, who has the right to decide, and on what basis, what is significant about their experience and how they should think about it. Some mental health service users and ex-users have argued that they should be seen as people having expertise because of their experiences of distress ('experts by experience') and that this should be seen as complementing professionals who have expertise as a result of their disciplinary training ('experts by profession'). A relevant concept is Miranda Fricker's 'hermeneutical injustice' (Fricker, 2006, 2007) which refers to the kind of injustice experienced by groups who lack shared social resources to make sense of their experiences, due to unequal power relations. This may apply to both the actual words (thus, 'testimonial injustice' may mean that their accounts are automatically subject to invalidation) and to people's whole ability to have confidence in their own knowledge and 'dissent from distorted understandings of their social experience' (Fricker, 2006, p.96). This can be termed 'epistemic violence', a situation in which a discourse is imposed on a subordinate, silenced group, thus facilitating further and more overt forms of violence or oppression (Spivak, 1988). Fricker shows that this may lead to a number of secondary harms, as well as creating barriers to protesting about and changing a group's marginalised social and epistemic position.

Although many of Fricker's examples are drawn from feminism, the concept of epistemic injustice has also been discussed in relation to Psychiatry (Sanati & Kyratsous, 2015) where it is equally applicable to people who have been diagnosed as 'mentally ill' and who, as a result, experience a kind of 'epistemic inequality' or structural discrimination in relation to their own knowledge, such that the 'whole engine of collective social meaning' effectively silences them (Fricker, 2006, p.99). The relatively recent 'Mad Studies' movement has grown out of the need to name, analyse and reverse this process (Russo & Sweeney, 2016), since, in the words of Jasna Russo, 'Powerful mechanisms have been at work for centuries (which) devalue not only our personal stories but also our very ability to understand and make meaning of experiences of our own' (Russo, 2016, pp.61–62).

Service users now increasingly speak, run research and organise services on their own behalf or at least have some involvement in the organisation of professional services but this has not been easy to achieve or maintain (Campbell et al., 2013; Hornstein, 2012; Morgan & Felton, 2013; Venner & Noad, 2013; Wallcraft, 2013). The Hearing Voices Network, for example, trains voice-hearers as peer facilitators for Hearing Voices groups. To avoid privileging one explanation, these groups may provide information on a number of accounts of distress, for example, biological, cognitive, trauma-focused, spiritual and so on. They may also focus more on how service users can integrate their preferred account into a meaningful life rather than offering one explanation.

12. Feminist perspectives

Feminist perspectives on women's distress developed in parallel with the wider women's liberation movement of the 1970s and later, and so have commonalities with the previous

two approaches. Feminist perspectives have also been influential in the application of social constructionist and critical realist approaches within Psychology. Over the past four decades, feminist theory has strongly criticised the psychiatric diagnostic system for systematically pathologising what are seen as women's rightful and reasonable responses to unreasonable events occurring in repressive, dangerous and damaging social contexts. Feminist psychologists have challenged abnormality as a construct and gender bias within psychiatric diagnosis, arguing that it is the 'pathologies' of patriarchy, of racism, classism, heterosexism and ableism that are the 'disorders' women suffer from, not 'disorders of mental illness' (Brown, 2000; Caplan, 1987; Chesler, 1972). The psychology of women and gender has highlighted the long history within Psychology and Psychiatry of pathologising women as less rational, less stable, less intelligent, less mature, and of marginalising non-dominant behaviour and experience. Historically and in current practice, this has been linked to women's reproductive functions, including through modern 'female maladies' such as 'premenstrual dysphoric disorder' (Boyle, 1997; Caplan, 1987; Showalter, 1987; Ussher, 1991, 2013). More generally, feminist psychology, influenced by feminist political philosophy, has argued that gender inequalities and injustice continue to be obscured within a psychiatric diagnosis system that locates pathology in the individual and not in social injustice and oppression, in the gendered hierarchies of power and value that shape women's lives and experience and pervade inner life (Brown, 2000; Johnstone, 2000; Miller, 1976; Williams & Watson, 2016).

The development of a feminist epistemology of power offered a language for describing power processes between dominant and subordinate groups that made visible the ways in which girls and women are trained in subordination and deference. It also made visible the ways in which lack of a shared framework of knowledge and understanding can make it difficult for women to challenge these processes of power and even to articulate their existence (Fricker, 2007; Miller, 1976; Smith & Siegal, 1985). Miller outlined the ways whereby inequality is internalised – the outside gets in – so that injustice and oppression can come to be experienced as personal failings, as helplessness, inadequacy, incompetence, badness and madness. These conceptual and empirical developments helped lay the groundwork for increased understanding of traumatisation resulting from power abuses and for the revisioning of 'symptoms' such as dissociation, voice hearing, self-harm and eating distress as survival strategies in the face of prolonged powerlessness, entrapment and overwhelming feelings of shame, terror, sadness, rage and loss (Courtois & Ford, 2013; Dillon 2011; Herman, 2001). Feminist psychology has also developed new languages for women's experience (Gilligan, 1981) and epistemologies that value subordinate strengths of connection, collaboration and connectivity (Jordan, 2008a, 2008b) and promote relational strength and resilience over radical individualism and intrinsic toughness (Hartling, 2008). The conceptual tools of feminist psychology, including attention to both the material and discursive, to processes of power and to gender biases within Psychology and Psychiatry, have also been influential in illuminating how constructions of masculinity are central not only to men's dominance over women but also to men's distress within patriarchal systems.

The feminist critique of psychiatric practice led to the development of feminist therapy which sought to be deprivatised and democratised – a radical therapy of equals (Brown, 2000; Rosewater & Walker 1985); it was seen as a liberatory part of a larger process of

social change. Central to feminist therapy was the demystifying of the therapy process and the development of a co-expert model of equal value and worth, with explicit attention to power processes within the relationship. Both personal meaning and the public and political realities forming this meaning were privileged, with the aim of addressing the internalisation of oppression and validating individual acts of courage and survival. Naming abuses of power and increasing access to personal and interpersonal power bases were seen as promoting relational strength and resilience (Brown, 2000; Miller, 2008; Watson & Williams, 1992). The development of feminist therapy was not without criticism. Dorothy Tennov described therapy as an ‘unproven and expensive tyranny of one person over another’ (Tennov, 1973, p.107) and the early Eurocentric feminist lens was criticised as whitewashed and heterosexist (Adams, 2015; hooks, 1981; Kitzinger & Perkins, 1993). This has led to an increasing focus on epistemologies of difference and the interactions of multiple systems of inequality relating, for example, to class, ‘race’ and sexuality (Addison & Coolhart 2015; Brown, 2009; Crenshaw, 1991). Links between therapy and collective action have been developed both through group therapy (Mendelson et al., 2011; Watson et al., 1996) and social action (Holland, 1992) and in radical women’s projects outside of statutory mental health services including Rape Crisis Lines and Women’s Refuges.

Feminist perspectives have been influential globally in the recognition that girls’ and womens’ distress often arises from social injustice and inequalities, and also in the development of health and mental health policies which acknowledge that the reduction of multiple intersecting inequalities is likely to be the most powerful intervention in decreasing this distress (NICE, 2014; United Nations, 2016; WHO 2013).

13. Indigenous Psychology

While we are mainly concerned in this document with developing alternatives in a Western context, we have noted at various points the importance of acknowledging the rich variety of healing approaches from other cultures. Indigenous Psychology was recognised as a discipline in its own right with the establishment of a task force within Division 32 (Society for Humanistic Psychology) of the American Psychological Association (APA) in 2010 (Dudgeon & Bray, 2016). It has been defined as ‘the scientific study of human behaviour or mind that is native, that is not transported from other regions and that is designed for its own people’ (Kim & Berry, 1993, p.2). It is part of a scientific tradition which advocates multiple perspectives but not multiple psychologies. Rather, it challenges the idea of decontextualised, mechanical, universal principles and focuses on understanding people in context (Kim et al., 2006). As such, it resists colonisation by Western discourses from both Psychology and Psychiatry. Instead, it supports the value of indigenous healing practices and the often very different worldviews that underpin them (Dudgeon & Bray, 2016; Kim et al., 2006). These may draw on a shared group identity defined by one’s relationship to the community, land and ancestors, and sometimes plants, animals and other elements of nature, along with awareness of the legacy of historical and intergenerational trauma (Ocampo, 2010).

14. Narrative approaches

Narrative is a key theme running throughout this document, and as such will be discussed in more detail in Chapter 3. Here, we note that narrative and narrative approaches play a central role in pulling together the conceptual threads outlined above, and in providing

alternatives to existing systems of categorisation and classification. We also emphasise that the personal meanings we create are much more than personal. An important related concept is dialogism – the idea that narratives and stories do not simply exist inside our heads, but emerge in dialogue with others. These dialogues shape our identities by locating us within larger narratives or social discourses (Bakhtin, 1981, and see also ‘cognitive approaches’, above).

A number of related philosophical and theoretical traditions have contributed to the narrative perspective, including phenomenology and social constructionism. More generally, Jerome Bruner (1986, 1990, 1991) distinguished between complementary forms of thought in understanding human behaviour and experience – ‘paradigmatic’ and ‘narrative’. The former is concerned with logic and universal truth conditions while the latter explores how human beings come to endow experience with meaning. Both are necessary, but neither is reducible to the other. This links to the distinction between positivist and interpretative approaches described earlier.

We emphasise that we are not suggesting that any one of these approaches should be adopted in its entirety in understanding distress and troubling behaviour from a non-medical perspective. We have highlighted areas of overlap and disagreement and none of the approaches is beyond criticism. Taken together, however, they offer an extremely rich resource of ideas, theory, research and practice specifically focused on human behaviour and experience, with some more than others incorporating the social and political contexts and power relations within which these develop.

Crossing cultures

A conundrum that has always presented major difficulties is the question of how to understand expressions of distress within ‘developing’ or less industrialised countries, sometimes referred to collectively as the Global South. Culture is defined here as the set of beliefs, habits, customs and discourses shared by people living in close proximity and time (Kenrick et al., 2010) which shapes their way of thinking, feeling and being in the world (Jenkins & Barrett, 2004). As such, it includes subcultures and minority ethnic groups within dominant white cultures.

As we have noted, psychiatric classification presents diagnostic categories as largely acultural. As such, they should have similar presentations across cultures, even if the incidence varies. But this does not appear to be the case. Even with core categories such as ‘schizophrenia’ or ‘bipolar disorder’ there are not only differences in the content of ‘symptoms’ such as hallucinatory voices or unusual beliefs, but in the contexts in which these are judged by others as abnormal (APA, 2013; Cromby et al., 2013; Littlewood & Lipsedge, 1997). One response is to claim that ‘surface symptomatology’ adds a different gloss in different cultures. The problem with this argument, as we saw in Chapter 1, is that the ‘surface’ is all we have to work with in functional psychiatric diagnosis – we have no access to (or evidence of) stable underlying pathology. If the surface presentation is different, then we could reasonably conclude that we are faced with a different phenomenon. A related problem is the existence of culturally-specific expressions of distress which do not fit current diagnostic categories. *DSM IV-TR* (APA, 2000) managed

these dilemmas by the addition of an appendix of 25 ‘culture bound syndromes’ such as ‘running amok’, found in Malaysia, Indonesia and the Philippines. *ICD-10* (WHO, 1992) has a similar section on ‘culture specific disorders.’

These ‘culture bound syndromes’ have long been a source of debate and confusion (Sumathipala et al., 2004), leading to much inconclusive discussion about whether these experiences are ‘really’ manifestations of a Western ‘illness’ such as depression (e.g. Okulate et al., 2004). The discipline of transcultural psychiatry has arisen out of attempts to find more appropriate conceptualisations outside Euro-American cultures. But even within this field, Western understandings often dominate local ones; although researchers are often members of the culture being studied, the Western version is still sometimes seen as the more valid or ‘correct’ one (Summerfield, 2008; Timimi, 2010). As Derek Summerfield puts it, ‘The socio-culturally determined understandings that people bring to bear.... seem little more than epiphenomenal. Underneath the cultural packaging lies the psychopathology... [the] universal and the “real” problem’ (2012, p.6). Similarly, it is often implied that expressions of distress such as somatic discomfort, said to be more common in non-Western cultures, are less mature or more ‘primitive’, as in the suggestion that ‘somatisation may constitute a defensive process in which psychological distress is expressed in somatic complaints’ (Ebigbo et al., 2015, p.312).

DSM-5 has tried to address debates around ‘culture bound syndromes’ by replacing this term with ‘cultural concepts of distress’, incorporating three related concepts: (1) *cultural syndromes*: ‘clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts...that are recognized locally as coherent patterns of experience’ (p.758). (2) *cultural idioms of distress*: ‘ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns’ (p.758). An example might be ‘everyday talk of “nerves” or “depression” to refer to varying forms of experience but ‘without mapping onto a discrete set of symptoms, syndrome or disorder’ (p.758). Finally, there are (3) *cultural explanations of distress or perceived causes*: ‘labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress’ (p.758). *DSM-5* also includes guidelines for a ‘cultural formulation interview’ intended to allow the identification of these aspects of distress, and cross-reference to the nearest equivalent *DSM-5* diagnosis. For example ‘*ataque*’, a ‘syndrome’ characterised by ‘intense emotional upset, including acute anxiety, anger, or grief; screaming and shouting uncontrollably; attacks of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive,’ is cross-referenced to panic disorder (p.833).

So, although *DSM-5* acknowledges that ‘all forms of distress are locally shaped, including the *DSM* disorders’ (p.758) it is clear that, as in transcultural psychiatry more generally, the medicalised Western version remains privileged. The medicalisation implicit in the word ‘disorders’ is still the primary model, and local ‘symptoms’ are still viewed as needing translation back into the dominant medical paradigms. The perceived superiority of this perspective is reflected in the claim that many *DSM* diagnoses may have started out as ‘cultural syndromes’, but become ‘widely accepted as a result of their clinical and research utility’ (p.758). Similarly, the importance of ‘cultural concepts of distress’ seems to lie in supporting ‘correct’ *DSM* diagnosis, service engagement and efficacy and helping identify

‘patterns of comorbidity and underlying biological substrates’ (p.759). Overall, there is very limited recognition that Western psychiatric diagnoses, based as they are on social and cultural judgements about normative thoughts, feelings and behaviour, are also ‘culture bound syndromes’ (although specific diagnoses, such as bulimia, have sometimes been proposed as examples of this type of problem (Littlewood, 2002; White, 2013)).

The issue here is not just that Western assumptions of distress as illness lack validity but that, as we discussed earlier, psychiatric classification systems, ‘are shaped by contemporary notions about what constitutes a real disorder, what counts as scientific evidence, and how research should be conducted. They are Western cultural documents par excellence’ (Summerfield, 2008, p.992). Psychiatric diagnosis thus encapsulates and conveys a whole set of deeply rooted post-Enlightenment assumptions. These include the separation of mind from body, individual from family and social group, and humans from the environment; the privileging of ‘rationality’ over emotion; a belief in objectivity, or the possibility of partialling out values, ethics and power interests from theory and practice in human systems; the marginalisation of spiritual or religious understandings; and the obscuring of the role of personal, social and cultural meaning in the emergence and expression of all human experience including emotional distress.

These arguments can be extended to the construction of the notion of personhood itself. Not only do certain philosophical and economic traditions encourage us to see ourselves in particular ways; they help ensure that this is how we will actually experience ourselves. Conversely, when we find ourselves or others feeling, thinking or behaving in contradiction to these assumptions – for example, (in the West) expressing very strong emotions, or talking in ways that do not seem to make sense, or becoming aware of different ‘selves’ through voices – we will be more likely to see ourselves, and be seen by others, as ‘mad’. In short, diagnosis may have the effect of ‘presenting as definitive the contemporary Western way of being a person’ (Summerfield, 2008, p.336). These assumptions will be further shaped by the dominant social discourses within any particular society. For example, high value may be placed on co-operation, or harmony with the environment, or respect for elders. Conversely, it has been argued that industrialisation and neoliberalism have resulted in the promotion of ideals of individualism, competition, materialism, consumerism, rationality, choice, and commodification, which may oppose or undermine such values. Those who are best equipped to live up to these expectations, in terms of abilities, resources and opportunities, will be at lower risk of experiencing distress and ‘madness’ or being labelled as such. Those who fall outside the dominant discourses are most like to be seen as, and to experience themselves as, ‘bad’ or ‘mad’.

All of this is reflected in psychiatric diagnosis’ inevitable dependence on social judgements, as we discussed in Chapter 1, and many critics have traced particular diagnoses back to the social norms they challenge: ‘borderline personality disorder’ for women who are too angry; ‘depression’ for women who are exhausted by domestic demands; ‘anorexia nervosa’ as a reaction to the unrealistic role and appearance standards faced by modern women; alcohol misuse and suicide for men whose socialisation does not permit the expression of despair in other ways; ‘ADHD’ for children who are not suited to educational regimentation, and so on (Bordo, 1996; Lafrance, 2009; Proctor, 2007; Timimi, 2010 and see Chapter 4, on gender). These rule transgressions can involve over-adaptation to the ideal image, as well as failing to live up to it; thus Paul Verhaeghe (2012/2014) sees ‘psychopathy’,

'narcissistic personality disorder' and 'sex addiction' as extreme examples of taking cultural messages on board. Similarly, it has been suggested that the enormous rise in diagnoses of 'autism spectrum disorders' and 'Asperger's' may partly reflect demands made by highly industrialised and service-oriented economies for successful employees to display emotional behaviours such as (faked) sociability, warmth, gratitude, passion and so on – skills which do not come easily to everyone (Roberts, 2015). (NB: Although autism in its most severe forms fits the profile of a neurodevelopmental disorder of some kind, the debates about these diagnoses are particularly complex – see the Exeter University 'Exploring Diagnosis' project at <http://blogs.exeter.ac.uk/exploringdiagnosis/>). Given all this, it is hardly surprising that in many parts of the Global South, there may be no equivalent categories to the experiences that *DSM* and *ICD* label as 'depression', 'anxiety', borderline personality disorder, anorexia, and so on. In fact, the distinction between thought and emotion may not even be recognised (Cromby, 2015) and the very notion of an individual who exists in some sense independently from their social network may be alien.

How, then, should we understand so-called culture-bound syndromes and what light do they throw on forms of distress that may be more familiar? Ethan Watters has argued, drawing on Edward Shorter, that in all cultures... 'People at a given moment in history in need of expressing their psychological suffering have a limited number of symptoms to choose from – a "symptom pool"' (2011, p.34). In order to convey their troubling and often confused emotions, they unconsciously seize on a form of expression that is a culturally-recognised signal of suffering. Newspapers and journals write about it, people start to seek help for it, and an unconscious process of negotiation takes place between doctor or healer and sufferer in which perceptions of the new problem are shaped. Thus, expressions of psychological distress and deviance, whether or not they are called mental disorders, do not exist independently of social and historical context. Similar arguments have been put forward by others (Littlewood, 2002; Littlewood & Lipsedge, 1997). This process of 'negotiation' – in which the *DSM* now plays a major role – may also help to explain the rapid spread of certain forms of distress both within and across societies, as individuals unconsciously select from culturally available forms of behaviour in order to express their despair. The same applies to the transient emergence of phenomena such as 'hysteria' in Victorian times, or the 'mad travellers' who felt compelled to undertake long journeys across Europe in the 19th century (Hacking, 1998).

The same also applies to current mental health practice, with its familiar landscape of self-harming, self-starvation, extreme fluctuations of mood, suspicious thoughts about hidden cameras and TVs, and so on. We can expect these presentations to continue to shift and change along with wider cultural meanings and upheavals as well as the contents of diagnostic manuals. This suggests the need for a meta-framework of understanding that is flexible enough to accommodate and respect cultural meanings and differences, while being aware of the historical and cultural specificity of any given expression of distress. This takes us even further away from the implied universality of medicalisation.

The ethics of exporting Western models of mental distress

There is a long history of dominant White groups imposing psychiatric categories on indigenous populations and local understandings, including the Maori people of New Zealand (Cohen, 2014) and North Africans in Algeria (Keller, 2007). In Europe, a similar

process has been documented in Latvia, in the years since it gained independence from Soviet Russia in 1991 (Skultans, 2003, 2007). A more recent development is the movement for Global Mental Health (<http://www.globalmentalhealth.org/about/aims>). Supported by the World Health Organisation, it emerged from a series of articles in *The Lancet* and was launched in 2008 with the aim of ‘scaling up’ psychiatric services in low-income and middle-income countries where there is said to be a ‘treatment gap’ depriving the majority of people of Western interventions. This is predicated on an assumption of ‘mental disorders’ as universal and primarily biological (Mills & Fernando, 2014).

This movement has not escaped criticism. Suman Fernando (2010, 2014) and others (Bracken et al., 2016; Bughra & Littlewood, 2001; Mills & Fernando, 2014; Sumathipala et al., 2004; Summerfield, 2012) have argued that to impose dominant Western models of social ‘deviance’ and distress on to other cultures is to fall into the racist assumption that our worldview is superior because more ‘true’; a subtle but no less damaging form of colonialism than more overt forms. These criticisms echo Frantz Fanon’s much earlier exposition of the links between Western ‘psy’ disciplines and colonialism in his book *The Wretched of the Earth* (1963/2001). Similarly, Derek Summerfield rejects the ‘medical imperialism’ that positions local populations as lacking ‘mental health literacy’ and needing ‘educating’ in Western psychological and psychiatric concepts (2008, p.336), with the resulting marginalisation or outlawing of indigenous knowledge systems and traditional forms of healing (Critical Psychiatry Network, 2014; Davar, 2014). Others have pointed to the potentially damaging impact of importing Western models of trauma management, with their focus on individual minds, following the 2004 Sri Lankan tsunami (Fernando, 2004; Watters, 2011) and more generally for refugees who have been caught up in conflict and war (Bracken et al., 1997).

If medicalisation obscures the links between social adversities and emotional distress within the Global North, it does so to an even greater extent in the Global South where ‘structural poverty and injustice, violent conflict, debt repayment, shifting weather patterns, environmental degradation, and inadequate budgets for health, education and social welfare provide a barely viable social context for millions of people’ (Summerfield, 2008, p.993). Lack of resources also means that the medicalisation of distress in the Global South often takes a particularly reductionist and coercive form including reliance on heavy doses of psychoactive medication and unmodified ECT (Davar, 2014; Mills, 2014; Summerfield, 2012), although there are also examples of helpful collaboration across cultures such as group support for women survivors of genocide and mass sexual violence (Hogwood & Rouf, 2016).

None of this is to deny that local practices, such as beating, confining or shackling the ‘mad’, which is sometimes linked to beliefs about spirit possession and witchcraft, may be equally oppressive (Mills & Fernando, 2014). There can be high levels of abuse and discrimination against those identified as ‘mad’ within communities and traditional healing centres, again sometimes linked to cultural explanations about spirit possession and witchcraft (Mental Disability Advocacy Centre and Mental Health Uganda, 2014). It is also true that pressure to frame distress in a way that does not challenge dominant social norms may be present in all cultures, albeit from slightly different perspectives. However, the Global Mental Health Movement raises serious ethical questions about promoting Western diagnostic concepts and their associated practices as a new way forward.

Cross-cultural considerations also raises serious epistemological questions. In this document we also dispute the assumption that non-Western worldviews have little to offer to our understanding of emotional distress. The fact that medicalisation has failed to achieve recovery rates equal to those in many non-Western countries (Davidson & McGlashan, 1997; Warner, 2004) along with high and rising levels of distress in the UK and the USA should suggest otherwise. In subsequent sections we will present evidence that our individual minds and bodies cannot be understood in isolation from those of others or from wider society; that the wellbeing of the individual is inseparable from the cohesion and well being of the whole community and that narrative is a powerful source of healing. In other words, and in keeping with the assumptions of many indigenous healing systems, the distress that dominant Western ways of thinking locates within the individual may be better understood in terms of disruptions to the social and moral order (Fernando, 2004; Summerfield, 2008; Watters, 2011).

Many of the alternatives to medicalisation we suggested earlier are compatible with this perspective. For example, social constructionism and radical behaviourism have been highly critical of a focus on individual minds; from their perspective, it is no surprise that constructions and expressions of distress are different from culture to culture or that similar experiences may be understood in very different ways. Social justice and community approaches can be seen as attempting to reintroduce some of the shared communal experiences that have been neglected, while dialogical, interpretative and phenomenological approaches also acknowledge the centrality of shared meaning in human experience and behaviour. Process psychology emphasises that cultures, for example, have properties such as languages and behavioural and ethical norms that are not simply properties of individuals, and that cannot be adequately understood in solely individual terms; these properties ‘emerge’ when the individuals who make up a culture come together in the conduct of everyday life. Equally, these perspectives are consistent with themes that frequently emerge from the personal accounts and testimony of service users. This includes developing dialogue with others, and thus being enabled to place experiences within a wider social and political context so that they become both valid and meaningful (Dillon, 2009; Dillon & May, 2003; Russo & Sweeney 2016).

Beyond medicalisation and diagnosis: Some principles from alternative perspectives

We have argued that constructive alternatives to psychiatric classification and diagnosis need to focus on aspects of human functioning which have been marginalised in theoretical frameworks derived from the study of bodily processes or objects in the physical world. We have outlined a number of alternative perspectives but are not suggesting that there is one universal answer. We believe, however, that collectively they provide a resource for developing a very a different understanding of emotional distress, unusual experiences and troubling behaviour, based on the principles below:

1. Our understanding of the thoughts, feelings and behaviour that are labelled as madness, distress or deviance should primarily be based on philosophical assumptions and theoretical frameworks related specifically to the study of human behaviour and experience.

2. 'Abnormal' behaviour and experience exist on a continuum with 'normal' behaviour and experience and are subject to similar frameworks of understanding and interpretation. These include the assumption that, unless there is strong evidence to the contrary, our behaviour and experience are intelligible responses to our culture, history, bodily capacities and current circumstances, although the links amongst these may not always be obvious or straightforward.
3. Causality in human distress and behaviour is probabilistic, contingent, synergistic and always shaped by core human attributes of agency and meaning-making. Thus, it will never be possible to make precise predictions about the impacts and outcomes of causal factors and events.
4. Experiences and expressions of emotional distress are enabled and mediated by, but not in any simplistic sense caused by, our bodies.
5. Humans are fundamentally social beings and our relationships shape all aspects of our experience and behaviour, including 'healing' from distress.
6. Human experiences of distress and troubled or troubling behaviour, whether described at an individual or group level, are inseparable from their material, environmental, socio-economic and cultural contexts. There is no separate 'disorder' to be explained, with context as an additional influence.
7. All indigenous forms of understanding and promoting change have useful aspects, but there can be no 'global Psychiatry' or 'global Psychology'. Patterns in emotional and behavioural difficulties will always reflect prevailing social and cultural discourses, norms and expectations, including accepted conceptualisations of personhood.
8. Theories and judgements about identifying, explaining and intervening in mental distress and troubled behaviour are not interest or value free. We always need to be aware of the ethical and social justice implications of our theories and practice. This does not mean that useful and reliable knowledge about distress is unobtainable but that trying to separate 'facts' from values is highly problematic.
9. We need to take meaning, narrative and subjective experience seriously. This will involve a central place for the narratives of experts by experience. It will also involve drawing on a wide range of research methods and giving equivalent status to qualitative and quantitative methods including the testimony of service users/survivors themselves.
10. We need full acknowledgement of the social justice implications of non-medical understandings of distress.

Conclusion

We began this Chapter by posing four questions in relation to our aim of understanding mental distress and troubling behaviour outside of a diagnostic or medicalised framework:

- What different assumptions should we make, what different theoretical frameworks can we draw on, in understanding *the behaviour and experience of persons within their social and relational environments* rather than the (mal)functioning of bodies?
- At the broadest level, what patterns have researchers described that might be helpful in understanding and alleviating emotional distress and behavioural difficulties from a non-diagnostic perspective?

- How might these broad trends and relationships be used to delineate narrower, provisional, general patterns which can inform our understanding of the particular difficulties of an individual, family or other group?
- What issues – therapeutic, social, ethical, legal – arise from adopting non-diagnostic approaches and how might we address them?

We have focused mainly on the first question and considered a number of potentially useful frameworks and perspectives, not all in agreement but with significant areas of overlap. Drawing on these, we have also suggested some principles and assumptions which should inform non-diagnostic approaches. We have shown that we need to go further than selecting a new model from existing alternatives. Instead, we need to re-visit a whole set of often unarticulated and unquestioned philosophical, theoretical, historical and cultural traditions and assumptions, supported by a range of personal, professional, economic, social and political interests. Moving away from what can be referred to in shorthand as the ‘*DSM* mindset’ is very difficult, since it is inextricably linked to deeply internalised aspects of the basic fabric of our thoughts, feelings, identities and worldviews. Such a move is also likely to reveal many social and ethical dilemmas which have been obscured by the current framework.

We have argued that meaning and narrative must play a central role in any new conceptualisation of distress that informs alternatives to psychiatric diagnosis. Before addressing the remaining three questions, we will therefore discuss these two related aspects in more detail.

Chapter 3: Meaning and narrative

In this chapter we will return to the theme of meaning and take a more detailed look at the central role it plays in the experience, expression and understanding of distress. We begin by looking at how meaning may be created and at the limitations of the idea of ‘personal meaning’, before briefly revisiting the ways in which meaning has been generally understood within psychiatric and psychological theorising in relation to emotional and behavioural problems. We then discuss the merits of the concept of narrative as providing a common language for the development and communication of meaning.

We have argued that personal, social and professional meanings of distress and troubling behaviour draw on broader cultural narratives and that these arise in a context where power relations make some narratives of distress more culturally available and of higher status than others. In Western industrialised societies, as we have seen, these narratives often involve deeply rooted assumptions about the separation of mind from body, and individual from social; the privileging of ‘rationality’ over emotion; and a belief in objectivity, or the possibility of partialling out values, ethics and power interests from theory and practice in human systems. These assumptions inform our core beliefs about personhood – what we mean by the ‘self’, and the relationship between self, others and the material and natural world. These ideas and beliefs, often unquestioned, are evident in dominant psychological and psychiatric theories (which themselves can be seen as forms of narrative), and thus there are strong links between cultural and scientific belief systems. Here, we will continue the discussion of how new psychological and psychiatric narratives of distress emerge in response to broader social changes and variations in political economy. We will also discuss the links between self-narratives and wider cultural narratives.

The dominance of certain narratives means that some (claimed) patterns of emotional and behavioural difficulties are more culturally available and that other potential patterns, possibly with a much stronger evidence base, are obscured. This theme is expanded through the identification of alternative research-based patterns of distress as described in Chapter 6. In Chapter 8 we elaborate on the role of narrative in therapy and healing, especially if supported by a resource of broader evidence-based patterns of distress.

How do we make meaning?

The process of meaning-making begins through the infant’s relationship with caregivers. As John Bowlby (1958) first argued, these relationships are key in providing a ‘secure base’ for learning. Lev Vygotsky’s model of internalisation provides a powerful account of how what we perceive as personal is actually constructed from the social (1934/1986). He describes how infants hear the speech of those around them and gradually internalize it – we can see this in the way that infants think out loud but, over time, this spoken thought becomes inner speech (see also Bruner, 1991). But infants and children not only internalize language, they also learn the norms of the culture: its particular symbols, ways of conceiving the self and relationships with others, its values, the ways in which affect is understood, experienced and communicated. In this process of learning the psychological, social and biological are interdependent (Schore, 2001a, 2001b; Trevarthen, 2011).

Personal meaning is, therefore, more complex than it superficially appears. First, personal meaning is 'personal' in the sense that it is mine alone, and to that extent at least slightly different from everyone else's. But, as Vygotsky's work shows, even within the privacy of inner speech the language we use is structured by our prior conversations and social relations. Children absorb fragments of conversations with parents, teachers and others, where they eventually become metacognitive tools that then guide their own activity.

Second, when we use language to produce meaning, for the most part we do not invent or create it – we acquire it, largely ready-made. Language is used personally but supplied culturally and collectively. When we use language to make personal meaning, we necessarily draw upon an already-shared resource. Languages are culturally shared and understood symbolic systems for communicating meaning. As we learn language so we learn culture. So to the extent that the learned codes and acquired structures of language help constitute the meanings we are able to make, personal meaning is already shaped by influences beyond our own control. One example of this is the fact that in Western cultures, the meanings of ideas or 'objects' are often built on a series of binary (and hierarchical) opposites: 'masculine' gains meaning by being contrasted with 'feminine'; sanity is contrasted with madness, reason with emotion, being gay with being straight and so on. Jacques Derrida (1978) has argued that oppositions like these, together with the meanings which surround each 'pole' and the value of one pole over another, are maintained only by obscuring the similarities between the two poles, by attaching a very limited set of meanings to each. When we apply terms like these to ourselves or others, we may give them more fixed or essential meanings than they merit, overlooking or unaware of their historical and cultural specificity. We may also introduce unintended nuances from the words used around them.

At the same time, language is not the only source of personal meaning. We live in a material world of objects, places and situations, of temperatures, textures, sights, sounds and smells. These objects and places have features, both facilitating and limiting, that shape our potential to interact with them, and also shape the meanings we can make (Gibson, 1979). We only know this material world through our bodies, which are always situated within it (Merleau-Ponty, 1945/2002). So our ability to make meaning also depends on bodily capacities: to see, hear, touch, taste, feel, smell and so on. These capacities are not simply uniform, from one person to the next. There is biological variation, of course, but there is also sociological variation produced by the many habits – of taste, style, comportment, posture, gesture and so on – that our bodies acquire. In regulating the way we interact with the world, these habits also regulate the ways we perceive it, and, therefore, the meanings we can make from it (Bourdieu, 1977; Young, 1998).

Both the material world and the bodily capacities by which we know and act upon it are largely already given to us. The typically uneven distribution of resources in the material world, for example, is not something that most individuals can change. Similarly, neither are the biological capacities and sociological habits of our bodies matters of individual willpower and choice. So just as language contributes to personal meaning in ways we do not entirely control, so the meanings created by our bodies as they encounter the material world are not entirely of our own choosing. We also have little control over the meanings others assign to our conduct. This highlights the importance of power relations in the creation of meaning, an aspect we discuss in detail in Chapter 4.

But personal meaning is even more complex than this because it also depends upon at least two other vitally important influences: memory (Bergson, 1908/1991) and feeling (Langer, 1967). Our experience is always shaped by memories that lend additional layers of meaning to everything we do: the shop assistant's impatient tone reminds us of the aggressive teacher we had at school, holiday photographs of children and friends remind us of times we spent with them, a favourite song reminds us of the time we first heard it. Thus, current meanings are always flavoured by past memories and painful or shaming experiences may be particularly hard to forget (Brown & Reavey, 2015). These events derive their meanings not only from their linguistic, material or physical qualities: the meanings arise, simultaneously, from the memories and feelings that constitute our actual lived sense of the experiences.

Meaning is constituted through both beliefs and feelings – and bodily reactions – not least because beliefs may also include an element of feeling (Cromby, 2015). Shame, for example, is constituted of both a feeling, and a belief about oneself, as are humiliation, failure, worthlessness, and so on. Fear, trappedness, panic and despair are embodied emotions which arise out of beliefs about one's situation. This contrasts with the view, particularly prominent in some versions of CBT, that we can reify and separate thoughts, feelings and beliefs into 'multiple isolable entities and processes... which causally trigger one another' (Gipps, 2013).

Thus, personal meaning is always a complex and multi-layered achievement. It is variously constituted from linguistic, material, social, bodily and psychological elements that combine to generate a lived, dynamic sense of intentionality and selfhood. Nevertheless, each of these constituents at least partially exceeds our individual powers of choice and control. Meaning is not simply personal, in the sense that it already depends upon shared resources, objects and places. Nor is it simply personal in the sense that none of us can entirely command its content and movements. Personal meaning, in short, is never just a matter of individual choice: it is always something that we both 'make and find' (Shotter, 1993).

Meaning in psychology and psychiatry

As we saw in Chapter 2, a variety of schools of thought are relevant to understanding the meaning of distress and troubling or troubled behaviour. Historically, however, Psychiatry has struggled to properly address issues of meaning. Psychiatry's relationship to meaning is also complicated by the assumption that 'mental disorders' cannot, by definition, be expected, normal or socially sanctioned – i.e. meaningful or intelligible – responses to particular circumstances or events (American Psychiatric Association, 1994, 2013). It is the implied lack of meaning which suggests an inner defect, dysfunction or pathology and justifies the switch to a medical framework and the search for biological abnormality.

The various traditions of (therapeutic) Psychology, as we have seen, have also taken different perspectives on the importance of meaning-making, and the level of attention they pay to it. For example, subjective accounts of meaning are not explicitly part of applied behavioural analysis, although implicitly the meaning of an experience of distress and its circumstances, is seen as the result of a particular learning history. In contrast, in existentialist psychotherapy broader questions about the meaning of life are a central concern.

The history of these different traditions has been very much bound up with how they have tried to conceptualise the meaning of distress. For example, is its meaning best found in the conscious or unconscious? Does meaning lie within the mind of an individual or in their relationships with others and the social context? These traditions often gave distress meaning via a dominant central metaphor, typically one popular at the time. For psychoanalysis this was a hydraulic metaphor, with its drives, pressures and forces. Early family therapy drew on a cybernetic metaphor of the family as a homeostatic system, whilst humanistic psychology promoted the idea of a self-healing organism oriented towards growth. Donald Meichenbaum (1993) discusses the changing metaphors used to explain people's thought processes within cognitive behaviour therapy: conditioning (following the work of learning theorists); information processing (relating to cognitive structures like beliefs); and, more recently, constructive narratives. For cognitive therapy, the computational metaphor of information processing made sense within a culture which was moving into the 'age of information'. As we are now living in an age of narrative (e.g. Fulford, 1999) it is, perhaps, no surprise that this has become a dominant metaphor.

What do we mean by narrative?

Corinne Squire and colleagues (2014) define a narrative as a set of signs (e.g. writing, sounds, images and so on) which convey meaning. Meaning is produced by movement between signs, for example between the words of a written narrative or between images in a film. Squire et al. add that narratives do not only expound, but also explain things, carrying particular and not just general meanings. This is a broad and inclusive definition because there are different kinds of narratives including 'accounts of temporally ordered events'; and 'telling about the past, or making sense of mental states or emotions' (2014, p.6).

In the context of psychological therapy, Polkinghorne (2004) provides a useful definition:

Narrative is a form of discourse that links events together across time, and, thus, it can display the temporal dimension of human existence. Narrative form captures the notion that human lives are 'becomings' or journeys in which actions and happenings occur before, after, and at the same time as other actions and happenings (Polkinghorne, 2004, p.58).

The stories we tell about our lives can be seen as an expression or representation of the meaning of events in our lives across time. Many of these narratives are about the self, and provide a context in which the happenings of our lives take on meaning: '[t]he meaning of life events is given through their placement in and importance for the plot of one's self-narrative' (Polkinghorne, 2004, p.58). We will now argue that the concept of narrative can form a bridge between individual and socio-cultural levels of context and between competing therapeutic traditions.

Narrative as a potentially unifying concept

Previous metaphors used to understand meaning-making within different theoretical and therapeutic approaches tended to be orientation-specific and did not translate from one tradition to another. Although initially finding favour primarily with therapists in the domains of psychoanalysis (e.g. Schafer, 1980, 1994; Spence, 1982) and family therapists influenced by post-Structuralist thought (e.g. White & Epston, 1990), the

narrative metaphor has the potential to integrate different perspectives on meaning (e.g. Angus & McLeod, 2004a). Because it pre-dates these therapeutic traditions, a narrative approach opens up the possibility of creating a common language to understand distress and troubling behaviour, one that allows us to draw on the insights of these different orientations (Angus & McLeod, 2004b; Gonçalves & Stiles, 2011). The narrative metaphor has in fact been influential across a variety of fields including clinical psychology (Stiles et al., 1999); health psychology (Crossley, 2000); social psychology (Sarbin, 1986); medicine (Greenhalgh & Hurwitz, 1998), psychiatry (e.g. Lewis, 2014; Roberts & Holmes, 1999; Thomas & Longden, 2013), psychoanalysis (Schafer, 1980, 1994; Spence, 1982); and psychotherapy (Mair, 1988, 1989; McLeod, 1997). The metaphor has also been taken up within cognitive therapy, particularly those cognitive traditions influenced by North American constructivism (Gonçalves & Machado, 1999; Meichenbaum, 1993; Neimeyer & Raskin, 2000), leading, for example, to the development of Narrative Exposure Therapy for trauma (Schauer et al., 2011).

Although narrative offers the possibility of a common language for conveying the meanings of distress, unusual experiences and troubling behaviour, a potential limitation is that each tradition interprets narrative through the lens of its own theoretical assumptions. Thus some cognitive scholars see narrative as a form of cognitive representation – that is, relating to some kind of internal state (e.g. Russell & van den Broek, 1992). In contrast, Jerome Bruner argued that a narrative approach was related to ‘folk psychology’ which he defined as ‘a culture’s account of what makes human beings tick’ (Bruner, 1990, p.13). For Bruner and narrative therapist Michael White (2004), such an approach, drawing on a tradition dating back to William James, focuses on ‘intentional states – beliefs, desires, intentions, commitments’ (Bruner, 1990, p.14) rather than internal state or trait concepts. Such intentional states re-introduce questions of human agency into narratives (White, 2004) whereas internal state narratives are more static and run the risk of being divorced from the social context. Furthermore, viewing narratives as simply stories in language risks missing the way in which narratives are lived out and embodied.

A related concept is dialogism. This refers to the way in which language and thought (as thought can be conceived of as internalised language) are dialogical rather than monological, as we discussed in Chapter 2. Within the modernist Western traditions we tend to think of language as a transparent medium and see ideas as monological in character – a single voice expresses an idea which can be understood without reference to context. For the Russian literary theorist Mikhail Bakhtin (1981, 1984), however, language is inherently dialogical. Thus, an idea, for example is always in dialogue with other ideas, setting a context for subsequent ideas. Within this tradition, ‘unfinalisability’ refers to the notion that a person cannot be fully understood, and meaning is never finally fixed, because new meanings can always be expressed. An example of this can be seen in Open Dialogue where a small team of practitioners meet with families to discuss mental health crises. Rather than trying to develop one single monological narrative, the team seeks to understand different possible interpretations of events through conversation:

It is in the particularities of exchanges between persons in the moment that meaning develops, not within either party’s head alone, but, rather, in the interpersonal space between them. (Seikkula & Arnkil, 2006, p.108).

One potentially useful aspect of the narrative metaphor is in bridging the divide between individual and socio-cultural levels of analysis. As we saw in Chapter 2, constructivism explores how people develop individual constructions of meaning but, as social constructionists remind us, these are drawn from, and shaped by, broader social constructions. It is to this issue we turn next.

Personal narratives and cultural narratives

While the psychotherapy literature focuses primarily on narratives told by individuals, these are always located within broader cultural narratives. As we attempt to construct meaning in our lives, including experiences of distress – our own or other people’s – we ‘choose’ narratives from those that are culturally available. As feminist writer Jill Johnston puts it, our self-narratives are ‘what you can say you are according to what they say you can be’ (1974, p.68). Johnston points here to the fact that not all narratives are equally valorised. We will return to the issue of power later, but will first briefly discuss some links between personal narratives and the socio-cultural context.

A narrative can be constructed by individuals, dyads, small groups or families and larger groups and communities (Denborough, 2008; Freedman & Combs, 2009; White, 2003). As discussed at the start of the chapter, the symbolic systems which the individual uses to construct meaning – including, for example, language – come from an already existing culture (Bruner, 1990). Our meanings do not develop in a social vacuum. When social constructionists refer to the social construction of the self (e.g. Gergen, 2011) it is to this process they are referring. Moreover, it is not simply that individuals draw on culture to construct meaning but that we are influenced by how those around us respond to our emerging self-narratives, as acknowledged within contemporary therapeutic practice such as the reflecting team approach (Anderson, 1991), narrative therapy (e.g. White, 2000) and Open Dialogue (e.g. Seikkula & Arnkil, 2006) and see Chapter 8.

In fact, we are surrounded by narratives – every culture has its myths and mythic traditions. In contemporary Western societies, older religious and folk myths co-exist alongside more modern technical and technological myths – thus, in our technological age we now talk of ‘memes’ rather than myths. Modern communications technology allows cultures to broadcast their myths to other cultures through, for example, advertising and popular media like books, films and TV programmes. Davies and Harré (1990) describe the process by which individuals position themselves in relation to others and to broader cultural narratives. These narratives will, in turn, position the teller in particular ways. For example, cultural narratives of illness can involve militaristic, moral or quasi-religious meanings (e.g. bravely fought battle against cancer; achieving a clean bill of health; effecting a miracle cure; having faith in your doctor, and so on). These make certain positions, implying identities and actions, available (and others less available) for various kinds of actor like ‘doctor’ and ‘patient’. For Davies and Harré this kind of positioning is not necessarily something done intentionally; rather, it flows from the way in which we give accounts of ourselves.

How do we learn these cultural narratives in the first place? As we noted earlier, infants and children not only learn about language, thought and relational bonds, but also the norms of their particular culture. Does it have a notion of affect and emotion and, if so, how are

these to be expressed and to whom? Take the example of romantic love. In Western and many non-Western cultures, we imbibe narratives of love from fictional literature, film, magazines and newspapers, dating websites, TV dramas, soap operas and adverts, opera, theatre and so on. Similarly, talking about gender and the ‘all but impossible task’ of non-sexist education, Cordelia Fine (2011) asked ‘How should children ignore gender when they continually watch it, hear it, see it; are clothed in it, sleep in it, eat off it?’ (p.238). And in learning about cultural norms we also implicitly learn what kinds of conduct would be seen as breaching those norms.

Since cultures do not share the same notions of the mind, the self and emotions it is overly simplistic to say that all cultures have a notion of madness. However, they do all have notions of what kinds of conduct would be considered to breach social norms and customs. In the next section we will give an example of the processes through which these norms are enshrined in cultural narratives about what counts as madness or deviance.

Narrative, distress and power: the enshrining of cultural norms

In the work of the French philosopher and historian of thought, Michel Foucault, power is seen as crucially linked to knowledge. Nikolas Rose (1985), drawing on Foucault’s work, has described, for instance, the development of a ‘psychological complex’ which refers to the development of certain kinds of disciplines like Psychology and Psychiatry (e.g. in the areas of health, education and welfare) which conceived of social problems in particular ways, creating new kinds of knowledge, which then legitimised the role of those professions in addressing those problems. One of the key aspects of these new kinds of psychological knowledge was that certain social norms became established. A norm can be defined as that ‘which is socially worthy, statistically average, scientifically healthy and personally desirable’ (Rose, 1999, p.76). Transgression of such norms results in social shame. Social standards and expectations are obviously not new but in contrast with older, more overt forms of power, modern, less visible forms of power achieve their effects partly by establishing new forms of knowledge – often claiming scientific status – which in turn create new norms. People then engage in self-surveillance across a wide range of behaviours, personal characteristics, desires and achievements, routinely comparing themselves to these implicit norms, and identifying themselves as inadequate, deficient or pathological if they deviate from them. Such self-surveillance has huge consequences for psychological distress (see Chapter 4).

We see this form of power at work every day in numerous exhortations in advertising, media articles and so on, which continually invite us to compare ourselves with (often contradictory) idealised cultural standards. For example, we should eat healthy foods and avoid obesity, but not become so focused on food that we develop an ‘eating disorder’. Parents should be emotionally present for their children but not fall into the opposite fault of being over-protective or ‘enmeshed’. In failing to meet these standards we feel shamed, and a highly profitable self-help industry arguably reinforces this while at the same time telling us how to improve ourselves further (LaRosa, 2013; Rimke, 2000). New technological developments have increased the many ways in which we can engage in surveillance of ourselves and others through social media, mobile apps and so on. One result is the increasingly common phenomenon of people applying diagnostic categories to themselves or family members before mental health professionals get involved at all. And globalisation has arguably increased the reach of these knowledge-based forms of power.

The diagnostic narratives which are part of this process may become so taken for granted that their implicit cultural norms are partially or completely obscured. In one fascinating study, Daniel Leising and colleagues (2009) attempted to make visible the assumptions underpinning the diagnostic criteria for personality disorder. They created statements that were the opposite to each of the 79 criteria in the *DSM-IV*'s version of this category. Student raters then sorted these statements into similar piles. Analysis revealed the implicit 'undisordered personality' which reflected the normative assumptions of *DSM-IV*. The clusters were given the following labels: 'Be self-reliant and independent'; 'be self-confident, but in a realistic manner'; 'get along with others'; 'tolerate uncertainty and imperfection'; 'look for the good in people'; 'be conventional'; 'have self-control'; 'connect with others emotionally and treat them fairly'; 'enjoy social relationships and activities'; 'be trusting'; be 'sexually modest', and so on. Exposed in this way, the implicit 'normal' personality criteria read almost like a guide to modern etiquette.

It is for these reasons that critics have argued that diagnoses are essentially lay judgements made by members of the community who are disturbed by certain forms of norm-breaking behaviour and who then, particularly in crisis situations, want this judgement rubber-stamped by a professional (Coulter, 1973; Pilgrim & Tomasini, 2012). Thus, attributions of mental abnormality arise for social reasons: some of us, some of the time, are distressed, or are distressing to others, and that distress is usually associated with a person's capacity to act in ways expected of them and/or that they expect of themselves. From this perspective, the specific diagnosis is less important than a professional endorsement of 'abnormality' or 'illness' which can serve numerous functions including avoiding interpersonal pain, protecting all parties from guilt and blame (Scott, 1973a) and upholding social norms and values.

Cultural narratives, then, encode various social norms, norms which are learned from infancy (and later, reflecting changing narratives) within any particular culture. These norms are intimately linked with power, and it has long been noted that the most dominant and available narratives in a culture will reflect the current economic and structural relationships in any particular society (e.g. Marx & Engels, 1845/1947). Social norms and discourses may be hard for individuals to identify; as Hagan and Donnison (1999) put it, '(t)hey can be regarded as forming the very fabric of our existence... to step outside such expectations and 'rules' is extremely difficult. They form the backdrop to the social world in which we live... and so can be seen to operate at a level of *unawareness*' (p.130; emphasis in original). Neoliberalism has been described by Paul Verhaeghe (2012) as the new 'grand narrative' of our times and as such, hard to challenge because of its very dominance. He suggests that like any major change in the social narrative, its effects are felt through the emergence of new identities which mirror its values. In Chapter 2, we discussed how the implementation of neoliberal economic policies included placing a high value on notions of autonomous individualism, materialism, consumerism, rationality, choice and responsabilisation (i.e. where people are invited to take responsibility for the solution of their own problems). Those who deviate from these injunctions, those who, for example, are dependent on others (or interdependent), those who place less value on material goods and do not identify primarily as consumers, those who act 'irrationally', those who refuse to choose and those who are seen as 'not taking responsibility' for their problems may be invited to experience shame at their failure to attain these norms. Indeed, they may even be publically criticised for their failure (Garthwaite, 2011).

The influence of power on narratives is seen not only in their embodiment of currently ruling ideas in a society but also in the ways in which they are not equally available or valued – simply because a narrative exists does not mean that it is regarded as legitimate or worthy. When homosexuality was more systematically pathologised than it is in the West today, lesbians and gay men often only had access to a dominant cultural narrative that depicted it as deviant, and until relatively recently, a form of mental illness requiring treatment. One’s social position may also determine which narratives one has access to as a result of, for example, education.

Of course, the negative operations of power are never totally successful in repressing alternative narratives. We need only think of the power of first person testimonies in the history of the service user movement (Crossley & Crossley, 2001) and their critiques of dominant ideas and practices in mental health. Foucault argues that power is never wholly repressive; rather, ‘Where there is power, there is resistance’ (Foucault, 1979, p.95). So although there might be dominant narratives of distress which represent it as a decontextualised disorder, there are alternative narratives which make life experiences much more central. In fact, these discourses have always been present as marginalised accounts in the history of Psychiatry (Scull, 1979). However, the operation of power limits their availability. Relatively few service users, for example, are aware that there are non-diagnostic ways of understanding their distress, and nor are they likely to encounter these alternative accounts in mental health services or the media.

In addition, it may not be a simple or easy task to adopt a different narrative. David Smail (2004) has criticised the idea that ‘social constructions can be reconstructed, or indeed deconstructed, at will’. He refers to this as an example of ‘magical voluntarism’, defined by Joshua Gunn and Dana Cloud (2010) as:

...an idealist understanding of human agency in which a subject can fulfill her needs and desires by simple wish-fulfillment and the manipulation of symbols, irrelevant of structural constraint or material limitation. (Gunn & Cloud, 2010, p.50)

Donald Polkinghorne also points out that there is a limit to the kinds of self-narratives we can develop:

Thus, while clients can re-author their life stories, they cannot simply choose any story for their lives; clients are constrained to those revisions that can be applied to the actual happenings in their lives. (Polkinghorne, 2004, p.59)

A person’s location in the social order and the availability of intellectual, emotional, relational and economic resources – resources that are unequally distributed in many societies – will influence how readily someone might take up a particular narrative. Thus, as Ian Parker notes, ‘people “make” discourse, but not in discursive conditions of their own choosing’ (1992, p.32).

A note on shame

The analysis above offers a perspective on the sense of shame often felt from being assigned a psychiatric diagnosis, in contrast to the reaction to most diagnoses of physical health problems. As one person put it, ‘Let’s just say I have a case of shame – I really

do' (cited in Warner, 2004, p.193). Shame has been described as both the most social of emotions and the most hidden and 'un-speakable' (Frost, 2016). We feel shame when we judge ourselves through the imagined disapproving eyes of others, and thus it functions as a powerful social regulator in promoting or discouraging certain beliefs, experiences and behaviours. Given the roots of psychiatric diagnosis in social norms, we can see that some degree of shame is an almost inevitable response, since the implicit, norm-regulating message of such labels is 'Your thoughts, feelings and actions are viewed by your social group as beyond what is acceptable, reasonable or understandable.' Humans are fundamentally social beings whose physical and psychological survival depends on others, and exclusion from, in this case, the 'normal' group can be a devastating experience (and see Chapter 4). The attribution of a psychiatric diagnosis is therefore very often experienced as a deep wound to one's identity (Goffman, 1963; Scheff, 1966). At the same time, the self-silencing effect of shame prevents us from opening ourselves up to acceptance from others who may secretly be struggling with the very same emotion. However, if, as we have argued, psychiatric diagnoses are actually based on social not medical judgements, the orthodox strategy of combating shame with anti-stigma campaigns based on the 'illness like any other' assumptions is doomed to failure, as evaluations confirm (see Chapter 8); we know when we are being subjected to social shaming.

So far we have argued that the narrative metaphor has the potential to provide a common language for understanding and communicating the meanings of distress and troubled or troubling behaviour. We have discussed how personal narratives draw on, and are shaped by, wider cultural narratives, and how these narratives embody cultural norms which we are invited to compare ourselves against, potentially resulting in social shame when we fail to attain these ideals. The operation of power influences both the cultural dominance of particular narratives, and the distribution of resources which allow people to access and enact different accounts. But cultures are not invariant; rather, they are in constant flux, and narratives of distress and troubling conduct have changed with them. Indeed the American Psychiatric Association's *DSM* has gone through five major revisions in 60 years. In line with this cultural specificity, Corinne Squire and colleagues argue that there are 'social and historical limitations on where and when (narratives) can be understood, and by whom' (2014, p.6). In the next section, we will continue the discussion of power through a focus on some of the ways in which cultural narratives of distress change over time.

The changing cultural vocabularies of distress

We have seen that in relation to emotional and behavioural difficulties, some of the most dominant and culturally available narratives are those which transform problems of living, usually involving deviation from a valued social norm, into an individualised medical problem. These are often termed pathologising or medicalising narratives because they draw on the theory and practice of medicine and more generally on what Kenneth Gergen (1990) has referred to as 'vocabularies of deficit'. Some earlier scholarship tended to see these narratives as the result of the psychiatric profession asserting its professional dominance, but such explanations now seem rather reductive, failing to account for the ways in which cultural narratives of distress and troubling conduct – including medical narratives – change over time, often in concert with broader changes in society. Such

a view also overlooks the fact that psychological narratives of distress can be equally individualising and pathologising. (We discussed this briefly in Chapter 2 in relation to the rise of neoliberalist economic policy.) Donald Light (1991) has also argued that professional dominance is moderated and shaped by powers including government regulation, the actions of the public and the mass media, corporate interests and so on – what he has termed ‘countervailing powers’. Joan Busfield (2010, 2012) has also made use of this concept.

Nikolas Rose (2006) has made similar points in relation to the recent apparent increase in rates of psychiatric diagnosis, arguing that we need to consider not only the role of doctors and pharmaceutical companies, but also the pressures and incentives that lead to the ascription of these diagnoses and their ‘treatment’ by drugs. For example, in relation to the reported rise in diagnoses of ‘depression’ – seen in year on year increases in the prescription of anti-depressants – Rose argues that this category is a ‘problem/solution complex’ which:

...simultaneously judges mood against certain desired standards, frames discontents in a certain way, renders them as a problem in need of attention, establishes a classification framework to name and delineate them, scripts a pattern of affects, cognitions, desires and judgements, writes a narrative for its origins and destiny, attributes it meaning, identifies some authorities who can speak and act wisely in relation to it and prescribes some responses to it. (Rose, 2006, p.480)

Rose, then, sees constructions of ‘depression’ as ‘ways of making aspects of existence intelligible and practicable’ (2006, p.480). He argues that it is too simplistic to view those seeking help simply as passive beings responding to the disease-centred messages of pharmaceutical companies and professionals. Instead he proposes a more subtle process in which:

Companies explore and chart the experienced discontents of individuals, link these with the promises held out by their drugs, and incorporate those into narratives that give those drugs meaning and value. (Rose, 2006, p.480)

Rose contends that in ‘engaging with these images and narratives, in the hopes, anxieties and discontents they shape and foster, individuals play their own part in the medicalization of problems of living’ (2006, p.480). He delineates a transition from the construction of a psychological self, populated with beliefs, desires and conflicts, in the first 60 years of the 20th century to a neurochemical self – a ‘somatic individuality’ in the latter years of the 20th and into the 21st century. Paul Verghaeghe (2012) traces similar themes in his account of the shift away from a focus on social progress, towards the project of the ‘perfectible individual’ who must work first on their minds (e.g. through various therapies) and then on their bodies, through a range of industries such as beauty, diet, fitness and plastic surgery. As he notes, ‘Meanwhile, a lot has changed in society without us noticing it: we’re all too much focused on ourselves’ (p.74).

Another example of the social effects of dominant narratives of the self can be seen in the increasing use of a risk discourse whose effects can be seen, for example, in relation to assessments of the dangerousness of individuals or in the likelihood that they will develop later mental health problems, thus supporting the development of ‘early detection’

approaches together with a series of related individualising concepts like ‘resilience’ (Harper & Speed, 2012; Rose, 1998). As Derek Summerfield has put it,

In a momentous shift, the concept of a person in Western culture has come to emphasise not resilience but vulnerability, with “emotion” as its currency. This has its roots in the way that medico-therapeutic ways of seeing have come to dominate everyday descriptions for the vicissitudes of life and the vocabulary of distress. In what has been called the “culture of therapeutics”, citizens are invited to see a widening range of experiences in life as inherently risky and liable to make them ill ... As more resources are provided for mental health services, more are perceived to be needed – an apparently circular process. (Summerfield, 2012, p.3)

In short, then, new (medicalised) narratives of distress emerge and take hold partly because they create powerful sets of meanings which, as we saw in Chapter 1, serve a variety of social and psychological, political and ideological functions but also have serious limitations.

Accounts of the emergence of psychiatric narratives by writers such as Michel Foucault (1967) and Andrew Scull (1979) (and see also Sass, 1992; Warner, 2004), have argued that the major social and economic changes associated with industrialisation, or in other words the shift from a mainly agricultural and rural society to an industrial and urban one, marked an important watershed in the evolution of modern day assumptions about what behaviours can be tolerated and what is defined as ‘normal’. As well as these more general accounts, there are now a number of studies of specific psychiatric diagnoses which reach similar conclusions – that narratives of distress are shaped by broader social forces. Allan Horwitz and Jerome Wakefield (2007) for instance, have written accounts of how experiences of sadness has developed into the category of ‘depression’ and experiences of fearfulness were transformed into the category of anxiety (Horwitz & Wakefield, 2012) while Derek Summerfield (2001) and Ethan Watters (2011) have traced the emergence of ‘post-traumatic stress disorder’. These processes of narrative transformation are not just changes in labels. Rather they are more fundamental and embodied – they make available new ways of accounting for, communicating, and ultimately expressing and experiencing distress and troubled or troubling behaviour.

The late 19th and early 20th century diagnosis of neurasthenia provides a striking historical example of the emergence of such narratives and their relationship to social forces (Schuster, 2011; Showalter, 1987). Originally described as ‘American nervousness’, the diagnosis was quickly taken up by English doctors and became a popular explanation for the many strains and stresses, and sapping of nervous strength, associated with a period of rapid social change, including urbanisation, immigration, increasing education and independence of women, competitive business and social environments, industrialisation and developments in science and technology. In a parallel metaphor, the body was seen as a kind of machine, powered through the nervous system by energy. It followed that people who experienced multiple hard-to-define complaints such as headaches, muscle pain, anxiety, irritability, insomnia and lethargy were seen as suffering from a depletion of energy as a side effect of social changes, and were diagnosed with ‘neurasthenia.’ The new illness had positive overtones; David Shuster shows that it ‘did not simply denote the presence of sickness ... it indicated the presence of an active mind, a competitive character, a lover of liberty – in short, the quintessential American’ (p.104). This refers to men. Neurasthenic

women were often favourably compared to ‘hysterics’ and were thought to be ‘cooperative, ladylike, and well bred’ (Showalter, 1987, p.134). For both men and women, neurasthenia was an illness of the white middle classes, at the same time reinforcing gender roles. Men were more susceptible when they spent too much time indoors, and, in the USA, were often cured by being sent West to resume more traditional activities such as horse riding and cattle rearing. Conversely, women who spent too much time outside the home were advised to undertake ‘rest cures’ of four to six weeks in bed, forbidden from moving or even reading, as described in Charlotte Perkins Gilman’s classic book *The Yellow Wallpaper*.

This analysis shows how ‘neurasthenia’, while describing real and debilitating experiences, was a cultural construct that reflected the anxieties and pressures of modernity. It was defined in terms of characteristically American, industrialist and Protestant virtues of competition, energy, and hard work, and as such, played a part in reinforcing these aspects of the (male) national character. At the same time, it supported the status quo by maintaining gender roles and medicalising the struggle to survive new social pressures and demands.

A century later, a series of observational studies by Vieda Skultans (2003, 2007) has traced the introduction of the narrative of medicalisation into Latvia, in the years following independence from Soviet Russia in 1991. Life under Soviet occupation was very hard, and some degree of distress was almost universal. This was typically expressed in terms of suffering ‘nervi’ or damaged nerves, a state of health which was seen as the result of political oppression under Russian rule. Thus, ‘[t]o ask about a person’s nervi was, and still is, to invite a life story... The discourse of nervi sets patients in the context of the shared past history and social circumstances’ (Skultans, 2003, p.2423). People described what their nervi had been through, experienced or survived, endured and suffered. ‘Talk of nervi, therefore, points simultaneously... outwards offering a way of understanding the world and its subjective importance and it points reflexively towards the speaking self, disclosing its particular nature and values’ (p.2423).

The rapid introduction of a market economy created further or different insecurity and hardship, while translation of *ICD-10* into Latvian introduced previously unfamiliar ‘disorder’ concepts. Skultans describes how these new medical discourses, promoted by pharmaceutical companies, redefined people’s struggles in their homes and workplaces as individual deficit and failure:

The brunt of economic injustice and social exclusion are experienced as very personal forms of pain, but in the clinic they are registered as various forms of disorder: depression, panic disorder, social anxiety disorder and obsessive compulsive disorder to name a few. In effect these terms are markers for social failure... The move from somatoform to psychological disorders and depression, in particular, represents the internalization of a heightened sense of accountability and responsibility for one’s life circumstances albeit limited opportunities for changing those circumstances. Thus, changing subjectivities are not simply a response to changing concepts but reflect the experience of a different kind of social world. (Skultans, 2003, p.2430)

Skultans documents how psychiatric consultations quickly moved away from people’s life circumstances towards ‘the construction of disease entities’ and the actions that must be taken in relation to them. Thus, there was a transformation ‘from process and context to categories: from verbs to nouns’ (2003, p.2427).

The psychosocial implications of narratives of distress

We have seen that personal narratives of distress are constructed and maintained not only in response to changing social conditions but according to which narratives are more culturally available and privileged; in Western cultures these are usually medicalised narratives. Leo and Lacasse (2008) for example, have documented the media's influential role in ensuring the availability of the chemical imbalance theory of 'depression' in spite of the lack of supporting evidence for it. As we have seen in Chapters 1 and 2, these narratives have many potentially negative effects. More generally, they act to shape and re-shape notions of the self, which is especially problematic cross-culturally given that constructions of the self are very varied. The resulting mismatch can be illustrated with some brief examples.

McGruder's (2004) exploration of how 'schizophrenia' (sic) manifests itself within different cultures describes how in Zanzibar, the sense of the self is much more permeable and body/mind/spirit are not seen as separate. Thus, people frequently experience themselves as being inhabited by visiting spirits, and contrary to orthodox psychiatric thinking, this is not seen as anomalous in itself. However, the local social norms promote calm, reserved, and non-confrontational behaviour, whereas sometimes these spirits are noisy, rude, emotional and selfish (McGruder, 2004). The resulting outbursts are usually explained as a form of madness caused by spirit possession. Clearly the very different notions of selfhood in Zanzibar have resulted in a dilemma for researchers trying to assimilate these experiences into the Western concept of 'schizophrenia.'

The Iban people of Malaysia have no equivalent of the psychiatric concept of 'thought disorder' because they do not clearly distinguish between thinking (in the internalised Western sense) and talking (Barrett, 2004). In fact, their understanding is closer to that proposed by the dialogical theorists mentioned in Chapter 2. Medical anthropologist Robert Barrett describes his struggle to explain to the Iban what he meant by thoughts, given that they '...have a more embodied and interactional notion of thinking... the closest equivalent to the Western notion of thinking is experienced as arising from the heart-liver region, and it is intimately tied up with emotion, desire and will' (p.96.) He concludes that his questions presuppose 'a Western cultural concept of personhood, which gives a privileged place to internal mental life as a defining feature of the person... recognised as located in the brain, and... experienced as disembodied' (p.99). In a similar vein, Cromby (2015) notes that not all cultures 'sharply distinguish the cognitive from the affective' (p.3), and moreover, that there may be culture-specific emotions with no exact equivalent elsewhere.

As we argued in Chapter 2, one effect of the globalisation of Western medicalised narratives is that they tend to colonise indigenous constructions – in other words they supplant and obscure other potential narratives (Mills, 2014; Watters, 2011). It is important to note that psychological as well as psychiatric narratives are implicated in this colonising process (De Vos, 2012) as we saw in our earlier discussion of links between individualism and economic policy. Similarly, the majority of Western psychotherapies appear to be founded on notions of the self which, in contrast to some non-Western cultures, assume individual, internal thought processes which can be separated out from the feelings and bodies they are said to influence.

Finally, one of the most damaging effects of medicalised and individualised narratives is

the marginalising of meanings that potentially link distress with adverse life experiences. For people struggling to survive within the ideological pressures and contradictions of modern Western societies, diagnosis may offer what has been described by social theorist Lauren Berlant as ‘cruel optimism’ – in other words, attachment to an idea which promises much (understanding, healing and so on) but actually becomes an obstacle to achieving what you need and hope for (Berlant, 2011). Overall, then, medical narratives of distress have profound implications for agency, subjectivity, constructions of the self, and the links between all these and issues of social justice.

However, and bearing in mind David Smail’s caveats, narratives can also play a central part in restoring agency, meaning and hope through a process of ‘re-storying’. Roy Schafer (1980) drawing on his study of narration in psychoanalysis, argues that a key outcome of psychotherapy is to retell a narrative ‘in a way that allows you to understand the origins, meanings, and significance of your present difficulties and to do so in a way that makes change conceivable and attainable’ (p.42). This process can take many different forms within and across cultures, including formulations; therapies and therapeutic documents; discussions in peer support groups; works of art and literature; community rituals and definitional ceremonies; and others (Harper & Spellman, 2013; Hughes & Afuape, 2016). As an example of the latter, Michael White (1995) refers to anthropologist Barbara Myerhoff’s (1982) study of a community of American Jewish elders, in which the communal telling of stories was responded to with other people’s reflections on those stories, thus leading to multiple interpretations of the original narrative. She described these communal story tellings as ‘definitional ceremonies’, a process in which the elders’ identities were continually transformed. Thus, the construction of identity became a public and social achievement rather than a private and individual one.

Many service user/survivor accounts, which may or may not encompass formal therapy, are examples of this process in action (e.g. Dillon, 2010; Geekie et al., 2011; Grant et al., 2011; Hornstein, 2011; Johnstone, 2014; Longden, 2013; Romme et al., 2009; Waddingham, 2013). In the words of survivor Beth Filson, ‘Being able to tell your own story – not the illness story – sets a new social context – one in which mad people are seen in a new light... In part, healing happens in the re-storying of our lives’ (Filson, 2016, p.22). Further, as survivor and campaigner Jacqui Dillon says, ‘The mark of a responsible society and responsive services is the willingness to share collective responsibility for these experiences, to honour them, support them and learn from them at all levels’ (Dillon, 2010, p.79).

We will discuss this in more detail in Chapters 6 and 8.

Meaning and narrative – an overview

Several important points have arisen from this discussion including:

- For humans, meaning is inescapable, a central aspect of our embodied experience of the world. ‘Personal meaning’ is never truly personal but arises out of linguistic, material, social, bodily and psychological elements and at least partially exceeds our individual powers of choice and control.
- Narrative can be seen as a carrier of meaning in our lives across time and across cultures. Like ‘personal meaning’, narrative is never simply personal, but at both an individual and community level, it is a pervasive human strategy for making sense of,

finding patterns in, or coming to terms with, fundamental aspects of our experience such as time, causality, change and suffering.

- Cultural narratives, including narratives of distress, are a means of communicating the values, norms, assumptions and expectations of any given society. This extends to the construction of the notion of personhood itself and thus how we experience ourselves as persons.
- Cultural narratives of distress and troubled or troubling behaviour reflect and arise in response to changes in social conditions, often acting to maintain aspects of the existing social order or support aspects of an emerging social order. They define what kinds of distress count as madness, deviance or ‘abnormality’ while also shaping its experience and expression.
- Some narratives are more socially visible and available, and/or given higher status than others; they bring into being certain ways of seeing the world and obscure others. This often reflects power relations in society and the important role of certain narratives in maintaining them.

What are the implications for alternatives to psychiatric diagnosis? Diagnosis is not a description on which a range of narratives can easily be built. Rather, diagnosis itself incorporates a powerful narrative about the nature and causes of troubling experiences and behaviour, about the kinds of patterns to be found amongst them, and about how and by whom these can be identified and alleviated. The diagnostic narrative draws on analogies to physical illness but, beyond this, is based on assumptions about the objective nature and universality of ‘mental disorders’, and about blame and responsibility, rationality and meaning (or the lack of these). It assigns a secondary role to the social world as a source of ‘triggers’ or ‘stressors’ and offers a particular construction of the person, often as biologically different and vulnerable, as someone who has become... ‘through no intention or action of his or her own... the setting for the operation of impersonal, harmful cause – effect processes’ (Jacobs & Cohen, 2010, p.312).

Versions of this narrative are culturally dominant in Western societies and increasingly across the world. This has been facilitated by the fit between the diagnostic narrative and Western cultural narratives of the self. But the presentation of these narratives as based on scientific knowledge and professional expertise also has a powerful marginalising effect on alternatives. Since scientific claims play such an important role in these marginalising processes, we need to scrutinise their evidence base very carefully. As we have seen, this highlights very serious problems in relation to the diagnostic narrative of distress. We should ask, then, about the evidence for alternatives, especially those concerned with aspects of emotional difficulties and their origins made less visible by diagnostic narratives. And, since narrative and meaning are of fundamental significance in all human experience, we can expect them to play a central role in alternative ways of conceptualising and alleviating madness and distress.

The next three chapters will bring together the discussion so far – on the problems of diagnosis and medicalisation, the conceptual foundations of alternatives, and the importance of meaning – in order to examine empirical evidence relevant to developing alternatives to medicalisation and diagnosis. As we have emphasised, this involves drawing on assumptions and theoretical frameworks appropriate to understanding the behaviour and experience of embodied persons within their social and relational environments, rather than the (mal) functioning of bodies.

We begin by returning to a major purpose of medical diagnosis as a means of understanding how someone's problems or complaints have come about by 'matching' them to research-based patterns. We have seen that psychiatric diagnosis is unable to do this. So, drawing on more appropriate theory and research, we will now address the second question posed in Chapter 2:

- At the broadest level, what patterns have researchers described that might be helpful in understanding and alleviating emotional distress, unusual experiences and troubled or troubling behaviour from a non-diagnostic perspective?

We begin (in Chapters 4 and 5) by discussing broad patterns in relation to social context and biology before (in Chapter 6) using these to derive a conceptual framework based on probabilistic, evidence-based, culturally influenced patterns which can support the construction of narratives in both service and self-help settings. Following a discussion of service user responses to this conceptual framework, we will discuss its potential for more effectively fulfilling other claimed purposes of psychiatric diagnosis including indicating interventions, making decisions about access to benefits and services, guiding service commissioning and design, making legal judgements, providing a basis for research, and informing social and public health policy.

Chapter 4: The social context

The following sections address the second of the four questions we need to consider as we move away from the assumptions underlying medicalised approaches:

- At the broadest level, what patterns have researchers described that might be helpful in understanding and alleviating emotional distress, unusual experiences and troubled or troubling behaviour from a non-diagnostic perspective?

In this Chapter, we discuss research on the relationship between social context and emotional and behavioural problems before addressing the role of biology in Chapter 5.

Introduction

There is a great deal of evidence, which we will discuss in detail in following sections, that the circumstances of people's lives play a major role in the development and maintenance of psychological, emotional and behavioural problems (further evidence is presented in the Appendix). Among the most important factors are: social class and poverty; income inequalities, unemployment; childhood neglect and sexual, physical and emotional abuse; sexual and domestic violence; belonging to subordinate social groups; war and other life-threatening events; bullying, harassment and discrimination and significant losses such as loss of a parent in childhood.

The evidence is long-standing and consistent across many countries (e.g. Friedli, 2009; Wilkinson & Pickett, 2010; WHO, 2000, 2013). Recently, researchers have tried to describe 'pathways' connecting negative experiences with emotional and behavioural outcomes, partly to explain why not everyone who experiences adversity will go on to have problems later. Some of this research has focused on cognitive factors, for example the mediating role of negative cognitive schemas or response styles. These include hyper-vigilance, dissociation, self-criticism and blame, body dissatisfaction, shame, hopelessness, insecure attachments, low mood, external locus of control, and coping styles such as rumination or suppression of thoughts. Measures of these mediate between a range of adversities such as childhood maltreatment and abuse, rape and social deprivation, and a range of outcomes including feelings of depression and anxiety, eating problems, hearing voices, and expressing very unusual beliefs (Bebbington et al., 2004; Bentall et al., 2015; Gander et al., 2015; Kinderman et al., 2013; Sitko et al., 2014; Tasca et al., 2013; Wickham et al., 2014).

This research has been vital in highlighting the importance of social context and suggesting how it might 'act' on people psychologically. But it shares some of the features we discussed in Chapter 2 in relation to research within a positivistic framework which can limit its usefulness in understanding emotional and behavioural difficulties.

- Much of the research relies on psychiatric diagnosis with all the problems of reliability and validity we discussed earlier. People may only be included in the research if they meet the criteria for a particular category. Many people whose problems fall short of this or who experience 'mixed' problems may be excluded while people assigned

to one category may show many ‘symptoms’ of another. This can lead to misleading claims about links between social factors and specific diagnoses and loss of important information.

- The nature of ‘context’ in this research can also be problematic. It may be seen as negative life events or stresses, trauma or adversity but these are often defined in restrictive, quantifiable ways chosen by researchers which can exclude wider social, cultural or symbolic factors. The research often explicitly or implicitly adopts a vulnerability – stress framework, whose problems we discussed in Chapter 1. In some versions of this approach, the underlying vulnerabilities are taken to be genetic or biological with context playing a secondary role in triggering a biologically based mental disorder. A variation of this sees childhood adversity influencing brain development which in turn creates oversensitivity to environmental stressors (Fowler et al., 2006; Goodman et al., 1997; Sedeli et al., 2012; Warner, 2000). In other versions, including much of the ‘pathways’ research, ‘vulnerabilities’ are seen as individual psychological characteristics – perceptions, beliefs, dispositions or deficits, capable of being objectively discovered and measured. These characteristics are said to arise from earlier adversity and to influence responses to later experience.
- Much of this research relies on quantification and measurement of statistical relations amongst discrete variables. This can be very valuable in establishing links between outcomes such as receiving a psychiatric diagnosis and, say, employment status, income, or certain life events; but, as we saw in Chapter 2, it is less suitable for understanding complexities of behaviour and experience in the social world.
- Ironically, these frameworks for the study of social context have actually helped to marginalise it. Biological versions of vulnerability – stress do this very obviously by drawing our attention away from people’s lives to their brains. But the idea of psychological vulnerabilities is also limiting, especially if we see schemas, dispositions, coping styles and deficits as stable, free-standing personal characteristics that cause someone to respond in particular ways to a social environment which remains ‘out there’. These problems are compounded by lack of attention not only to wider social and economic aspects of context but also to personal meaning and the ways it is socially shaped.
- It is also ironic that research which might have aimed at greater specificity (*this* aspect of context links with *that* diagnosis or *this* pathway results in *that* mental disorder) has actually highlighted the opposite (see later). We discussed earlier a major problem of psychiatric diagnosis – that there is a great deal of heterogeneity within categories and overlap between them. We might characterise this as the ‘everyone suffers from everything’ problem. Research on social context has added another dimension that might be characterised as ‘everything causes everything’ – each type of adversity seem to raise the risk for a whole range of problems and, similarly, each type of mediating factor is associated with a wide range of outcomes. Although this highlights the complexity of any patterns we might be able to draw on in understanding psychological and emotional distress and troubling behaviour, it is not a problem for non-diagnostic approaches. But it does emphasise the need for a different approach to thinking about both social context and people’s responses to it.

An alternative approach to context

Some of the strongest associations between social context and mental distress and troubling behaviour are in relation to factors which loosely describe social inequalities. This is not surprising because apart from material consequences of inequality, there is strong evidence that humans, like other animals, are extremely sensitive and responsive to social hierarchies and their place in them.

The term ‘social inequalities’ is often popularly used to refer to inequalities of income or wealth but it has a much broader meaning of inequalities in power and privilege. As Jennie Williams and Gilli Watson (1988) have pointed out, dimensions of social inequality are also hierarchies of domination that limit and restrict some people while privileging others. Social inequalities do not just exist ‘out there’ but are pervasive, embodied aspects of our identities. This psychological impact of inequality is mediated through social practices and institutions in which ‘markers’ of inequality are often deeply embedded. It is these two aspects of social context – its identification with inequalities of power and privilege *and* the constant, dynamic interaction between individual psychology and social practices and institutions, which tend to be missing from mainstream research on the impact of social factors on mental health problems.

We discussed the importance of power in relation to the dominance of particular theories and cultural narratives of distress in Chapters 2 and 3, and noted that these might influence the experience and expression of distress. The strong links between social inequalities and the development and maintenance of distress and troubling behaviour, their form and prevalence in particular groups, emphasises again how central the idea of power has to be to our understanding of them. ‘Power’ has been conceptualised in various ways historically and in the social sciences (eg Clegg, 1989; Lukes, 1974). David Smail has defined it broadly as ‘the means of obtaining security and advantage’ (2005, p.28); it can involve influencing people, events and outcomes to suit your own interests and needs. There is debate about ‘types’ of power, but agreement that in any society, it will be exercised or manifest in a range of ways. Power can obviously operate positively or negatively but because we are concerned here mainly with negative outcomes, we will focus more on the negative operation of power. ‘Types’ of power include:

- **Biological or embodied power** operates through the possession of embodied attributes and their cultural meanings, for example strength, physical appearance, fertility, skin shade and colour, embodied talents and abilities, physical health.
- **Coercive power or power by force** is always part of war and conflict but also involves any use of violence, aggression, threats or greater physical strength, to frighten, intimidate or ensure compliance. Although often negative, coercive power can be used positively for example when parents remove young children from danger.
- **Legal power** may also involve coercion, such as power of arrest, imprisonment or hospitalisation. It also refers to a wide range of rules and sanctions which regulate and control many areas of our lives and behaviour, support or limit other aspects of power, offer or restrict choices and so on.
- **Economic and material power** involves having the means to obtain valued possessions and services, to control others’ access to them and to pursue valued activities. This includes housing, employment, transport, education, medical treatment, leisure, legal services, safety and security, and privacy.

- **Ideological power** involves control of meaning, language and ‘agendas’, so that certain issues or groups may be held back from public scrutiny or people may be brought to see their interests and wants in particular ways. Ideological power also involves power to create beliefs or stereotypes about particular groups, to interpret your own or others’ experience, behaviour and feelings and have these meanings validated by others, and the power to silence or undermine.
- **Interpersonal power** although all forms of power can operate through relationships, this refers more specifically to the power to look after/not look after or protect someone, to abandon or leave them, to give/withdraw/withhold love.

The operation of power is related to Pierre Bourdieu’s concept of cultural capital, a mix of valued qualifications, leisure activities, knowledge, skills and social connections which can be passed indirectly to the next generation in a kind of symbolic inheritance process, making a vital contribution to the ongoing capacity of some groups to enhance themselves (Bourdieu, 2010; Savage et al., 2015).

These forms of power are closely interrelated, their operation reinforcing and perpetuating advantage and disadvantage. They operate through social structures, institutions and organisations; through our physical environment; through the media, education and social and family relations. As David Smail noted, power is the fundamental dynamic of social structure. We can go further and say that the operation of power also constitutes the functioning of our minds, as social phenomena ‘come into the brain’ and ‘become part of our cerebral biology’ (Fausto-Sterling, 2000; Kaiser et al., 2009, p.9). All of this reminds us that the operation of power does not require intentional acts by individuals or groups although of course it may sometimes involve these.

All forms of power are potentially important, but some are more visible than others and, as we will see, this is especially relevant for understanding emotional distress. The French social theorist Michel Foucault, whose work we also discussed in Chapter 3, has provided what is perhaps the most comprehensive analyses of some of the less visible aspects of power and one of the most useful for linking social context and psychological processes. Foucault (1979, 1980) was critical of some traditional depictions of power as an entity which could be possessed by particular individuals or groups and was located in a centralised source. Such power exists and is important but it is often repressive, an accumulation of laws, taboos, prohibitions and sanctions often backed by the use of force. Foucault called this ‘power by subtraction’ and the threats involved are fairly obvious – physical punishment, loss of liberty, possessions or even life. His interest was in power as exercised rather than possessed, as relational rather than top-down, as pervading every social interaction and reaching ‘into the depth of society – to the bodies, wills, thoughts, conduct and everyday life’ of all of us (O’Grady, 2005, p.14). He saw language and the production of knowledge as inseparable from systems of power and, above all, saw these systems as creative and productive rather than repressive, in their ability to create norms, standards, identities and desires. This obviously overlaps with the notion of ideological power mentioned earlier; both are crucial in shaping the *meaning* of events and experiences. The threats here are more subtle – invalidation through imposition of others’ meaning; shame and humiliation; loss of valued identities or imposition of devalued identities. The idea of behaviour and experience as ‘illness’, the codification of standards in the *DSM* and its role in producing new identities via forms of mental disorder, could be seen as examples of this process.

Foucault coined the terms ‘biopower’ and ‘disciplinary power’ to convey the ways these relational and creative forms of power act to discipline bodies and minds (1979). As we also noted in Chapter 3, self-surveillance and self-policing are central to this disciplinary process where individuals ‘incorporate the “gaze” of external social structures, including dominant cultural ideas and practices, which embody certain prescriptions for thinking and living’ (O’Grady, 2005, p.18). Our highly individualistic culture, where individual brains or minds are often seen as responsible for people’s behaviour and emotions, encourages self-surveillance and masks the role of social context in how we act, think and feel. People are then more likely to blame themselves and be blamed by others for aspects of life over which they have little control and for failing to reach certain standards, for example as a ‘real man’ or ‘good mother’ or for ‘not having a perfect body’ or ‘for getting raped’. Foucault’s focus on the creation of identities is also important here, particularly how our culture consistently affirms certain identities, for example being white, heterosexual or a mother, to the point where the process can seem invisible except to those whose identities and sense of self receive far less social support.

Foucault has been criticised for placing too much emphasis on power at the micro-level of society, in relations among people, for underemphasising the impact of coercive, economic and legal power and for providing only an outline of the relationship between these processes (MacCanell & MacCanell, 1993; Ramazanoğlu & Holland, 1993; Smart, 1989). These and other writers, however, have extended his work to address these issues in areas such as reproduction, the law, gender relations, madness and ‘depression’ (Boyle, 1997; Lafrance, 2009; Parker et al., 1995; Ussher, 2011). Their analyses have highlighted not only the very close relationships among different forms of power but also how the (less visible) processes of ‘disciplinary’ power described by Foucault – and ideological power more widely – can mask the operation of what might otherwise be more visible structural, economic and legal power. We can certainly see how in some social contexts linked to emotional distress, such as living with an abusive partner, several forms of power are operating: coercive, legal, economic, ideological and disciplinary. David Smail has argued that the relative invisibility of many forms of power is heightened by the much greater salience of our bodies and feelings, and the actions of those immediately around us, in our everyday lives, so that we tend to overestimate the influence of these proximal powers and underestimate the influence of more distal power. Faced with emotional or behavioural difficulties, the result may be not only self-criticism and blame but a sense of uncertainty or even bewilderment about the causes of distress.

The visibility or invisibility of power is also important in relation to the different experiences of privileged and more marginalised groups. The latter may be more sharply aware of the operation of power. This is partly because it more often operates against their interests but also because subordinate groups have to be more concerned and knowledgeable about the lives and preferences of privileged people (whom they often serve) than vice versa (Fiske, 1993). Similarly, and in relation to the ‘unconscious’ exercise of power, the African-American family therapist Ken Hardy has an interesting perspective: ‘In my experience, the privileged almost always deal in the realm of intentions, while the subjugated almost always deal in the realm of consequences. Often this means that there can’t be a dialogue between the privileged and the subjugated because the reference points are so different. It’s important to realise that you can have good intentions that

render very damaging consequences. In order for talking to take place, the privileged must stop routinely using their position to clarify their intentions in ways that disregard the very real effects of their actions' (2001, p.47).

Although we have focused here on more negative aspects of power which may be relevant in understanding distress, it's important to bear in mind that power can also be benign or positive, for example the power of parents or friends in creating positive, close attachments and connections; of teachers in conveying knowledge and skills; of the law in protecting human rights and giving access to courts or tribunals; of governments in providing housing, education, and healthcare and of professionals in providing skilled and humane services. Experiencing benign power is a very important protective factor in the face of adversity.

In trying to understand the established links between people's social context and their experience of emotional and behavioural problems, we therefore need an approach to social context which acknowledges the networks of power and interest – material and discursive, more and less visible – in which people find themselves. We also need an approach to people's *responses* to adversity which equally acknowledges the importance of power.

An alternative approach to responses to adversity

In the discussion of medicalisation and diagnosis in Chapter 1, we described some of the problems of labelling emotional and behavioural difficulties as symptoms of mental disorder. We are arguing instead that these 'symptoms' are more accurately seen as intelligible responses to various types of social and relational adversities, attempts to change or mitigate a situation, to keep safe or even survive. Some aspects of these responses seem to arise from our common heritage as evolved humans, for example trying to maintain close attachments or fear and avoidance in the face of danger; others reflect culturally influenced strategies to manage and reduce adversity such as repetitive cleaning, binge eating or alcohol use. The networks of power people are embedded in and their access to resources – physical, social, economic and psychological – will play a major role in how people respond – for example, in how or whether they are able to escape, avoid or constructively change their situation; in the meanings they are able to impose on it and in whether their responses compound or alleviate the problems, bring support, concern or disapproval from others. It seems likely that the less access people have to valued resources, and the less they are able to exercise socially approved forms of power, then the more likely it is that their responses will bring concern and disapproval from others. In the following sections we will describe many examples of these processes in relation to various social groups and situations that research suggests are associated with emotional and behavioural difficulties: childhood adversity, sex and gender, ethnicity and 'race' and class/poverty. These, of course, are not the only relevant groups and situations but the processes which seem to link psychological and behavioural problems with social contexts, and especially inequalities in power and privilege, are often shared across different groups so that the research we discuss has more general applications.

The groups and situations we will discuss are obviously also not independent and people's relationship to power and inequalities can be complex. None of us belongs to only one social group or has only one identity and our multiple identities may have conflicting

meanings in terms of power and privilege, for example, male and Black; upper-class and female, or they may cumulatively reinforce or reduce privilege, for example, wealthy, White, heterosexual male or lower class, Black and disabled. There is a great deal of debate about how these intersections should be conceptualised (Walby, et al., 2012; Weber et al., 1998); we will try to convey some interactions while not losing sight of distinct group characteristics and experiences. It is also important to bear in mind that just as social groups and identities are not independent neither are adversities. It is not simply that harmful social contexts are often made up of multiple adversities but that once someone has experienced serious adversity, for example, childhood sexual abuse or early loss of a parent, they are likely to face more adversity later in life and have fewer resources for dealing with it (Aglan et al., 2008; Korkeila et al., 2010). So, although we start the following sections with childhood adversity, this does not imply that personal or family circumstances are the primary cause of distress – the nature and impact of these can only be understood in relation to the wider social, political and economic contexts. Equally, there are many causes of emotional and behavioural difficulties that do not necessarily involve childhood adversity although whether or not someone has experienced this will likely influence how they respond. And that we end the chapter with social class and poverty does not in any way imply lesser importance but reflects the fact that other forms of disadvantage, in this case relating to childhood adversity, gender and ‘race’ and ethnicity, are over-represented among people of low income and low socio-economic status so that the harmful effects of each can come together in often synergistic ways. In line with the question we posed earlier about what *broad* patterns researchers have described, we are also concerned here mainly with *group* or population processes and outcomes. There will be much individual variation and we will return to that point later. Finally, we have adopted a slightly different structure to each of the sections. This is partly because, for example, being male or female is not ‘the same’ as being in a particular social class. But the structure is also partly dictated by the different kinds of theoretical and research literatures which have grown up around these topics.

The social context: 1. Childhood adversity

Some of the very negative experiences we will be discussing are often called ‘trauma’ to convey their severity and harmful effects. Reflecting this, we do use the term in the document. However, we will mostly use the term ‘adversity’ in this section and throughout the discussion of social context, partly to avoid the medical overtones of ‘trauma’ but also to avoid the potentially misleading impression of discrete, possibly very unusual, extreme or life-threatening events impinging from outside, rather than, as is often the case, of continuous or repeated very negative experiences, embedded in people’s lives and relationships and in the discourses, structures and practices of our social world. We would argue that these qualities of adversity can be crucial in understanding the experiences themselves and children’s and adults’ responses.

The nature and scope of childhood adversity

The following is not a complete account of childhood adversities but includes those which have received most attention from professionals and researchers. Inevitably, figures

describing the scope of these problems vary because of differences in definitions, methods, sampling and so on across studies. There is strong evidence however (and see later) that the scale of the problem presents considerable threats to many children's wellbeing and development.

Bullying: Refers to a specific type of victimisation – threat or violence deliberately inflicted by another person – that is generally intentional, repetitive, pervasive and enacted in a context of unequal physical or social power. It includes physical violence and relational or social aggression such as exclusion, verbal abuse, taunts and threats or spreading malicious gossip. The term cyberbullying has recently been used for the use of the Internet and allied technologies to persecute, humiliate and harass victims through, for example, the use of forums, webpages, imaging and instant messaging (Hinduja & Patchin, 2009). Cyberbullying can extend threat physically and temporally, seriously restricting times and places where a victim feels safe. A survey of 35 countries by the World Health Organisation estimated average bullying incidence rates of 11 per cent amongst school-aged children (Craig & Harel, 2004) although higher incidence and prevalence rates of between 15 and 32 per cent have been reported across a range of countries with even higher figures for cyberbullying (Bowen & Holtom, 2010; Ditch the Label, 2013, 2015; Kshiragar et al., 2007; Nansel et al., 2001). There is no 'typical' recipient of childhood bullying, but victims are more likely to belong to groups that are already disempowered and discriminated against in other ways, for example by sexuality, ethnicity, chronic illness or intellectual or physical disability (Englander, 2007; Minton, 2017; Sentenac et al., 2011; Stonewall, 2012).

Neglect: Unlike sexual, physical or emotional abuse, in which deliberately destructive acts are committed against a child, neglect refers to a more passive form of maltreatment where adults withhold adequate care from their dependent children. This can include failing to provide or maintain necessary schooling and intellectual encouragement, insufficient nourishment, warmth, supervision, hygiene or health care or denying emotional nurturing and affection. Neglect is amongst the commonest forms of child abuse in Western societies (Hildyard & Wolfe, 2002). For example, it is estimated that one in seven children in the UK aged between 11 and 17 have been neglected with one in 10 experiencing severe neglect (Radford et al., 2011). It is the most common reason in the UK for taking child protection action (Bentley, et al., 2016); in North America, it accounts for the highest incidence of child abuse cases (Public Health Agency of Canada, 2001; Sedlak et al., 2010) and is implicated in a majority of child abuse fatalities (US Department of Health and Human Services, 2016). Our perceptions of neglect may also be influenced by social class. Children can experience emotional neglect from absent, preoccupied or uninterested parents and guardians while their physical, material and educational needs are met by (paid) others. These children are unlikely to come to the attention of the authorities or researchers studying more visible aspects of neglect (Duffell & Basset, 2016).

Sexual and physical abuse: Child sexual abuse refers to an adult's (or adolescent's) unwanted sexual activity with a child (or adolescent), most often involving force or threat. It includes rape and other forms of sexual assault as well as coerced viewing of pornography or other sex acts, filming and sexual talk. Research suggests that many sexually abused children do not tell anyone about what is happening, either at the time or later, with silence often secured with threats or violence. A recent report (Office for National Statistics, 2016) found that around three in four victims had not told anyone

about childhood sexual assault by rape or penetration at the time it happened. People in mental health services are also unlikely to be asked about these experiences; they, and people interviewed by researchers may also be unwilling to disclose them or may not even clearly remember them (Radford et al., 2011; Read et al., 2005; Ussher, 2011; van Dam et al., 2012). Many researchers acknowledge that reported figures are therefore likely to be serious underestimates. Depending on methods and definitions, these range from 11 to 46 per cent of girls and 3 to 10 per cent of boys (Bolen et al., 2000; Finkelhor, 1994; Kendler et al., 2000; Nelson et al., 2002; ONS, 2016; Ussher, 2011). Data collected by the National Society for Prevention of Cruelty to Children (NSPCC) through Freedom of Information requests from 43 police forces in England and Wales, revealed an average of 64 child sex offences reported daily in 2009–2010, the equivalent to one assault every 20 minutes. Of these victims, one in four were 11 or younger and over 1000 were four or younger. Eighty-six per cent of the reported victims were female. (<http://www.bbc.co.uk/news/education-13542007>). Children with learning disabilities are especially vulnerable; they are more dependent on others for care, less able to understand and communicate when abuse happens and may be seen as easier to silence (Sequeira & Hollins, 2003). Children who experience frequent hospitalisations may also be more vulnerable to sexual (and physical) abuse because they have become socialised to adult strangers engaging in personal and intimate care for them or causing them pain ‘for their own good’. Men are reported as perpetrators in the majority of cases of sexual abuse, with girls more likely to be abused within the family and boys outside it (Ussher, 2011). Other patterns of sexual abuse include grooming, exploitation and assault by organised gangs; in a 14-month period from 2010 and 2011, over 2400 children in England were confirmed as victims of this kind of abuse (Berelowitz et al., 2012). Sexual abuse obviously often involves physical harm but many children experience nonsexual physical abuse, including hitting, beating with belts or other implements, verbal aggression and threats. In the US, physical abuse is implicated in almost half of maltreatment fatalities in children (US Department of Health and Human Services, 2016); in the UK overall, physical abuse was noted as a major reason in almost 20 per cent of children identified as needing protection from abuse and maltreatment (Bentley et al., 2016). Physical abuse also includes female genital mutilation (FGM) and the fabrication or induction of illness in a child by a carer. It has been estimated that over 20,000 girls under the age of 15 are at high risk of FGM in the UK each year and that 66,000 women in the UK are living with the consequences, although its true extent is unknown due to the nature of the crime (HM Government, 2011). Estimates of fabrication or induction of illness are also difficult to make, particularly as these children may also experience other forms of abuse or neglect and may previously have been seriously ill, for example as a result of prematurity or have had minor problems at birth or in the first few months of life. It has been estimated that the annual UK incidence of this form of abuse in under 16s was at least 5 per 100,000 and for children under one year at least 2.8 per 100,000 but it is acknowledged that these are likely to be underestimates (McClure et al., 1996).

Witnessing violence in the home: Even when children are not themselves victims, they are often witnesses to violence (and may be both) – it is estimated that over two thirds of assaults in the family home are witnessed by children (Moffitt & Caspi, 1998); around 8 per cent of adults interviewed in a large-scale study in England and Wales, reported witnessing domestic violence or abuse in the home when they were children (ONS, 2016). This

includes rapes and sexual assaults as well as physical assaults. In these homes, children are also likely to be witnesses to 'low-level' aggression such as shouting and threats. If children are not actually present during attacks, they are still likely to be within hearing of them. It is often children who call for help during attacks, take responsibility for younger siblings or look after the victim (more frequently their mother) after an assault. As Arlene Vetere points out, children in this context can often develop social, moral and interpersonal competence beyond their years, but alongside very negative emotional and behavioural effects not dissimilar to those shown by children who are assaulted themselves (van der Kolk, 2005; Vetere, 2011; Vetere & Cooper, 2005).

Emotional abuse: Some of these experiences will also involve emotional abuse, where a child is persistently criticised, humiliated, shouted at, threatened or rejected by caregivers, so that it can be difficult to determine its separate scale and effects. However, it has been estimated that about 7 per cent of children have (separately) experienced emotional abuse from a parent or guardian (Radford et al., 2011) and, in 2016, the NSPCC reported that almost 19,000 children in the UK had required assistance from child protection services for this reason (Bentley, et al., 2016). It has also been argued that in spite of its prevalence and the fact that it can be as psychologically harmful as physical or sexual maltreatment, emotional abuse is often under-addressed in both prevention and intervention (Spinazzolla et al., 2014).

'Everyday' adversity: This includes threats or challenges which arise from 'normal' cultural practices, often in media and advertising, but also in schools (Thomas, 2014) which create social pressure and encourage comparison with other children or with an ideal standard, especially in relation to appearance or achievement. For example, over a third of adolescent boys and almost half of girls across several surveys report having dieted to change their body shape or lose weight (All Party Parliamentary Group on Body Image, 2012) with one study reporting that one in four 7-year-old girls in its sample had tried to lose weight at least once (Westerberg-Jacobson et al., 2012). Adolescent girls are also routinely subject to sexual harassment from men in public places including unwanted 'chatting up', sexualised insults and being followed (Bates, 2014). Such harassment, and sexual violence, are also endemic in UK schools (House of Commons Women and Equalities Committee, 2016). A survey by the World Health Organisation (2016) reported that teenagers from England and Wales were among the least likely to report high levels of satisfaction with their lives, with children from only two out of forty-two countries less satisfied. While some of this may be attributed to more severe adversities, these children reported high levels of stress about schoolwork and worries about health.

To these can be added further childhood adversities such as dealing with the pain, restrictions on activities, aversive treatments, school absences and separation from families often associated with chronic illness or disability; loss of a parent through separation or death; having a parent with serious physical or emotional problems, including problems with drugs or alcohol; having carers whose communications are inconsistent, fragmented or contradictory; being taken into care; and living in or having to escape conflict or war zones.

Some of these adversities, of course, can happen to adults but there are several reasons for supposing that experiencing them as a child is particularly significant. These include:

- There is a very large discrepancy in power between adults and children who may be wholly dependent on their caregivers and other adults for their physical, material, educational and psychological needs.
- Partly because of this, and depending on their age and abilities, children may have few if any of the resources needed to escape or avoid harmful adults and circumstances.
- Children who seek support or protection from others about abuse or maltreatment may not be believed, with adults able to draw on cultural discourses of children's overactive imaginations, tendency to make up stories and, in the case of sexually abused girls, of seductiveness and inherent sexuality.
- Depending on their age, children may not have the cognitive resources to make sense of their situation in a way which does not involve blaming themselves (or, in the case of infants or very young children, the resources to make any sense of it at all). This can make it very difficult for children to describe their situation to others and make them very vulnerable to adult constructions of it. For children with learning disabilities, this disadvantage can be much greater.
- The kinds of experiences we have described are not only very aversive, they can also severely limit children's exposure to vital, early opportunities for constructive emotional, social and intellectual learning as well as creating an extremely negative view of the self. This can make it far more difficult for children to achieve educationally, to develop supportive relationships and to deal with later difficulties in life, often creating multiple adversities in adulthood.
- Related to this, children who have been maltreated will often find it difficult to provide good parenting for their own children, possibly repeating the neglect and violence which they themselves have suffered or witnessed. Adversity and its effects can therefore become intergenerational.
- Childhood adversity happens at a time when brain development is very active and incomplete. Given that a primary role of the brain is adaptation to the environment, it is not surprising that there is strong evidence that childhood adversity can have significant negative effects on brain development (see Chapter 5 on Biology). This can set the scene for later cognitive, emotional and social difficulties.

The impact and outcomes of childhood adversity

Although the separation is artificial, we will focus here on social and psychological aspects and discuss the role of biology in Chapter 5.

Research on the impact of childhood adversity has used a variety of samples, methods, measures, statistical analyses, and definitions of both adversity and outcomes. For obvious reasons, researchers have often relied on retrospective reports from adults but there is little evidence of false positives and more concern about underreporting (Bebbington et al., 2004; Keyes et al., 2012; Nelson et al., 2002). This variety can make comparisons across studies difficult but it is also a strength given that it has produced an extremely robust and consistent body of evidence which strongly links childhood adversity to negative outcomes across the lifespan including: anxiety and very low mood; drug and alcohol problems; antisocial behaviour; low educational achievement; relationship problems; self-harm and suicide. Childhood adversity is also linked to almost every functional diagnostic category including 'anxiety and mood disorders'; 'eating disorders'; 'personality disorders';

‘conduct disorders’ and ‘psychosis’, to self-harm and suicide; to ‘mental wellbeing’ in general, to health harming behaviours such as smoking and poor diet, as well as to a range of physical health problems including heart disease, lung cancer, liver disease, obesity and diabetes (Bebbington et al., 2011; Bellis et al., 2014; British Psychological Society, 2014; Couper & Mackie, 2016; Cutajar et al., 2010; de Sousa et al., 2014; Dong et al., 2004; Edwards et al., 2007; Ford & Gomez, 2015; Gander et al., 2015; Green et al., 2010; Johnson et al., 1999; Kendler et al., 2000; McLaughlin et al., 2010; Matheson et al., 2013; Phillips et al., 2005; Public Health Wales NHS Trust, 2016; Varese et al., 2012; Williamson et al., 2002).

Studies of the impact of childhood adversity include large-scale general population or community surveys, some of which, such as the US Adverse Childhood Experiences (ACE) project, follow participants over a number of years, and studies which begin with people who have been given a psychiatric diagnosis or who have a known history of adversity. Among other things, the population studies have quantified some of the risks from various kinds of adversity by comparing adults who report them with those who do not. For example, people who had been abused, either physically, sexually, psychologically or emotionally before the age of 16, but who reported no psychotic experiences at the start of the study, were 13 times more likely to meet the criteria for ‘pathology level psychosis’ in the following two years than people who had not been abused in childhood (Janssen et al., 2004). Similarly, Paul Bebbington and colleagues (2004) reported that people who had experienced sexual abuse were almost four times more likely to meet the criteria for ‘probable psychotic disorder’ at the time of the study and twice as likely if they had been exposed to other violence in the home. Adults who had been raped as children were almost 15 times more likely to meet the criteria for ‘probable psychosis’ (Bebbington et al., 2011). In a twin study, those who had experienced childhood rape were 14 times more likely to meet criteria for a conduct disorder or to attempt suicide than children who had not experienced sexual abuse and 10 times more likely to experience rape as an adult (Nelson et al., 2002). Similarly, adolescents who had been exposed to multiple and severe adversities, including violence, were almost 14 times more likely to attempt suicide (Borges et al., 2008). Women who had experienced any form of childhood sexual abuse were more than three times more likely to receive a diagnosis of major depression (Cong et al., 2012). Sara Scott and colleagues (2013) reported that adults who had experienced extensive physical and sexual violence, extending back to childhood, were 15 times more likely to meet the criteria for three or more ‘mental disorders’, 15 times more likely to attempt suicide, 12 times more likely to be admitted to an inpatient unit and four times more likely to hear voices or experience visual hallucinations.

The US ACE project was a collaboration between the Centre for Disease Control and the Kaiser Permanente clinic in California, one of the largest clinics of its kind in the US, offering medical evaluations to members of the Kaiser health care plan. Based on self-reports from over 17,000 participants followed up over 15 years, the project examined the impact of a wide range of abuse, neglect and family dysfunction, a total of 10 ‘types’ of adverse experience. Reporting an adverse childhood experience in any category conveyed a two to five-fold increased risk of attempted suicide, and compared to those reporting no adverse experiences, those who reported seven or more ACEs were at a 31-fold increased risk of a suicide attempt (Dube et al., 2001). Those reporting four or more ACEs had a 4 to 12-fold increased risk for depressed mood in the previous year, illicit drug

use and injecting street drugs, alcohol misuse and suicide attempts (Feletti et al., 1998) while childhood emotional abuse was found to increase the risk of receiving a diagnosis of a 'depressive disorder' around 2.5-fold, with a significant graded relationship between overall ACE score and the probability of recent lifetime diagnosis of 'depressive disorders', including maternal depression (Chapman et al., 2004). In another of the project's studies, experiencing five or more ACEs was associated with a 10-fold increase in the likelihood of being prescribed neuroleptic medication ('antipsychotics') and a 17-fold increase in the likelihood of being prescribed 'mood stabilising' drugs (Anda et al., 2007). Similarly, Richard Bentall and colleagues (2012) reported that children who had experienced four or more types of adversity were around 17 times more likely as adults to be assessed as 'paranoid' and almost 14 times more likely to experience 'auditory verbal hallucinations'. And, as well as links to many physical health problems (see above) multiple childhood adversities also increase the probability of long-term consequences such as homelessness, prostitution, unemployment, criminal behaviour and early death.

Studies which begin with people who have already received a psychiatric diagnosis suggest that the majority have experienced some kind of childhood adversity and maltreatment. Even these figures may be underestimates given that people seem particularly unlikely to report child abuse when they are psychiatric patients although they are more likely to do so in confidential self-report surveys than in routine interviews with professionals (Dill et al., 1991; Read et al., 2005). One review of 15 studies of female inpatients found that 64 per cent had experienced either sexual or physical abuse as children (Read, 1997). A later review of 39 studies of female patients reported a similar figure of 69 per cent while a review of 31 studies of male patients reported a figure of 59 per cent (Read et al., 2005). These studies did not include emotional abuse or neglect and the figures would likely have been higher if they had been included. A study of 214 consecutive admissions of women given a diagnosis of borderline personality disorder found that 75 per cent of them had previously reported a history of childhood sexual abuse (McFetridge et al., 2015). A meta-analysis of population and patient-based studies and including a wide range of adversities, reported that people who had been exposed to any of them in childhood were almost three times more likely to report psychotic experiences (including 'subclinical' experiences) or to receive a diagnosis of a 'psychotic disorder' (Varese et al., 2012).

There are good reasons to believe that the associations between childhood adversity and these negative outcomes are causal, using several criteria (Bentall & Varese, 2012; Read et al., 2005). There is strong evidence that the more severe the adversity or the more types experienced, then the more severe the outcome – the 'dose-response effect' (Bebbington et al., 2011; Bentall et al., 2015; Chapman et al., 2004; Cong et al., 2012; Dube, 2001; Longden et al., 2016; Read et al., 2005). Prospective studies show that the adversity and maltreatment precedes negative outcomes (de Sousa et al., 2014; Janssen et al., 2004) although this is also obvious from many retrospective studies. Several studies have controlled for possible confounding factors but still found very significant effects (Bebbington et al., 2004; Bentall & Varese, 2012; Borges et al., 2008; Nelson et al., 2002; Shevlin et al., 2009). There are also known psychological, social and biological mechanisms which could account for the links between adversity and negative outcomes (see later and Chapter 5). In spite of this, it has been suggested that the links between childhood adversity and, especially, schizophrenia diagnoses can be explained in other ways, for

example that children who later ‘develop schizophrenia’ may have attributes which make adults more likely to mistreat or abuse them or that parents who carry ‘schizophrenia genes’ are more likely to maltreat their children, creating a possibly spurious relationship between adversity and diagnoses; it has also been suggested – echoing the vulnerability-stress hypothesis – that being abused in childhood may ‘kindle’ a serious adult ‘disorder’ in genetically or biologically predisposed children (Bebbington et al., 2004; Fowler et al., 2006; Goodwin et al., 1990; Sedeli, et al., 2012; Trotta, et al., 2016). These alternative suggestions are not supported by evidence, especially when we consider the difficulties faced by genetic research in producing reliable evidence linking genes and psychiatric diagnoses (see Chapter 5). Some of the arguments simply assume that genetic family relationships imply a shared genetic propensity to a particular ‘disorder’ but studies using twins suggest that the effects of adversity cannot easily be explained by genetic relationships (Alemany et al., 2013; Arseneault et al., 2011). Similarly, studies of adopted children whose biological mothers had been given diagnoses including schizophrenia, have found little evidence for the importance of genetic relationships rather than adverse environments in raising the risk of a range of diagnoses (Boyle, 2002a; Tienari et al., 2003). A recent pilot study using polygenic risk scores from analyses of genetic material found no interaction between these scores and childhood adversity in raising the risk of a psychosis diagnosis in adulthood (Trotta et al., 2016).

Do specific adversities cause specific outcomes?

As we have seen, childhood adversity, overall, is associated with many diagnostic categories. This can create the misleading impression that adversity produces specific categorical outcomes and encourage the search for links between particular kinds of adversity and particular diagnoses. There are at least three problems here. First, diagnostic categories are imposed by researchers, often using methods which limit what people can talk about, such as scales or questionnaires with pre-set questions and response categories. Second, and as we emphasised in our discussion of diagnosis, the kinds of experiences people report, and which might count as symptoms, such as panic and anxiety, very low mood, voice hearing, dissociation and flashbacks, are common to many diagnostic categories (Bebbington et al., 2004; British Psychological Society, 2010; Dorahy et al., 2009; Read et al., 2005). Third, diagnostic categories, with their assumptions of underlying pathology, imply that adversity results in specific illnesses rather than meaningful, functional responses to complex social contexts. Diagnostic categories, then, are unlikely to give an accurate account of patterns in children’s responses to adversity.

Within these constraints, however, researchers have reported some more specific patterns. Maltreatment at a younger age and intentional adversity, for example bullying or sexual abuse compared to the death of a parent or accidents, are usually reported to have more damaging effects, including suicide attempts, while physical and sexual abuse appear to have stronger links to ‘psychosis’ than does neglect (Arseneault et al., 2011; Ford & Gomez, 2015; Heins et al., 2011; Ussher, 2011; van Nierop et al., 2014). Sexual abuse involving rape or other genital contact is far more likely to result in psychiatric diagnoses, self-harm and suicide attempts than other kinds of child sexual abuse such as unwanted sexual talk or non-genital contact (Bebbington et al., 2011; Ford & Gomez, 2015; Nelson et al., 2002 Ussher & Dewberry, 1995). Some research suggests that sexual abuse, compared

to other kinds of childhood adversity, is more strongly related to 'psychosis' and is also more strongly related to 'psychosis' than to other diagnoses (Bebbington et al., 2004). However, Eleanor Longden and colleagues (2016) reported that the childhood adversities which showed the largest number of associations with 'psychotic' experiences in a group of adult service users were poverty and being fostered or adopted. Katherine Keyes and colleagues (2012) found a complex set of relationships amongst childhood adversities and outcomes represented as 'internalising and externalising liability dimensions' inferred from diagnostic categories – the internalising dimension includes mood 'disorders', 'generalised anxiety disorder', 'panic disorder' and 'social phobia'. The externalising dimension includes 'substance disorders' 'conduct disorder' and 'antisocial personality disorder'. These researchers reported that although childhood sexual abuse was associated with diagnoses reflecting both the internalising and externalising dimensions, it was most strongly associated with the internalising dimension for both women and men. There were sex differences in outcomes for physical abuse which was associated only with the internalising dimension for women and the externalising dimension for men. Some of these results are in contrast with an earlier twin study (Kendler et al., 2000) which reported that sexual abuse was associated most strongly with alcohol and drug problems in women. Neither of these two studies involved assessment of 'psychotic' experiences.

Another approach to the search for more specific patterns has involved assessment of particular experiences which may be labelled as psychotic in response to childhood adversity, rather than diagnostic categories. Some studies have shown associations between parental communication which is vague, fragmented and contradictory and 'thought disorder' (de Sousa et al., 2014). Richard Bentall and colleagues (2015) have argued that sexual abuse may be particularly related to hallucinatory experiences, especially voice hearing, and that being raised in institutions, physical abuse and bullying may be more strongly related to 'paranoia'. There is some evidence of this pattern (Bentall et al., 2012; Shakoor et al., 2015) and psychological mechanisms which could account for it (see later).

But there is also conflicting evidence. A study of service users (Read et al., 2003) found that, of those who had experienced child sexual but not physical abuse, 52 per cent reported hearing voices and 40 per cent suspicious thoughts and beliefs; of those who had experienced physical but not sexual abuse, 41 per cent reported hearing voices, and 26 per cent 'paranoid' beliefs. Although the researchers did not test for the significance of these differences, there is not much evidence here of specificity. Similarly, Eleanor Longden and colleagues (2016) did not find evidence of specificity between child sexual abuse and hallucinatory experiences. And, in this study, although suspicious thoughts and beliefs were significantly related to being fostered or adopted, so too were hallucinatory experiences. Martine van Nierop and colleagues (2014) have argued that analyses of possible specific effects requires the use of statistical models which allow for appropriate testing of differences in the strength of relationships between different types of adversity and different outcomes, and that these models have not usually been used. In a general population study, they found strong links between a range of childhood adversities and psychotic experiences but no evidence for specificity in the relationship between particular adversities and particular experiences of voice hearing or suspicious beliefs.

This type of research and the research we discussed earlier, have been invaluable in establishing links between childhood adversities and negative social and psychological

outcomes. However, there are several reasons why its emphasis on complex statistical relations amongst researcher defined variables, and its search for greater specificity through statistical control, limit its ability to provide a more comprehensive picture of relationships between childhood adversity and its effects.

First, childhood adversities are not independent, with many children experiencing more than one 'type' (Bentall et al., 2015; Keyes et al., 2012). As Eleanor Longden and colleagues (2016) point out, some adversities such as fostering or adoption can be seen as proxies for a range of more general and cumulative disadvantages. In a twin study, children who had not been sexually abused but whose twin had, showed significantly greater negative outcomes as adults than twins where neither had been abused, suggesting misreporting on the part of some twins and/or the influence of related adversities (Nelson et al., 2002). And, as we have noted, outcomes of adversity such as anxiety, low mood, eating problems, voice hearing, 'paranoia', dissociation, and alcohol and drug problems are also correlated; the wide range of problems that can result from childhood adversity may not be detected in research which focuses on one or two diagnostic categories or on specific experiences, creating a misleading impression of specificity. In research which does assess a range of problems, the various statistical techniques used to control for these correlations, to try to highlight specific effects of specific adversities, can also be misleading because the results do not reflect the lived experience of many children who have to live with multiple adversities and their multiple outcomes.

Second, the impact of childhood adversity seems to be not just cumulative but synergistic in that experiencing an adversity increases the chances of experiencing subsequent ones while multiple adversities may have effects different from and greater than the sum of 'single' events (Bebbington et al., 2011; Finkelhor et al., 2007; Longden et al., 2016; Morgan et al., 2014; Nelson et al., 2002). Third, adversities in childhood, including sexual abuse and violence, often continue into adulthood, often compounded by poverty (Scott et al., 2013). This can make it difficult to separate out the specific impact of particular childhood adversities. Finally, the effects of childhood adversities are sometimes described in rather mechanical terms, for example that they 'act on' various hypothetical biological, emotional and cognitive systems. This can give the impression of children as passive recipients of events rather than active social agents whose responses may be functional attempts to survive aversive or dangerous environments. Related to this, the kind of research we've discussed has paid little or no attention to the personal and social meanings of adversities and how these shape people's responses.

All of this recalls our discussion in Chapter 2 on the need for models of causality reflecting the fact that patterns of human behaviour and experience, and their relationship to the environment, are highly probabilistic and contingent and powerfully shaped by social and cultural meanings. The variable and sometimes conflicting evidence on links between specific adversities and specific outcomes does not mean that there are no cause-effect relationships or that we cannot account for the particular 'pathway' taken by an individual. But in describing detailed patterns of relationships between childhood adversity and psychosocial outcomes we need to focus on the psychosocial processes and contexts involved in childhood adversities and potential responses to them, as well as on the specifics of statistical relations.

The processes and contexts of childhood adversity

Quality of attachments: Forming social and emotional attachments to other people is one of the most basic and necessary processes of human development. Attachment theory (Bowlby, 1988) suggests that our early experiences of this process, in relationships with caregivers, have profound consequences. These formative relationships are thought to shape and sustain fundamental beliefs about ourselves, other people and the world, creating an ‘interpersonal template’ that strongly influences how we relate to others, regulate emotion, infer others’ mental state and manage autonomic arousal in order to cope with threatening feelings and situations. Disruptions in the formation of early social and emotional bonds seem to be implicated in virtually every type of childhood adversity and in responses to them, both in child and adulthood. For many reasons, including adverse social contexts and their own childhood experiences, carers may be absent, neglectful or unresponsive; they may be confusing in their communications; they may be hostile, threatening, controlling or overprotective. Or, they may be highly inconsistent, unpredictably nurturing or rejecting. Children who are placed ‘in care’ are very likely to experience disrupted attachments but so too are young children sent to boarding school or who experience any form of institutional care. Early relationships which do not involve consistent and appropriate responses to the needs of infants and children are said to produce insecure attachment styles, including *anxious/preoccupied* where someone tries to gain approval and acceptance from others while feeling unworthy themselves; *avoidant/dismissing* where the person may see themselves as lovable but avoid others as untrustworthy and rejecting; and *fearful*, reflecting negative views of both self and others and avoidance of relationships to protect against rejection (Bartholomew & Horowitz, 1991; Hesse, 2008). There is consistent evidence of links between various measures of insecure attachment styles, childhood adversity and a wide range of diagnoses but evidence of links between a specific attachment style, specific adversities and specific diagnoses is more limited (Bakermans-Kranenburg & van IJzendoorn, 2009; Gander et al., 2015). Katarzyna Sitko and colleagues (2014) reported that the relationship between childhood neglect and adult ‘paranoid’ beliefs in a general population sample was fully mediated by anxious and avoidant attachment but the results for other adversities and types of distress were less clear. This lack of specificity is perhaps not surprising given that both adversities and expressions of distress tend to correlate, and diagnostic categories show a great deal of overlap. But ‘styles’ of attachment also overlap and do not form discrete categories; they are assessed by different methods and there is no agreed number of them, with up to 20 being suggested, including a ‘cannot classify’. They are perhaps better thought of as provisional representations of complex psychosocial patterns, which may change over time and be influenced by social context (Bakermans-Kranenburg & van IJzendoorn, 2009). All of this suggests that while we can be confident of a general pattern of relationships between childhood adversity, attachment disruptions and emotional and behavioural problems, very specific relationships may only be apparent at the level of individual narratives.

Threat, vigilance and suspicion: Childhood adversities involve multiple threats including humiliation, rejection, abandonment, physical discomfort and harm, as well as harm to others such as mother or siblings. These happen in contexts where adults, and peers in the case of bullying, may behave inconsistently and unpredictably and where the child

has little control and few means of escape. Mitigating these threats and securing adequate resources for safety or some degree of comfort and reassurance, demands constant vigilance and is likely to involve very high levels of anxiety. Refusing to go to school may be a way of escaping bullies or trying to ensure a parent's safety; 'conduct disorders' such as 'attention deficit hyperactivity disorder' may reflect 'major distraction behaviours such that [children] never sit still long enough to contemplate the terrible fact that the people they turn to for support and protection want to hurt them' (Vetere, 2012, p.114). As we have seen, suspicious thoughts and beliefs are linked to many forms of childhood adversity, including neglect, physical and sexual abuse, bullying, and institutional care. 'Paranoia', involving beliefs about vulnerability and the dangers posed by others, that your life is controlled by external forces and that vigilance is helpful and necessary, can be a reasonable and accurate response to these experiences, easily generalisable to anyone or anything reminiscent of threatening persons or situations (Bentall et al., 2015; Freeman et al., 2002; Read et al., 2005). These beliefs may be labelled delusional if they later dominate situations which seem unthreatening to others or are expressed in indirect or symbolic ways. But this labelling is problematic not only because of difficulties with the concept of delusion but also because of the strong links between childhood and adult adversity, so that suspicion, vigilance or beliefs of protection by powerful others, may still be meaningful and helpful responses well beyond childhood (Harper, 2004, 2011). Not surprisingly, there is a correspondence between the themes in someone's 'delusional' beliefs and the circumstances of their everyday life and their past (Rhodes & Jakes, 2000).

Dissociation: Dissociation exists on a continuum, with around 60–65 per cent of the general population reporting some kind of 'non-clinical' dissociative experience (Waller et al., 1996). At the far end of this spectrum it refers to a process of mentally detaching from ongoing reality in the face of experiences that are too overwhelming for the psyche to process, such as immediate and inescapable threats (van der Hart et al., 2006). By definition, this mechanism is central to the diagnostic category of 'dissociative disorders' but, emphasising overlap across categories, it is part of a range of diagnoses including depression, post-traumatic stress disorder and borderline personality disorder. It also appears to be an important mediating factor in linking sexual abuse with self harm and suicide attempts (Ford & Gomez, 2015). Dissociation can seem like an involuntary response to experiences of devastating intensity, but as a protective human capacity it is also actively used to reduce conscious awareness of intolerable information and emotion – it is both biologically enabled and prompted and regulated by experience. For example, one woman recalling her sexual abuse as a child, reported 'just kind of [going] somewhere else in my head till it was over'; another said she '[thought about] other things apart from what he was doing...like, oh what should I do when I go home and... I have to go and do my homework and I wonder if I can go out and play on my bicycle tonight, things like that', while another described trying to 'go out' of her body while waiting for her father to assault her, picking something in her room to focus on while the abuse happened (Ussher, 2011, pp.130–131). Dissociation, then, is a highly functional mechanism but the intensity of events which prompt it means that cognitive, affective and somatic representations of them may be stored in a fractured, unassimilated way (Brewin et al., 1996). This dissociative fragmentation can cause considerable distress especially if it becomes a habitual way of responding to anxiety or psychological threat (Dell, 2009); it is also associated with hallucinatory experiences and difficulties in regulating emotion

(see below). Although dissociation can happen to or be done by individuals it is also a prominent feature of the situations some children find themselves in. They are often expected to 'forget' their abuse, as the adults around them behave as if nothing has happened. One woman described how after assaulting her, her father would take her and her siblings for ice cream and play with them in the park. She was expected to participate in games even when she had difficulty moving following the assault. Another woman talked of sitting down for family meals with the perpetrator: 'You know... 20 minutes after being raped we could be doing quite sort of normal, friendly things. It's that bizarre really' (Ussher, 2011, pp.131–132). Children may witness or overhear their mother being assaulted only for things to carry on 'normally', with no reference ever made to what has happened. This sense of unreality can be compounded if a child tells another adult about their situation and is not believed or no action is taken, reflecting the fact that dissociation also operates at a societal level (Herman, 1997). Dissociation therefore not only acts as to protect against intolerable knowledge or emotion but also to ensure continuing care and support from adults who do not acknowledge the child's experience.

Hallucinatory experiences: This refers to experiences that would seem to require an external stimulus or non-self source but where none is obviously present. Many types of childhood adversity are associated with them, including sexual and physical abuse, bullying and institutional care (Bentall et al., 2012; Sitko et al., 2014; van Nierop et al., 2014). Several closely related processes might account for these links. All of us, on a moment-to-moment basis, engage in 'source monitoring' (Bentall, 1990), making judgements about what is real and what is imaginary, what is internal and external to us. Anything which makes these judgements more difficult or ambiguous will increase the chances of experiencing imaginings as real (Sarbin, 1967). This is more likely when we are in states of high arousal or altered consciousness brought about for example by fear, pain, grief, personal crises or sleep deprivation. Accurate source monitoring is also more difficult when the contents of consciousness are experienced as unintended, threatening or emotion laden, as they often are when fragmented memories of abuse and adversity return as intrusive cognitive, emotional or somatic experiences. Some hallucinatory experiences, then, can be understood as dissociated emotional and/or experiential content, such as the voice of a past abuser, that intrudes into conscious awareness and is felt by the person as a disowned, 'alien' phenomenon that feels detached and separate from autobiographical experience (Longden et al., 2012). In line with this, reports of dissociation often precede the onset of voice hearing (Varese et al., 2011). Many forms of childhood adversity such as bullying, sexual and physical abuse, hostility and rejection, involve the forceful and persistent imposition of others' beliefs and feelings about the child and what is happening to them. This, too, can blur the boundaries between what is real and what is imaginary, what mental contents 'belong to' and can be controlled by the person themselves and what is unintended and alien. Hallucinatory experiences, especially voice hearing, are also linked with social isolation (Bentall, 1990; Nayani & David, 1996) which can increase attention to our own hopes, wishes and fears and lead to 'underconstrained perceptions' or 'cognitive self-consciousness' (Behrendt, 1998; Morrison et al., 2000). Isolation, loneliness and social anxiety can result from the negative attachment styles we discussed earlier; these are related to hallucinations and especially to themes of criticism, rejection and threat in voice hearing (Berry et al., 2012; MacBeth et al., 2008). Many people who hear voices or have other hallucinatory experiences are not distressed by them, indeed

they may gain comfort, reassurance and guidance (Beavan et al., 2011; Boyle, 2002a). However, those who have experienced childhood adversity, such as physical or sexual abuse seem much more likely to be distressed (Bak et al., 2005). In line with this, for service users, the content of hallucinatory voices is often very negative – critical, commanding and abusive; voices can resemble perpetrators in tone and content and often reflect the way people have been treated or are being treated in relationships (Hardy et al., 2005; Nayani & David, 1996; Romme et al., 2009). Voice hearers' beliefs about their voices, for example how powerful or dominant they seem, are also related to their perception of their own power or lack of it in relationships (Birchwood et al. 2000). Like dissociation, hallucinatory experiences can be an active process. It may be protective to experience fragmented memories as not belonging to oneself or to develop 'delusional' explanations of them, rather than have to remember or re-live actual events. It can also be protective not to keep a clear distinction between reality and imagination, when reality is so threatening and may be denied by others. And the content of voices may be mixed, with comforting and benevolent voices being actively sought (Chadwick & Birchwood, 1994; Ensink, 1993; McCarthy-Jones et al., 2015; Read et al., 2005).

Negative views of the self: Childhood adversity often leads to very negative beliefs about oneself, including feelings of inferiority and worthlessness, shame, guilt and hopelessness. Since these match what are said to be symptoms of depression, is not surprising that those who have experienced childhood adversity are much more likely to meet the criteria for a diagnosis of depression. Paul Bebbington and colleagues also found that very low mood mediated the relationship between adversity and 'psychosis' (Bebbington et al., 2004; Bebbington et al., 2011). It is not difficult to see how childhood adversity can produce such negative views. The behaviour of caregivers, other adults or peers can teach children that they are unworthy and undeserving of others' attention or concern, that their wishes do not matter and that others are rejecting, unresponsive and cannot be relied on to meet their needs. Many forms of maltreatment can convey this message, but Sheree Toth and colleagues (1997) have suggested that the chronic disregard of severe childhood neglect may have a particularly devastating impact on sense of self compared, for example, with physical abuse which may still include some periods where children are responded to positively by their parents or caregivers. Children may also receive negative messages about themselves more directly, for example being told that they are inferior or defective in some way or that they deserve to be treated badly. In the case of sexual abuse, perpetrators often silence their victims by telling them that they wanted and enjoyed the abuse or that they invited it. The secrecy surrounding this and other forms of childhood adversity means that alternative, more positive views are unlikely to be available. All of this can have serious consequences for future relationships. Negative internal working models of relationships, lack of trust, and, possibly, fear of disclosing early experiences and being blamed, are unlikely to sustain constructive adult relationships (Vetere, 2012). Some adults might seek affection from anyone who seems to give it, possibly leading to 'revictimisation', but persistent loneliness is also a common outcome and may be related to 'psychosis' (Murphy et al., 2014, 2015; Tritt, 1997).

Difficulty 'regulating' emotions: An important function of early attachment relationships is to comfort and soothe the child in the face of negative emotions; the child can then learn to do this independently, to 'self-soothe'. This process is not only disrupted in the

case of childhood adversity but repeated exposure to fear or intimidation can overwhelm the child's capacity to learn to calm themselves. Dissociative responses and later exposure to cues or events reminiscent of early adversity, can result in automatic physical and emotional arousal, split off from conscious verbal recall, creating a somatic sense of threat or 'speechless terror' (Ogden et al., 2006; Vetere, 2012). However, for some people the experience of adversity is not a distant or suppressed memory, but is clearly recalled and, for example, in the case of sexual abuse, may provoke feelings of intense anger and betrayal, experienced as 'rage' which may be labelled as symptomatic of 'borderline personality disorder' (Ussher, 2011).

'Challenging' or 'self-injurious' behaviour: All children may respond to adversity in ways that are challenging to others, including self-harm and suicide attempts. However, children with intellectual disabilities are perhaps more likely to express distress about sexual or physical abuse or neglect through 'self-injurious behaviour' such as head banging, skin picking or eye gouging. This behaviour might then be seen as 'part of the condition' or as arising from particular sensory needs rather than as a response to abuse (Sequeira & Hollins, 2003).

Limitations on cognitive, social and emotional learning: Joint attention or 'dyadic engagement' between adult and child plays a crucial role in the development of more complex social and cognitive abilities (Carpenter et al., 1998; Hobson et al., 2004). This, and other forms of mental stimulation are likely to be lacking where, for whatever reason, caregivers are neglectful, unresponsive or unavailable. In the case of neglect, malnutrition and inattention to a child's physical needs can also seriously limit cognitive and social development and neglected children are more likely to show language delays and more general social and intellectual disadvantage, to the point of placing children on the intellectual disabilities spectrum (Hatton, 2012; Hildyard & Wolfe, 2002; Weinstein & Weinstein, 2000). As we have noted, repeated exposure to fear or intimidation, or concerns about the safety of a parent, can create distraction, anxiety and hypervigilance which denies children the state of 'attentive calm' necessary for learning and development (DePanfilis, 2006). This in turn can result in low educational achievement and future problems in employment. At the same time, children who are neglected, abused or witness violence in their homes have far fewer opportunities to learn pro-social behaviour in relationships, again setting the scene for later problems.

Childhood adversities have many features in common and elicit a range of protective and adaptive responses. And, as well as greatly increasing the chances of experiencing further adversity in adulthood, adversity in childhood also limits people's social, psychological and biological resources for dealing not only with more serious adversity but also with more commonplace setbacks. As we noted in the introduction, however, childhood adversity happens in a wider context of power relations and social practices which strongly influence its impact and the behaviour and resources of caregivers. For example, poverty – an adversity in itself – increases the risk of several types of childhood maltreatment, including sexual and physical abuse, neglect and witnessing violence in the home (Drake & Pandey, 1996; Gillham et al., 1998; Turner et al., 2006). Gender is also important. Girls are more likely to be sexually abused than boys but Katherine Keyes and colleagues (2012) also found that females were significantly more likely than males to report 18 out of 19 specific examples of physical, sexual and emotional abuse and neglect as 'often' or 'very often' true

of their upbringing. The exception, an example of physical abuse, was equally reported for both sexes. A similar pattern was reported by a recent English crime survey (ONS, 2016). Social discourses of masculinity and femininity, and the very different contexts created by them, can strongly shape both the nature of childhood adversity and children's and adults' responses to it. The broad research-based patterns we can draw on to try and understand an individual's problems therefore have to include this wider context. Focusing on it also encourages us not to construe the outcomes of childhood adversity in terms of individual symptoms, deficits, impairments or dysfunctions but to see them as intelligible responses to complex social and interpersonal contexts. And it moves us away from the 'family blaming' discourse which so often surrounds discussions of the role of childhood adversity in emotional and behavioural problems. We will therefore revisit some aspects of childhood adversity in the following sections in discussions of gender, ethnicity, poverty and social class.

The social context: 2. Sex and gender

Traditional research comparing men's and women's experience of distress and various forms of behavioural difficulties is subject to all the problems outlined in the introduction. But this research can still provide a starting point for thinking about the role of sex and gender in emotional and behavioural problems. Some of the most useful studies are epidemiological surveys of the general population. Not all of these give separate results for females and males but Daniel and Jason Freeman (2013) identified 12 which did and also met certain basic methodological criteria; some of these and other similar studies are also discussed by Jane Ussher (2011). Bearing in mind that the results should not be regarded as facts about specific 'mental disorders' men and women 'have' or 'develop' but as possible indicators of broad differences in reported behaviours and experience, then several quite consistent patterns emerge. First, women are two to three times more likely than men to meet diagnostic criteria for anxiety or depressive 'disorders'. They are also more likely to be diagnosed with 'borderline personality disorder', 'panic disorder', 'post-traumatic stress disorder', some sexual problems, and 'eating disorders' while men are more likely to meet criteria for 'conduct and antisocial personality disorders' and 'substance use disorders'. Men are more likely to kill themselves but women report more suicidal thoughts and make more attempts to kill themselves (Bebbington et al., 2009; ONS, 2016a). Second, the majority of the surveys suggest that more women (around one in three) than men (around one in four) meet the criteria for at least one diagnostic category. A recent Adult Psychiatric Morbidity Survey (McManus et al., 2016) reported that women aged 16 to 24 were more than three times as likely as their male peers to meet the criteria for 'PTSD' and that young women's reported rates of self-harm had trebled between 2007 and 2014 while those for young men had doubled. Children and adolescents also show sex differences, with boys predominating in 'attention deficit hyperactivity disorder' and 'conduct disorders'. In relation to 'depression', there is an interesting change in adolescence with younger boys and girls equally likely to report depressed mood (or, in some studies, boys more likely); older girls are more likely than older boys to report being depressed, echoing the pattern shown amongst men and women (Rutter et al. 2003; Wichstrøm, 1999).

As we have said, this research does not tell us that men and women 'suffer from different mental disorders'. What it does seem to tell us is that women and men experience quite

high rates of various kinds of distress, with women possibly experiencing higher rates, and that there may be important differences in how this distress is reported or expressed. Men and women, of course, also differ in other ways very relevant to understanding emotional and behavioural problems such as social class and ethnicity. This section, however, will focus on the importance of sex and gender in understanding both the nature and extent of emotional and behavioural problems amongst women and men.

Sex and gender – why are they so influential?

The social importance of the categories of male and female can be gauged by the fact that the first question we usually ask on hearing of a new baby is not ‘Is it healthy?’ or ‘Is the mother alright?’ But ‘Is it a boy or girl?’ The terms sex and gender are often used in discussing the two categories, ‘sex’ referring to biological characteristics and ‘gender’ to social roles, norms and expectations attached to particular bodies – masculinity and femininity. More recently, this important distinction has been blurred by using ‘gender’ to refer to both. But although ‘sex’ is often taken as a dichotomous, biological given and ‘gender’ as more historically and socially contingent, *both* sex and gender are on a continuum and both can be seen as social constructions (Fausto-Sterling, 2000). Although there are historical and cultural variations, those who do not fit neatly into a society’s male/female or masculine/feminine dichotomies such as people who are lesbian, gay and bisexual; transsexual, transgender or who have disorders of sexual development, can face huge challenges (Boyle, et al., 2005; Carr et al., 2016; Institute of Medicine, 2011; Liao & Boyle, 2004; McDermott & Luyt, 2016; Semlyen et al., 2016). The social context created by the binary ideas of male and female, masculinity and femininity, however, profoundly affects the experience of all of us.

Our preoccupation with whether someone is male or female arguably has less to do with the need to distinguish two types of body, important though that may be for some purposes, than to distinguish two types of persons, with very different (assumed) social and psychological characteristics and very different access to power and privilege. Historically, and in a great many known societies, these differences have been institutionalised in the social system known as patriarchy. The historian Gerda Lerner has defined patriarchy as ‘the manifestation and institutionalisation of male dominance over women and children in the family and the extension of male dominance over women in society in general’ (1986, p.239). Heterosexuality is important to patriarchy because traditional marriage and the family are key sites of male dominance. Homosexual men and women and any groups who do not fit traditional masculine/feminine dichotomies can also be seen as threatening the *separation* of male and female which is an important feature of patriarchal systems (see below).

Patriarchy, however, is a complex and changing system. Unlike other power hierarchies, for example between rich and poor, male-female relations are marked by extremely close biological and family relationships. And Lerner notes that patriarchy has always included the possibility of women’s acceptance of subordinate status in exchange for protection and privilege. She uses the term ‘paternalistic dominance’ for this relation and argues that it characterises much of women’s experience throughout history. The sociologist Bryan Turner has argued that a comprehensive system of institutionalised patriarchy supported by legal regulations no longer exists in Western societies but that in its place there is

widespread *patrism*, ‘a culture of discriminatory, prejudicial and paternalistic beliefs about the inferiority of women’ (1995, p.157). He also argues that this culture is expanding precisely because institutionalised patriarchy is shrinking, leaving men with less and less power over women and no longer able to depend on the law to support their dominance in public or private. This echoes Foucault’s arguments about the growing importance of disciplinary power as various kinds of legal power decrease in democratic societies; it is similar to Lerner’s characterisation of sexism as the ‘ideology of male supremacy, of male superiority and of beliefs that support and sustain it’ (p.240), an ideology which can exist in societies where institutionalised patriarchy has been abolished.

Social systems where men are dominant depend in one way or another on the *separation* of male and female, physically, socially and psychologically. In strongly patriarchal societies physical separation may be enforced but even in weakly patriarchal or patrism societies, separation plays a fundamental role in female and male experience, in work or domestic roles, clothing and appearance, for example, acceptable adornment, or amount of facial or body hair. Overall, this separation has been characterised as the assignment of women to the private or domestic sphere and men to the public sphere of government, law and the economic marketplace. It has also involved the assignment of women to the realm of nature, and the body, and men to the realm of culture and the mind (Ortner, 1974).

The laws, customs and practices which support the separation of male and female, and men’s power over women, have always been accompanied by what might be called narratives of justification about women’s and men’s very different attributes and character. This *psychological* separation – often based on real physical differences, especially women’s reproductive capacity – has always been important but has arguably become even more so as legal and regulatory structures supporting male dominance diminish. While the details of these narratives may have changed – wandering womb is not much talked about now – some of their basic messages are remarkably unaltered, including the conflation of woman and ‘sex’, women’s greater emotionality, their interest and skill in relationships and vulnerability to reproduction related psychic weakness, in contrast to men’s greater rationality, need for autonomy, and interest and skill in the external world. What has changed is the sources of support for these claims, from religion and philosophy to, from about the late 19th century onwards, ‘science’, mainly Medicine, Psychiatry and Psychology. The content of these narratives has also changed according to the circumstances of the time, for example the separation of home and work required by industrialisation greatly strengthened claims about women’s capacity for care and nurturance, and lack of intellectual stamina or interest, and men’s capacity for independence, self-control and success in the public sphere. (Tavris, 1992) The content also differed – still differs – by ‘race’ and class, supporting white dominance and accommodating the fact that poor women have always had to work outside the home. There are, too, cross-cultural differences but as Deborah Cameron (2007) notes in discussing gendered language in a range of cultures, whatever is said to be typical of women’s speech is also usually said to make women less well-suited than men to occupy positions of power and authority.

Because of the strong links between these narratives and hierarchies of power, we should not be surprised that there is little evidence that males and females are inherently different in the ways claimed for them (Cameron, 2007; Fine, 2011; Jordan-Young, 2011). But narratives about male-female differences, and social and economic practices which reflect

and maintain them, are ubiquitous; these, and the high levels of interaction between males and females means that sex and gender are ‘omni-relevant’ for all of us including children, who quickly learn gender stereotypes (Campbell, 2013; Fine, 2011). Inevitably, the power imbalance between men and women, and the social construction of masculinity and femininity, affect women’s and men’s experience of emotional and behavioural problems to the point where it is difficult to see how we can understand these problems without acknowledging that they are experienced by *gendered* selves. The next sections will look in more detail at the interrelated contexts – economic, social, interpersonal and psychological – created by ideas about sex and gender and how they can help make sense of emotional and behavioural difficulties, first for women and then men. In terms of personal relationships we will focus mainly on heterosexual relationships. This is partly for reasons of space but also because the beliefs and practices surrounding heterosexuality and the male-female dichotomy, can so strongly influence the experience of anyone who is outside them.

Sex, gender and emotional and behavioural problems – girls and women

The social contexts created by male/female inequality

- In line with the separation of male and female, women in heterosexual relationships, and in society more generally, are expected to take most responsibility for the domestic sphere, for cooking, cleaning and childcare, and for the quality of relationships (Jack & Ali, 2010; Lafrance, 2009; O’Grady, 2005). Even when male and female partners are in full-time paid work, women do about twice as much childcare and domestic work as men (Campbell, 2013; Fine, 2011) – the ‘second shift’ (Hoschild, 1990) and this pattern is changing extremely slowly (Campbell, 2013). In some couples, the balance may change as a woman’s earnings approach that of her partner but women who earn more than their partners may revert to a very unbalanced division of labour (Tichenor, 2005) so as not to appear powerful or emasculating. Especially after the birth of children, these arrangements lead to many women becoming economically dependent on their male partners. The expectation of domestic and caring responsibilities is accompanied by social constructions of idealised femininity as synonymous with suitability for these roles – expressing warm emotions, unselfish concern for others’ feelings and needs and lacking competitive striving or aggressiveness (Jack & Ali, 2010; Stoppard, 2000). In spite of being historically contingent (Grimshaw 1986; Weber et al., 1998), these constructions are also naturalised through religion and increasingly in Western societies, through psychology and neuroscience, for example, in the idea of male and female brains (Baron-Cohen, 2003). In the same way, much more emphasis is placed on the importance of relationships for girls and women (Stoppard, 2000). But in spite of apparently positive constructions of femininity and the centrality women’s nurturing role in society, both are devalued. For example unpaid domestic and caring work is not counted in economic indices such as Gross Domestic Product (GDP) although paid sex work is (Campbell 2013) while work involving care or other ‘feminine skills’ attracts lower pay than work associated with ‘masculine skills’ such as computing, science and engineering. And women’s dependence on heterosexual and family relationships is often secured by economic inequality while the relationships themselves are an important site for acting out and reinforcing gender inequalities (see below).

- In the workplace, women at most levels of employment earn less than men for similar work and are clustered in lower paid, often part-time and less secure employment. Combined with career breaks for children or other caring, this results in a significant lifelong wealth difference between women and men (Campbell, 2013; ONS, 2016b). In male dominated occupations, especially higher status work which offers opportunities for promotion and leadership, women have additional problems (Islam & Schlösser, 2016). For example, lower performance, real or perceived, may be primed by frequent environmental reminders of men's dominance in a particular area (Fine, 2011; Nosek et al., 2009). Women are also often taken as less, sometimes much less, senior than they actually are and may receive less cooperation from colleagues than their male equivalents (Bates, 2014; Cameron, 2007; Jefferson et al., 2015) so that they repeatedly have to re-establish their authority and competence. But they are also often expected to take on less visible pastoral or caring roles (Parker, 2014; Walsh, 2002) which add to their workload but not to their chances of advancement. The constructions of femininity which underlie all this, and which we discussed earlier, together with the fact that 'top' jobs are almost always considered to require male characteristics such as achievement oriented aggressiveness and emotional toughness (Heilman, 2001) can leave women walking what the sociologist Janet Holmes (2006) calls a tightrope of impression management, between being regarded as competent but cold or nice but incompetent (Davies, 2003; Rudman & Glick, 1999; 2008). Some women resolve this conflict by 'shedding the feminine attributes they perceive as a liability', including supporting other women (Fine, 2011; Hewlett et al., 2008). These are among many changes women make to avoid feeling that they do not belong or to manage subtle or not so subtle exclusionary behaviours (Cameron, 2007; Fine, 2011; Murphy, et al., 2014; Shaw, 2005). The sexual harassment which many women experience at work, ranging from 'banter' and propositions to physical assault (Bates, 2014; Hinze, 2004) also reminds them that they are not equal colleagues and that their acceptance, promotion or continued employment can depend on being pleasing to men.
- Women are judged on their appearance rather than their activities and achievements, to a far greater extent than men (Gill, 2007; Ussher, 2011). Women who challenge this by high achievement may be quickly reminded of its lack of importance in comparison with appearance, for example, the media's speedy labelling of new women MPs as (Prime Minister's) 'Blair's babes' or (prime Minister's) 'Cameron's cuties' or the depiction of newly appointed women Cabinet ministers as 'The Downing Street catwalk' focusing on their clothes and bodies (*Daily Mail*, 16 July 2014). Assertive or high achieving women judged unattractive may receive sexualised insults or threats referring to their lack of desirability while any woman in the public eye can expect to have her appearance closely scrutinised. This is part of a pervasive social process, greatly intensified by social media, of conflating women with sex, presenting women far more than men in sexualised ways and depicting women as passive objects rather than active subjects or as 'things' rather than 'persons'. And this process starts early, with young girls frequently depicted as sex objects (American Psychological Association, 2007; Bates, 2014; Ussher, 2011). In line with this, women are expected, or even required by some employers, to devote substantial amounts of time and effort to maintaining a 'pleasing' appearance even if this involves discomfort, pain or physical harm (Jeffreys, 2005). For Black women in White dominated societies, this

‘pleasing’ appearance may involve looking like a White woman: a survey of mainstream women’s magazines and Black women’s magazines, found that the majority of Black women represented were young, slim, with light skin and straight hair and that this presentation was most evident in the small minority of Black women pictured in mainstream women’s magazines (Jankowski et al., 2017).

- Women’s reproductive bodies – in menstruation, pregnancy, childbirth and menopause – have traditionally been strongly associated with psychological weakness, especially increased emotionality and irrationality, from Hippocrates’ ‘wandering womb’ causing hysteria, to the *DSM*’s sole category (apart from specific sexual problems) which can only apply to one sex – premenstrual dysphoric disorder. Similarly, the large majority of pregnancy terminations in England and Wales are carried out on the grounds that the woman already is or is otherwise likely to become mentally disordered (ONS, 2016c). And the effect of female and male hormones on the brain are frequently cited as a major source of sex differences in attributes and behaviour, but in ways which often seem to justify women’s employment and economic disadvantages (Boyle, 1997; Fine, 2011; Jordan-Young, 2011; Olff et al., 2007; Ussher, 2013).
- Girls and women worldwide, in public and private, experience high levels of harassment, abuse and violence from men, ranging from unwanted ‘chatting up’, name-calling, sexualised insults and threats, various kinds of control and coercion, to physical and sexual assaults, rape and murder. This is not limited to interpersonal relations but can also be carried out by state actors such as the police and military or be state sanctioned, such as child marriage. In some cases, such as female genital mutilation (FGM) it may be carried out on girls by older women, with approval of the wider social group. The scope of harassment and abuse of girls and women has also been increased by technology and social media (Bates, 2014; Campbell, 2013; Gavey, 2005; House of Commons Women and Equalities Committee, 2016; Millilo, 2006; Nicolson, 2010; ONS, 2015; Salter, 2012; Ussher, 2011; WHO, 2005, 2013). What has become known as gender-based violence is recognised as one of the leading causes of psychological harm, injury and death to girls and women, and its impact on mental and physical health has been compared to that of heart disease or cancer, smoking or obesity (Heise et al., 1994; Nakray, 2013; Stöckl et al., 2013; Trevillion et al., 2012; WHO, 2013). There is also wide agreement that official figures probably greatly underestimate the scale of the problem. Gender-based violence can be seen as operating along several continua: first, of severity and danger (Johnson, 2008; Salter, 2012); second, of time – it is often repeated, it happens to females of all ages and being abused in childhood may increase the chances of being abused in adulthood (see section on childhood adversity); and, third, it is on a continuum with what is considered normal or even desirable male behaviour (Gavey, 2005; Jukes, 1999; Nicolson, 2010). Gender-based harassment and violence is also functional, in eliciting deference, enforcing subordination, and establishing and maintaining a relation of dominance over the victim (Jukes, 1999; Salter, 2012; Schrock & Shwalbe, 2009). This process often involves blaming the girl or woman for the harassment or violence and imposing the man’s meaning on what is happening. The combination of this and the continuum from ‘normal’ to abusive behaviour can make it difficult for girls and women to name what is happening (Bostock et al., 2009; Nicolson, 2010; Ussher, 2011, and see below).

The scale of gender-based harassment and violence means that virtually all girls and women experience it as a general, impersonal threat for example by observing other women's experience, hearing talk and seeing images supportive of harassment and violence, and being frequently reminded to be 'careful' in certain places and especially 'at night'. But for many girls and women the threat is highly personalised and intentional, including acts by strangers directed at individual women. As we pointed out in the discussion of childhood adversity, personalised threat is much more likely to lead to serious psychological harm (Grossman, 2009; van Nierop et al., 2014).

- Men have much greater control over sources of meaning making, such as historical accounts, the judiciary, Parliament, science and research, media and business. Women therefore have far less opportunity to name and interpret either public events or their own experience. They also often witness or experience women's perspective being dismissed, trivialised or silenced. The experience of invalidation is common to subordinate groups but Marsha Linehan (1993) has argued that it is especially common for girls and women; she also highlighted its fundamental role in the harmful effects of child sexual abuse. Michael Salter (2012) similarly argues that the power to dismiss, trivialise or silence the perspective of another is not evenly distributed throughout society; as he and others have pointed out, meaning making and invalidation are not only specific dimensions of masculine privilege but also play a fundamental role in maintaining it. Invalidation can be seen on a continuum, for example from male-centred accounts of historical or recent events, to women not being invited to or having their views overlooked at meetings, to sexual insults or harassment being dismissed as 'just banter' to much more forceful and violent imposition of male desires and points of view in sexual assault, domestic violence and rape. These latter experiences are obviously inherently invalidating because they involve force but as we noted in the discussion of childhood adversity, the process of invalidation goes beyond that to the repeated imposition of a particular construction of the event on the victim, for example that they 'asked for it', enjoyed it or even that it did not happen; invalidation is also often used to ensure compliance or silence (Gavey, 2005; Henning & Holdford, 2006; Linehan, 1993; Nicolson, 2010; Ussher, 2011). The continuum of invalidation, however, does not end there but may continue in the responses of family, the community, legal and medical systems, where girls' and women's attempts to report what has happened to them and give their version of it may be met not just with disbelief but with a version of events which blames or denigrates them in similar terms to the perpetrator. If this includes characterising the man as an innocent or naive victim of false allegations, such an account may be supported by psychological concepts such as miscommunication or false memory syndrome (Bostock et al., 2009; Cameron, 2007; Coates & Wade, 2007; Lisak, 2010; Nicolson, 2010; Salter, 2012; Stanko et al., 2007). Several aspects of the construction of femininity are important in supporting women's restricted access to meaning making. These include the construction of women as generally inferior to men, whose views are less important or worthwhile; the idea that women's hormones, emotions or personal involvement may get in the way of producing an objective viewpoint and the not infrequent claim that women make false allegations against men. If girls and women respond to invalidation with any show of emotion such as anger or tears, then that may simply reinforce their lack of 'fitness' to provide valid meanings of their or others'

experiences. For women who are also devalued in other ways, for example, by learning disabilities or mental health problems, then the experience of invalidation is even more likely (Boyle, 1997; Campbell, 2003; Stanko et al., 2007; Ussher, 2011).

- Male and female behaviour is judged by different standards, often, though not always (see section on men and masculinity) to girls' and women's disadvantage. This happens in schools and at work (Cameron, 2007; Fine, 2011; Lavy & Sand, 2015) but the double standard of judgement is perhaps most evident in sexual behaviour and parenting. For example, women are more likely than men to be held responsible for unplanned pregnancies (Boyle, 2000). It is also difficult to find pejorative male equivalents for terms such as slut, slapper, nympho, prude, frigid, tart or whore which are widely applied to girls and women judged to engage in too much or too little sexual activity (Bates, 2014; House of Commons Women and Equalities Committee, 2016). As we've seen, negative judgements may go beyond verbal insults to blaming girls and women for rape and sexual violence; women may also be blamed for their partners' physical violence, while female victims of violence from men can experience lower levels of social support than male victims as well as being more negatively judged by family and friends (Andrews et al., 2003). Women's perceived responsibility for maintaining relationships is reflected in the much greater theoretical and media attention paid to mothers' roles in family outcomes. The behaviour of individual women is also often taken to be indicative of the nature of women in general. For example, a woman's poor performance in a high status role may be taken as evidence that women in general are not suited to that kind of work rather than simply reflecting the performance of an individual. This is related to the positioning of women as a collective 'other', judged by a 'neutral' but often male, standard (Tavris, 1992; Weber et al., 1998). The application of different standards to male and female behaviour is supported by a range of cultural beliefs and discourses. For example, there is no female equivalent of 'boys will be boys' or 'sowing wild oats', ideas which can be invoked to 'excuse' potentially harmful male behaviour. Similarly, constructions of 'a good woman' or 'a good wife', which may include 'standing by' a misbehaving man, can seriously restrict what counts as acceptable female behaviour. Taken together, these constructions, the application of a 'neutral' (male) standard, the naturalisation, even glamorisation of male aggression and claims that 'the male brain' is less capable of empathy, can also support the frequent calls to women rather than men, to change in the face of inequality, from becoming more confident or assertive at work to dressing differently or controlling their drinking to avoid being raped (Anderson & Doherty, 2008; Cameron, 2007; Nicolson, 2010).
- Women who are unhappy or worse in the face of inequalities in relationships with men, at home or work, can find it very difficult to negotiate equality. First, the relationships will be complex and often include not only biological and family ties but sexual intimacy, love, liking, friendship and respect. These can support greater equality but they can also make challenging inequalities more difficult especially if challenges seem to threaten the relationships. And, in her study of marital relations, Caroline Dryden noted that women were more likely than men also to present the situation from their partner's point of view, which could in theory help communication but in practice made change less likely (Dryden, 1999). Dryden also found that many men were often not available to their partners, either by going out,

or working long hours, dropping off to sleep in front of the television, or simply not engaging in conversation so making discussions about change very difficult. Second, an employer's power to hire and fire, a woman's fear of being ostracised or of legal fees if a formal complaint is made, economic dependence on a male partner, fear of anger or even violence, can place serious material obstacles in the way of negotiating equality. Third, feelings of isolation, lack of confidence, insecurity and fear of abandonment, sometimes apparently fostered by men in a complex dynamic (see section on men and masculinity) can prevent women from challenging the status quo. Fourth, cultural constructions of women, men, work and relationships can naturalise inequality and make it very hard to challenge. These include ideas of good women and mothers as self-sacrificing and biologically suited to nurturing and domestic roles; of women as susceptible to hormonal changes, liable to complain for no good reason at certain times of the month; of men as vulnerable beneath their 'toughness' and therefore in need of support rather than challenge and of women as oversensitive, lacking in humour and not tough enough to endure the demands of the workplace, including sexual harassment. (Cameron, 2007; Dryden, 1999; Fine, 2011; LaFrance, 2009; Ussher, 2011).

Some outcomes of male/female inequality

Fatigue/exhaustion: This can be a result of the physical and mental labour involved in domestic, relationship and caring work, in paid work and in maintaining an acceptable appearance. It is compounded by the fact that a woman's performance in these areas, including her demeanour, may be seen as a measure of her femininity or adequacy as a wife or mother (Stoppard, 2000). Further mental labour may be needed to negotiate potential conflicts between different areas of women's lives, for example: between paid work and home, between self-care and care for others; between appearing 'nice but incompetent' or 'cold but competent' in the workplace and between complaining about discrimination and harassment, or ignoring, trying to avoid, or reframing it (Hinze 2004; LaFrance, 2009; Shaw, 2005). Perhaps not surprisingly, sociologists Elizabeth Gorman and Julie Kmec (2007) using large datasets from Britain and the US, found that, across different jobs and levels of domestic responsibilities, women reported that their jobs required more effort than men. All of this can result in sleep and sexual problems (Freeman & Freeman, 2014; Kaschak & Tiefer, 2002) and feelings of being overwhelmed or defeated, possible precursors of more serious problems of low mood, anxiety and poor physical health (Gilbert & Allan, 1998; LaFrance, 2009; Stoppard, 2000).

Self-objectification/self-surveillance: Girls' and women's frequent exposure to images portraying them as sexual objects or body parts, and frequent reminders that desirability to men is their most important attribute, encourages them – especially heterosexual women – to adopt an observer's perspective of their bodies and selves, to see themselves as objects to be judged (Fredrickson & Roberts, 1997). This is reflected in a pervasive concern with their appearance apparent across women's lifespan and in the (realistic) belief that a woman's appearance is seen as a measure of her worth and can control access to valued resources (Stoppard, 2000). In line with Foucault's analysis of disciplinary power, women and girls cooperate in this process (O'Grady, 2005) as girlfriends, mothers and daughters monitor each others' weight, clothes and appearance. All of this is greatly intensified by social

media which extends and personalises judgements about appearances and desirability well beyond a woman's immediate social circle. The resulting self-objectification or persistently taking an observer's perspective, is related to harsh and critical self-judgements, shame and anxiety about appearance (Fredrickson et al., 1998; Tiggemann & Lynch, 2001), eating problems (Grabe et al., 2008) and very low mood (Tiggemann & Kuring, 2004). Girls and women whose bodies are forcibly and literally treated as objects, in sexual abuse, rape, and physical and sexual assault, may experience pervasive body shame and hatred as well as self blame and guilt, reflecting meanings imposed on them by perpetrators as well as wider society (Ussher, 2011).

Self-silencing/self-doubt/insecurity: There is strong evidence that, in the face of unequal relationships and the injunction to put others' needs before their own, women may extensively regulate or silence their thoughts, feelings, speech or actions to conform to the image of a 'good' woman, wife or mother, avoid disapproval or conflict with a partner, maintain relationships or ensure physical safety (Gilligan & Brown, 1992; Jack & Ali, 2010; Thompson et al., 2001). More generally, self-silencing is reinforced by women's restricted access to meaning making which we discussed earlier and the fact that their views are less often asked for or listened to than those of men (Salter, 2012). These and other factors may also contribute to women's self-doubt. For example, they often question their interpretations of hostile discrimination, harassment or violence, and wonder if the fault lies in them (Andrews & Brewin, 1990; Gavey, 2005; Hinze, 2004) or query their adequacy as mothers, especially new mothers (Mauthner, 2010) or have their clear decisions about important aspects of their reproductive lives repeatedly questioned by others (Boyle, 1997). Sandra Lee Bartky and Caroline Dryden also highlight the potential for self-doubt in the contradictions between a professed commitment to gender equality in institutions or personal relations, or even claims that it has been achieved, and its actual though covert and unacknowledged absence. In her study of married couples, Dryden also found evidence of men systematically undermining their wives or fostering feelings of insecurity, an outcome also highlighted by Adam Jukes (1999) in the more extreme situation of men's violence to their partners. Self silencing, self-doubt and insecurity are associated with a judgemental relationship with the self, what Paul Gilbert calls 'internal harassment' and with a debilitating sense of defeat and low mood, intensified by feelings of isolation (Bartky, 1990; Dryden, 1999; Gilbert, 2010; Jack & Ali, 2010; Lafrance, 2009; Thompson et al., 2001).

Entrapment/powerlessness: Being in an aversive situation from which there seems no escape or possibility of change is a major cause of emotional distress, especially feelings of anxiety, hopelessness and depression (Brown et al., 1995; Kendler et al., 2003). For young children in aversive situations, entrapment is almost inevitable; for women, it may result from poverty or economic dependence on a partner, lack of childcare or threats to physical safety. But feeling trapped and powerless can also result from some of the processes discussed earlier. For example, shame, self-blame, fear of being alone, and feeling responsible for the quality of relationships can hold women even in violent and abusive relationships (Andrews & Brewin, 1990; Bostock et al., 2009; Nicolson, 2010). Similarly, deferring to the needs of others and 'silencing the self' can also involve inhibiting self-directed action so making it more difficult to form coherent plans for the future.

Anxiety and fear: The situations we've described involve threats of various kinds and so

anxiety and fear are common elements in responses to them and may be expressed in a range of ways (see below). The threats may relate, for example, to demands to meet high standards of femininity, motherhood or ‘career woman’ and difficulties of negotiating conflicts amongst these, or to fears of abandonment by an (apparently) less committed partner. Severe anxiety and fear, perhaps attracting a diagnosis of ‘post-traumatic stress disorder’, are common in experiences of physical and sexual assault, with women around two to three times as likely to be given this diagnosis than men and to continue to experience severe anxiety years after the events (Kessler et al., 1995; Koss et al., 2003; McManus et al., 2016).

Gender-based voice content: As we saw in the section on childhood adversity, sexual violence and other forms of abuse in childhood – and adulthood (BPS, 2017) – can lead to distressing experiences of voice hearing. The content of these voices very often includes undermining messages about women, reflecting both the wider culture and what girls and women have been told by perpetrators. For Black and other minority ethnic women in the UK, voice messages often include racial as well as sexual insults (Haarmans et al., 2016; Nayani & David, 1996).

Outbursts of anger, with guilt and anxiety about losing control: ‘Inappropriate, intense anger or difficulty controlling anger’ are listed in *DSM-5* as potential symptoms of ‘borderline personality disorder’. But feelings of intense anger and betrayal, perhaps experienced as ‘rage’ are a frequent, long-term and understandable response to child sexual abuse; the diagnosis of borderline personality disorder is associated with child sexual abuse (Newnham & Janca, 2014; Waller, 1994). Women may feel (though not directly express) intense anger against the perpetrator, against others seen as failing to protect them as children or against themselves for ‘inviting’ or ‘allowing’ the abuse. Situations which trigger memories of the abuse or seem to replicate aspects of it such as invalidation or powerlessness can also elicit intense anger, often labelled as ‘inappropriate’. ‘Persistent and marked anger or increased interpersonal conflicts’ are also listed as potential symptoms of ‘premenstrual dysphoric disorder’, but Jane Ussher and Janette Perz (2010, 2013) have argued – from women’s accounts of their situation – that both anger and increased conflict more accurately reflect a rupture in the self-silencing that these women engage in at other parts of the month in the face of high levels of domestic and, often, employment responsibilities. Similarly, Danna Jack and Alisha Ali (2010) suggest that many women are inwardly angry about the inequalities in their relationships but ‘exert tremendous energy against themselves to appear outwardly [pleasing and] compliant’ (p.11). This process is perhaps reflected in the ‘Jekyll and Hyde’ metaphor often used by women who experience severe premenstrual distress to describe the split between their calm, responsible self and the irritable, angry premenstrual self, overwhelmed by the demands of others (Ussher & Perz, 2010). Women appear more able to exert control at work, possibly because of the demands of ‘impression management’ we discussed earlier but also experience high levels of guilt and self-criticism following ‘loss of control’ within the family, often followed by renewed efforts to comply with social standards of ‘a good woman’ (Ussher, 2004). The timing of these changes can also lead to invalidation from others, often increasing the woman’s anger, but women may also invalidate themselves to avoid further conflict with a partner, family or colleague by ‘blaming the body’ (Ussher & Perz, 2010, 2013).

Adoption of problematic strategies: Many of the responses we've discussed clearly serve important functions for women in negotiating unequal relationships while at the same time potentially creating further difficulties. For example, focusing on pleasing and appeasing others at the expense of 'silencing the self' can lead to very low mood and feeling defeated. But it can also avoid or de-escalate conflict. This increased vigilance to others' needs, and their power, can also be protective by directing attention to potentially damaging or dangerous situations and can be experienced as empowering (Gilbert 2007; Jack & Al, 2010; O'Grady, 2005). Similarly, ignoring or refusing to identify harassment or hostile discrimination can preserve self-esteem by directing attention away from inequality (Fine, 2011). Retreating to the home in the face of anxiety or panic might lead to a diagnosis of agoraphobia, mainly given to women. Several analyses, however, suggest that both panic and anxiety, and retreat to the home with the resulting 'fear of fear', can be closely linked to relationship conflicts, to conflicts between domestic demands and a desire for more independence or to a woman's difficulties in asserting her own needs or preferences. And 'staying at home' is a response obviously more available to women than men (Capp & Ochs, 1995; Gelfond, 1991). There is also much evidence that eating problems, such as self-starvation, bingeing and vomiting serve complex functions including communicating, managing and preventing the direct expression of emotions, especially anger, sadness and loneliness. They are also linked to objectification, and the achievement of a 'slim ideal' while ritualistic behaviours such as calorie counting or excessive exercising can give a sense of control to women who feel overwhelmed by others' demands (Cockell et al., 2002; Gale et al., 2006; Milligan & Waller, 2000; Serpell & Treasure, 2002; Serpell et al., 2004). Women who have been sexually abused as children or raped or persistently sexually harassed may also use self-starvation to 'un-sex' their bodies and protect them from further attention as well as using this and other 'disordered' eating to manage the emotional consequences of abuse (Geller et al., 2010). In these situations, women may also express hatred of their bodies (often directly reflecting what they have been told by perpetrators) through self-harm and, at an extreme, suicide (Ussher, 2011).

Men, masculinity and emotional and behavioural problems

Men's status as a dominant group might suggest they would have few problems as a result of inequalities. But men do not have equal access to power and privilege and live within hierarchies, for example of class, ethnicity, sexuality and (dis)ability. Men positioned as privileged can also be psychologically harmed by conventional systems of gender relations. And, as Jennie Williams and colleagues point out, they might find it especially difficult to decode their experiences in the absence of the shared understanding, support and solidarity that can come from belonging to a disadvantaged group. In this section, we will look at some of the problems faced by men in general within a semi-patriarchal or patrist society and how these relate to emotional and behavioural problems; more specific problems experienced in relation to class, ethnicity and childhood adversity are discussed in other sections.

- Social constructions of (heterosexual) masculinity vary across history, class and culture but common themes are domination of women and avoidance of femininity. Valued masculine characteristics are usually consistent with the exercise of power and authority, and control not just of women but of feminised sites such as nature

and the body; these characteristics include strength, physical and moral courage, independence, energy, exercise of reason and controlled aggression. Women's subordinate status means that male 'transgressions' into femininity may be less tolerated than some female 'transgressions' into masculinity, for example in clothing or job choice. Constructions of masculinity are not abstract but are highly institutionalised, for example, in sport, business, the military and the law; they are widely available in the media, in film, literature, music and online games; they also guide the development of valued identities for boys and young men and indicate how they might demonstrate their worth and gain respect from others. As we will see, the high status given to masculine attributes and their association with male self-esteem set the scene for a range of emotional and behavioural difficulties. (Branney & White, 2008; Connell, 2005, 2011; Frosch et al., 2002; Sjoberg & Via, 2010; Weber et al., 1998; Williams et al., 2014).

- Men's dominance in the public sphere confers many advantages, psychological, material and social but it also exposes men to potentially harmful working cultures of dominance hierarchies, intense competition between colleagues, very strong investment in work as a source of identity and self-worth and long hours incompatible with family and other relationships. And, reflecting the strong association of men with work, they receive almost no guidance on how to balance the competing demands of work and family or how to achieve a 'work-life balance' (Fine, 2011). Perhaps, not surprisingly, a 2016 British survey of men's uptake of statutory paternity leave, suggested that very few men were taking advantage of it mainly due to fear of being disadvantaged at work (Osborne, 2016). Changes in work patterns in the last few decades have also placed more emphasis on stereotypical female roles, involving communication aimed at making customers feel good via active listening, empathy and expression of positive feelings. There is little evidence that men are any less skilled at all this than women but employers may think differently leaving men disadvantaged in changing job markets (Cameron, 2007). There is, however, a great deal of evidence that unemployment is psychologically harmful for both men and women (Classen & Dunn, 2012; Fryer & Stambe, 2014; Jefferis et al., 2011). For men, however, loss of their major identity, imposition of an increasingly devalued and denigrated unemployed identity and potential loss of power in the home, may be especially damaging. This is supported by suicide rates: there are clear links between economic recessions, unemployment rates and suicide (Stuckler & Basu, 2014) but figures for England and Wales for 2012, at the height of an economic recession, showed a male-female ratio at its highest in 30 years. The rate for middle-aged men, who might have most to lose by unemployment or less chance of re-employment, was the highest for this age group since the early 1980s (ONS, 2014). More generally, male suicide is strongly linked to socio-economic status, interacting with many other factors discussed here (Wyllie et al., 2017).
- The acceptability of masculine displays of intimacy and feeling has varied throughout history – they are often more acceptable where women are more subordinate – but in the West, the combination of industrialisation, imperialism and the women's rights movement has left, at best, an ambivalent relationship between masculinity and emotions (Haggett, 2014). Boys and men often feel pressured to appear competent and invulnerable and equate masculinity with being 'strong and silent' about emotion;

displays of emotion are often associated with femininity and homosexuality and may attract social sanctions, from women as well as other men (Frosh et al., 2002; Levant, et al., 2007; O'Brien et al., 2005). But we are not talking here about all feeling – only feminised feelings such as tenderness, sadness or shame. Claimed links between masculinity and emotional inhibition only make sense if we do not think of anger, aggression or violence as emotional displays. The problem of masculinity and feminised feeling is very apparent in discussions of 'depression', one of the most feminised diagnostic categories with its 'symptoms' of tearfulness, hopelessness, guilt and passivity. As we have seen, men are much less likely to receive this diagnosis than women but it has been suggested that they experience 'depression' differently, with 'symptoms' including anger, aggression, irritability and hostility (Addis, 2008; Branney & White, 2008). This is problematic because there is no objective way of deciding whether anyone is or is not 'depressed' or what might count as a symptom. But even if they are resistant to talking about them, men do experience feminised feelings which might lead to a diagnosis of depression. What is then striking is professional concern to protect conventional masculinity. This ranges from the US National Institute of Mental Health's 'Real Men, Real Depression' campaign (Rochlen et al., 2005) to assurances that men's 'depression' is not a sign of emotional weakness or failing masculinity, but a real and treatable illness, that it can happen even to men with powerful personalities. Men are further reassured that once they recognise that there is no reason to feel ashamed, they can 'face the challenge head on' (www.helpguide.org/articles/depression/depression-in-men.htm www.nimh.nih.gov/healthpublications/men-and-depression/ www.rcpsych.ac.uk/healthadvice/problemdisorders/depressionmen.aspx). These messages place men in the difficult position of preserving a masculine ideal of strength and power at the same time as experiencing distress possibly caused by it. They are also likely to add to men's difficulties in acknowledging, understanding and reflecting on emotional experiences associated with lack of power (Emslie et al., 2005).

- Men's relationship with their bodies is becoming more complex as they face increasing pressures to achieve an idealised appearance and monitor their health at the same time as conforming to masculine pressures to transcend these traditionally feminised preoccupations. And, similarly to advice about 'depression', messages to men about physical health tend to focus on masculine qualities such as fitness, stamina and endurance rather than potential weakness of the body. Perhaps not surprisingly, men may be increasingly expressing emotional distress through their bodies, with rising incidence of eating problems and self harm (Michison & Mond, 2015; van Camp et al., 2011).
- Constructions of masculinity, their institutionalisation and the ready availability of powerful models, encourage boys and men not only to inhibit feminised emotions but to construct a sense of self separate from relationships, to sacrifice relationships for hierarchy and show they can thrive without emotional and physical intimacy (Gilligan, 2010; Williams et al., 2014). This is unlikely to foster close, positive relationships. It might also help explain why adolescent boys and young men are more likely to be diagnosed as 'psychotic' than their female counterparts, at a time when they are under pressure to develop a strong, independent identity (Harrop & Trower, 2003). Nor does it foster constructive relations between men and women, a situation unlikely to

be helped by young men's increasing reliance on pornography for information about sexual relationships (Bates, 2014; Levy, 2005). Caroline Dryden's detailed study of married couples illustrates the conflict between intimacy, autonomy and domination. She points out that emotional intimacy and the need to feel loved were obviously important to the men she studied. But this was evident mainly from private interviews; in joint interviews with their wives and in the day-to-day business of marriage, many of the men seemed to equate being strong and capable with marking status differences between them and their wives. This included using distancing tactics to control or block discussions about domestic tasks or childcare and withholding expressions of feeling in ways that fostered insecurity in their wives. While these imbalances might preserve a relationship in the short term (see previous section on women) in the long term they can contribute to relationship breakdown (most divorces are instigated by wives: Brinig & Allen, 2000; Hewitt, 2009; Kalmijin & Poortman, 2006) with potentially serious psychological consequences for men (Rotermann, 2007).

- Relationship practices that focus on marking status differences are on a continuum with more extreme attempts to exert dominance. Men who adopt 'hypermasculine' values are more likely to use violence against their female partners in the face of perceived challenges to their authority or status. These threats may come from the woman herself, for example not having meals ready 'on time' or wanting to work outside the home, refusing to have sex, or questioning or disobeying the man, or they may arise elsewhere, for example, defeat of a sports team or challenges at work. (Archer, 2000; Jukes, 1999; Nicolson, 2010; WHO, 2002). Worldwide research suggests that men's violence to their partners is associated with both relatively low and relatively high social and economic status for women and with cultural support for male authority (Levinson, 1989; Yllo & Straus, 1984; WHO, 2002). 'Private' violence is therefore closely linked to social structures and ideology, including beliefs in women's natural inferiority and, at an extreme, that they are not entitled to independent opinions or desires. Men who hold these beliefs may see themselves as under constant threat from a partner's attempt to undermine or control them so that violence restores their control and reduces anxiety. It is not uncommon for men to have been exposed to violence as children, as victims of physical or sexual abuse or witnesses to violence against (usually) their mothers. Apart from many other negative outcomes (see section on childhood adversity) these experiences can teach boys and men that violence is an effective way of asserting control and authority. For men, but not women, this message can receive strong support from media and the wider culture. In the face of frightening behaviour from adult males around them, boys may seek an illusion of safety by identifying with the aggressor and see aggressive behaviour as a way of feeling powerful (Vetere, 2012). Again, this stance can receive strong support from the wider culture. Similarly, Katherine Keyes and colleagues (2012) reported that for men but not women, physical abuse as a child was associated with outcomes described as externalising, such as 'conduct disorder' and 'antisocial personality disorder'. Men may also be victims of violence from their female (and male) partners although in the case of violence from women, some of this appears to be defensive (Dasgupta, 2002; Nicolson, 2010; Swan & Sullivan, 2009). Male victims of female violence may be extremely reluctant to report it from fear of being labelled weak for not stopping it. Men's relationships with each other may also

be marked by status competition and inhibition of any signs of 'weakness'. This can be legitimately played out at work or, literally, in sports; men can also form very close bonds in highly masculinised environments such as sport and the military. But they may find it difficult to communicate the value and meaning of these bonds and some contexts which promote them can carry considerable psychological costs – military service is associated with a wide range of emotional and behavioural problems (Castro & McGurk, 2007; Goodwin et al., 2015; Thomas et al., 2010). In other contexts, where men lack access to socially sanctioned sources of respect and esteem, and social controls are weak – and these contexts are particularly likely for young Black and working-class men – then 'illegitimate' violence and threats of violence amongst men are more likely (Archer, 1994; Campbell & Muncer, 1994; Connell, 2005).

- Jennie Williams and colleagues (2014) refer to anger and aggression as 'manly ways of surviving' both the unreasonable expectations of masculinity and ordinary human experiences such as loss or rejection. These 'manly ways' also include reliance on alcohol and other drugs, risk-taking, overwork and retreat into a fantasy world of power and control offered by technology. Similarly, Brownhill et al. (2005) refer to the 'big build', a debilitating trajectory of destructive behaviour described by men in the face of emotional distress, ranging from avoidance behaviours such as overwork; numbing 'it' through self medication; escaping 'it' for example through affairs and casual sex; aggression towards self and others, self-harm and suicide. None of this includes directly communicating distress to others or seeking help. The problem for men is that these coping or survival strategies can seriously compound the problem, for example, alcohol is implicated in men's violence to their partners, (Abramsky et al., 2011) and lead to legal sanctions. All of this could contribute to men's much higher representation in the criminal justice system. They are also heavily overrepresented amongst the single homeless and in drug and alcohol services where links between their behaviour and emotional distress may not always be recognised (Crisis, 2011; Department of Health, 2012).

The social context: 3. 'Race' and ethnicity

Although the terms 'race' and 'ethnicity' are often used as if they refer to fixed characteristics, they are and always have been social constructions whose meanings vary across time and place. As Suman Fernando (2010) points out, in the West, 'race' is usually seen as physical, cultural and social, and 'ethnicity' as psychosocial, overlapping in meaning with both race and culture, and involving a sense of identification with people who share ancestry, language, and social, cultural or religious traditions and experiences. The meanings attached to any of these aspects and their perceived importance in defining particular groups, can vary greatly depending on who is doing the defining and for what purpose; but socially powerful meanings are often imposed by dominant groups in ways which serve their interests and which emphasise value laden differences between the dominant or majority ethnic group and minority or subordinate groups; the latter are also often presented as more homogeneous, physically, socially and psychologically.

In this section, focusing mainly on the UK, we will discuss the experiences of those minority ethnic groups who have received most attention from psychiatric researchers. In the UK, these are mainly people who are themselves or whose families/ancestors are originally from Africa, the Caribbean and Asia, mainly India, Pakistan, and Bangladesh; in the US, they are

often descendants of African and African-Caribbean slaves but they may also be colonised indigenous peoples, for example in North America and Australasia. Different terms have been used to describe these groups including Black and minority ethnic (BME) in the UK, people of colour or African-American in North America, and aboriginal or first nation referring to colonised people. Our aim is to understand possible links between being a member of a visible minority – in this case, and reflecting the persistent importance of skin colour in defining race and ethnicity, being Black or Asian in a White dominated society – and distress and troubled or troubling behaviour (see Appendix 1 for evidence relating to a wider range of minority ethnic groups within the UK).

Demographic research

Over 50 years of research has consistently found higher rates of diagnoses of ‘schizophrenia’ and other ‘psychoses’ in people who are themselves or whose families were immigrants to Western countries, especially from Africa and the Caribbean. One recent large-scale UK study found that adults of Black African and African Caribbean descent, including immigrants and those born in the UK, were overall 5.8 and 9.1 times more likely than White people to be diagnosed as ‘schizophrenic’; the equivalent figures for a diagnosis of ‘manic psychosis’ were 6.2 and 8 (Fearon et al., 2006). Earlier UK studies of African Caribbean immigrants and their UK-born children have found similarly raised (adult) rates for ‘schizophrenia’ in comparison with White people (Harrison et al., 1988; Thomas et al., 1993). A Dutch study found that people living in the Netherlands who themselves or whose mothers were born in Morocco, were 5.8 times more likely to receive schizophrenia diagnoses than those who themselves and whose mothers were born in the Netherlands (Veling et al., 2006). Meta analysis of studies over several decades have reported overall lower, but still strikingly raised rates of ‘schizophrenia’ and related diagnoses for immigrants in general with the highest overall rates for Black immigrants and their children born in the White dominated ‘host’ country (Bourque et al., 2011; Cantor-Graae & Selton, 2005). The rates for Asian-born immigrants and their families born in the host country, are consistently lower than those for African or African Caribbeans but still higher than for Whites. Some studies have taken account of factors known to be strongly linked to ‘schizophrenia’ diagnoses such as socio-economic status. This does lower the differentials but far from abolishes them (Bresnahan et al., 2007). Other diagnoses such as depression have received less attention but one community US study found that African-Americans and Caribbean Americans were less likely than non-Hispanic White Americans to fulfil criteria for ‘major depressive disorder’ but when they did, they were more likely to rate their problems as severe or very severe and more disabling (Williams et al., 2007).

Though the stresses of migration itself may explain some aspects of these patterns, they cannot be the whole story. For example, Michaeline Bresnahan and colleagues (2007) found that established African-Americans were three times more likely than White Americans to be diagnosed as ‘schizophrenic’ while studies of colonised people in New Zealand and Canada have found significantly higher rates of ‘schizophrenia’ diagnoses than amongst white people (Read et al., 2013). Similarly, rates of ‘schizophrenia’ diagnoses in immigrants’ children who were born or mainly raised in the ‘host’ country, have been found to be either no lower (Bourque et al., 2011) or higher (Cantor-Graae & Selton,

2005) than for immigrants themselves. There is also no evidence to support theories of ‘selective migration’ – the idea that those predisposed to ‘mental disorder’ and perhaps already in difficulty in their home country, would be more likely to migrate (Cooper, 2005; McKenzie & Murray, 1999). Claims that some ‘mental disorders’ are ‘misdiagnosed’ in minority ethnic groups, leading to relatively high or low rates, are not so much lacking in evidence as meaningless given the subjective nature of diagnostic judgements and the lack of validity of diagnostic categories. Of course this does not rule out the possibility of clinicians applying diagnostic criteria differently for minority and majority ethnic groups although some studies have tried to ensure that this was not the case. We will return to this point later but it is also important to note that differences in diagnostic rates, whatever the reasons for them, are matched by differences in interventions: evidence over several decades shows that Black (African-Caribbean and African) and to a lesser extent, Asian people are more likely than White people to be involuntarily committed and sectioned under mental health legislation, given higher doses or long-acting versions of drugs and are less likely to receive psychological or other alternative therapies (Care Quality Commission, 2014; Fernando, 2010; Littlewood & Lipsedge, 1997; Mind et al., 2013; NIMHE, 2003; Williams et al., 2007).

Although some attempts to explain these findings are problematic, the differences in diagnostic rates and treatments are well established. But it is difficult to interpret these patterns and their implications for alternatives to diagnosis without taking account of the ideological and social context surrounding minority ethnic groups’ experience of distress or troubling behaviour *and* professionals’ response to it.

The ideological context

There is a good deal of overlap in the processes which position women as subordinate, which we described in the section on sex/gender, and those which position Black and minority ethnic people as subordinate. This is partly because of general similarities in the ways unequal power relations are created and maintained but also because the (neutral) standard, ideal person suggested by philosophers of the European Enlightenment and later implicitly adopted by psychological and psychiatric theory, was not only male but White. Combined with a history of slavery and colonisation, this ‘standard’ has shaped the experiences of non-White people throughout the world but especially in White dominated societies. For example:

- European classifications of ‘races’ from the 18th and 19th centuries were based mainly on skin shade and colour but in a context where the terms black and white already carried strong social and psychological connotations of good and bad, desirable and undesirable (Fernando, 2010; Littlewood & Lipsedge, 1997). Similarly, valued European attributes of reason and civilisation were mainly located in White people, especially White males, helping to create an unquestioned sense of cultural and racial superiority, the assumption that only ‘people with white skins were capable of thinking and governing’ (Eze, 1997; Fryer 1984, p.169).
- In the late 19th and early 20th centuries, theories of biological evolution which traced complex organisms back to earlier, simpler lifeforms were transferred to theories of civilisation, with ‘primitive’ societies (and their peoples) seen as occupying less advanced positions on the cultural evolutionary scale but with the capacity to move

closer to a Western ideal. While some of this involved beliefs about cognitive capacity and rationality, much of it was concerned with sexual behaviour (Macleod, 2011).

- These ideas produced mixed and sometimes contradictory Western accounts of ‘mental disorder’, from the claim that freedom from the responsibilities of Western civilisation brought freedom from mental disorder to the claim that non-Europeans were mentally degenerate because they lacked Western culture or that their closeness to nature allied them with the mad. Melancholia and depression in particular were often claimed to be absent and this was attributed to a more childlike demeanour and to the absence of a highly developed individual mind, capable of introspection and self-reflection. By contrast, violent explosive reactions or ‘transient psychoses’ which might involve attacks on others, were said to be common (Fernando, 2010; Littlewood & Lipsedge, 1997).
- Assumptions of racial difference and inferiority were always central to colonialisation and slavery but the role played by later ‘scientific’ theories of race in Medicine, Psychology and Psychiatry is less clear. Roland Littlewood and Maurice Lipsedge (1997) have argued that an ingrained belief in European cultural, technical and administrative superiority played an important role in British colonialism in Africa and Asia and that it was only when dominated peoples threatened to achieve some sort of equality that systematic ‘scientific’ typologies of biological and psychological inferiority and pathology came to the fore. This was especially so in the US where these ideas were used extensively in the 19th and 20th centuries to oppose the abolition of slavery and justify continued domination of Black and Native Americans. Whatever the role of ‘scientific’ theories of ‘race’, it was certainly the case that well into the 20th century, much psychological and psychiatric theory was explicitly racist or eugenicist, for example, in the work of Kraepelin and Freud, Galton and Spearman and in twin and family studies of ‘mental disorders’ criminality and IQ; claims about the mental inferiority of Black people continued to be made throughout the 20th century and into the 21st (Fernando, 2010; Richards, 1997).
- The now largely hidden origins of the Western concept of adolescence provide a striking example of the kind of thinking we have discussed. The idea of adolescence as a distinct and natural developmental stage, a transition from simple (childlike) to complex (adult) forms of biological, emotional, cognitive and social functioning can be traced to G. Stanley Hall’s 1904 landmark text. Various social trends such as increasing segregation by age, the spread of mass schooling and outlawing of child labour, supported Hall’s claim that young people should be allowed to develop according to their true nature and not expected to take on adult responsibilities at an early age (Macleod, 2011; Moran, 2000); but the popularity of Hall’s construction of adolescence as a developmental transition from child to adult was also due to its basis in an analogy with ‘primitive’ and civilised cultures. As Catriona Macleod (2011) points out, he believed that ‘the transitional stage that humankind went through to move from primitiveness to civilisation plays itself out in similar form in the developmental transition of humans from childhood to adulthood’ (p.18). Prolonged chastity and sublimation of sexual desire (claimed not to be a feature of ‘primitive races’) was seen as essential in the evolution of a civilised race and in the transition of the individual to a cultural ideal of rational adult. The ‘adult’ was assumed to be White and male, so that females and non-Whites were implicitly constructed as potentially perpetual

adolescents (Deluzio, 2007; Macleod, 2011). Although Hall's analogy of individual and cultural development was not explicitly taken up by later psychologists, Catriona MacLeod has argued that 'the fear of a threat of degeneration that accompanied colonial interactions with so-called primitive people continues to haunt our talk about teenagers' (p.16) and, it seems likely, Black teenagers in particular.

This may seem mainly a historical context but just as the dismantling of many of the legal and economic structures of patriarchy has not ended the subordination of women or its psychological impact, the ending of legally sanctioned racial domination or physical oppression may simply mean that racism now 'frequently operates... without any overt reference to 'race' itself or biological notions of difference which still give the term its common sense meaning' (Gilroy, 1993, p.23). This could include derogatory references to 'migrants', the conflation of 'race' and 'culture' and the frequent pairing of 'advanced' and 'Western'; or subtle, rationalised discrimination by people who endorse equality (Dovidio & Gaertner, 2000; Fernando, 2010); it is also apparent in the extensive underrepresentation of Black and minority ethnic people in positions of power and influence in the UK (Equality and Human Rights Commission, 2016) and in the increasing export of Western theory and practice about emotional and behavioural problems to non-Western countries, where they may be presented as more scientific or advanced (see Chapters 2 and 3).

It would be surprising if some aspects of this ideology did not influence Western mental health services since those who develop and apply theories of emotional and behavioural problems (and who are mainly White) are part of a society where the ideology operates. The highly permeable boundaries between these theories and practices, and society in general through this interaction, through the media and from service users' experience, ensures that professional assumptions and practice both reflect and become part of the wider social context which shapes the experience of black and minority ethnic people. Examples of this include:

Individualised or deficit-based explanations: Many of the explanations for Black people's overrepresentation in services and some diagnostic categories have focused on difference or deficit such as genetic vulnerability in migrants, low immunity to viral infections, difficulties in absorbing vitamin D because of their dark skin, and a different, more florid and antisocial presentation (Cooper, 2005; Littlewood & Lipsedge, 1997; McGorry, 2000). This is related to the continuing use of 'race' as a biological rather than social construct, for example, in research on 'race' differences in neuroleptic response or complaints that there is a lack of information about 'race' differences in brain morphology and neuropsychological functioning in schizophrenia (Boyle, 2002a). This not only encourages a perception of Black and some minority ethnic groups in White dominated societies as fundamentally different, but also as a 'problem', a perception heightened by a lack of attention to *lower* rates of some problems such as suicide or alcohol misuse amongst some minority groups.

'Cultural-syndromes': These are defined by *DSM-5* as '...clusters of symptoms and attributions that tend to co-occur, among individuals in specific cultural groups, communities or contexts that are recognised locally as coherent patterns of experience' (APA, 2013, p.758). Suman Fernando (2010) puts it rather differently suggesting that, 'what happens in developing psychiatric knowledge is that when the symptom

constellations identified in non-Western settings cannot be pushed into an illness category within psychiatry, a culture-bound syndrome is identified. Psychopathology in the West is seen as culturally neutral' (p.39). As we saw in Chapter 2, *DSM-5* has made some effort to move away from this but still privileges the medicalised Western version, not least in its claim that many *DSM* diagnoses may have started out as cultural syndromes, but become 'widely accepted as a result of their clinical and research utility' (p.758), implying that they are no longer 'cultural syndromes' but something more scientific. All of this creates an impression of Western groups who develop standard biological illnesses and non-Western groups who express 'abberant behaviour and troubling experience' according to local idioms. The evidence, instead, as we might expect, shows that people throughout the world express distress and deviance using verbal and non-verbal symbols and idioms which are familiar to them from their cultural context (Littlewood, 2002; Watters, 2010) and that none of these resembles a medical syndrome. The impression of difference and otherness created by 'culture bound syndromes' or 'cultural syndromes' can be reinforced by the idea of cultural awareness or sensitivity, intended to encourage professionals to take account of someone's cultural background and especially to avoid misdiagnosing culturally normative reactions such as hearing voices or bizarre seeming beliefs as mental illness. But, as Black writers have long noted, 'cultural awareness' often seems to apply only to non-Western cultures so that 'culture' becomes reified as a thing special to Black people (Black Health Workers and Patients Group, 1983; Mercer, 1986) and capable of producing the most extreme behaviours and experiences which, in Western groups, are attributed to brain pathology. By contrast, Western customs and practices are implicitly presented as a neutral (or possibly more advanced) standard, less relevant to distress and deviance.

Somatisation: It has been suggested that people from some ethnic groups are more likely to present and possibly experience distress through bodily complaints (Littlewood & Lipsedge, 1997; Wilson & MacCarthy, 1994). The idea of somatisation recalls earlier claims about the absence of melancholia in 'primitive' groups and about 'conversion hysteria' as a less advanced way of dealing with emotional difficulties (Littlewood & Lipsedge, 1997). Similarly, and reflecting the hierarchy implicit in the idea of somatisation, *DSM-IV* (APA, 1994) claimed that 'somatisation disorder' was rare amongst US men with the exception of Greeks and Puerto Ricans. *DSM-5* does not name any ethnic groups in its discussion of 'somatic symptom disorder' and notes that high numbers of somatic complaints are found in population-based and primary-care studies around the world. However, it also claims that 'Somatic symptoms are prominent in various "culture-bound syndromes"' (2013, p.313). Since *DSM-IV* and *DSM-5*'s lists of 'culture-bound' or 'cultural syndromes' only include non-Western examples, then we could gain the impression that somatisation is more common in non-Western groups.

Perceptions of dangerousness: As we noted earlier, in the UK, Black people – mainly men – are more likely to have police involvement in their admission to psychiatric services, to be sectioned under mental health legislation, to be admitted to secure or forensic services and to be given higher or longer acting doses of psychotropic drugs. This is in line with what Maurice Lipsedge (1994) calls a well-established Western stereotype of Black psychiatric patients as volatile and dangerous. This stereotype goes beyond psychiatric services, with, particularly, young Black men far more likely than their White peers to be

'stopped and searched' by police (Bowling & Phillips, 2007; EHRC, 2010). Several studies confirm this dangerousness stereotype within psychiatric services but do not show that it is based on objective evidence (Spector, 2001). It could, however, become a self-fulfilling prophecy as forced admission and treatment may be more likely to produce anger and resistance (Littlewood & Lipsedge, 1997; Lloyd & Moodley, 1992; Noble & Rodger, 1989). It is difficult not to link the general perception of dangerousness – at least amongst White people – with the striking excess of 'schizophrenia' diagnoses in Black people we described earlier, given that schizophrenia is the diagnosis most strongly associated in the public mind with violence and dangerousness. It is also difficult not to link this perception of Black people's potential dangerousness with the 'threat of degeneration' apparent in colonialist and academic writings of the 19th and 20th centuries (MacLeod, 2011).

We are not arguing that the overrepresentation of Black and some other minority ethnic groups in UK psychiatric services or diagnostic categories is entirely due to White stereotypes and certainly not to misdiagnosis; as we said earlier, the question of misdiagnosis is irrelevant given the lack of validity of psychiatric diagnostic categories. We are arguing that the long history of unequal power relations between Black and White people has involved an ideological context which powerfully constructs Black people as different and inferior and which in more or less explicit ways continues to shape their day-to-day lives. The next sections will discuss this process in more detail and how it might be linked to a range of emotional and behavioural difficulties.

The impact of racism and discrimination

Racism and discrimination take many forms, some more visible than others. They include subtle putdowns, insults and dismissals ('micro-aggressions') as well as more overt racist insults, hostility and violence. Discrimination may also be deeply embedded in the procedures, policies, laws and employment practices of organisations and services (institutional racism) in a way which renders it more or less invisible except to those discriminated against. All of this is supported by the ideological context described earlier and there is consistent evidence that these various forms of racism and discrimination can have very negative effects on mental and physical health.

Correlational studies in several Western countries have found a 'dose response' relationship between extent of reported experience of racism and discrimination and the likelihood of meeting criteria for a range of psychiatric diagnoses including schizophrenia and other psychoses, anxiety and depression. For example, Wim Velling and colleagues (2007) reported incidence rate ratios for 'schizophrenic disorders' of 4, 1.9, 1.58 and 1.2 for high, medium, low and very low degrees of reported discrimination while Saffron Karlsen and James Nazroo (2002) found a 150 per cent increase in estimated rates of 'depression' and 'psychosis' among those who had experienced verbal abuse compared with those reporting no experience of racism and three to five times higher rates for those who had experienced racially motivated assault or property vandalism. Similar results were reported from a later study (Karlsen et al., 2005). A longitudinal study (Janssen et al., 2003) found a significant relationship between reported experiences of discrimination by people with no psychiatric history, 'symptoms' or 'paranoid ideation', and measures of 'delusional ideation' three years later.

These studies involved people's own reports of racism and discrimination but the results are consistent with research using other measures. For example, admission rates for 'schizophrenia' among some minority ethnic groups in London were found to be lower in areas where there was a 'clustering' of particular ethnic groups (Boydell et al., 2001). Similar results were found in a Dutch study – 'psychosis' rates were raised only for those from minority ethnic groups when they lived in neighbourhoods where their own ethnic group was a very small minority (Veling et al., 2008). Bruce Kennedy and colleagues (1997) used measures of 'collective disrespect' – or racism as an 'ecological characteristic' – based on yes/no answers to questions in a US national survey: "On the average blacks have worse jobs, income, and housing than white people. Do you think the differences are: (a) mainly due to discrimination?; (b) because most blacks have less inborn ability to learn?; (c) because most blacks don't have the chance for education that it takes to rise out of poverty? or (d) because most blacks just don't have the motivation or will power to pull themselves up out of poverty?" Scores were calculated for each state. Across 39 states, the researchers found that both measures of 'collective disrespect' correlated strongly with lower life expectancy for Black and to a lesser extent White people. They also found a significant increase in Black mortality rate with just a 1 per cent increase in the prevalence of those who believed that Black people lacked innate ability.

These results emphasise that the impact of racism goes beyond psychological harm, affecting physical health and even life expectancy. In line with this, US studies have shown an association between self-reported experience of racism, raised blood pressure, and more reported days spent unwell in bed (Kreiger, 2000; Kreiger & Sidney, 1996) while Saffron Karlsen and James Nazroo (2002) found that those who had experienced racial verbal abuse were about 50 per cent more likely to describe their physical health as fair or poor while those reporting physical attacks or having their property vandalised were over 100 per cent more likely.

Minority ethnic groups differ in how far they experience social stigma (Levin & van Laar, 2006; Veling et al., 2007); we also noted earlier that people from African-Caribbean and African groups in the UK and other Western countries, are much more likely to be diagnosed as 'psychotic' than people from other minority ethnic groups. In line with this, European and US studies linking racism and psychiatric diagnoses have consistently found a systematic relationship with skin colour, with darker skinned people reporting higher levels of harassment and discrimination (Karlsen et al., 2005; Veling et al., 2007; Williams, 1999).

The impact of socio-economic status

As we will see in the section on class and poverty, low socio-economic status is related to a wide range of negative psychological outcomes including 'psychosis'. In White dominated societies, Black and some minority ethnic people are, in general, overrepresented in lower income groups and amongst the unemployed; in the UK and US, amongst those with a diagnosis of 'psychosis', African Caribbeans, whether immigrants or established in the country, are more likely than Whites to be unemployed and experience other forms of social disadvantage (Bhugra et al., 1997; Cooper, 2005; Mallett et al., 2002; Morgan & Hutchinson, 2010; Morgan et al., 2008; Williams & Earl, 2007). Some of the research we discussed on discrimination has taken account of this and still found significant

independent associations between reported harassment and discrimination and mental health problems (Janssen et al., 2003; Karlsen & Nazroo, 2002; Veling et al., 2007). Of course, low socio-economic status and racial discrimination are not experienced separately so that the processes we will discuss in relation to class and poverty are very relevant in the lives of many Black and minority ethnic people but are experienced in a racialised context. For example, the belief that 'the poor' are responsible for their situation may be intensified by beliefs about social and intellectual inferiority of Black people. The complex links between racism and socio-economic status are highlighted by the fact that there is greater heterogeneity in income, education and qualifications amongst Black and some minority ethnic groups in lower social class groups and neighbourhoods than there is for White people in similar neighbourhoods, reflecting a history of 'race'-based employment discrimination and social segregation (Karlsen & Nazroo 2002; Littlewood & Lipsedge, 1997; Williams & Earl, 2007). The structural disadvantages experienced by many Black people in White dominated societies also seem to interact in complex ways with 'personal' adversities such as bullying or sexual abuse and with other sociopolitical influences in the development and phenomenology of 'psychotic' experiences (Rosen et al., 2017).

Those who arrived in a country as refugees or asylum seekers face even greater problems. They will have lost not only their home but many or most of their possessions, probably been unable to make many preparations for leaving or even had much choice in their destination. They may be forbidden to work or be unable to use their education and qualifications, and experience hostility at odds with their perception of their destination as a place of safety. They may be extremely socially isolated, unable to or fearful of communicating with others or with relatives in their home country. Almost by definition, they are likely to have experienced extreme adversity and trauma in their home country and probably on their journey. Several writers have been critical of the practice of conceptualising reactions to these experiences as objectively diagnosable pathology such as 'post-traumatic stress disorder'. This can overlook not only complex cultural and personal meanings of events but also the often extraordinary resilience of refugees and asylum seekers (Fernando, 2010; Miller & Rasco, 2004; Mueke, 1992; Patel 2008). Even if they are able to establish new relationships and find meaningful work, people who have been forced to leave their homes are likely to experience a permanent sense of loss and may communicate this and perhaps also a sense of fear and powerlessness to their children (Fernando, 2010; Moorehead, 2006).

Research on racial discrimination, social status and psychiatric diagnoses has been extremely valuable in highlighting the potential impact on physical and psychological wellbeing. But inevitably the research has limitations, including the use of standardised questions and response sets and a reliance on psychiatric categories. These may have produced under-reporting of racist experiences and, possibly, of their psychological effects (a point acknowledged by the researchers): in studies where we have figures, the majority of respondents reported no experience of discrimination. Yet research using in-depth interviews has found a very different picture with many people from Black and minority ethnic groups seeing interpersonal and institutional racism as part of everyday life and being made to feel different as routine and expected (Allan, et al., 2004; Chahal & Julienne, 1999; Connolly & Keenan, 2002). Similarly, people who had initially reported on a questionnaire that they had not experienced discrimination said later in an in-depth

interview that they had, but had found it too difficult to discuss (Parker et al., 1994). Our understanding of the impact of several other aspects of racial discrimination would also benefit from the use of a wider range of research methods. These include:

The gendered nature of racism: Saffron Karlsen and colleagues (2005) found that across a range of ethnic groups a higher proportion of women than men reached the threshold for ‘common mental disorder’, a pattern also reported by the UK Adult Psychiatric Morbidity Survey (McManus et al., 2016) although there is no way of knowing whether this is due to differences in willingness to report. But both Black men and Black women have historically been constructed (by White men) as closer to nature, and therefore more sexualised, than White men while there is often a strong racial element in sexual insults reported by Black women as part of ‘everyday sexism’ (Bates, 2014). There are also direct and indirect expressions of concern about high birth rates amongst minority ethnic groups which are likely to have a greater effect on women as the group which becomes pregnant and gives birth. And Catriona MacLeod’s (2011) argument that ‘the ghost of a discourse of degeneration’, stemming from the colonialist roots of theories of adolescence, haunts our understandings of young women and reproduction, may apply to ‘teenage pregnancies’ in general but arguably applies most to Black teenage pregnancies. It has also been suggested that women are more likely than men to internalise their experiences of harassment and discrimination by accepting their subordinate status and unfair treatment – also imposed by their sex – as in some way ‘deserved’ (Karlsen & Nazroo, 2002).

Cumulative effects of multiple disadvantage: We have noted that some Black and minority ethnic groups are overrepresented in lower status residential areas and employment, and amongst the unemployed. This segregation can reinforce stereotypes of difference and inferiority and resulting social and economic exclusion, producing pervasive and accumulating negative experiences across the lifespan.

Different relationships to the dominant culture: Different minority ethnic groups obviously have different relationships to the dominant White culture in terms of history, language and cultural traditions. Roland Littlewood and Maurice Lipsedge (1997) have suggested that the ascription of inferior identity together with obstacles to achieving shared goals, in the context of similarity in language and tradition, can create particular difficulties for those from African-Caribbean backgrounds which may be a factor in the overrepresentation of these groups in diagnoses of ‘psychosis’. Whether or not this is true, the impact of racism is likely to be mediated by discrepancies in expected and actual relationships with the dominant culture. This relates more generally to the issues of group membership and the social identities associated with them. As Alex Haslam and colleagues have shown, these play a central role in our health and wellbeing (Haslam et al., 2009; Jetten et al., 2012b). But, while secure ethnic identity may be a protective factor against the effects of racism, including psychosis, racism may simultaneously make it unsafe to feel strongly connected to one’s own ethnic group (Read et al., 2013) – while also making it unsafe to feel connected to the dominant group.

Wim Veling and colleagues (2007) have described racism and discrimination as having a pervasive, adverse influence on the health of many minority ethnic groups. As we have noted, similar processes are likely to be involved in adverse outcomes across different subordinate groups, and intensified for those with multiple subordinate identities, although the specific content and meaning of experiences may be different. For people

from Black and minority ethnic groups in White dominated societies these processes and outcomes are likely to include:

- Anxiety, suspicion or ‘paranoia’ in the face of persistent hostility and threat or uncertainty about language or the meaning of others’ behaviour (Cromby & Harper, 2013; Harper, 2011; Littlewood & Lipsedge, 1997).
- Collective representations or shared understanding of devalued status and knowledge of negative cultural stereotypes (Levin & van Laar, 2006; Veling et al., 2007), potentially damaging to self-esteem and limiting expectations of achievement (Karlsen & Nazroo, 2002). This may also produce ‘negative identification’ with one’s ethnic group, found by Wim Veling and colleagues (2008) to increase the chances of being diagnosed as ‘schizophrenic’ in a context of social adversity.
- Self-imposed restrictions on activities, travel, places visited, etc. to avoid racial harassment, leading to social isolation, feelings of entrapment and low control (Karlsen & Nazroo, 2002; Virdee, 1995).
- Anger, which may be pathologised.
- Achievement of status and recognition in socially problematic ways, for example, gang membership when (especially male) attributes valued by the dominant culture are not easily available (Weber et al., 1998).

These understandable, often protective negative responses, however, may be mitigated or transformed by various ‘counter strategies’ that aim to challenge power inequalities and make more visible their individual and social effects and the reasons for their persistence. The strategies include assertion of cultural identity/heritage and its inclusion in mainstream education; civil rights campaigns; arts and literary projects, and influence on the media, law and policy. These and other strategies may be used across subordinate groups, particularly important when we consider the often multiple nature of subordinate identities.

The social context: 4. Poverty and low socio-economic status

Introduction

The links between poverty, low socio-economic status and a wide range of psychiatric diagnoses – from depressive and anxiety ‘disorders’, to ‘post-traumatic stress disorder’, ‘personality disorder’, ‘substance use disorder’ and ‘schizophrenia’ – are well established across many countries (Cromby et al., 2013; Fell & Hewstone, 2015; Lorant et al., 2003; Melzer et al., 2004; Murphy et al., 1991; Read, 2010). For example, having a parent of low socio-economic status can more than triple the risk of being given a diagnosis of severe depression (Ritsher et al., 2001) while suicide rates can rise steeply in economic recessions (Stuckler & Basu, 2014). One of the strongest relationships seems to be with a diagnosis of ‘schizophrenia’. Sixty years ago, the New Haven study (Hollinshead & Redlich, 1958) found that those in the poorest social class were three times more likely than those in the two wealthiest to receive psychiatric treatment but that the poorest were eight times more likely to be diagnosed as ‘schizophrenic’. Later research has confirmed this steep gradient including in those with no family history of ‘psychosis’ (Harrison et al., 2001).

These relationships hold across several of measures of poverty and individual status such as income, asset ownership, neighbourhood and living conditions, education and occupation; but it is also becoming increasingly clear that the distribution of income across a country's population as a whole, the extent and visibility of income inequalities, is significantly related to its incidence of emotional and behavioural problems, including 'psychosis' (Burns et al., 2014; Burns & Esterhuizen, 2008; Johnson et al., 2015; Keating & Hertzman, 1999; Wilkinson & Pickett, 2010).

Although the links between low socio-economic status, income inequality and emotional and behavioural problems are widely accepted, interpretation of these links as causal has been contested, often in defence of a medicalised approach. Perhaps not surprisingly, most of the controversy has centred round the diagnosis of 'schizophrenia'. It has been suggested that the poverty and low social status of many people diagnosed as 'schizophrenic' is a result of downward 'social drift' or of their failing to reach their occupational potential or being oversensitive to adversity as a result of a predisposition to 'mental illness'. There is little evidence that these and similar theories offer a strong alternative to the extensive support for the hypothesis that poverty, low socio-economic status and income inequality are major causes of emotional and behavioural problems (Read, 2010; Read et al., 2013; Wilkinson & Pickett, 2010); but it is certainly the case that being seriously distressed or disturbing to others reduces people's chances of functioning well at home or work or of escaping poverty. The kinds of childhood adversity (see section 1) which often lead to mental and emotional problems in adulthood can also limit achievement in education or at work. And, once people are given a psychiatric diagnosis, they are more likely to be discriminated against in finding or keeping work (Read, 2010; Thornicroft, 2006; Warner, 2000). There is also evidence that psychiatric drugs, through their effects on cognitive, social and occupational functioning, can make it more difficult for people to move away from disability payments and into education or well-paid work (Bentall, 2009; Whitaker, 2010). So too can intellectual disabilities.

Poverty can also lead to many other adversities, themselves strongly related to mental health problems; it is, in Jennifer Newton's (1988) phrase, 'an event producing situation'. Poverty and low socio-economic status then, can be seen as both cause and consequence of a wide range of mental, behavioural and emotional difficulties. In this section we will describe some of the material, social, psychological and biological contexts 'set up' by poverty and income inequalities, and the ways they might lead to or exacerbate psychological problems (and see also Psychologists against Austerity, 2015). As we emphasised in the introduction, what is often called 'social inequalities' – including poverty – actually involve inequalities of power, so that the negative operation of different forms of power, especially material/economic, legal and ideological are part of these contexts and the distress they produce. Three further points should be emphasised. First, as with other forms of inequality, research on socio-economic status is often dependent on psychiatric diagnoses. But as we pointed out in the introduction, this research can be useful even if we reject the validity of diagnostic concepts because they stand as proxy for a wide range of distressing and troubling experiences. Standing back from diagnostic categories also helps us see commonalities across groups given different diagnoses and helps us understand how the same context might give rise to different forms of distress and different contexts to similar forms. Second, poverty and low socio-economic status

interact strongly with other forms of social subordination and disadvantage, such as having a physical or intellectual disability, being very old, female or from a minority ethnic group so that the disadvantages these groups already face are compounded. Third, we are talking here about groups. As with other forms of disadvantage, there are many individual differences in people's experiences of and responses to poverty and low economic status which help explain why some people and not others might enter psychiatric services. We will return to this point later in the document.

Poverty contexts

Entrapment and powerlessness: Being in an aversive situation from which there seems no escape is strongly associated with emotional distress (Brown & Harris, 1995; Kendler et al., 2003). The chronic, long term state of adversity implied by 'entrapment' also appears to be more damaging to mental and emotional wellbeing than acute, sudden negative events (Mathiesen et al., 1999). Poverty is particularly likely to lead to entrapment because by definition it means the lack of a commodity which underpins almost every area of our lives. It is more difficult for people with very little money to use what for others would be routine ways of 'escaping' even mildly stressful situations – retreating to your own space at work or home; having a night out with friends; going on holiday; purchasing various forms of help and so on. Lack of money can also preclude larger and longer-term changes – moving house, school or job or leaving a relationship. It also leaves people very dependent on public services and government policies controlling, for example, the availability of affordable housing or legal aid. Poverty can therefore trap people for long periods in very aversive and abusive situations and relationships; older people and those with physical or learning disabilities may be at more risk of financial abuse, exacerbating their entrapment, for example, in exploitative situations with families or others they depend on. Poverty also creates conditions where changing your economic status can come to seem so difficult as to be almost impossible. As Sendhil Mullainathan and Eldar Shafir (2014) point out, trying to alleviate a shortage of money is much harder than trying to alleviate other personal shortages such as time or skills, which we can use money to compensate for. People may become trapped in debt, where the amount owing increases steeply, particularly if money has been borrowed from companies charging extremely high interest rates. Trying to work more may not be feasible, assuming as it does time and energy to find, apply for and carry out more work or that extra work, or any work is available or will produce significant extra income. As we will see, severe shortage of money and low socio-economic status also affect social, cognitive, emotional and physical functioning so that the poverty context can seem all-encompassing and inescapable, creating a state of mind dominated by anxiety, rumination and feelings of hopelessness and defeat (Moffatt et al., 2016; Tirado, 2014). In their study of people's experiences of poverty, Elaine Chase and Robert Walker (2012) reported that several of their participants had considered or attempted suicide because they could see no way out of their current circumstances.

Exposure to unpredictable and uncontrollable events: There is a great deal of evidence that experiencing important aspects of life as unpredictable or uncontrollable is strongly related to distress (Marmot, 2004; Mineka & Kelly, 1989; Sapolsky, 1999). Similarly, measures of Albert Bandura's concept of 'self-efficacy' – beliefs about one's capabilities and sense of control over important outcomes – are consistently related to income and education; low scores on these measures are strongly associated with complaints of

depression, with scores often falling sharply following unemployment or uncertainty in economic status (Bandura, 1997; Maclejewski et al., 2000; Maddux & Meier, 1995). Low control over important outcomes can also partly explain links between low socio-economic status and paranoia (Mirowsky & Ross, 1983). As David Harper points out, ‘When you are not fully in control of your life – when you could be sacked from your poorly paid job at any moment – in a very real sense others *are* in control of your life and it may feel as if they are persecuting you’ (2011, p.59).

Although all of us experience events we can neither predict nor control, people with very low incomes, in low status jobs or unemployed, experience unpredictability and uncontrollability across many important areas of their lives including:

- **Level of income:** For those in work, this can arise, for example, from job insecurity (itself strongly linked to distress, De Witte, 1999) and/or from contracts without guaranteed working hours, so-called zero-hours contracts. For those receiving benefits, in or out of work, uncertainty about income can arise from actual or proposed changes in government rules about levels of or qualifications for benefits, from discretion in application of rules, or from difficulties in understanding complex criteria or accessing advice.
- **Financial demands:** All of us experience unexpected financial demands but those on low incomes may always be unsure if they can meet expected and unexpected demands, including debt repayments, while facing extremely negative outcomes if they do not. Research on the experience of people in poverty suggests daily dilemmas about which bills to pay, whether to spend on food or clothing, transport, repairs or heating, which family gatherings or outings to attend and so on (Chase & Walker, 2012; Moffatt et al., 2016; Shildrick et al., 2012). The outcomes of these decisions can be momentous. One woman remarked that ‘It sounds ridiculous but three or four pounds can sometimes can be the difference with getting evicted... and living in your property’ (Moffatt et al., 2016, p.4) while Linda Tirado, in her account of long-term poverty, noted that ‘It’s amazing that the things which are absolute crises for me are simple annoyances for people with money’ (p.132). Elaine Chase and Robert Walker noted that these day-to-day struggles for control over financial demands ‘frequently led to a sense of powerlessness and a degree of physical as well as psychological disintegration’ (p.748); Suzanne Moffatt and colleagues noted ‘a sense of hopelessness verging on desperation’ while Colleen Heflin and John Iceland found that ‘hardships’, especially problems paying bills and managing the consequences, significantly mediated correlations between poverty and ‘depression’ (2009).
- **Work behaviour and ‘attitude’:** People in low status jobs may have very limited control over their behaviour and demeanour at work, including timing of toilet breaks, what to say to customers, emotional expression and amount and timing of work to be performed on each shift, with close surveillance to gauge compliance (Mason, 2015; Tirado, 2014).
- **Areas targeted for scrutiny and change:** Initiatives aimed at ‘social problems’ such as eating and drinking patterns, parenting behaviour, educational attainment and ‘antisocial behaviour’ in practice often focus more on the behaviour of people in the lowest social economic classes. People who are unemployed may be required to discuss

and try to change their psychological characteristics such as self-esteem, aspiration and motivation as a condition of receiving unemployment benefits, although the criteria for assessing change may not be clear (Friedli & Stearn, 2015). While some people may find these initiatives helpful, others can experience them as humiliating and intrusive, especially when they have few resources to control public scrutiny and censure (and see below).

In these areas and others, not having much control can be compounded by lack of intellectual or physical resources, which already restrict people's control over important aspects of the lives. More generally, control is restricted by a lack of 'social capital', for example knowing influential people or who to ask for help, which institutions or departments to approach and having the knowledge, skills and confidence to communicate effectively and persist in resolving problems (Cromby et al., 2013).

Shame and humiliation: Research across many countries suggests that feelings of shame and humiliation are integral to living in absolute or relative poverty (Walker et al., 2013). And, although they may not be named as such, these feelings are a major part of many types of emotional distress such as very low mood (Gilbert, 2000; Kendler et al., 2003; Perese, 2007) anxiety, social anxiety and post-traumatic stress (Gilbert, 2000; Lee et al., 2001). It is not easy to talk about shame – the sociologist Robert Scheff (2000) has highlighted the taboos surrounding it in Western countries – to the point where James Macdonald and Ian Morley (2001) found that shame was the emotion that therapy clients were most ashamed of disclosing. Shame is often presented in Psychology as if it is a property of the individual – dispositional shame or shame proneness – existing independently of the contexts where it is felt (Jo, 2012; Leeming & Boyle, 2004). But shame is a fundamentally social emotion, often reflecting comparison with cultural or idealised norms. Yongmie Jo (2012) describes it as emanating from the scorn and contempt of others, real or imaginary, imposing feelings of denigration of the entire self and instilling a sense of failure or inferiority (pp.518–519); Paul Gilbert (1998) describes it as 'an inner experience of oneself as an unattractive social agent' (p.22). Feeling shame is therefore inseparable from being shamed; it involves a sense of powerlessness, of being judged by others 'who consider or are deemed to consider themselves to be socially and/or morally superior to the person sensing shame' (Chase & Walker, 2012, p.740).

The social nature of shame in poverty and low socio-economic status arises from several sources. An obvious one is lack of material power and resources. Although lack of high status possessions and other material markers of success is a source of shame across many countries (Walker et al., 2013) the effect is partly dependent on the degree of perceived difference or separation between self and others. There seems to be greater potential for shame in societies where personal worth is judged largely in relation to economic goals and where, as in the UK, there are large inequalities of income, possibly because greater inequality heightens anxiety about social evaluation by increasing the importance of social status (Chase & Walker, 2012; Wilkinson & Pickett, 2010). A second source is the fact that poverty is more common in groups who are already subordinate or devalued, for example people from some minority ethnic groups, women, people with physical and intellectual disabilities and people with psychiatric diagnoses, so that the potential for shame is compounded.

Another, major, source of shame is cultural constructions – words, images, ideas – of poverty, ‘the poor’ and, especially, of ‘welfare claimants’. Because dominant constructions are generally shaped by relatively powerful groups, reflecting the operation of ideological or disciplinary power, they can attain credibility and truth status which makes them very difficult to resist or challenge (Foucault, 1975, 2001; Smail, 2005). In Britain, people who are unemployed and/or claiming welfare payments are often exposed to very negative constructions of themselves as responsible for their situation, as ‘scroungers’ or ‘skivers’ or even fraudsters; they are also exposed to constructions which conflate ‘welfare claimant’, ‘unemployed’ and ‘workshy’. And, although unemployment is spread across social classes, media images tend to focus on lower socio-economic groups. These negative constructions are reinforced by suggestions that a wide range of socially disapproved behaviours such as eating habits, ‘poor’ parenting or smoking result from ignorance or irresponsibility on the part of those in poverty rather than from the circumstances of their lives (Jo, 2012; Shildrick & MacDonald, 2013). Constructions of some welfare claimants as psychologically deficient can also be reinforced through work programmes which emphasise internal characteristics such as aspiration, self-esteem, mind-set or motivation, and further reinforced when attempts to change these are not linked to success in finding work (Friedli & Stearn, 2015). These representations are widely available through the media and political and policy statements; they are reinforced by psychological processes of in-group and out-group stereotyping, causal attribution and ‘just world’ beliefs which can support the idea of ‘deserving’ and ‘undeserving’ poor (Fell & Hewstone, 2015; Lerner, 1980). The representations are also generally accepted by the public (Baumburg et al., 2011; NatCen Social Research, 2013;). People living in poverty, and especially those claiming welfare payments and unemployed, are acutely aware of them and describe how they are played out, and – with other markers of poverty – become a potential source of shame in a range of day-to-day interactions, for example, with neighbours, teachers, welfare, legal, housing and financial officials, leading to feelings of awkwardness, discomfort, degradation, uselessness, worthlessness and failure (Chase & Walker, 2012; Moffatt et al., 2015). Elaine Chase and Robert Walker describe people’s talk of shame and poverty as a complex mix of an internal sense of inadequacy, including guilt at being unable to provide for their children or ‘keep up appearances’, and anger about others’ often successful attempts to generate feelings of failure and insignificance.

These feelings are obviously very aversive and it is not surprising that people make extensive attempts to avoid, mitigate and repair shame (Goffman, 1967; Jo, 2012; Leeming & Boyle, 2013). One way is to try to conceal potential sources of shame. People living in poverty report extensive efforts to do this, for example by managing social interactions to conceal where they live or that they are unemployed or receiving benefits; not asking for help from neighbours or family or accessing ‘public’ help such as food banks; making a pretence of coping, and hiding from bailiffs and debt collectors to avoid public exposure of debt (Chase & Walker, 2012; Jo, 2012; Moffatt et al., 2016). These tactics do not always work and anticipated shame often leads to social withdrawal and isolation. This, of course, can happen simply from not having enough money for transport, meals or suitable clothes for an occasion but it also involves more general withdrawal from any social situation which might expose your hardship or where the effort of managing the situation to conceal it seems too great (Chase & Walker, 2012; Moffatt et al., 2016). This, of course, can compound the problem because social isolation and loneliness both cause and exacerbate

a range of mental and emotional problems including very low mood, hearing voices and the development of unusual, often ‘paranoid’, beliefs (Boyle, 2002a; Bhugra & Arya, 2005; Read & Bentall, 2013; Warner, 2000). Another way of avoiding or lessening shame is through ‘projected shaming’. For those in poverty, this often involves constructing a positive identity for themselves by avoiding the direct language of poverty, using instead a language of hardship, fortitude, resourcefulness, managing and ‘getting by’. It also involves contrasting this identity with that of a perceived out-group who seem to conform to many media images, and is believed to be workshy, blameworthy, claiming benefits illegitimately, engaging in irresponsible consumption and unable to manage. But this group has proved difficult to find, so that shame may simply circulate rather than be avoided (Chase & Walker, 2012; Lister, 2004; MacDonald & Marsh, 2005; Shildrick & MacDonald, 2013). Some instances of violence and especially domestic violence may also involve projected shaming. As we pointed out in the discussion of sex and gender, men’s violence to their partners often follows perceived challenges to their authority or status. Given that living in poverty provides many such challenges, then some men may project feelings of shame from these encounters onto their partners, for example through the claim that they deserve or ‘asked for’ violence. Alternatively, John Cromby and David Harper (2009, 2013) highlight the links between shame, fear and anger – especially if shame is repudiated – in the development of ‘paranoia’.

Although people in low socio-economic groups use many strategies for avoiding and repairing shame, they are often unsuccessful not least because, like shame itself, shame avoidance and repair are social processes, dependent on reciprocal responses from others and rarely undertaken successfully by individuals alone (Leeming & Boyle, 2013). For example, welfare claimants or loan applicants have to reveal many details of their lives and finances so that it is very difficult to conceal the full extent of their poverty or how they manage it; these interactions, and the way they are handled, are often cited as key areas of shame and humiliation, as is the requirement to reveal details of work history (Chase & Walker, 2012). Some people hold more than one potentially shaming identity, for example single mother welfare recipient, while women as a group are generally held responsible for the welfare of their children, including their nutrition, behaviour and educational achievement (Shildrick & MacDonald, 2013). Shame is also an embodied, somatic experience which can produce a sense of defeat or paralysis, making constructive responses less likely (Leeming & Boyle, 2013). John Cromby (2004) has highlighted the fact that memories of devaluing messages or of shame inducing situations always involve a somatic component which will be reactivated in situations which carry reminders or where competence or self-worth is at stake. Making choices that could affirm competence such as dealing confidently with bureaucracy or being interviewed for jobs, can *feel* impossible, resulting in even greater feelings of defeat or hopelessness. Overall, being poor and of low social economic status makes it much more likely that you will be shamed and much more difficult to employ strategies of shame avoidance and repair such as concealment, avoidance of potentially shaming interactions and creation of a positive, non-shaming identity. It is this combination of relative powerlessness and the social nature of shame which makes it such a pervasive problem for those in low socio-economic groups.

Living in aversive environments: People in low socio-economic groups are more likely to live in environments where levels of crime and violence threaten their safety and

security and may demand high levels of vigilance (Belle, 1990). Fear of crime can deter protective social activity, community involvement and use of services, resulting in low mood and self-esteem (Whitley & Prince, 2005). People in low socio-economic groups may also live in overcrowded homes leading to loss of privacy, limited control over activities and use of space, disrupted sleep and conflicts over use of rooms. (Office of the Deputy Prime Minister, 2004). In these kinds of environment, many people in any one person's social network may be stressed, potentially leading to a kind of 'stress contagion' (Fell & Hewstone, 2015; Wilkins, 1974) and reducing opportunities for social support. As we noted earlier, people on very low incomes are also more likely to be disadvantaged in other ways and may feel particularly unsafe. Higher levels of unemployment and uptake of welfare in a community have also been found to be negatively related to individual measures of self-efficacy, even when personal socio-economic status is taken into account. This may be because limited community resources – employment, social, leisure, educational – restrict opportunities to display and learn skills which might encourage feelings of mastery and/or because there are fewer opportunities to observe others' achievements and so fewer positive role models (Boardman & Robert, 2000; Fell & Hewstone, 2015). The generally lower levels of trust and empathy found in more unequal societies (Wilkinson & Pickett, 2010) are intensified in threatening environments (Ross et al., 2001) again limiting opportunities for social support and increasing the likelihood of fear, anxiety and 'paranoia', characterised as it is by suspicion and mistrust (Harper, 2011). Overall these factors can help explain consistent findings of a strong relationship between levels of trust in a community and a wide range of emotional and behavioural problems, including psychosis (Araya et al., 2006; Fujiwara & Kawachi, 2008; Rogers & Pilgrim, 2010). They can also help explain the consistent and apparently causal relationship between urban living and diagnoses of 'schizophrenia' or 'psychosis' (Kirkbride et al., 2014; Krabbendam & van Os, 2005; Newbury et al., 2016).

Reduced cognitive capacity: Many aspects of the behaviour and choices of people in poverty such as smoking, unhealthy eating, borrowing at very high rates, renting goods rather than saving and buying at a much lower price, not taking medication, using negative discipline for children and so on, can seem problematic, self-defeating and likely to lead to problems in the future; they certainly attract social disapproval and, it's suggested, might be linked to enduring aspects of 'personality' or brain structure (Krishnadas et al., 2013; Marteau & Hall, 2013; Packard et al., 2012). But Sendhil Mullainathan and Eldar Shafir (2014) have argued that this kind of behaviour is more accurately seen as situational, linked to the impact of 'scarcity' on cognitive functioning. They define scarcity, for example of money, time or friends, as a clustering of several important concerns which create cognitive demands in addition to those most people might face in day-to-day life. As we have seen, for people with very little money, these demands might include constant dilemmas over payment of bills, decisions over how to spend limited resources, keeping children occupied without spending money, constructing a non-shamed identity, negotiating support from family and friends and what may be extremely time-consuming and emotionally depleting interactions with the welfare system and officials. Mullainathan, Shafir and their colleagues have been concerned with the impact of resource scarcity on two linked components of mental function – cognitive capacity, related to our ability at any given time to solve problems, retain information, or engage in logical or abstract reasoning, and executive control, relating to how well we are able to manage cognitive

activities such as planning, attention, initiating and inhibiting actions and controlling impulses. Through a series of constructed and natural experiments they have been able to show the situational impact of resource scarcity on general tasks of abstract reasoning and executive function (Mani et al., 2013; Mullainathan & Shafir, 2014; Shah et al., 2012). They argue that scarcity produces a ‘tunnelling’ effect in which people focus so intensely on solving immediate challenges (repairing the car so they can travel to work, keeping the children quiet, paying the electricity bill) that there is no ‘spare’ cognitive capacity for thinking of less immediate problems and a greater chance of forgetting other commitments such as taking medication, stopping smoking or monitoring children’s homework. There may also be little capacity for acquiring new skills even if these could be helpful in the long term. Although these effects happen across the intellectual range, they will likely be even more serious for people who are already cognitively disadvantaged such as people with learning disabilities trying to live independently. This research helps us see apparently self-defeating or harmful decisions and choices not as the outcome of personal deficits but as understandable responses to extremely difficult circumstances (and see below).

Adopting negative coping strategies: Although the cognitive impact of poverty can partly account for apparently self-defeating or harmful behaviours, many of these can also function as protective or coping strategies, as we have seen of attempts at shame avoidance. Similarly, some of the higher incidence of problematic drug and alcohol use amongst those in low socio-economic groups (Harkness et al., 2012; Harrison & Gardiner, 1999; Khan et al., 2002; Murali & Oyebode, 2004) is likely to be protective in reducing anxiety or raising mood. In her account of living and working in poverty, Linda Tirado (2014) says of her smoking: ‘It’s expensive. It’s also the best option. You see I am always, always exhausted. It’s a stimulant. When I’m too tired to walk one more step I can smoke and go for another hour. When I am enraged and beaten down and incapable of accomplishing one more thing, I can smoke and I feel a little better, just for a minute’ (p.xvii). Similar protective functions might also be served by what seems like an unhealthy diet – high-fat, high sugar diets can provide short-term pleasure, while ‘convenience’ foods are just that – or by negative parenting, where parents may be passing on their experience of adversity and teaching their children how to cope in a hostile environment (Tirado, 2014; Wilkinson & Pickett, 2010).

Physical health problems: There is a well-established relationship between low socio-economic status and poorer physical health, and also between various overall measures of physical health such as life expectancy and infant mortality, and the extent of a country’s income inequalities. (Loopstra et al., 2016; Marmot et al., 1978; Wilkinson & Marmot, 2006). There are several possible reasons for this. First, the material environments experienced by people in low socio-economic groups are often physically harmful, for example low quality or overcrowded homes, too little money for food or heating, poorly regulated workplaces and jobs requiring hard physical labour. Second, psychologically aversive circumstances have biological effects, possibly reducing resistance to infections and other health problems. This seems especially so for circumstances where people have little control over important outcomes, including in insecure or low quality employment, or where they are often worried about negative judgements by others (Bosma et al., 1997; Chandola & Zhang, 2017; Dickerson & Kemeny, 2004). As we’ve seen, all of these

apply to many people living in poverty. Third, many of the behaviours we discussed earlier, reflecting cognitive challenges of poverty or serving protective functions, are also potentially harmful to health and, in that context, difficult to change (Fell & Hewstone, 2015; Mullainathan & Shafir, 2014). Fourth, some of those groups who are more likely to be poor, for example older people or people with learning disabilities, may experience discrimination in health care (MENCAP, 2007) or those with psychiatric diagnoses may be prescribed psychotropic drugs with negative effects on their health (De Hert et al., 2012). Finally, illness can also lead to (further) poverty through loss of income coupled with extra costs of increased heating bills, home modifications, specialised equipment etc. And, even when some health care is free, it can still be difficult for people to pay travel and parking costs to health centres and hospitals, take time off work without risking their job or to afford 'extra' treatments such as physiotherapy or dental work. Macmillan Cancer Support (2013) reported that people with a cancer diagnosis are on average £570 a month worse off because of this and are 25 times more likely to ask for help on financial issues than on death and dying. The result of all this can be a downward spiral of physical and emotional problems – long-term physical health problems are associated with anxiety and very low mood (Naylor et al., 2012) – potentially deepening poverty and increasing a sense of entrapment.

Childhood adversity: We discussed this in detail in an earlier section, but some aspects are particularly relevant to poverty and low socio-economic status. Children in these groups can be disadvantaged from birth, cognitively and physically, because of poorer maternal health, obstetric problems, low birthweight and prematurity (Save the Children, 2015). Aspects of the physical environment such as overcrowding or other housing problems are associated with children's behaviour problems and accidents; these are also associated with low socio-economic status in general (Alwash & McCarthy, 1988; Blackman et al., 1989; Evans & English, 2002; Evans et al., 2001; Hunt, 1990). And, no matter how concerned parents are for their children's welfare, the 'poverty contexts' we have described can leave them without the considerable cognitive and emotional resources needed to engage in positive and attentive parenting or to protect their children from conflicts (Harris, 2014; Mullainathan & Shafir, 2014). Inevitably, this is reflected in children's performance at school. As Ben Fell and Miles Hewstone (2015) point out, there is a clear and persistent disparity between children from high and low SES home backgrounds on a wide range of measures of cognitive function including language, memory, executive function and overall academic achievement, with aspects of their performance similar to that of adults under scarcity or threat (Farah et al., 2006; Noble et al., 2005). This can be compounded by teachers' judgements: in a study of 5000 pupils Tammy Campbell (2015) found that children from low socio-economic backgrounds were, overall, perceived as less able even when their test scores were equivalent to children's from higher status backgrounds. Children living in poverty are also more likely to have problems with friendships, either having conflicts or having few or no friends (Gibb et al., 2016). All of this can set the scene for later emotional and behavioural problems involving lower school achievement, low self-worth, and restricted job prospects.

In the introduction, we described poverty as 'an event producing situation' (Newton, 1988) and we have described some of the 'events' produced by poverty and low socio-economic status. But poverty can also result – gradually or suddenly – from other highly stressful

events, themselves associated with emotional distress such as separation, divorce, illness, redundancy or bereavement. We also noted that poverty is more common in already lower status groups – women, people who are older, have a disability or are from some minority ethnic groups. Poverty, then, is associated with multiple adversities and, as has often been pointed out, although people can often manage isolated or short-term stressful situations, the accumulation of multiple, chronic difficulties ‘can rapidly diminish one’s ability to effectively deal with any of them’ (Albee, 1996, 2006; Fell & Hewstone, 2015, p.21). As we have seen, poverty also involves often extremely negative cultural constructions of ‘the poor’ and especially those who seek state support. The result is a complex material, social, psychological and discursive ‘environment’ over which those living in poverty often have little control. It is these characteristics which help explain the strong connections between poverty, low socio-economic status and such a wide range of emotional and behavioural problems.

The social context: Overview and conclusions

At the beginning of the discussion of social context, we briefly noted what might be called the ‘everything’s problem’ which has dogged attempts to divide ‘abnormal’ behaviour and experience into discrete diagnostic categories, to link specific causes to specific ‘disorders’ and to develop specific ‘treatments’. Put very generally, this involves four points:

Everything causes everything: For example, as we have seen, childhood adversity and many types of social inequalities increase the likelihood of all kinds of emotional and behavioural difficulties as well as numerous other kinds of social problems and physical ill-health. Similarly, attachment disruptions appear to be common across the range of mental health presentations. Conversely, we have shown that the risk of receiving any specific diagnosis, such as ‘depression’ or ‘schizophrenia’, appears to be raised by a whole range of social factors and adversities.

Everyone has experienced everything: Few people in psychiatric (or other welfare/criminal justice) settings have had single social disadvantages or adversities; as we have seen, adversities are correlated and facing one increases the likelihood of experiencing more.

Everyone suffers from everything: In diagnostic terms, this is known as co-morbidity. Most adults who come to mental health services struggle with anxiety, hopelessness, distrust, shame, low mood, and relationship difficulties. Many also have unusual perceptual experiences and beliefs (depending on how broadly these are defined), use safety rituals and various forms of self harm and control their eating. The same frequently applies to children. All of this is reflected in research showing large amounts of overlap in the problems of people given different diagnostic categories (see Chapter 1). Initial difficulties also often evolve and take new forms over time so that people may be given several different diagnoses.

Everything is a treatment for everything: Although we have not specifically discussed interventions, this ‘everything’ follows from the others. Claimed specificities for particular drug regimes are not borne out in practice; for example, ‘antipsychotics’ have been recommended for diagnoses of ‘schizophrenia’, ‘bipolar disorder’, ‘personality disorder’ and ‘ADHD’, as well as complaints of anxiety and depression while the indications for ‘antidepressants’ are said to include ‘borderline personality disorder’, ‘obsessive-

compulsive disorder’, ‘anorexia’, ‘panic disorder’ and fear of social situations as well as complaints of depression (Moncrieff, 2009, 2013). Similarly, psychological therapies aimed at, say, reducing anxiety and avoidance behaviours can be applied across a wide range of diagnoses (Brown & Barlow, 2009) while some research suggests that the therapeutic relationship may be as or more important than particular theoretical approaches or therapeutic techniques (Paley & Lawton, 2001; Sparks, et al., 2008).

In our discussion of context, and drawing on a range of research traditions, we have tried to show how all of this might come about while still allowing for patterns and regularities, but very different from those assumed by a diagnostic framework. We have described how different adversities are related so that, for example, neglected children may become targets for bullying; discrimination against some minority ethnic groups shows itself not just in their clustering in lower paid jobs and poorer quality housing, but also in humiliating and frightening personal experiences of racial insults and abuse. And it is why poverty is sometimes known as ‘the cause of the causes’ since it so often leads to a whole range of other problems, whose impacts, like those of any adversities, are not linear or additive but synergistic. We have discussed the well-established phenomenon of ‘re-victimisation’ whereby people who have experienced abuse or neglect are rendered psychologically vulnerable to further and possibly different abuse by perpetrators. We have also shown how different adversities can present similar challenges and threats and prompt similar (mal)adaptive and protective responses. For example, child sexual abuse, poverty and domestic violence are all associated with anxiety, low mood, shame, withdrawal and social isolation. Indeed, themes such as social avoidance, guilt, shame and self-blame appear repeatedly as reactions across a range of adversities. In addition, almost any negative context can make it more difficult for people to function well in fundamental areas of life such as education, personal and community relationships and work, so creating further problems. And economic, social and psychological adversity has significant effects on physical health, often making the original problems worse. Above all, we have tried to show the functional and strategic nature of many responses to adversity, their links to cultural and personal meanings, that they cannot be understood separately from the circumstances in which they arose and that they may change over time as circumstances or the effectiveness of responses change.

This complexity is a serious problem for diagnostic approaches but not for non-diagnostic approaches which do not see responses to threat and adversity as symptoms of mental disorder or try to place these responses into discrete categories or use frameworks developed for the study of bodies or objects. The complexity certainly does not rule out more specific patterns within this very general picture (see Chapter 6). But, as we have argued throughout, it does require a very different perspective. One way of looking at the research is in terms of what it might tell us about the general conditions in which we flourish or struggle. It supports representations of humans as fundamentally social beings who will strive to achieve and maintain certain states or circumstances (Jetten et al., 2012a; Max-Neef et al., 1989; Tay & Diener, 2011; United Nations General Assembly, 1948; World Health Organisation, 2012). We might call these ‘core needs’ and, very generally, they appear to include:

- safety and security;
- as infants and children, close attachments to caregivers;

- positive relationships within partnerships, families, friendships and communities;
- to have some control over important aspects of our lives, including our bodies and emotions;
- to meet basic physical and material needs for ourselves and our dependents;
- to experience some sense of justice or fairness about our circumstances;
- to feel valued by others and effective in our social roles;
- to engage in meaningful activity and, more generally, to have a sense of hope, meaning and purpose in our lives.

The adversities we have discussed can be seen as presenting challenges or threats to these core needs but the research also suggests that certain aspects of negative social contexts increase (or decrease) the likelihood of serious emotional damage, contributing strongly to individual variation in responses. These include:

- developmental stage;
- challenges/threats which are which multiple, long lasting, repeated or severe;
- availability of people to validate /support/confide in/provide protection;
- degree of control, predictability or ability to avoid, escape or change the situation;
- challenges/threats enacted by more than one person;
- intentional versus impersonal adversity;
- physical invasiveness of threat.

It would be very misleading to see any of this simply as ‘stressors’ or ‘life events’. We have shown that negative social contexts involve the operation of power, embedded in social structures, institutions, organisations and day-to-day interactions, all with both material and discursive or symbolic elements. We have also shown close links between the operation of power and control of meaning – control of these discursive and symbolic elements; how this constitutes experiences of adversity, shapes our identities and sense of self and influences psychological outcomes.

This applies equally to those more extreme responses to adversity which are labelled as symptoms of mental disorder so it is not surprising that these behaviours and experiences do not present in patterns similar to those of bodily problems. Instead, they can be seen as attempts to find alternative ways of meeting core needs; attempts to escape, mitigate or otherwise change our situation; to communicate our distress to others; to impose coherent meaning on our situation and ourselves in relation to it. We will also impose meaning on our responses (e.g. ‘I’m a bad person to think or act like this’) all within a wider context of power and meaning. This wider context includes the fact that those who are least powerful and have fewest resources may be more likely to respond in ways which are harmful to themselves and/or troublesome to others or to society as a whole. This may bring constructive help, but it can also create competing claims about the meaning of someone’s situation and their responses, and about what action should be taken. As we discussed in Chapter 3, psychiatric diagnosis offers one apparently authoritative set of meanings and possible actions but non-diagnostic approaches may draw more attention to the social nature of what are called mental health problems as well as of professional and public judgements about them.

Bringing together our discussion here of social context, in Chapter 2 of ‘crossing cultures’,

and in Chapter 3 of narrative and meaning, we can argue that it is the fundamentally social nature of humans and of the contexts and predicaments which 'produce' distress, as well as the social nature of its modes of expression and of judgements and evaluations of them, which also construct similarities and differences in patterns of distress within and across social groups and cultures. There are no 'mental disorders' which can be separated from all of this and diagnosed. However, we are not just social but embodied beings. So, before proposing a framework for delineating more specific patterns, we will continue the discussion of general patterns described by researchers but in relation to biology.

Chapter 5: The role of biology

Introduction

It is now more than a century since researchers began systematically searching for biological causes of distress. Having presumed that distressing or unusual experiences should be understood as diseases or illnesses, it then seemed reasonable to search for their hypothesised biological causes. Medical researchers, having identified possible clusters of subjective physical complaints, often search for more objective ‘signs’ which might precede and account for people’s ‘symptoms’. In much the same way, researchers studying biology in relation to distress have searched for biological abnormalities that might precede and therefore (they presume) account for people’s difficulties.

Given that it has followed this medical research practice, it is not surprising that the great majority of this research has adopted one or another version of the medicalised approach that was described in previous chapters; in this case, however, this involves, to a very large extent, assuming the validity of the very model being investigated. Emotional and behavioural difficulties have been conceptualised as ‘symptoms’ associated with ‘disorders’, broadly equivalent to the physical illnesses addressed by medicine, and defined by one or more psychiatric diagnoses. Consequently, researchers have typically presumed that there are, or must be underlying biological abnormalities – genetic, hormonal, neuro-anatomical or neurochemical – that are more-or-less specific to these disorders, and which are their primary causes. These presumed abnormalities are often called biomarkers.

This sustained, well-funded research effort has produced an enormous quantity of data claiming to show possible links between emotional and behavioural difficulties and biology. Most of this research comes from psychiatry, genetics, neuroscience and related biosciences. In recent years it has increasingly been facilitated by powerful new technologies such as brain imaging and genome scanning. The findings from this research get applied in contexts where the interests of different groups – mental health professionals, the pharmaceutical industry, researchers, policy-makers, service providers, carers, service users – are at stake and, sometimes, in competition with each other. Since these findings can be used to warrant drug and other treatments, they have significant real-life implications. More generally, they have been used both to support and to critique the medicalisation of mental distress and all of the structures and practices that depend upon it. This means that seemingly straight-forward questions about biology and distress are sometimes contested and controversial.

Given the profound difficulties associated with medicalisation and with the practice of psychiatric diagnosis upon which it centrally depends, it is to be expected that biological evidence for their legitimacy would be difficult to establish. It is perhaps unsurprising, then, that consistent evidence for biomarkers – for example, in the form of organic ‘diatheses’ whose presence is necessary for individuals exposed to stressors to fall prey to ‘clinical’ distress – has not been found.

This situation is recognised in the distinction that mental health services routinely make between organic and functional disorders. In a small minority of cases it is not

always possible to decide whether a person's difficulties are primarily functional or primarily organic. In other cases, one or other aspect may be overlooked. For example, it has been suggested that neurological impairments sustained from domestic abuse may be insufficiently recognised as maintaining factors in subsequent psychological and behavioural difficulties (Valera & Kucyi, 2016). Given the causal role of social determinants in all forms of physical and mental health difficulties, it is also important to be aware that poor physical health, which may also implicate cognitive functioning, is very likely to be accompanied by poor mental health and vice versa. The distinction between 'functional' and 'organic' is, then, a loose one which in practice is often not easy to make, and if applied too rigidly, may lead to neglect of relevant psychological aspects of physical or neurological conditions, and conversely, neglect of the physiological or neurological aspects of mental health presentations. We argue, however, that there is a meaningful and important difference between forms of distress and troubling behaviour that are enabled and influenced by our biology – as all human experience is – as opposed to those cases where there is evidence for a primary causal role for biological pathology or impairment in the major aspects of the difficulties. This would include diagnoses such as the dementias, Korsakoff's syndrome, Huntington's disease, syphilis, urinary tract infections in older adults, and so on. But, as we noted in Chapter 1, in relation to the great majority of psychiatric diagnoses including those experiences and behaviours labelled as schizophrenia, bipolar disorder, depression or depressive disorder, anxiety disorder, personality disorders and eating disorders, there are no consistent associations with any biological pathology or impairment, and no biomarkers have been identified.

There are nevertheless hundreds of studies claiming to have discovered relationships between these functional diagnoses and one or other aberrant biological feature. For example, and with respect to the diagnosis of 'schizophrenia' alone, in recent decades these claims have focused upon anatomical features such as enlarged ventricles, cerebral asymmetry, temporal lobe abnormalities, thickened corpus callosum, thinner corpus callosum, abnormalities of the basal ganglia and cerebellum, and reduced overall brain volume. At the same time, relationships have also been claimed between schizophrenia diagnoses and abnormalities of, or differential functioning within, neurotransmitter systems and pathways for dopamine, glutamate, serotonin, acetylcholine, gamma-butyric acid, prostaglandin and neuropeptides (Cromby et al., 2013). Nevertheless, in all of this research there is no pattern of well-designed studies with large samples and adequate controls, replicated successfully by other groups and not significantly contradicted by other findings, and which consistently demonstrates associations between any of these features and the diverse experiences associated with a 'schizophrenia' diagnosis. In any case, even if such a pattern were to emerge we would still need to remain wary of assuming that correlation means causation.

Evidence for biological causation is not only absent in relation to the diagnosis of 'schizophrenia': a similar pattern can be seen in relation to the other functional diagnoses. In relation to the diagnosis of 'major depression', for example, high-profile claims for a causal 'imbalance' of neurotransmitters such as serotonin remain unproven. Studies that show serotonin depletion amongst people given this diagnosis (as compared to controls) sit alongside others that show equivalent or even raised levels of serotonin. The overall

picture is that there is no consistent pattern relating serotonin (or any of the other monoamines) to the experiences associated with a diagnosis of ‘depression’.

The examples of ‘schizophrenia’ and ‘major depression’ show how the extensive and generously funded research effort of the last 100 years or so has generated masses of data concerning possible biological causes associated with these and other presumed disorders. They also show that there is no consistent evidence for primary biological influences, and that no biomarkers have been identified. The published data frequently finds variation between individuals with respect to one or other of the biological features studied. However, as discussed below, these variations do not map onto distressing experiences with anything like the specificity and regularity needed to justify assuming that biological influences are their primary causes.

At the same time, we do need to recognise how much has been learned about the human brain and body in recent years. A brief summary follows.

Setting the scene 1: Brain and body

A good starting point is to remind ourselves that we place the bottom-most boundary of the brain somewhere close to the base of the skull on the basis of disciplinary convention rather than biological fact. Physiologically, the nervous system is a seamless outgrowth of the brain that permeates the entire body. At the same time, ‘bodily’ influences – sensory feedback, and a continuous wash of hormones, peptides and other chemicals – continuously saturate the brain: not only is the brain embodied, the body is ‘embrained’ (Damasio, 1994).

The average adult human brain is now thought to contain about 80 billion neurons – cells with extended axons that communicate across the tiny gaps separating them by releasing neurotransmitting chemicals. These neurotransmitters influence the probability that a receiving neuron will become active or ‘fire’, so releasing its own neurotransmitters into the next synapse (the gap between the neurons). Sometimes this influence is excitatory, making firing more likely; sometimes it is inhibitory, and makes firing less likely. The probability of other neurons firing is also modulated by other chemicals, notably hormones and peptides, and in some cases also by ‘ephaptic’ influences such as ion exchanges and local electromagnetic fields. At the same time, of course, it is continuously influenced by ongoing events and stimuli external to the organism.

It is widely accepted that various aspects of specific functions are enabled by neural activity localised to particular parts of the brain’s gross structure, and that this functional organisation is shared, with slight variation, by most individuals. For example, although exceptions have been discovered, in most people language is largely specialised to left hemisphere systems (Gazzaniga, 1998), whereas affective understandings are more associated with the right hemisphere (Borod et al., 1998).

At the same time, brains show considerable variation and significant plasticity at the level of *fine* structure. Brain lesions do not always have the effect predicted on the basis of their location, and regions typically specialised for one kind of function can get recruited for others: for example, in the brains of visually impaired people, areas that usually process vision may be used for reading Braille (Roder & Neville, 2003).

Whilst the number of synaptic connections between them varies considerably, each of the human brain's 80 billion neurons is frequently connected to many thousands of others. At the gross level these connections form patterns that are broadly shared (the 'connectome'), but again these patterns display variation when examined more closely (e.g. Sporns et al., 2005). The almost uncountable numbers of synaptic connections in the brain, continuously regulated by chemical and other influences, mean that it functions as an open, self-regulating, immensely complex and massively parallel 'system of systems'. These multiple systems are distributed widely across brain regions, contain multiple feedback loops both within and between relevant areas, and are organised into neural networks: in other words, relatively stable patterns of neurons in different regions that frequently fire together.

This means that, with the exception of the very simplest functions, our actions and perceptions depend upon multiple brain areas and systems operating together, both sequentially and simultaneously. Again, firing can be either inhibitory or excitatory, and can simultaneously recruit areas that enable disparate functions. For example, remembering can recruit affective areas in the so-called limbic system at the same time as it activates declarative systems in the neocortex. Additional areas will also be activated that reflect the memory's content; hence, visual memories can recruit occipital cortical areas specialised for processing vision. So even very simple functions and tasks frequently recruit entire systems operating in concert across multiple brain regions. Given this, we should not be surprised that there is no consistent evidence for simplistic explanations for distress that implicate particular neuroanatomical features in isolation, or which attribute it to deficits or excesses within single neurotransmitter systems. Explanations of this kind simply do not match the complex, dynamic reality of the functioning human brain in its ever-changing environmental milieu.

Setting the scene 2: Some basic principles

As this very brief sketch suggests, we explicitly recognise that all human experience is reflected in some way in the activities of our brains. This is as true for the experiences labelled 'schizophrenia' as it is for any other example of human thoughts, feelings or behaviour, such as happiness, sleepiness, planning a holiday, riding a bike, or making a cup of tea. Likewise, as we describe later in this section, we explicitly recognise that all human activities and experiences are, in a very general sense, the product of both genes and environments. In the subsequent pages we will present and endorse a sophisticated biological model of how genes and environments are related, and how their ceaseless responsiveness, each to the other, continuously shapes activity and experience of all kinds.

So by highlighting the absence of biomarkers for functional psychiatric diagnoses we are *not* proposing a mind-body split, as critics are sometimes accused of doing. We are simply questioning whether the particular kinds of thought, feeling and behaviour that attract these diagnoses are best understood as illnesses or diseases with primary biological causes (in the manner, say, of diabetes or cancer). In fact, we do not understand every instance of extreme emotion or behaviour in this way. Grief, for example, is a very real embodied experience that is frequently overwhelming, disabling and highly distressing – but we don't typically think of it as an illness, rather as an intelligible response to extreme events (although *DSM-5* proposes 'persistent, complex bereavement disorder' as a 'condition')

for further study). Our question, similarly, is whether the very real, embodied, and highly distressing experiences that often lead to a psychiatric diagnosis are best understood as diseases or illnesses, as is assumed in analogies with diabetes and so on, or whether an experience such as grief is a more appropriate parallel.

When considering this question we must keep some cautionary points very firmly in mind. First, any biological differences between groups with and without diagnostic labels could be the result of many other factors that are also linked to mental distress – such as poor nutrition, or medication. Second, the relevant causal pathways may run in the opposite direction from that proposed by medicalised approaches: abuse, mistreatment and long-term emotional distress might produce enduring changes in bodily functioning and even brain structure. Third, because biology reflects and mediates all of our experiences, there may not always be straightforward causal pathways between social and psychological influences and biological features. Consequently, social, psychological and biological explanations are sometimes best understood as different levels of description of the same phenomena. Fourth, interpretations of the evidence are frequently hindered by methodological issues such as the use of flawed or inappropriate measures, relatively small sample sizes, failures to adequately control for confounding variables such as the effects of medication, the use of inappropriate control groups to draw comparisons, and – almost universally – reliance upon psychiatric diagnostic categories known to be of questionable validity and reliability. Fifth, a lot of the relevant evidence is in any case correlational. Clearly, this raises the spectre of confusing correlation with causation. However, it also highlights the absence of developed theories of what these correlations might actually mean: for example, precisely how alterations in general processes of calcium channel signalling between cells could be responsible for the specific patterns of activity and experience that might attract psychiatric diagnoses (Cross Disorder Group of the Psychiatric Genetics Consortium, 2013). Sixth, there are striking differences between thoughts and feelings, on the one hand, and on the other hand any neural pathways or brain areas putatively associated with them. There is a considerable literature attesting to the significant conceptual difficulties raised by attempts to move between these two domains, and noting the absence of appropriate general frameworks to guide such attempts. And seventh, and as described in Chapter 2, models that see biology, emotion, cognition and the environment as separate and independent variables are unlikely to furnish adequate explanations. In summary, we need to be aware not just of the logical and methodological pitfalls in making claims about biological causation of mental distress. We also need much more sophisticated ways of conceptualising mind/brain/body/environment interactions.

In this regard, a particular concern is the way that neuroscience frequently attributes psychological capacities to brains and neural systems. This is a conceptual error because activities such as believing, interpreting and deciding can only sensibly be attributed to persons, not brains. It makes no logical sense to confer these activities upon brain circuits or networks because – whatever their activity levels – neural systems cannot themselves choose, believe or decide. These human activities only make sense when conducted by living persons embedded in social relations and material settings, persons with access to appropriate cultural resources and situated with respect to relevant norms, conventions and expectations:

It is not that as a matter of fact brains do not think, hypothesise and decide, see and hear, ask and answer questions; rather, it makes no sense to ascribe such predicates or their negations to the brain. The brain neither sees, nor is it blind – just as sticks and stones are not awake, but they are not asleep either. The brain does not hear, but it is not deaf, any more than trees are deaf. The brain makes no decisions, but nor is it indecisive. Only what can decide can be indecisive. So, too, the brain cannot be conscious; only the living creature whose brain it is can be conscious – or unconscious. The brain is not a logically appropriate subject for psychological predicates. (Bennett & Hacker, 2003, p.72, emphases in original)

Effectively, say Max Bennett and Peter Hacker, many neuroscientists are simply equating the person with the brain, as though the two were wholly identical. They describe this as a mutant form of Cartesian (mind-body) dualism that will inevitably generate errors, simply because the qualities and attributes of brains and persons are so strikingly different. If we ignore these vital differences we will make erroneous, reductionist interpretations of brain imaging that ignore or conceal how:

....no amount of neural knowledge would suffice to discriminate between writing one's name, copying one's name, practising one's signature, forging a name, writing an autograph, signing a cheque, witnessing a will, signing a death warrant, and so on ... the differences between these are circumstance-dependent, functions not only of the individual's intentions but also of the social and legal conventions that must obtain to make the having of such intentions and the performance of such actions possible. (Bennett & Hacker, 2003, p.360)

Bearing all these principles in mind, we first briefly survey current biological research associated with the medicalisation of distress and disturbing conduct. We then describe a way of conceptualising biology that is compatible with the conceptual principles set out in Chapter 2, and consider in some detail the potentials of emerging 'trauma-informed' approaches.

Current research

Contemporary biological research into distress is in something of a state of flux. On the one hand, the legacy of psychiatry's 'biological turn' of the 1980s remains influential, and the widespread tendency to presume that psychological distress has primary organic causes still predominates. Many studies posit biological deficits that, their authors suggest, might be causally associated with one or other functional diagnosis. On the other hand, there is now greater acknowledgement both of the considerable evidence for environmental influence, and of the methodological and conceptual complexity that its inclusion demands.

On balance, however, we are still a very long way from a full recognition of the implications of this evidence as applied to the role of biology in emotional and behavioural problems. Although new research strategies are emerging, most research still presumes the primacy of biology, and most work conceptualises its influence in terms of disease, illness and pathology.

Mirroring this context, we first briefly describe current research that more-or-less presumes notions of biological disease or illness as the primary causes of distress. We then briefly

review some emergent research strategies that are, at least potentially, less closely aligned with these presumptions.

Neurotransmitters

Most hypotheses about neurotransmitter function followed, rather than preceded, the use of medication targeting these systems (hence, the dopamine hypothesis of schizophrenia was only formulated after the discovery that the major tranquilisers given to people with this diagnosis damped down dopamine activity).

In the recent past, biological explanations for distress based upon notions of neurotransmitter imbalance were posited. However, evidence suggests that levels of neurotransmitters and hormones do not get stuck in states of ‘imbalance’, rather that they respond continuously to activities, relationships and life events (e.g. Coates & Herbert, 2008). Currently, not only is it widely acknowledged that these ‘imbalance’ hypotheses are unproven, some even argue that the belief that psychiatry ever endorsed them is merely an ill-founded slur promoted by critics (e.g. Hickey, 2015; Pies, 2015). This argument is challenged, firstly, by the presence of these hypotheses in textbooks: one well-regarded psychiatry textbook claims that ‘schizophrenia results from increased levels of dopamine in the brain’ (Burton, 2006, p.44) and that ‘depression results from the depletion of the monoamine neurotransmitters’ (Burton, 2006, p.64). The argument is also challenged by evidence that public awareness of and belief in ‘imbalance’ hypotheses is widespread (Park & Ahn, 2013), a finding these authors attribute largely to pharmaceutical industry marketing. Psychiatric service users continue to be told, and therefore to believe, an account of their difficulties that has never been supported by the evidence.

Lack of support for the idea of biological causation due to neurotransmitter system abnormalities or imbalances is discussed by Joanna Moncrieff (2008), who details how studies of serotonin function in relation to diagnoses of ‘depression’ have shown no differences from ‘normal’ groups, as well as showing both hypo- and hyper-function. Likewise, the dopamine hypothesis of ‘schizophrenia’ lacks consistent evidence, and seems unlikely to account for the great variety of experiences associated with this diagnosis. It cannot explain why the effects of medication only become apparent some days after it is administered, nor why, in up to 30 per cent of those given the diagnosis, it does little or nothing to ameliorate distress (Bentall, 2003; Burton, 2006).

Neurotransmitters do nevertheless play a key role in regulating brain activity and in communicating and co-ordinating across different brain regions and systems, and efforts to establish links between neurotransmitter systems and psychological distress continue. Recent studies include an investigation of thalamic glutamate levels (in conjunction with particular brain activation patterns) amongst people considered at risk for psychosis (Allen et al., 2015); an assessment of levels of GABA and monoamines amongst people given diagnoses of major depressive and bipolar disorder (Mann et al., 2014); and a revised version of the dopamine hypothesis of schizophrenia that emphasises increased dopamine synthesis (Howes & Murray, 2013).

As with previous research of this kind, however, consistent differences between people with psychiatric diagnoses and controls have not been established. For example, Howes and Murray (2013) acknowledge that ‘abnormal’ patterns of dopamine synthesis found amongst some people with a ‘schizophrenia’ diagnosis are only related to ‘symptoms’

amongst that group, and not to the same experiences when they are manifest amongst the general population; that findings on dopamine ‘abnormalities’ in patients’ relatives are inconsistent; and that some people given other diagnoses or described as having ‘subclinical psychotic symptoms’ may also show dopamine function different from that of ‘normal’ control groups. Additionally, the cautionary points summarised in the introduction to this section (for example, about confusing causation with correlation) would apply even if regularities and associations were to be identified. Not only that, but this research is almost always based on group differences where there is in fact a great deal of overlap in dopamine or other neurotransmitter functioning amongst those with and without diagnoses, even if there is a significant group difference. This is not a problem if we are trying to understand one possible aspect of the complex mechanisms which may be involved in, say, hearing voices; it is a problem if we claim that ‘people with schizophrenia have raised dopamine levels’.

Genetic research

Genetic research in distress and disturbing behaviour has long been prominent, and the behavioural genetic research with which it began has a controversial history. Although strong claims about genetic influence were frequently made, both the methodology of these studies (using twin, family and adoption designs) and the ways in which they were analysed (using probandwise concordance or heritability estimates) artificially inflated the extent of apparent genetic influence (Joseph, 2003, 2014). These methods have now largely been supplanted by molecular genetic research, primarily genome-wide association studies (GWAS). But when using these new methods, false positives are easy to produce, so replication is vital before findings can be considered meaningful (Joseph, 2006). In any case, although varying degrees of genetic influence have been posited using molecular genetic methods, no major genes of significant effect have been identified for any functional diagnosis (Bentall, 2009).

The failure to find major genes has given rise to a new strategy of searching for multiple genes. For example, Elliott Rees and colleagues (2014) report a study comparing the prevalence of 15 genetic variations between nearly 7000 people given a diagnosis of ‘schizophrenia’ and a similar number of controls. Six of these variants were associated with the diagnosis at the 0.05 level, although by combining their data with that from other published studies the authors potentially raise this number to 11. Similarly, the Schizophrenia Working Group of the Psychiatric Genomics Consortium (2014) identified 108 different genetic loci possibly associated with this diagnosis, although the authors acknowledge that these associations may not be specific to the diagnosis of ‘schizophrenia’.

The validity of this strategy of searching for ‘polygenic’ causes of psychiatric disorders is questioned even within Psychiatry, with Tim Crow (2008) describing it as ‘magical thinking’. In any case, notwithstanding the strikingly large sample sizes, the degree of genetic influence suggested by these studies is relatively slight. As Jonathan Leo (2016) has pointed out, for each of the 108 loci in the study mentioned above, there is a very small difference between the percent found in those diagnosed with ‘schizophrenia’ and the control sample. Similarly, in the Rees et al. (2014) study, the estimated prevalence of relevant variants amongst people given a ‘schizophrenia’ diagnosis was only 2.5 per cent, as compared to 0.9 per cent in controls. In other words, this genetic research actually suggests that ‘schizophrenia’ is at least 97.5 per cent environmental. It also suggests that existing

diagnostic categories are not valid, since the claimed genetic contributions cut across diagnostic groups, as was found in the Cross Disorder Group of the Psychiatric Genetics Consortium (2013) study of 30,000 people diagnosed with autism, ‘ADHD’, ‘depression’, ‘bipolar disorder’ or ‘schizophrenia’.

Other studies have also shown very substantial overlaps in gene patterns between psychiatric groups and controls (CNV and Schizophrenia Working Group of the Psychiatric Genomics Consortium, 2017) and have failed to detect any genetic links to diagnoses such as major depressive disorder (Demirkan et al., 2016). Nor have they supported particular hypotheses such as links between certain genes and life events in causing ‘depression’ (Risch et al., 2009), between polygenic risk for ‘schizophrenia’ and brain volume (van der Auwera et al., 2015; Franke et al., 2016); or the role of genes linked to the dopaminergic system in diagnoses of ‘schizophrenia’ (Edwards et al., 2016) or sex differences in genetic disposition to ‘depression’ (Hyde et al., 2016). Overall, then, this research provides very little support for the idea that genes are involved in any major way in causing psychiatric problems (Chaufan & Joseph, 2013). However, this does not prevent findings from being misrepresented in ways that continue to imply strong genetic effects – for example, by describing the proportion of the variance attributed to environmental influences as ‘missing heritability’. Indeed, this tendency to misrepresent the findings of genetic research has a long history, since many of the foundational assumptions regarding heritability are themselves based upon misrepresentations of data from previous twin and adoption studies (Joseph, 2014, 2016.)

Again, none of this is to deny the general relevance of genetics: every human experience and behaviour will have some more-or-less distant genetic contribution. For example, it is quite possible that footballers are more likely to carry genes for faster, more agile or more powerful legs. But we would not take this to mean that playing football is best understood as a disease with a genetic predisposition; nor would we conclude that these genes somehow ‘caused’ the person to sign with a team and then run up and down a field chasing a ball. In relation to distress, however, the prior presumption that these experiences simply must be expressions of disease or illness makes this kind of flawed reasoning appear superficially plausible.

The false impression that distress is strongly genetic is also encouraged by media headlines in which even the most respectable sources frequently proclaim research ‘breakthroughs’ or ‘game changers’ that serve to bolster presumptions of illness or disease. For example, in 2013 the blog of Harvard Medical School posted the claim that ‘Shared genes link depression, schizophrenia, and three other mental illnesses’ (LeWine, 2013), while the same study was reported on ‘The Scientist’ website as ‘Key mental illness genes found’ (Grant, 2013). However, despite these dramatic claims the authors of the study in question acknowledge that the effects they found are small, may not be specific to the diagnoses they studied, and that the identification of possible increased risk in relation to the four gene loci they identified could not be used for either diagnosis or treatment (Cross Disorder Group of the Psychiatric Genetics Consortium, 2013). Thus, while each ‘breakthrough’ tends to be greeted with announcements to the effect that ‘The findings represent the first time that the origin of this devastating psychiatric disease has been causally linked to specific gene variants’ (Broad Institute of MIT and Harvard, 2016), retractions of the previous findings are almost never given the same attention. However,

each excited claim adds to the impression that the evidence we need is just around the corner, if not already in our possession – while also, of course, reinforcing the message that these are medical diseases. As Joseph (2016) documents, overstatements of this kind in relation to genetic evidence can be traced back many decades.

Neuroanatomy

Historically, this research was concerned primarily with relatively gross features such as enlarged ventricles or reduced overall brain size. Whilst these studies did sometimes show associations between these neuroanatomical features and a range of diagnoses, consistent differences were not found. For example, enlarged ventricles (especially the third ventricle) were sometimes associated with ‘schizophrenia’ (and with other diagnoses including ‘major depression’ and alcohol dependency). Population norms for ventricular size are not usually central to these studies, which typically compare relatively small groups of patients with controls. A confounding factor is that ventricular size fluctuates according to various influences including pregnancy, dehydration and medication status (Bentall, 2003) and that it changes with age. Also, the specific biological and cognitive processes whereby enlarged ventricles might produce the experiences associated with the diagnosis of ‘schizophrenia’ (or ‘clinical depression’, or alcohol dependency) have never been established.

Current neuroanatomical research frequently considers more subtle variations in the brains of people experiencing distress, including: claims that a combination of grey-matter alterations in prefrontal, perisylvian and subcortical areas could be a biomarker for incipient psychosis (Koutsouleris et al., 2015); possible micro-structural abnormalities in various areas of the brains of some young people given a diagnosis of obsessive-compulsive disorder (Lázaro et al., 2014); and links between subtle structural deficits in the prefrontal-thalamic-cerebellar circuit to functional connectivity anomalies in the brains of some people given a schizophrenia diagnosis (Guo et al., 2015). Notwithstanding their enhanced technological capacities, sample sizes in these studies are all relatively small, and none has identified deficits common to all people given a specific diagnosis. And, as we have previously emphasised, the discovery of consistent deficits would not confirm a medical disorder or illness model: questions about what caused these deficits, and what precise mechanisms linked them to experiences of distress, would still need to be answered.

Regional brain activation

Functional magnetic resonance imaging (fMRI) generates graphic computer models of regional differences in the activity of living brains. Whilst these striking images have done much to capture the public imagination, considerable caution is needed when interpreting them. We should expect to see differences between the brains of people who are experiencing very different emotional states, whether diagnosed as ‘mentally ill’ or not – but by itself brain imaging tells us nothing about the causes of these differences. Just because a certain neural system or brain region is associated with a particular phenomenon, this need not mean that the association is causal: both the activation *and* the phenomenon could be caused by something else.

It is also vital to be clear that brain scans are *not* photographs of the activity of living brains. They are computer-generated models of what an average brain might have been doing, under tight experimental conditions, and provided that certain assumptions are satisfied. The sample sizes in many of these studies are too small (Button et al., 2013),

control groups are not always appropriate, and the relatively limited spatial and temporal resolution of these technologies actually leaves considerable detail still unresolved (Rose & Abi-Rachid, 2013). At the same time, the ‘subtraction’ method used in many studies can produce both methodological artefacts and omissions (Cacioppo et al., 2003).

Whilst these methodological concerns are widely recognised and discussed by neuroscientists themselves, relatively less attention is paid to the crucial conceptual issues that functional brain imaging raises (discussed at the start of this chapter). Notwithstanding these profound difficulties, some recent research is investigating neural systems such as the default mode network (the set of interconnected brain regions that is consistently active during both experimental and control conditions) in relation to distress. Studies have been published that claim to show patterns of aberrant connectivity between the default mode, task-positive and salience networks in some patients given schizophrenia diagnoses (Wotruba et al., 2014); unusual resting state connectivity patterns in some patients given diagnoses of either ‘schizophrenia’ or ‘bipolar disorder’ (Argyelan et al., 2014); reduced connectivity in parts of the default mode network in some patients given a first diagnosis of ‘schizophrenia’ (Bastos-Leite et al., 2015); excessive activity in subsystems of the default mode network in some patients given a diagnosis of ‘major depressive disorder’ (Nixon et al., 2014); and differences in the activity of various default mode network subsystems in some people given a diagnosis of ‘obsessive-compulsive disorder’ (Beucke et al., 2014).

The default mode network is sometimes thought of, somewhat simplistically, as the neural basis of selfhood (Callard & Margulies, 2011); this helps explain the considerable interest in possible disruption to its functioning. Critical consideration of the composition of experimental and control groups, and of the bases upon which claims of ‘excessive’ or ‘aberrant’ activity are made, is nevertheless needed. In any case, none of these studies have consistently identified significant differences between people with and without psychiatric diagnoses. Moreover, doing so would not necessarily take us further than the rather obvious point that the kinds of extreme experiences which bring people to the attention of psychiatric services are inevitably reflected in our biological functioning. Further research would still be needed to establish how those differences arose, and to explain precisely how they related to distress and disturbing behaviour. Additionally, as we have already emphasised, there is necessarily an enormous conceptual gap between potential descriptions at a biological level, and a full understanding of the multi-layered, meaning-shaped human experiences that attract diagnoses such as ‘depression’ or ‘psychosis.’

Social neuroscience

It has recently been proposed that studies in social neuroscience might shed new light upon the biology of psychological distress. Social neuroscience studies the brain systems and structures that enable social behaviour, and has been described as a way of ‘bringing an end to the destructive and misguided “social” versus “biological” in psychiatry’ (Craddock, 2014, p.140). Craddock was commenting on a paper co-authored by one of the founders of social neuroscience (Cacioppo et al., 2014), which tried to clarify how this might be achieved by focusing on breakdowns of specific component processes that are implicated in social behaviour. Cacioppo et al. illustrate their suggestion with reference to diagnoses of ‘major depression’, ‘antisocial personality’ and ‘female hypoactive sexual desire disorder.’

However, although this research is explicitly aligned with *social* neuroscience, it still presumes biological causation. Arguing that distress might be understood by investigating the brain processes that enable social behaviour, Cacioppo et al. (2014, p.131) say: 'Deficits in any one of these component processes can result in personal difficulties and interpersonal problems that are prominent features in a variety of mental disorders'. In other words, they first propose that impairments of social behaviour are important features of the experiences and behaviour associated with psychiatric diagnoses and then hypothesise that these behavioural 'impairments' might be caused by neural deficits in systems specialised for interacting and relating. In short, Cacioppo et al. are suggesting that these (hypothetical) neural 'deficits' are the primary causes of the experiences and behaviours said to be symptoms of 'mental disorders'. Panksepp (2014) observes that this suggestion largely de-emphasises the prominent affective aspects of psychological distress, and that reintegrating these aspects with those proposed from within social neuroscience is likely to be difficult. Also, to the extent that its studies rely upon imaging research, social neuroscience is confounded by the conceptual difficulties identified by Bennett and Hacker (2003). Additionally, Cacioppo et al. simply do not consider the origins or causes of these putative neural deficits. While some may have a marked genetic component (although they cite no compelling evidence for this), others are more likely to be the outcome of adverse childhood experiences. Ironically, in failing to consider this possibility, the suggestions from social neuroscience are therefore insufficiently social.

Animal research

A considerable amount of research into biological causes of distress is still conducted using animals. Even where this is not the case, however, biological research is frequently at least partially dependent for its interpretation on animal studies (Marcotte et al., 2001). Many researchers hold that the greater degrees of experimental control possible in work with animals mean that it is the only way whereby competing interpretations of the contribution of different brain structures and systems – which would be difficult or impossible to resolve in work with humans – can be tested empirically.

However, this also means that, sometimes, the implications of animal research get overstated. For example, Tremolizzo et al. (2002) produced a 'mouse model of schizophrenia' based upon impairment of the 'reelin' gene. Whilst the authors clearly state that their results do not identify disease processes and are merely a partial pharmacological model, others have gone beyond this interpretation and cited their paper as though it contributes to evidence for a pathogenic process (e.g. Maric & Svrakic, 2012; Toyokawa et al., 2012; Tsankova et al., 2007).

The limitations of animal models in understanding human emotional distress are obvious. As discussed later on, we all share certain evolved bodily capacities such as fear reactions, aspects of which are also seen in higher mammals. However, animals do not experience unemployment, divorce, war, anomie, role conflict, role strain and other uniquely human stressors. They also lack the elaborate, constantly changing systems of culture and meaning which, as we have shown, are integral to experiences of distress. When findings are validated with reference to animal models this effectively means that the intrinsic significance of meaning, culture and complex human social relations in experiences of distress has been diluted or bracketed off.

Summary

Investigations which presume that mental distress and many forms of ‘deviance’ are the result of biological diseases or illnesses have, over the last 50 years of recognisably modern research, produced no solid findings at all. Studies of neurotransmitters, neuroanatomy, regional brain activation and genetics have all failed to identify biomarkers for functional psychiatric ‘disorders.’

This has been forcefully pointed out by critics, and also acknowledged (although not in information typically disseminated to the general public) by supporters of the traditional paradigm. In their ground-clearing discussion preparing for *DSM-5*, Charney et al. (2002, p.55) observe that ‘the field of psychiatry has thus far failed to identify a single neurobiological phenotypic marker or gene that is useful in making a diagnosis of a major psychiatric disorder’. Subsequently, a review in ‘Nature’ noted that: ‘Our understanding of the biological mechanisms of diseases such as mood disorders, schizophrenia and autism is frustratingly limited... There is also a lack of reliable biological markers for characterising these diseases’ (Chou & Chouard, 2008, p.889). More recently, a review of the ‘neurobiology of schizophrenia’ concluded that ‘(e)fforts to understand the neurobiological bases of the clinical heterogeneity that schizophrenia comprises, mainly by correlating neurobiological measures with specific symptoms, have been largely unsuccessful. Indeed, it is fair to say that “inconsistency” has been the most consistent finding to emerge from such efforts’ (Mathalon & Ford, 2012). And David Kupfer, who chaired the committee that produced *DSM-5* in 2013, said at the time of the manual’s publication: ‘In the future, we hope to be able to identify disorders using biological and genetic markers... Yet this promise, which we have anticipated since the 1970s, remains disappointingly distant. We’ve been telling patients for several decades that we are waiting for biomarkers. We’re still waiting’ (Kupfer, 2013).

Perhaps the most salient aspect of this situation, from the point of view of this document, is that both critics and traditional researchers now agree that the current diagnostic groupings are not validated by biomarkers, do not represent valid categories, and must be replaced. From that point, there is a divide. Critics (both professional and service user/survivor) argue that we need a fundamentally different way of conceptualising mental distress. Traditionalists have not given up the search for biomarkers, and generally maintain that in the meantime we should hold onto the current system as the best we have. The argument is sometimes made that a classification system is like a map, provisional but still useful. Of course, this analogy only holds if there is reason to believe that the map does indeed provide a reasonably reliable guide to the territory, and that no better ones are available; otherwise, it will be actively misleading. Meanwhile, Mary Boyle (2007) has observed that psychiatric classification and diagnosis, far from providing a useful map, has distorted research in at least three ways: it prioritises the outcomes of committee discussions over observed behavioural patterns; it emphasises form at the expense of content (e.g. the presence of hallucinatory voices rather than the meaning of what they say); and it directs resources ‘within’ individuals and away from the circumstances with which they are coping. The lack of reliability and validity of these categories also makes it very difficult to interpret biological research that is based on them.

These problems of reliability and validity underpin the highly significant move by the world’s largest funding body for mental health research, the US National Institute of

Mental Health (NIMH), away from studies based on psychiatric diagnosis. The institute is also supporting the development of a completely new and different taxonomy (the Research Domains Criteria or RDoC project. However, as we pointed out in the Introduction, this does not amount to a fundamental change in thinking because the project is explicitly based on the assumption that ‘Mental disorders are biological disorders’ (Insel, 2013). Thomas Insel, the then director of NIMH, reinforced this continuity in thinking 2015: ‘RDoC is about improving diagnosis, not negating it, and biology is fundamental to the approach.’ Similarly, the opening statement on the Psychiatric Genomics Consortium’s webpage declares that: ‘The purpose of the... PGC... is to conduct... analyses of genome-wide genetic data for psychiatric disorders’ (What is the PGC?, 2016).

The investment in RDoC confirms the profound problems associated with psychiatric diagnosis. It is claimed that RDoC will bring much-needed strengths to this confusing field, including an emphasis on the continuity between everyday and disturbed functioning, and a commitment to being open to new explanatory dimensions. Unfortunately, as with DSM and ICD, there is limited recognition that notions of normal and abnormal functioning are always necessarily context-dependent. There is also insufficient acknowledgement of the difficulties of moving between biology and phenomenology when making such judgements. These presumed abnormalities are currently described in relation to loosely-defined brain systems such as ‘fear’ and ‘loss’, and the hope is that these will eventually be identified with particular brain circuits. However, the RDoC largely ignores both the differences of dynamics and scale between different kinds of circuits, and their necessary functional embedding within the immensely more complex network of circuits that constitutes the brain as a whole (Kirmayer & Crafa, 2014). It also glosses over the necessity of making value judgements in order to decide ‘When is fear a mental disorder? Does fear of bears and snakes indicate need for treatment? What about fear of illness? Or the fear a soldier experiences when going to war? And what about loss? Should I seek psychiatric treatment if I lose my mortgage? My wife? My job?’ (Kamens, 2013). In addition, the RDoC’s emphasis on animal models obscures the interplay between biology and culture, and negates the significances (and possible consequences) of human phenomenological experiences, social relations and personal meanings.

The RDoC project illustrates what has been described as an emerging paradox within neuroscientific research in distress; studies are often based on diagnostic categories that are recognised by many neuroscientists as lacking reliability and validity (Cohn, 2010). This paradox is reflected at other levels as well. NICE guidelines, in their full versions, typically make reference to the limitations of diagnostic categories, but then proceed as if this was unproblematic in terms of practice recommendations (Midlands Psychology Group, 2010). As we have seen, service users are rarely informed about the provisional status of the diagnoses they are assigned, even though leading professionals and researchers are increasingly open about the failure of current classification systems. Moreover, most of these professionals have not accepted that years of disconfirmation of diagnostic approaches constitute a fundamental challenge to medicalisation itself. Nor have they taken the many opportunities provided by ongoing relevant research in the biosciences, psychology, social science and the humanities to begin forging sophisticated, genuinely interdisciplinary and evidence-based alternatives. Instead, most still maintain or assume

that biologically-grounded illness or deficit categorisations are required, and that we simply need a better system based on the same principles. The various tensions associated with this situation provide the immediate backdrop to a discussion of the emerging strategies, as outlined below.

Emergent research strategies

Current biological research includes relatively new strategies within which hypothesised biological influences are now studied as only one amongst a range of factors. It has been claimed, for example that, ‘Nearly every neuropsychiatric illness involves social behavioural disturbances’ (Mendez & Manes, 2011, p.1). Researchers have also had to take on board the growing evidence for the causal influence of social factors and childhood adversities in mental distress. As a result, it is not uncommon now to find papers containing statements such as ‘Evidence for the effects of social factors on schizophrenia has become well-established’ (Howes & Murray, 2014, p.1679); that childhood maltreatment ‘is increasingly understood to be an environmental exposure that acts much like a toxin’ (Tyrka et al., 2013, p.1); or that ‘early social experiences can affect the development, structure and functioning of the brain’ (Maj, 2014, p.105).

As we saw in the discussion of childhood adversity, it is certainly true that negative early experiences (and physical characteristics associated with social deprivation such as low birthweight, Class et al., 2014) significantly increase the likelihood of being given various diagnoses as adults, including ADHD, schizophrenia and bipolar disorder. At the same time, as the quotes above show, this research is still often presented in medicalised and diagnostic terms. As a result, there are still widespread tendencies within this work for environmental, social and relational influences to either be subordinated to, or translated back into, biological influences. This is happening at the very same time that these environmental and experiential influences are nominally gaining more recognition. Both of these tendencies – to recognise social and relational influence, and to integrate them back into a medical disorder or illness model – are apparent within the emergent research strategies described below.

Epigenetics

The failure to find genes of significant effect related to the functional psychiatric diagnoses has been one driver of the rapid growth during the last 15 years of epigenetic research. Research into epigenetics and mental ill health has increased exponentially in recent years (Cromby et al., 2016) and significant amounts of research funding and infrastructure have already been committed. Despite this, there is no single agreed definition of what epigenetics is, nor even a solid consensus that it actually constitutes a new field of research (Pickersgill, 2016).

This is partly because epigenetics has changed its meaning in recent years. Previously, the term was used to refer to the ways that acquired characteristics could be transmitted across generations without changes to core (nucleic) DNA. It was also used to describe the ways that developmental pathways differentiate within organisms, enabling identical genetic codes to produce very different kinds of cells within different parts of the body. Increasingly, though, research described as epigenetic is less concerned with these intergenerational or developmental processes, and more with exploring the

environmentally-driven processes that continuously regulate gene expression (Meloni & Testa, 2014).

The epigenetic process that has perhaps attracted most attention so far is methylation. This is where environmental influences cause methyl groups to get attached to the ends of the chemical sequences that constitute genes. The addition of these molecules has the effect of ‘silencing’ the genes – of muting or blocking their effect when the DNA replicates. Other environmentally-regulated epigenetic processes include acetylation (which amplifies the effects of a gene sequence), and histone modification – changes to the ways in which DNA is stored and coiled, which may make some genes more or less available to be transcribed. By means of epigenetic processes such as these, it is being suggested, environmental influences can become part of the physical make-up of organisms. In simple terms, it has been shown that the action of genes can be changed by the environment. In addition, it may be possible for these changes in the way genes are expressed to be passed on to subsequent generations.

Although most current epigenetic research is associated with cancer, there is now a growing body of research into mental health. Like other biologically-oriented research, this work largely depends upon diagnostic categories. The diagnosis of ‘schizophrenia’ has been by far the most studied to date, followed at some considerable distance by ‘major depression’ (Cromby et al., 2016). Interest has been heightened by high-profile studies such as the research by McGowan et al. (2009) which found evidence of increased methylation in the brains of ‘suicide completers’ who were known to have been abused as children. On the basis of findings such as this, epigenetics is seen by many researchers as having considerable potential to integrate social, environmental and biological influences, and to generate comprehensive accounts of distress that include all of these influences coherently and on equal terms.

To date, however, these potentials have not been realised. In part, this is because in many epigenetic studies there is a ‘condensation of the environment’ (Chung et al., 2016, p.172) which is now taken to refer to everything outside of the individual cell boundary (or in some cases the cell nucleus). As we have seen, epigenetics explores how biochemical processes such as methylation are regulated by environmental influences. However, these influences themselves may then receive relatively little attention, and are effectively reduced solely to their molecular or biological consequences. Instead of studying actual childhood adversities, for example, an epigenetics researcher might measure levels of methylation of a specific gene. They might then treat the methylation as a proxy measure for adversity, on the presumption that adversity matters only to the extent that it produces quantifiable molecular effects. When this happens, however, important aspects of personal meaning and social relations will be omitted or obscured. For example, as we noted in our discussion of social context, van Nierop et al. (2014) found evidence that childhood trauma is associated more closely with ‘psychosis’ when there is a deliberate intention to harm, while Boydell et al. (2001) showed that Black people in London are more likely to be given ‘schizophrenia’ diagnoses if they live in majority White areas. Relational and socio-demographic influences such as these cannot easily be reconciled with a research strategy that simply converts adverse influence into its (presumed) individual molecular correlates.

Another concern is that epigenetic research often builds on previous lines of biological investigation, despite the lack of evidence to support them. For example, epigenetic studies

of 'schizophrenia' have looked for defects within neurotransmitter systems including those for dopamine (Melas et al., 2012), GABA (Kundakovic et al., 2007) and serotonin (in association with increased methylation of the serotonin receptor 5HTR1A gene: Carrard et al., 2011). In this way, interest in earlier unproven hypotheses is being revived.

Re-situating diagnosis

Another emergent strategy is to retain the diagnostic categories but treat them differently, for example, by grouping them in various ways. This is not an entirely new development: the diagnosis of 'schizophrenia', for example, has long been described as being part of a broader syndrome. What has changed more recently is that different combinations of diagnoses are now appearing as clusters within various studies. Hence, 'schizophrenia' is still sometimes subsumed with other diagnoses under the category of psychosis (e.g. Fillman et al., 2014). However, this diagnosis is now also being considered in other combinations – for example, with 'bipolar disorder', 'major depression', 'autism' and 'ADHD' (Cross Disorder Group of the Psychiatric Genetics Consortium, 2013). Faraone (2013, p.82) argues that such approaches 'challenge the validity of the distinct Kraepelian categories instantiated by the *DSM/ICD*', although, of course, they may also lead to degrees of conceptual incoherence, and can be used to support adventitious 'data trawling'.

In addition, there are research strategies that effectively displace diagnosis from its central position. For example, some biological researchers have returned to traditions of research going back many decades in order to study what they now describe as endophenotypes. These are defined as 'biobehavioral characteristics that are more proximal to actions of genes than clinical syndromes' (Reilly et al., 2014, p.1011). Impaired prepulse inhibition of startle (PPI) – difficulty in inhibiting startle responses even when stimuli are signalled in advance – has been proposed as an endophenotype. This response was first studied in animals (indeed, its applicability to humans is sometimes questioned – Csomor et al., 2005) and – based upon laboratory studies of sensorimotor responses and their habituation – is often said to be associated with 'schizophrenia' (e.g. Cadenhead et al., 2000). However, impaired PPI is not ubiquitous amongst people given this diagnosis (i.e. it is not a biomarker), and has also been studied in relation to diagnoses of 'anxiety disorder' (Pynoos et al., 1999), 'obsessive-compulsive disorder' (Hoenig et al., 2005), 'schizotypal personality disorder' (Cadenhead et al., 1993) and 'post-traumatic stress disorder' (Grillon et al., 1996). It would not be surprising to find that some individuals, and perhaps especially ones who have been psychiatrically diagnosed, have PPIs different from 'normal' control groups. However, as with the other suggested biological variations we have discussed, this would beg numerous questions about correlation and causation, about the possible origins, causes or meanings of these heightened startle responses in people's lives, about the assumption of pathology as opposed to natural or adaptive variation, and so on.

Taken as a whole, then, research into endophenotypes is inconclusive and has not generated consistent findings. Its main relevance in the present context is that it challenges diagnostic categories, and demonstrates the depth and the extent of the problems associated with them.

Overall, rather than being guided by empirically supported theories of the nature of 'mental disorders', research seeking biological bases of diagnostic categories has been directed mainly by unrelated advances in biology and genetics such as the discovery

of neurotransmitters and drug mechanisms, descriptions of the human genome, and technical advances such as brain imaging and large-scale analyses of genetic linkage. These advances have then been recruited to the field of ‘mental disorders’ as offering the potential for breakthroughs in understanding. Even with little evidence of progress, the process continues with recent claims about the importance of microbiomics and ‘neural circuits’. For example, one study found differences in the microbial constitution of throat bacteria between 16 people with a schizophrenia diagnosis and 16 without. In spite of potential confounds including tobacco smoking, medication status and demographic variables, the authors speculated that ‘The establishment of a link between the microbiome and behavioral and cognitive functioning in humans might lead to the development of new strategies for the prevention, management, and treatment of psychiatric disorders’ (Castro-Nellar et al., 2015, p.13; see also Foster & McVey Neufeld, 2013, and Severance et al., 2016). Similarly, in relation to the RDoC project described earlier, Thomas Insel (2011) recently claimed that ‘mental disorders appear to be disorders of brain circuits’, visible via brain imaging techniques. He went on to say that although research was in its early days, ‘there can be little doubt that clinical neuroscience will soon be helping people with mental disorders to recover’ and that ‘earlier notions of mental disorders as chemical imbalances or social constructs are beginning to look antiquated’. Insel’s successor as director of the US National Institute of Mental Health, Joshua Gordon, similarly claimed that ‘neural circuits could be delivering treatments in 10 or 15 years’ – in spite of acknowledging that ‘most work on neural circuits has been done in genetically modified mice’ (Abbot, 2016). Claims such as these help to perpetuate an unwarranted narrative of progress as each new focus of research is announced.

In principle, many of the processes which have been the subject of biological research – from epigenetics and neurotransmitters to gut microflora – might have some relevance to emotional distress and disturbing behaviour. But the research has rarely managed to distance itself from the unsupported presumption that psychological distress takes the form of discrete disorders associated with specific causal biological impairments or deficits. If the environment is included at all, as, for example, in epigenetics, there is a tendency either to marginalise its impact or to translate it into purely biological terms. We conclude, therefore, that genuine progress requires a fundamentally different conceptual basis which does not rest upon unproven presumptions of disease, illness or the primacy of biology. This, in turn, means that we need to think about the role of biology in much more sophisticated ways.

An alternative approach

Like any other discipline, biology is the site of debate between different perspectives. One which can accommodate the inconsistent evidence for biological influences upon distress, and offer a promising basis for the more sophisticated understanding of biology that is needed, is provided by the work of neuroscientist and biologist Steven Rose.

Rose (1997, 2005) rejects tendencies in biology toward methodological (and, sometimes, theoretical or philosophical) reductionism (that is, reducing the complexity of human behaviour to a series of biological processes). Instead, he points to the extensive evidence that as systems (including biological systems) become more complex, they acquire ‘emergent properties’: in plain language, that the whole is greater than the sum of its parts.

Single celled creatures such as amoeba have properties and capabilities that viruses and proteins don't; multi-cellular creatures such as humans are more complex still, and have yet more abilities. These complex abilities require biology, but cannot be reduced to it. Humans need functioning biological systems in order to make meanings, but the meanings they make are not the products of their biology alone: they also depend upon factors like language, symbols, tools, social relationships and culture.

Rose emphasises how biological systems are continuously open to external influences, such that every single instance of gene replication takes place within an environment. This is why genetically identical twins are never actually wholly identical, even at birth: for example, they have different fingerprints. The impact of many million instances of cell division, of tiny random variations in nutrient and blood oxygen levels, caused by arbitrary movements of both embryos within the womb, accumulates and multiplies over the nine months of pregnancy. The end product is two individuals who entirely share a genetic code but are nevertheless, at least subtly, physically different.

So the idea that genes and environment, individuals and their worlds, are simply separate from each other is mistaken. Whilst biological systems are self-organising and have their own potentials and tendencies, these potentials are continuously modified by, and always responsive to, environmental forces. This is one implication of the great many brain imaging studies that show how one or other brain region changes its size or activation levels as a consequence of some stimulus or experience – in other words, exhibiting plasticity. While this ability to adapt has long been known about (and whilst its supposed implications are sometimes based on unquestioned assumptions of the kind discussed earlier – Pitts-Taylor, 2010), brain imaging studies have strongly reinforced the significance of this plasticity in recent years. They have shown that, at least at the level of fine structure, the brain is largely plastic and is constantly responsive to external social, relational and physical influences. Another way of putting this is to say that, in the brain, biology and social relations come together – the brain itself is socialised. Or, as we noted in our discussion of social context, social phenomena 'come into the brain' and 'become part of our cerebral biology' (Kaiser et al., 2009, p.9).

From this perspective, biology is never separate from culture and social relations. Nature is never opposed to nurture such that their influences can be quantified separately – for example through the (misunderstood and misused) heritability estimate (Bentall, 2009). Rather than assuming two fundamentally opposed influences – genes and environment – the evidence supports a more sophisticated model in which they *always* act together. Instead of numerically apportioning the presumed contribution of each, we should investigate how their combined influence sometimes produces relative specificity and, at other times, relative plasticity.

During early brain development, for example, the joint influence of genes and environment might produce specificity as neural structures that will endure throughout life are being formed. During the first two years of life human infants form 30,000 new synaptic connections under each square centimetre of cortex *every second*. Both this genetically impelled activity, and the genetically-programmed period of pruning that follows, are continuously open to environmental influence that modulates this growth and pruning. Because many important brain structures and pathways are constructed during this period, the combined effects of genes and environments during this time

can therefore produce enduring specificities. For example, the pattern and density of inhibitory and excitatory connections between the frontal cortex and the limbic system, laid down during these years, is then specified and largely fixed for the life of the individual (Schoore, 2001). At other periods, once the brain has a more stable form and its basic structures are established, their combined influence will yield plasticity as the brain responds flexibly to changing external influences. We have already noted how regional patterns of brain activation, for example, seem to be very much plastic in their ready responsiveness to experiences and events.

To capture this complex interplay of biological and environmental influences, Rose proposes the notion of the lifeline: the trajectory of an organism from birth to death. Lifelines are particular to individual creatures and reflect their unique history of situations and circumstances. At the same time, the individual lifelines of members of any given species will share common features, because they tend to live for similar amounts of time, reproduce at around the same point in their lifespan, have a similar number of offspring, have common features in their environments and so on.

Lifelines are characterised by what Rose calls *process unity*. In other words, they are the product of many interacting processes, only some of which are biological in nature. Ultimately, what matters is the different ways these processes come together, over time. Their interactions produce constraints and possibilities, similarities and differences, and so create both functional and dysfunctional outcomes. This is why ‘we are defined as individuals by our history at least as much as by our molecular constituents’ (Rose, 1997, p.39).

The lifelines model is a general account of biological functioning. With specific reference to distress, it provides a considerably more sophisticated way of thinking about biology than the assumptions of deficit, impairment or illness that currently dominate. When illness or impairment is presumed, causality is necessarily seen as largely uni-directional. By contrast, the lifelines model explicitly recognises that the influences between biology, experience and environment are continuously multi-directional. This makes it compatible with claims that ‘complex trauma... can radically compromise psychobiological, social and emotional development’ (Blue Knot Foundation, 2012, p.47). It is also compatible with evidence that neurotransmitter and hormone levels fluctuate according to experience and situation, and equally compatible with evidence that chronic stress is associated with profound changes in the brain and body (Cozolino, 2002). The lifelines model also fits with the evidence that patterns of regional brain activation are responsive to experiences and events; and equally with the lack of consistent evidence for current diagnostic and ‘disorder’ models of distress.

In summary, the lifelines model integrates biology as an essential component of our understanding of distress, while avoiding the unproven assumption that biological influences are more significant than others. Simply put, it avoids positing the existence of biological deficits as inevitably the primary cause of people’s problems. Instead, it suggests that it may be more productive to investigate the ways in which general biological processes can be activated and primed as necessary elements within complex sequences of interacting processes that are at once, and equally, psychological, biological and social (and see also Greenberg, 2011).

The kinds of general biological processes likely to be frequently implicated in distress include:

- those that enable so-called fight, flight and ‘freeze’ responses (Blue Knot Foundation, 2012);
- those that enable us to feel emotions of various kinds (Panksepp, 1998), and to have our decision-making and planning shaped by feelings in ways we cannot necessarily easily recognise (Damasio, 1994);
- those that enable us to remember, including memories described as affective or emotional (Brown & Reavey, 2015);
- those that enable us to experience and regulate different levels of arousal (Cozolino, 2002);
- those that enable us to ‘somatise’, or to experience mental distress as bodily discomfort (Stein & Muller, 2008);
- those that enable us to dissociate in order to mentally detach from overwhelming events (van der Kolk, 2003);
- those that enable us to interpret experience (including emotion) by producing inner speech (Gazzaniga et al., 1996), and so, in more extreme circumstances, to hear voices (Fernyhough, 2016);
- those biological developmental capacities which may be disrupted by adverse childhood experiences, including those described as disrupted or disorganised attachment relationships with caregivers (Schoore, 2001).

As we describe later, explanations of distress associated with the emerging ‘trauma informed’ approach frequently draw on biological capacities such as these. From the perspective of the lifelines model it is the activation of these kinds of general biological capacities within specific circumstances and relationships that produces experiences of distress. While this activation might sometimes lead to enduring changes in brain-body functioning (what Steven Rose calls ‘temporal specificity’), at other times it will not (Rose calls this ‘temporal plasticity’). In turn, this means that distress might sometimes be associated with long-term biological differences, and at other times might not.

The notion of lifelines captures the sense in which general biological capacities are always feeding into, and simultaneously being modified by, environmental, social, cultural and relational processes. The lifelines concept suggests that diagnostic and ‘disorder’ approaches are simplistic, quite apart from being unsupported by the evidence. Indeed, the literature already suggests a variety of possible explanations for biological variation across different groups, all of which are compatible with the more sophisticated understanding of biology suggested here, and most of which are not mutually exclusive. These include the following:

1. Biological variation can be ‘normal’

By normal, we mean that some biological variation might actually fall within the range of population norms. Likewise, genetic variation might fall within the ‘norm of reaction’ (Rose, 1997, p.133): the frequently unknown range of variation within which phenotypic expression remains effective, and beyond which it breaks down. For example, we do not know the range of ‘normal’ brain function or what degree of change might be deemed ‘abnormal’. Nor do we have norms for levels of neurotransmitters like dopamine,

serotonin and so on, nor any population-level information on the ways in which they fluctuate.

2. Biological variation can be caused by medication

There is considerable evidence that psychiatric medication causes measurable changes in the brain (Fusar-Poli et al., 2013; Ho et al., 2011; Moncrieff & Leo, 2010; Smieskova et al., 2009.). Since very few participants in studies have been entirely medication free, it is likely that some changes are the result of psychiatric medication rather than the cause of distress. For example, some post-mortem studies show an increased density of dopamine receptors amongst people who were given schizophrenia diagnoses (Cross et al., 1981). However, one consequence of the medication given to most people with this diagnosis is to reduce the levels of dopamine in the brain, which then compensates by producing more dopamine receptors (Snyder, 1974). Medication effects are also relevant to the evidence associating enlarged ventricles and reduced overall brain volume with distress.

3. Biological variation can simply mediate distress

Davidson and Henriques (2000) claimed, using fMRI, that compared with controls, people given a diagnosis of ‘depression’ had on average relatively higher levels of activity in the right frontal lobes and relatively lower levels in the left. Like other hypothetical biomarkers, this variation is not observed in everyone given a diagnosis of ‘major depression’. To the extent that it is present, though, this pattern might simply be how the brain mediates the experiences associated with this diagnosis – experiences which arise within specific material, cultural and relational environments.

4. Biological variation doesn’t just mean brains

Biological researchers’ focus on brain structure and function can distract attention from the fact that we are *embodied* creatures all of whose experience and behaviour is necessarily enabled and influenced by our bodily capacities; equally, studies of the embodiment of distress need not always return exclusively to biological processes (Cromby, 2015). One aspect of this is that our learning about our worlds and selves includes a felt, somatic aspect. Memories do not only include images, sounds or tastes; they also incorporate feelings or body state profiles (Damasio, 1994). Memories of humiliation, deprivation, neglect or harm – or their opposites – are not merely visual or auditory: the feelings that accompany these experiences can also be remembered or re-experienced. The well-established associations between social inequality and the diagnosis of ‘major depression’ can be considered from this perspective. Social inequality frequently supplies devaluing messages, and those exposed will also acquire a range of accompanying negative somatic states, experienced as feelings of worthlessness, hopelessness and powerlessness (see Chapter 4). These feelings may then exert unhelpful influences, for example, finding it hard to make choices that affirm one’s worth or ensure one’s safety. If adverse social and material circumstances persistently reactivate these feelings, this tendency will be reinforced (Cromby, 2004). Links between embodiment, meaning and distress are also central to cognitive approaches to the experiences of panic and extreme worries about health (Salkovskis, 2007; Salkovskis & Warwick, 2001). We also discussed (in Chapter 4) some complex relations between embodiment and distress in relation to gender: for example, for some women, premenstrual variation, perhaps in blood glucose levels, fluid retention or headaches, is associated with reduced tolerance for heavy domestic or work

demands, or reduced ability to remain silent in the face of lack of support. This in turn can lead some women to feel guilty at their failure to meet cultural stereotypes of a good wife and mother, and in some cases lead to a diagnosis of ‘premenstrual dysphoric disorder.’

5. Biological variation can be (indirectly) causal without being pathological

There are many socially significant traits and activities that almost certainly have a genetic component, that are not intrinsically pathological, and that have some association with distress. Whilst being less conventionally attractive than others is not a sign of pathology or biological disease it is presumably associated with patterns of genetic inheritance, and it is associated with higher rates of psychiatric diagnosis (Langlois et al., 2000).

Conversely, excelling at a socially-valued activity such as music or sport (where, again, genetic inheritance is likely to contribute) is likely to offer some protective influence that raises social status and enhances social relations and networks, with the overall effect of making distress less likely (even though rates of some kinds of distress are higher amongst professional sportspeople). But perhaps more significantly, the (perceived) lack of such abilities and attributes can impact negatively upon social status and social relations, and in this way have harmful effects. These and other indirect effects might account for at least some of the associations found in large-scale genetic linkage studies.

6. Biological variation can be produced by everyday experience

The field of epigenetics, discussed above, is based on the understanding that gene expression is continuously modified by environmental forces. For example, Gregory Miller and colleagues (2009) found evidence that lower childhood socioeconomic status was associated with epigenetically-encoded changes in adolescence, with some evidence of a ‘critical period’ at ages two to three. However, it is important to note the evidence that these effects can sometimes be reversed. It is well-established that one consequence of stress and trauma can be that the hypothalamic-pituitary-adrenal (HPA) axis becomes more sensitive to external events. Recent studies suggest that psychotherapy can enhance the ability of the HPA axis to respond to stress, in both children (Schuengel et al., 2009) and adults (Jones & Moller, 2011; Olf et al., 2007).

Everyday experience has also been shown to produce biological variation within the classical conditioning paradigm. Learning processes that are helpful in other contexts can create conditioned fear responses when people find themselves in threatening or toxic circumstances. Fear conditioning has been studied in relation to diagnoses including ‘generalised anxiety disorder’, ‘social phobia’ and ‘PTSD’ (Mineka & Oehlberg, 2008) and has been shown to be associated with activity within the amygdala, whilst defensive responses related to conditioned fear may activate multiple brain regions including premotor/motor cortices, striatum, hypothalamus, brainstem, and cerebellum (Lorberbaum et al., 2004). This kind of evidence forms part of the basis for the trauma-informed perspectives described below.

7. Biological variation can be an outcome of adversity, threat, and abuse

The idea that biological variation in distress can be the outcome of adversity – that it should be understood as *injury*, as opposed to illness – has received considerable attention in recent years. This should not be surprising, given that a major role of the brain is to respond to experience. Numerous studies and meta-analyses have provided evidence in

support of the claims that both structural (e.g. hippocampal size) and functional (e.g. HPA axis functioning) aspects of brain-body systems can be altered by neglect, abuse and other childhood adversities (Varese et al., 2012) and that these alterations can be enduring. For example, John Read and colleagues (2001) reported differences between the brains of controls and of some people given a schizophrenia diagnosis, such as in activity of the HPA axis, dopamine, serotonin and norepinephrine levels, and structural features including hippocampal damage, cerebral atrophy, ventricular enlargement and reversed cerebral asymmetry. Importantly, these variations were comparable to those found between the brains of children who either had or had not been traumatised. The cognitive difficulties and reduced intellectual functioning sometimes portrayed as possible precursors of ‘schizophrenia’ are similarly associated with adverse childhood influences in the ‘traumagenic neurodevelopmental model’, as is heightened sensitivity to stress (Read et al., 2001). By 2014, 125 papers had been identified which provided either direct or indirect support for this model (Read et al., 2014).

These findings have led to models which integrate evidence about childhood maltreatment, adversity and poor attachment, HPA axis function levels of brain-derived neurotrophic factor, NMDA and oxytocin. It is proposed that maltreatment and neglect lead to epigenetic changes which might be reversible by therapeutic strategies. The model has been explored in relation to a range of diagnostic categories (e.g. Barker et al., 2015; de Bellis, 2002; Heim et al., 2008; Moller, 2011; Olf et al., 2007). Important as these findings are, we must also bear in mind the usual difficulties of controlling for variables such as medication, the degree of overlap and variability found in the brains of those who have and have not experienced adversity, the social and psychological complexity of adversity, and the dangers of reductionism, especially given the role of meaning in shaping the experience and expression of all forms of distress. In other words, we must be wary of replacing the notion of the ‘schizophrenic brain’ with the ‘traumatised brain’, and of simplistic assumptions that broken lives cause broken brains which then cause ‘mental illness.’

'Trauma-informed' perspectives

The ‘trauma-informed’ approach is a particularly influential way of thinking about the role of biology as mediator and enabler of experiences of distress, in line with the principles described above, and has important practical implications. It will therefore be considered in more detail. Bearing in mind our cautions about the use of the word ‘trauma’ (see section on childhood adversity, Chapter 4), we will use ‘trauma-informed’ here as the label given to a particular approach to understanding and providing services for people with emotional and behavioural difficulties.

The trauma-informed perspective is based on the recognition that the majority of people using human services – not just mental health, but addictions, social services, and the criminal justice system – have experienced significant adversity and threat in their past, and often their current, lives (e.g. Mendelsohn et al., 2011; Ross & Halpern, 2009; www.asca.org.au; www.acestoohigh.com; and see Chapter 4). Many of these people will have experienced what is referred to as ‘complex trauma’ which is interpersonally generated and cumulative, as distinct from single-incident trauma such as RTAs and natural disasters (Herman, 1992). The powerful causal impact of these experiences on a range of mental, physical and behavioural outcomes has, as discussed earlier, been strongly demonstrated.

These facts have given rise to a large amount of interdisciplinary research uniting evidence about the effects of threatening and abusive experiences with what is known about human brain development, especially in the context of early relationships. The field, which draws upon affective neuroscience and other biosciences, is sometimes known as ‘interpersonal neurobiology’ Siegel (2001). It illustrates some of the ways in which various evolved and acquired responses to threats – the capacity to dissociate, to enter extreme and prolonged states of stress, to become mistrustful and hyper-vigilant, and so on – are both biologically enabled and regulated by experience. In other words, trauma-informed approaches integrate biological, psychological and social evidence to forge new understandings of mental distress. In line with the notion of lifelines, these models emphasise that the brain is constantly open to experience, with important implications for practice (see Chapter 8).

In line with the principles outlined here, we emphasise that not everyone who is mentally distressed has experienced an identifiable ‘trauma’, and conversely, not all who have done so will suffer lasting effects. We are emphatically not arguing that ‘all mental distress is caused by trauma’, and still less are we making a diagnostically-specific argument of the type ‘schizophrenia is caused by sexual abuse.’ As we have emphasised, both the impact of adversity and its personal meaning are continuously mediated by a myriad of social, relational and biological factors. Recent research in this area attempts to move beyond simplistic nature/nurture divisions by throwing light on ‘the constitutive role of social and environmental impacts in activating neural mechanisms’ in such a way that ‘the sociocultural environment becomes physically structured in the brains of individuals’ (Blue Knot Foundation, 2012, p.55). This process is shaped through our relationships, starting from the earliest interactions with our caregivers.

The impact of adversity on the brain

As we have seen, evidence clearly shows that the brain responds to adversity – indeed, the brain’s primary purpose is to respond to the environment (Read et al., 2009). These reactions can be particularly problematic if they occur during childhood while the brain is still developing: in terms of Rose’s ‘lifelines’ model, there is the potential for ‘temporal specificity.’ Because the brains of infants and young children are so heavily dependent on experience for development, they can be readily and severely affected by abuse and neglect especially if such adversities are prolonged and repeated (Perry et al., 1995). However, we also need to take into account caregivers’ more subtle inability to provide attunement, comfort and support because they are struggling with their own unmet needs and difficult circumstances (Blue Knot Foundation, 2012). Bruce Perry and colleagues describe how the brain systems enabling either hyperarousal (the ‘flight or fight response’) or dissociation can become sensitised as a consequence of chronic threat. (In technical terms, hyperarousal can include activation of the autonomic nervous system, the immune system and the hypothalamic–adrenal–pituitary (HPA) axis, under the control of brain regions including the pons, the locus coeruleus and the ventral tegmental nucleus, and involving the release of ‘stress hormones’ like cortisol and ACTH. Dissociation can include brainstem mediated activity in the central nervous system (CNS) with increased vagal tone (resulting in lowered heart rate and blood pressure), coupled with increases in epinephrine and in mesolimbic and mesocortical dopaminergic systems, together with the release of endogenous opioids).

Over time, repeated induction of states such as fear and anxiety or detachment and numbness can sensitise these systems, converting short-term states into longer-term traits. Temporary survival strategies that started as adaptive reactions to neglect, abuse or other adversities, can become problematic once they generalise and persist across other situations. Individual variation in the extent to which this occurs may be due, in part, to whether the threat coincides with sensitive or critical periods in brain development. Individual responses will also be influenced by factors such as age, the nature of adversity and gender, for example, dissociative responses appear to be used more often by females than males (Perry et al., 1995) although this may be a result of exposure to different kinds or intensities of adversity (see section on childhood adversity). All of these responses will be both shaped by and dependent on meaning, encoded at various overlapping levels, some more directly biologically-primed (e.g. overwhelming felt urges to fight, flee or freeze) and others more mediated by personal narratives (e.g. ‘the abuse was my fault’) and gender stereotypes. Clearly, there is no reason to suppose that these sensitising effects will map onto diagnostic categories.

Allan Schore (2009) has used attachment theory to integrate a considerable mass of evidence about human brain development, and the links between caregiver interactions and the regulation of neurotransmitters. In relation to what is called ‘disorganised attachment’, he observes that these infants are frequently both over-stimulated by abuse and under-stimulated due to neglect. Consequently, their sympathetic and parasympathetic nervous systems may become dysregulated so that infants cycle rapidly between under- and over-arousal. These arousal states are themselves influenced by fluctuating neurotransmitter levels in different brain regions. The relative availability of these neurotransmitters could have enduring consequences for brain development when they coincide with periods of neural growth and pruning.

To give a detailed example: fear is characterised by the release of cortisol, and of the excitatory neurotransmitters noradrenaline and glutamate. These chemical changes, created by the infant’s relationship with its carers, increase metabolic activity within the immature limbic system, a set of regions especially involved in a range of emotional experiences. Because excitatory neurotransmitters alter calcium metabolism they can accelerate cell-death, and so might produce excessive pruning – for example, of the inhibitory connections between the limbic system and the orbito-frontal cortex. Cortisol has a more complex effect: whilst moderate levels facilitate development, higher levels impede it in areas including the orbito-frontal region and the hippocampus.

Schore suggests that combinations of these effects may lead infants in disorganised attachment relationships to develop long-term problems in recognising and regulating emotion, because vital connections between the frontal cortex and the limbic system may be either under-developed or excessively pruned, especially if adverse experiences coincide with critical periods. In essence, if the main attachment figure (usually a parent) is also someone who is perceived as a threat, early potentials for learning necessarily become oriented largely toward survival. Adaptation to victimisation or other adversity then becomes ‘a state of mind, brain and body around which all subsequent experience organises’ (Blue Knot Foundation, 2012, p.61). This may result in difficulties that, through their impact upon meanings, relationships and choices, increase the likelihood of experiencing mental distress in the future. Whilst Schore bases his account on disorganised

attachment, other unhelpful attachment patterns could presumably also impact upon the developing brain.

Bruce Perry (2009) suggests that this understanding of the experience-dependent character of brain development provides the basis for a 'Neurosequential Model of Therapeutics' that locates developmental insults within a neural hierarchy. In this hierarchy, initial brainstem activity leads to activity first in limbic and then in cortical systems. This has implications for children's ability to engage with therapy. A very severely traumatised child, for example, may need to utilise bodily soothing before they are able to engage cognitively. The same applies to adults who are currently overwhelmed by high levels of physical and emotional arousal and threat responses. Establishing a degree of self-regulation and safety is therefore the first priority in the classic three-stage trauma model, before the traumatic events are addressed directly (Courtois & Ford, 2012).

Dissociation and memory

As we have seen, compelling evidence is accumulating about how both developmental attachment processes and trauma/abuse are encoded in the brain and autonomic nervous system (ANS), and linked to long-term difficulties in adult life, such as voice hearing, self-injury, suspiciousness and lack of trust, anxiety, low mood, and emotional reactivity.

An important mechanism in this process is dissociation. We noted in Chapter 4 that this exists on a continuum, the far end of which is understood as a protective mechanism that enables individuals to detach mentally from experiences that are too overwhelming to process (van der Hart et al., 2006). Due to their devastating intensity, representations of these events are stored in the brain in unassimilated form, in which different aspects (e.g., cognitive, emotional, physical) 'are not integrated into a unitary whole but are stored in isolated fragments' (Brewin et al., 1996; van der Hart et al., 1998, p.253). In the short-term, in the face of immediate threats, this can function as a survival strategy by reducing conscious awareness of unbearable events. However, dissociation can cause considerable distress and disruption if it becomes a habitual, long-term way of responding to any type of anxiety or threat. We also noted that dissociation and the related experience of depersonalisation (a persistent sense of unreality about one's sense of self) is one of the most frequently reported psychiatric complaints (Putnam, 1997). Dissociative mechanisms have been implicated in a diverse range of diagnoses, including 'depression', 'posttraumatic stress disorder', 'psychosis', and 'borderline personality disorder'.

In relation to traumatic situations, different types of memory (sensory, emotional, verbal, pre-verbal) appear to be encoded in different cortical areas: 'What makes memories traumatic is a failure of the CNS [central nervous system] to synthesise the sensations related to the trauma memory into an integrated memory' (Blue Knot Foundation, 2012, p.51). If threats are severe, the memory is more likely to be stored in the right brain, split off from the conscious language-based functions of the left hemisphere. Furthermore, if traumatic stressors and/or disordered attachment occur in infancy, brain regions that record conscious autobiographical memory (the cortex) will not even have developed. Instead, traumatic representations will be stored in the limbic system (emotional and sensory memory), midbrain (emotional arousal, sleep, appetite), and brainstem (regulation of instinctive responses and the ANS) – thus being less amenable to influence by thought and less easy to regulate through language (e.g. by talking about what one is

feeling and experiencing). This phenomenon is well summarised in Harvey's (1990) claim that trauma survivors have 'symptoms' instead of memories (see also Courtois & Ford, 2009; Herman, 1992; Moskowitz et al., 2009).

In such circumstances, our 'memory' of threatening and/or pre-verbal experiences may surface only as an automatic physical and emotional arousal response, split off from conscious verbal recall. This fight or flight reaction was adaptive when the threats occurred, but the ANS can remain permanently primed for threat, responding to every reminder of the original stressor. Correspondingly, distress that remains unresolved and unintegrated is often associated with physical and emotional dysregulation and intrusive thoughts and memories, which in turn are constantly triggered by overt and covert trauma reminders. However, 'the capacity to assimilate the traumatic experience within the life narrative is not yet available to such individuals, both because traumatic memories are encoded subcortically, rather than in autobiographical memory, and because the recurring traumatic activation continues to create a somatic sense of threat, or speechless terror' (Ogden et al., 2006, p.2). For example, as we noted in the discussion of childhood adversity, voice hearing can be understood as dissociated emotional and/or experiential content (e.g. the voice of a past abuser) that intrudes into awareness, and is consequently perceived by the person as a disowned, 'alien' phenomenon that feels separate from their conscious experience (Dorahy et al., 2009; Longden et al., 2012; Moskowitz & Corstens, 2007). Similarly, experiences like unusual beliefs, numbing, flashbacks, panic attacks, chronic pain, low mood, etc., can be understood as examples of unintegrated emotional or behavioural trauma memory, or 'post-traumatic flooding', in which survivors may alternate between being detached from their feelings and overwhelmed by them, in parallel with the process of physical hyperarousal that swings back to numbness.

John Read (2013a) has noted that these mechanisms may be described with different terminology in different models. For example, an intrusive, de-contextualised memory of abuse might be deemed 'projection' by a psychoanalyst, 'impaired source monitoring' by a cognitive psychologist, or 'depersonalisation' by a dissociative theorist. Nevertheless, a shared theme is the conceptualisation of the psychological aftermath of adversity, including such phenomena as hearing voices, or 'paranoid' beliefs, as meaningful ways of surviving overwhelming events.

An overview

Caution is needed with respect to *all* of the models linking adversity to neural or physiological changes. This is because, although the central contribution of adversity to mental distress (and other health, behavioural and social outcomes) is well-established, its precise biological consequences and their relationship to experience and behaviour are less clear. These emerging new models integrate impressive amounts of evidence about the relationships between adversity, threat and distress, and about neural function and development. At the same time successful direct tests of their specific predictions are relatively scarce (though, it should be acknowledged, no more scarce than in relation to illness-based hypotheses).

There are also warning signs that the awareness of the extent of adversity and abuse is being assimilated back into a medical framework, evident in statements such as 'There is no such thing as a purely psychological disorder: Invariably, it is an abnormality of brain

circuits that disrupts normal development of emotions, thought, behavior, and social cognition' (Nasrallah, 2014, p.32). David Fowler and colleagues have also suggested that '[h]igh vulnerability to [developing intrusions of traumatic events] may be conferred from genetic or constitutional factors' (2006, p.116). Such claims set the scene for primarily biologically-oriented research and treatment which would once again marginalise the social and relational aspects of experiencing and surviving adversity.

Another example of advocating modified versions of the existing diagnostic paradigm is seen in suggestions for a division between 'traumatic psychosis' and true 'schizophrenia' (Callcott & Turkington, 2006). As well as retaining the category of 'schizophrenia', the effect is to suggest that there is an intervening medical condition or 'psychosis' over and above an understandable reaction to adversity. A contrasting position would hold that: 'There is the abuse, and there are the responses to the abuse. There is no additional "psychosis" that needs explaining' (Johnstone 2009, p.197). Mary Boyle has warned about the possible sanitising effects of the neat summary word 'trauma' (and, we might add, 'adversity') which may be used to avoid 'spelling out the troubling and sometimes shocking experiences people have actually had' (Boyle 2006, quoted in Johnstone, 2009, p.188) and to take the focus away from issues of power such as poverty, inequality and discrimination.

Finally, we repeat that the impact of threat and adversity is non-specific. On the one hand, it is not specifically associated with any particular constellation of emotional and behavioural difficulties. On the other, it is also causally related to physical health problems like cancer and respiratory disorders as well as to a whole range of expressions of emotional distress. Importantly, this does not negate our argument that problems of emotion and behaviour should be understood through different frameworks than bodily dysfunction. At root, this is because human behaviour is purposive and functional. *Meaning* continuously contributes to the form and content of human behavioural and emotional problems, and is absolutely central to their resolution. Hence, as we have seen, patterns of mental distress and disturbing behaviour do not readily fall into the kind of diagnostic categories used in physical medicine. Likewise, the relevant causal pathways are more complex because they necessarily include shifting patterns of social, relational and material influence – not just in relation to the origins of mental distress, but also in relation to its persistence and amelioration. So, threat and adversity have simultaneous physical, neural, physiological, psychological and behavioural consequences which play themselves out in non-specific ways within the lifelines of individuals. However, the ongoing significance of personal and cultural meanings within experiences of distress means that these non-specific effects can only be understood within a perspective that includes biological factors as just one amongst a range of important influences.

With these cautionary points firmly in mind, we can welcome recent attempts to unite extensive evidence about the effects of traumatic and abusive experiences with what is known about human brain development and activity. These models have also begun to show some of the ways in which various evolved and acquired responses to threats – the capacity to dissociate, to enter extreme and prolonged states of emotional and bodily stress, to hear voices, to become hyper-vigilant, to enact fight/flight responses, phobic reactions, avoidance reactions and so on – are both biologically enabled and triggered and regulated by experience. Like the notion of lifelines, then, these models emphasise how the brain is constantly open to experience, and its features and characteristics cannot be

understood in isolation. The models also have implications for practice, as illustrated in trauma-focused therapies, the three-stage trauma model, and the development of ‘trauma-informed services’ (see Chapter 8).

Conclusions

Psychological distress is widely portrayed as a kind of illness. This seems to have misled many researchers into assuming that it must inevitably be associated with causal biological deficits or impairments. While the very serious limitations of current diagnostic systems are openly admitted by senior researchers and clinicians nationally and internationally (including those who were involved in drawing them up), assumptions of disease or illness are still largely unquestioned.

As we have seen, the evidence has not supported these assumptions: alternative ways of thinking about biology in relation to distress are therefore required. Emerging evidence drawing on more sophisticated frameworks already suggests that the biosciences can contribute to non-medicalised, non-reductionist understandings of distress and do so in such a way as to incorporate culture, context and meaning. To be both comprehensive and valid this thoroughly interdisciplinary endeavour will therefore need to draw simultaneously upon multiple sources of knowledge, including for example attachment theory, trauma studies, cultural, social scientific and historical studies, phenomenological analyses and survivor accounts, as well as on research in the neurosciences, epigenetics and genetics (Dillon et al., 2012; Woods et al., 2014).

Research programmes of this kind are still in their infancy, although some promising avenues of investigation have begun to appear. In this chapter, we have provided a conceptual model of biology based upon the notion of lifelines, along with an illustrative selection of explanations for biological variation in distress that are not based on unquestioned assumptions about causal impairments or diseases. We have described new evidence-based models that integrate analyses of biological processes with analyses of adverse experience. We have also highlighted the danger that ‘trauma-informed’ models will be assimilated back into existing disease, illness or other reductionist models of distress. Indeed, it is almost impossible to overstate this danger, since biological research has long functioned to support medicalisation and draw attention away from social context, power and meaning. Yet people’s many ways of surviving and creating meaning out of adversity can never be explained along solely or primarily biological lines. They are dependent on available cultural narratives, within the lives of people with varying degrees of access to material, relational and ideological resources, circumstances which are themselves dependent on wider social structures. Acknowledging this allows for the development of comprehensive, sophisticated accounts that recognise how distress, unusual experiences and troubled behaviour are enabled by biology but produced and experienced in social situations: not just by brains or their component systems, but by embodied, meaning-making persons in their relational and material worlds.

Chapter 6: Describing patterns within a Power Threat Meaning Framework

Introduction

In Chapters 4 and 5, we discussed some of the very broad patterns of relationships between social, psychological and biological aspects of emotional distress, unusual experiences and troubled or troubling behaviour that have been described by researchers. This chapter will continue the discussion by addressing the third question we posed in Chapter 2 in relation to alternatives to diagnosis:

How might these broad trends and relationships be used to delineate narrower, provisional general patterns which can inform our understanding of the particular difficulties of an individual, family or other group?

We will then outline the Power Threat Meaning Framework and show how it can meet the requirements for an alternative to diagnostic approaches. This meta- framework draws upon a variety of models, practices and philosophical traditions but is broader than and not reliant on any particular theoretical orientation. Rather, the aim is to inform and expand existing approaches by offering a fundamentally different perspective on the origins, experience and expression of emotional distress and troubled or troubling behaviour.

In order to orient the reader, we recap some of the core principles on which alternatives need to be based:

- Constructive alternatives to psychiatric classification and diagnosis need to focus on aspects of human functioning which have been marginalised in theoretical frameworks derived from the study of bodily processes or objects in the physical world. In particular, alternatives should be based on the study of embodied humans behaving purposefully in social and relational contexts.
- ‘Abnormal’ behaviour and experience exist on a continuum with ‘normal’ behaviour and experience and are subject to similar frameworks of understanding and interpretation. These include the assumption that, unless there is strong evidence to the contrary, our behaviour and experience can be seen as intelligible responses to our current circumstances, history, belief systems, culture, and bodily capacities, although the links amongst these may not always be obvious or straightforward.
- Causality in human distress and behaviour is probabilistic; that is, it has an ‘on average’ character and it will never be possible to predict precise impacts. Causal influences also operate contingently and synergistically, meaning that the effects of any one factor are always mediated by and contingent upon others, and that influences can magnify each others’ effects.
- Experiences and expressions of emotional distress are enabled and mediated by, but not in any simplistic sense caused by, our bodies and biology.
- Humans are fundamentally social beings whose experiences of distress and troubled or

troubling behaviour are inseparable from their material, social, environmental, socio-economic, and cultural contexts. There is no separate ‘disorder’ to be explained, with context as an additional influence.

- All indigenous forms of understanding distress have useful aspects, but there can be no ‘global Psychiatry’ or ‘global Psychology’. Patterns in emotional and behavioural difficulties will always reflect prevailing social and cultural discourses, norms and expectations, including accepted conceptualisations of personhood.
- Theories and judgements about identifying, explaining and intervening in mental distress and troubling behaviour are not interest- or value-free. This does not mean that useful and reliable knowledge is unobtainable but that trying to separate ‘facts’ from values is highly problematic.
- We need to take meaning, narrative and subjective experience seriously. This will involve a central place for the narratives of experts by experience. It will also involve drawing on a wide range of research methods and giving equivalent status to qualitative and quantitative methods, including the testimony of service users/survivors and carers themselves.

These core principles inform the Framework’s main features and purposes, which are as follows:

- It allows provisional identification of general patterns and regularities in the expression and experience of distress and troubled or troubling behaviour, as opposed to specific biological or psychological causal mechanisms linked to discrete disorder categories.
- It shows how these response patterns are evident to varying degrees and in varying circumstances for all individuals across the lifespan.
- It does not assume ‘pathology’; rather, it describes coping and survival mechanisms which may be more or less functional as an adaptation to particular conflicts and adversities in both the past and present.
- It integrates the influence of biological/genetic and epigenetic/evolutionary factors in mediating and enabling these response patterns.
- It integrates relational, social, cultural and material factors as shaping the emergence, persistence, experience and expression of these patterns.
- It accounts for cultural differences in the experience and expression of distress.
- It assigns a central role to personal meaning, emerging out of social and cultural discourses and belief systems, material conditions and bodily potentialities.
- It assigns a central role to personal agency, or the ability to exercise influence within inevitable psychosocial, biological and material constraints.
- It acknowledges the centrality of the relational/social/political context in decisions about what counts as a ‘mental health’ need or crisis in any given situation.
- It provides an evidence base for drawing on general patterns of coping and survival responses to inform individual/family/group narratives.
- It offers alternative ways of fulfilling the service-related, administrative and research functions of diagnosis.
- It suggests alternative language uses, while arguing that there can be no one-to-one replacements for current diagnostic terms.
- It includes meanings and implications for action in a wider community/social policy/political context.

Part 1: Overview of theory and research

Conclusions from the literature on the roles of social context and biology

As we have shown, there is overwhelming support for the causal impact of relational and social adversities, mediated by bodily responses, in emotional distress and troubled or troubling behaviour. Broad patterns of relationships between social, psychological and biological aspects of emotional distress, unusual experiences and troubled or troubling behaviour have been described by many researchers. However, to date, attempts to identify specific pathways or patterns have been hampered by three broad trends in the evidence which we have summarised in Chapter 4 as: *Everything causes everything*; *Everyone has experienced everything*; and *Everyone suffers from everything*. In summary, and as a generalisation, all types of adverse events and circumstance seem to raise the risk for all types of mental health presentations (as well as for criminal and offending behaviour, physical health problems, and a range of other problematic social outcomes). This appears to be mediated, for better or for worse, by all types of attachment relationships, and by all kinds of social support, biological mechanisms and emotional and cognitive styles.

This evidence emphasises the limitations of assuming causal pathways in which specific adversities or biological states are hypothesised to be associated with specific outcomes or 'disorders'. While producing some valuable insights, this kind of research does not take us very much further in understanding causal links between particular risk events (e.g. physical or sexual abuse, social deprivation) and particular outcomes or consequences (e.g. low mood, anxiety, eating problems, hearing voices). Some of these limitations can be attributed to the retention of diagnostic categories and the persistence of positivist assumptions, and the consequent downplaying of social, material and cultural contexts, along with marginalisation of the role of personal meaning and agency. In other words, this approach is still largely situated within the 'DSM mindset'. It is also, therefore, limited in its ability to conceptualise causality and identify causal patterns in relation to the thoughts, feelings and behaviour of embodied human beings who are actively making sense of their lives in interdependence with their relational, social, cultural and spiritual environments.

We have presented an extensive discussion of the principles and research that offer philosophical, theoretical and empirical bases for moving beyond these limitations and for identifying non-diagnostic, non-medicalised patterns in the emergence of psychological and emotional distress. Before describing in more detail how to move from broad trends and relationships to more specific patterns, we will briefly consider three other bodies of work that have attempted the same task.

Patricia Crittenden's Dynamic Maturational Model (Crittenden, 2002, 2005, 2006) synthesises sources from evolutionary biology, ethology, epigenetics, cognitive neuroscience, attachment theory, psychoanalysis and general systems theory, to conceptualise mental health problems in terms of attachment-based psychobiological response patterns. The DMM is an ambitious and inclusive framework that addresses the impact of interpersonal threat (ranging from overt abuse to less severe forms of adversity) on various aspects of human functioning.

Crittenden suggests that early attachment experiences produce emotional, behavioural, cognitive and somatic responses that are defensive and self-protective, and which are adapted throughout development to promote survival. The child will thus be likely to react to threat by reverting to particular ‘dispositional representations’ (i.e. ‘patterns of neurological activity that dispose individuals to act in some manner’: Damasio, quoted in Crittenden, 2005, p.3) which roughly correspond to attachment styles A, B or C. The representation process is the central mediating factor that results in the adoption of particular strategies – hence, the same experiences can lead to different outcomes in different individuals. She proposes that when certain adaptations extend beyond the original threatening circumstances in which they developed, they tend to be seen as ‘pathological’. Current difficulties such as dissociation, ‘paranoia’, anxiety and so on are seen as former ‘solutions’ that have outlived their original usefulness.

Crittenden suggests the identification of ‘functional formulation patterns’ as an alternative to symptom-based diagnoses (Crittenden & Dallos, 2012, p.407). She elaborates on the basic A, B and C attachment patterns by positing a range of Type A and Type C strategies, more of which become available as the individual matures. For example, she suggests that ‘Type A strategies’ are based on the use of cognition in order to cope with threat, while minimising awareness of feelings. Depending on the degree of reliance on such strategies, the end result might range from mild emotional inhibition to more disabling problems such as ‘depression’ and ‘psychosis’. ‘Type C strategies’ are triggered by strong emotions like anger and fear, as well as physical arousal (e.g. elevated heart rate) and a corresponding reduction in the capacity to use cognitive information to, for example, predict and estimate risk. In mild forms this type of strategy might cause problems with aggression or anxiety, and in stronger versions, result in states of extreme insecurity which may be diagnosed as ‘paranoia’, ‘personality disorder’ or eating problems. ‘Type B strategies’ are more likely to be associated with positive assumptions and representations about oneself, other people, and the world. These groupings describe relational styles and strategies for coping with threat and achieving safety in particular situations, not people themselves, or traits or characteristics residing within people.

The end result is an array of possible ‘functional formulation patterns’ that individuals may call upon in certain situations in order to predict, avoid or survive perceived or actual threat, and to maintain relationships. The DMM proposes that different responses (or in psychiatric terminology ‘symptoms’) may be utilised for similar protective purposes. Conversely, the same experiences (‘symptoms’) may not cluster together, because they may perform different functions for each person. The DMM also emphasises the importance of customising therapeutic interventions to each person’s response set.

Dallos and Crittenden have attempted a synthesis between the DMM and systemic family therapy (Crittenden & Dallos, 2009) in order to understand how DMM strategies may be played out in mutually reinforcing ways within families. They emphasise that, like individuals, ‘families are meaning making systems’ (Crittenden & Dallos, 2012, p.402), and that these meanings are shaped by language and social discourses. Awareness of wider circumstances helps to decide whether intervention is best carried out at individual, family, community, and/or cultural political levels (p.406).

Paul Gilbert (2007) draws on evolutionary theory, neuroscience, and developmental

and social psychology in order to propose a model that relates personal attributions, attachment styles, and biologically-based affect systems to different manifestations of low mood (and more recently to other presentations such as 'psychosis'). He posits that these mood states stem from evolved defence strategies that help us to negotiate interpersonal threat and loss, as well as other dangers. He suggests that in order to survive, we need to be able to elicit and give care; to co-operate with others; and to compete to win resources and find a place within the social group. Correspondingly we are primed to feel very distressed by disconnection, exclusion, and 'social defeat' – responses that may have parallels in animal behaviour.

Gilbert suggests that these defence strategies interact via affect regulation systems and in turn give rise to 'sequences of interacting processes that create complex biopsychosocial patterns' (Gilbert, 2007, p.17) based on broad meanings (for example, about whether others are safe). Affect regulation is said to occur through three main systems: (1) threat systems (associated with high arousal and emotions like anger, anxiety and disgust); (2) soothing/affiliative/emotional regulation systems (associated with feelings of connectedness, safety, and contentment) and (3) drive/excitement systems (associated with rewards and goal-seeking, and feelings of energy and pleasure). Taken together, the three interacting drives are believed to shape subjective experiences and meanings of distress, partly through the activation of protection strategies (such as fight/flight/freeze, strive, protest and so on), partly by emotional memories and past experiences, and partly by current events.

In this model, adulthood wellbeing is significantly influenced by the 'emotional memories' that have been encoded in association with these three emotional drives, and early attachment experiences are believed to be a formative way of regulating them. For example, in an abusive or neglectful environment, drive-seeking and threat systems will be more readily rehearsed and activated while the capacity for self-soothing and affiliation will be inhibited. Our human capacity to think, reflect, interpret and use language and symbolism adds another layer of complexity which in turn feeds back into the response patterns in both adaptive and non-adaptive ways – for example, by strengthening or moderating our beliefs that we have been/will be abandoned, hurt, shamed, excluded, and so on.

Although these complex defence strategies may not always be experienced as positive, they are premised on the notion that individuals draw on familiar, learned adaptations to try and manage experiences of loss, rejection, or threat. As such Gilbert shares Crittenden's view that these evolved survival strategies are essentially protective, although likely to be seen as 'pathological' if prolonged beyond the original circumstances. Similarly, he sees these strategies as potentially serving different purposes for different people. These dynamics exist within what Gilbert calls 'social and physical ecologies,' which implies a need for interventions at systemic, social and political levels as well: 'Psychological models must address these issues (and questions of social justice) and not see problems in coping and thinking as personal deficits (rather than linked to protection strategies)' (Gilbert, 2007, p.106). His work thus conceptualises low mood (and potentially other forms of distress) within a broad context, and suggests practical and non-blaming explanatory frameworks for tailoring therapeutic interventions to the person's specific circumstances (e.g. reducing feelings of threat, disconnection, inferiority, and/or shame; and the large

literature on developing the capacity for self-compassion and self-soothing; for example, Lee & James, 2012).

The ‘Trauma-informed approach’ is based on the recognition that the majority of people using welfare services have experienced significant adversity and threat in their past and/or current lives (e.g. Sweeney et al., 2016; www.blueknot.org.au; www.cestoohigh.com). It argues that healing through having experiences witnessed and validated within trusting relationships is key to recovery. The core question is thus not ‘What is wrong with you?’ but ‘What has happened to you?’ (Blue Knot Foundation, 2012, p.14). In this document, these events and circumstances are generally referred to as ‘adversities’ to encompass the many forms that they can take. The resulting research unites evidence about the effects of threatening, traumatic and abusive experiences with what is known about human brain development, especially in the context of attachments and early relationships. This is a rapidly-expanding field, and there is now a very considerable body of evidence linking these experiences to a whole range of emotional, physical and social outcomes. In line with this, a growing number of mental health services have taken on elements of this perspective. Trauma-informed projects are also running in service design, education, prisons, and public health (examples at www.cestoohigh.com).

Work based on this approach has two linked aspects: ensuring that systems as a whole are ‘trauma-informed’, and offering trauma-specific interventions. The former implies that all staff will be trained to recognise and work with the effects of threat and adversity, and that all aspects of services will be designed to promote safety, choice and empowerment, and avoid re-traumatisation. The latter are typically based on the three-stage trauma-informed model, consisting of Safety/Stabilisation; Processing; and Integration (Blue Knot Foundation, 2012; Herman, 1992; Courtois & Ford, 2013; and see Chapter 8). The three-stage model thus offers an over-arching structure for therapeutic interventions from all modalities, along with other kinds of support as appropriate. It is important to note that there is no assumption that every service user will have a history of specific traumatic events, or that if they do, they will wish to address this directly. This is not ‘one-size-fits-all’, but a flexible, service-user-oriented approach based on awareness that adversity, broadly defined, is very likely to be part of the picture. Clearly this approach has generated important and innovative therapeutic work, and the general causal links between adversity and distress are indisputable. However, as discussed in Chapter 4, claims to have identified pathways between specific traumatic events and specific kinds of distress have very weak support, as would be predicted by the principles underpinning our proposed framework.

Overview of the models

There are significant areas of overlap across the models. Their strengths and limitations can be summarised as follows:

- Response patterns are not seen as pathological, but rather as adaptive reactions which may have outlived their usefulness. Furthermore, it is not assumed that response patterns are found solely in a particular group such as the ‘mentally ill’; and nor do those so labelled rely on them all the time. Rather, we all employ a variety of strategies that may be more or less useful in particular situations. The implication is that ‘co-

morbidity' is not a nosological problem to be solved, but a reflection of the fact that people can use multiple ways to respond to adversity and threat.

- The models are able to accommodate heterogeneity because they allow for general, functional patterns of individual adaptation as opposed to hypothesising links between (specific) causal events and (specific) consequences or outcomes. The implication is that it will not be possible to identify universal aetiological causal pathways, nor to devise standardised packages of intervention linked to particular expressions of distress.
- The models incorporate a non-reductionist role for biology as mediator and enabler, and the core elements of the psychobiological response patterns are, unlike diagnostic categories, based on extensive evidence across a range of areas. In other words, they are 'psychobiosocial' in a sense that does not imply the primacy of (unevidenced) biological causal factors, contrary to most current uses of the term 'biopsychosocial' in relation to mental health. However, the assembly of these multiple factors into patterns, meanings and pathways is more speculative. Gilbert's three main affect-regulation systems and his 'old brain/new brain' distinction is not universally accepted (Le Doux, 1999; Goldstein, 1995; Panksepp, 1988), while there are also critiques of aspects of attachment theory (see review by Cassidy & Shaver, 2008).
- The models suggest how response patterns can arise out of, and be co-created within, developmental and relational contexts. However, only the trauma-informed approach fully incorporates current evidence about the extremely high rates of adversity in those who access mental health and other welfare systems.
- All these models place a welcome emphasis on personal meaning and the importance of healing through relationships. Gilbert makes the most explicit links to wider power interests through social discourses about competition, status and so on (e.g. Gilbert, 2007). Integrating a family systems approach into the DMM promotes recognition of the need to address meaning at all levels of organisation from familial to political, cultural and societal (Crittenden & Dallos, 2009) in line with current family therapy traditions (Dallos & Stedmon, 2014). Overall, though, this is an aspect of the models which is relatively underdeveloped.
- Despite some acknowledgement of social, material and political contexts, the emphasis in both Gilbert's and Crittenden's work tends to be on solutions in terms of therapy (individual and family) rather than, or not supplemented by, self-help, community support, and other forms of social policy and action. The evidence supporting trauma-informed approaches has been applied more widely, and has also been influential on public health policy (www.acestoohigh.com; and see Chapter 8). However, preventative work within this field generally stops short of challenging the discrimination, inequality, and socioeconomic structures that create the fundamental conditions within which adversities multiply.
- Trauma-informed approaches emphasise the importance of working with diversity (<http://www.samhsa.gov/nctic/trauma-interventions>). There are specific projects looking at, for example, the experience of intergenerational trauma in Aboriginal peoples in Canada (Arthur et al., 2013). Overall, though, the models give relatively little attention to cross-cultural influences on the experience and expression of distress, and the assumptions underpinning their work are primarily Western in origin. For example, it has become apparent that the shape, emergence and

consequences of attachment relationships are far from universal and may present very differently in non-Western settings, implying the need for a more culturally-sensitive conceptualisation of how these developmental trajectories are played out (Otto & Keller, 2014).

- A major limitation from the perspective taken here is that the models are only partially successful in distancing themselves from diagnostic terms and assumptions. Gilbert's impressive body of work largely takes the diagnostic category 'depression' as a given (Gilbert, 2007). Although 'depression' has a lay meaning as well as a clinical one, this reification of meaningful response states is potentially unhelpful. Crittenden suggests the interesting possibility of 'functional formulation patterns' as an alternative to psychiatric diagnoses, but also uses terminology such as 'personality disorder', 'psychopathology' and so on. Leading practitioners of trauma-informed care still use diagnostic categories (see critique by Burstow, 2003) and attempted, unsuccessfully, to introduce new diagnostic categories of 'Complex Post-Traumatic Disorder' into *DSM IV* and 'Developmental Trauma Disorder' into *DSM-5* (Van der Kolk, 2014). While this was partly driven by the need to accommodate US insurance requirements (Wylie, 2010), the effect is to stop short of a fundamental rethink of the whole concept of psychiatric diagnosis.

In summary, then, the models collectively suggest a range of innovative and important perspectives on non-diagnostic conceptualisations of distress, which have valuable implications for practice and intervention. Their shared message, based on a considerable amount of evidence, is that the experiences usually described as 'symptoms' may be better understood as strategies for surviving adversity, rather than as 'psychiatric illnesses' or 'disorders'. At the same time, they fall short in various ways from presenting a comprehensive and conceptually coherent alternative to psychiatric diagnosis. There is a risk that these perspectives will be assimilated back into individualistic accounts of emotional and psychological distress. There is a need for a more fundamental shift in thinking, as described below.

Part 2: The Power Threat Meaning Framework

An alternative basis for the identification of patterns in mental distress, unusual experiences and problematic behaviour

We will now synthesise the principles and practices, theory and evidence described in Chapters 2, 3, 4 and 5 in order to describe our alternative framework in more detail.

The evidence cited in this document supports the contention that humans are social beings whose **core needs** include:

- To experience a sense of justice and fairness within their wider community;
- To have a sense of security and belonging in a family and social group;
- To be safe, valued, accepted and loved in their earliest relationships with caregivers;
- To meet basic physical and material needs for themselves and their dependants;
- To form intimate relationships and partnerships;
- To feel valued and effective within family and social roles;

- To experience and manage a range of emotions;
- To be able to contribute, achieve and meet goals;
- To be able to exercise agency and control in their lives;
- To have a sense of hope, belief, meaning and purpose in their lives

...all of which will provide the conditions for them to be able to offer their children...

- Secure and loving early relationships as a basis for optimum physical, emotional and social development and the capacity to meet their own core needs.

Anything that prevents these core needs being met may be experienced as a threat to emotional, physical, relational and/or social safety and survival.

Earlier sections of this document have collectively summarised evidence on fundamental aspects of the emergence of mental distress, unusual experiences and problematic behaviour as follows:

- the operation of **POWER** (in its various forms of biological/embodied power; coercive or power by force; legal power; economic and material power; social and cultural capital; interpersonal power; and ideological power). These manifestations of power, both negative and positive, operate through social structures, institutions and organisations; through our physical environment; through the media and education; and through social and family relations;
- the kinds of **THREAT** that the negative operation of power may pose to the individual, the group and the community, with particular reference to mental distress;
- the central role of **MEANING** (as produced within social and cultural discourses, and primed by evolved and acquired bodily responses) in shaping the operation, experience and expression of power, threat, and our responses to threat;
- the evolved and learned **THREAT RESPONSES**, mediated through meaning-based bodily capabilities, that any individual (or family, group or community) experiencing threat arising within the Power Threat Meaning process, may need to use to protect themselves. Rather than being ‘diagnosed’ as *passively suffering biological deficits*, we suggest that service users (and all of us) can be recognised and validated as *activating threat responses for protection and survival*. The experiences that are described as ‘symptoms’ are therefore better understood as reactions to threat, or ‘survival strategies’.

In line with our earlier analyses, we therefore propose a conceptual framework for the origins and persistence of distress, unusual experiences and troubled or troubling behaviour which we have named the **Power Threat Meaning (PTM) Framework**.

To put it at its simplest, the PTM Framework replaces ‘What is wrong with you?’ with four key questions:

- ‘What has happened to you?’ (How is **Power** operating in your life?)
- ‘How did it affect you?’ (What kind of **Threats** does this pose?)
- ‘What sense did you make of it?’ (What is the **Meaning** of these situations and experiences to you?)
- ‘What did you have to do to survive?’ (What kinds of **Threat Response** are you using?)

Translated into practice with an individual, family or group, two additional questions need to be asked:

- ‘What are your strengths?’ (What access to **Power resources** do you have?)
- ...and to integrate all the above: ‘What is your story?’

It is important to note that we are conceptualising this framework in a fundamentally different way from the more traditional biopsychosocial model:

- Although a tripartite structure is a convenient heuristic, the three elements are not independent, but evolve out of each other. There is no actual divide either within or across the proposed core aspects. The person does not exist, and cannot be understood, separately from his/her relationships, community and culture; meaning only arises out of the interaction of social, cultural and biological elements; and biological capacities cannot be separated from the social and interpersonal environment.
- Unlike (some versions of) biopsychosocial models, there is no assumption of pathology, and the ‘biological’ aspects are not privileged. Rather, biological aspects constitute one level of explanation, arising out of and shaped by all the others.
- The capacities for creating meaning (within available discourses) and the exercise of agency (within material and biosocial restraints and cultural understandings) are fundamental attributes of human beings. Personal meanings are not simply freely chosen but are reflective of experience, relationships and wider social and cultural circumstances. ‘Meaning’ is intrinsic to the expression and experience of all forms of emotional distress, giving both shared and unique shape to the individual’s personal responses.
- While most mental health (and related) work is aimed at the individual, we argue that meaning and distress must also be understood at social, community and cultural levels. Thus we see the PTM Framework as applying equally to understanding, intervention and social action in a wider sense. In other words, the PTM Framework aligns with a recent UN report recommending a shift of focus towards ‘power imbalance’ rather than ‘chemical imbalance’ (UNHRC, 2017, p.19).

A key purpose of the PTM Framework is to aid the provisional identification of evidence-based patterns in distress, unusual experiences and troubled or troubling behaviour. In contrast to the specific biological causal mechanisms which support some medical disorder categories, these patterns are highly probabilistic, with influences operating contingently and synergistically. However, this does not mean that no regularities exist. Rather, it implies that these regularities are not, as in medicine, fundamentally patterns in biology, but *patterns of embodied, meaning-based threat responses to the negative operation of power*. These responses, and the patterns of which they form a part, can be described by verbs that will be as near as we can come to replacing diagnostic terms. *‘Reconfigured as verbs, diagnostic categories become strategies for living’* (Laura Kerr on dxsummit.org).

The PTM Framework demonstrates how these probabilistic patterns can be described at various levels, starting with the ‘Foundational Pattern in the PTM Framework’. This sets the scene for the identification of seven Provisional General Patterns which emerge from within the Foundational Pattern. They are not one-to-one replacements for diagnostic

clusters, but are based on broad regularities which cut across diagnostic groups, and which arise out of personal, social and cultural meanings.

These Provisional General Patterns fulfil one of the main aims of the PTM Framework, which is to restore the links between meaning-based threats and meaning-based threat responses. These responses arise out of core human needs to be protected, valued, find a place in the social group, and so on, and represent people's attempts, conscious and otherwise, to survive the negative impacts of power. Understood as 'survival strategies' rather than 'symptoms', they cut across diagnoses, across specialties, and across the boundaries of what is usually considered 'normal' versus 'pathological'. They are present at some points and to some degree in everyone's daily life.

One important implication of the principles outlined above is that they suggest a potential solution to the hitherto irresolvable dilemma about the application of Western psychiatric classification systems to non-Western cultures and expressions of distress, both within the UK and around the world (see the discussion of ethnicity and culture in Chapters 2, 3 and 4). The PTM Framework predicts and allows for the existence of widely varying cultural experiences and expressions of distress without positioning them as bizarre, primitive, less valid, or as exotic variations of the dominant diagnostic or other Western paradigms. Since expressions of emotional distress will always be to an extent local to time and place, there can never be a universal lexicon of such patterns. The same applies to historical phenomena such as 'hysteria'. Viewed as a meta-framework that is based on universal evolved human capabilities and threat responses, the basic principles of PTM apply across time and across cultures. Within this, open-ended lists of threat responses and functions (described later) allow for an indefinite number of locally and historically specific expressions of distress, all shaped by prevailing cultural meanings.

More specifically, the PTM Framework can suggest alternatives to diagnosis for clustering/administrative/legal/service planning/research purposes. It can inform the construction, or co-construction, of personal narratives and open up the possibility for different, non-diagnostic stories of strength and survival. Along with this, it offers a way of more effectively fulfilling some of the reported benefits of diagnosis, such as providing an explanation, having distress validated, facilitating contact with others in similar circumstances, offering relief from shame and guilt, suggesting a way forward and conveying hope for positive change.

The Power Threat Meaning Framework therefore fulfils the following main purposes:

- Highlighting the common meaning-based threats posed by various manifestations of power.
- Highlighting the evolved and acquired strategies commonly employed to counteract these threats.
- Highlighting the links between threats and protective threat responses that have been obscured by the use of diagnostic labels.
- In the place of traditional psychiatric models, providing a basis for identifying broad, evidence-based patterns that synthesise the influences of Power, Threat, Meaning and associated Threat Responses.
- Utilising these patterns to generate personal, group and/or social narratives that help to restore meaning and agency, in line with the relevant cultural assumptions, and

along with this, have the potential to create hope, rebuild relationships, and promote social action.

The Foundational Power Threat Meaning pattern that arises out of the various elements of the PTM Framework will now be described. This pattern underpins the specific patterns described later on, by summarising regularities in the experience and expression of distress at the most general level.

The Foundational Power Threat Meaning Pattern

In order to identify meaningful patterns in distress within the trends and regularities described in detail in Chapters 4 and 5, we need to start with the most general foundational pattern which underpins all the others, whether applied at an individual, family, group or population level. The Foundational Pattern described below uses the PTM Framework to synthesise the extensive amount of research and evidence into the whole range of social and interpersonal adversities. This suggests a summary of population-level trends and regularities as follows:

- All forms of adversity are more common within contexts of inequality and other forms of deprivation, discrimination, marginalisation and social injustice.
- Social discourses and ideological meanings shape the experience and expression of distress.
- Disrupted early attachment relationships are a form of adversity in themselves, and also set the scene for biologically-mediated emotional responses to subsequent adversities.
- A large part of the impact of adversity can be accounted for by factors which exacerbate the experience of threat. These include younger developmental age; entrapment; interpersonal and intentional threat; unpredictability and lack of control over the threat; repeated and multiple threats; physical invasiveness; chronic background threat; and lack of someone to confide in and act as protector.
- Ameliorating factors such as later developmental stage, having someone to confide in, being able to escape, are the opposite of the exacerbating ones (see Box 1, Exacerbating aspects of adversities).

Box 1: Exacerbating aspects of adversities

- Early developmental stage
- Lack of person to support/confide in/protect
- Multiple kinds of danger
- Long-lasting/repeated danger
- Severity of the danger
- Escapability or 'trappedness'
- Lack of predictability and control over the threat
- Physical invasiveness of the threat
- Closeness in time/Co-occurrence to other threats
- Threat to sense of self
- Interpersonal and intentional threat
- Sense of betrayal by individuals or institutions
- Perceived social threat
- Greater number of perpetrators
- Threat that occurs within an emotional or attachment relationship
- Chronicity, background threat, either environmental or personal

There is robust evidence to show that these factors increase the likelihood of emotional damage in the face of threats and adversities. These are not specific threats in themselves, but are *aspects of threatening situations that exacerbate the experience of threat*. Their opposites – e.g. later developmental stage, having someone to confide in, being able to escape – will, other things being equal, reduce the experience and impact of threat.

- *The impact of adversities is cumulative.* There is a clear dose-effect, and as adversities multiply, the negative outcomes (biological, psychological and social) increase in a graded fashion.
- *Experiencing one or more adversities increases the risk of experiencing subsequent adversities.* This means that simple patterns – single threat to single threat response – will be relatively rare in service settings.
- *The impact of adversities is synergistic.* The combined effect of more than one adversity is usually greater than, and may be qualitatively different from, the sum of their individual effects.
- *The more adversities someone experiences, the more kinds of threat responses they will use.* In these circumstances people will need to draw upon a greater number of survival strategies, reflected in the application of multiple psychiatric diagnoses.
- *Some threat responses, such as those diagnosed as 'psychosis', become more common along with the cumulative and synergistic effects of adversities* and can therefore be regarded as reflecting a greater degree of damage.
- The impacts of adversity may be *transmitted down the generations*, thus perpetuating these destructive cycles.

- Finally, *mental health and other human systems are often traumatising and re-traumatising in themselves*, setting up further cycles of cumulative and synergistic events in which diagnosis can act to confirm feelings of shame, deficit and exclusion, and admissions, labels and interventions may multiply.

Putting all this together results in what can be described as the Foundational Power Threat Meaning Pattern in mental distress and other behavioural, health and social outcomes.

The narrative summary of the Foundational Pattern is as follows:

Economic/social inequalities and ideological meanings which support the negative operation of power result in increased levels of insecurity, lack of cohesion, fear, mistrust, violence and conflict, prejudice, discrimination, and social and relational adversities across whole societies. This has implications for everyone, and particularly those with marginalised identities. It limits the ability of caregivers to provide children with secure early relationships, which is not only distressing in itself for the developing child, but may compromise their capacity to manage the impact of future adversities. Adversities are correlated, such that their occurrence in a person's past and/or present life increases the likelihood of experiencing subsequent ones. Aspects such as intentional harm, betrayal, powerlessness, entrapment and unpredictability increase the impact of these adversities, and this impact is not just cumulative but synergistic. Over time, the operation of complex interacting adversities results in a greatly increased likelihood of experiencing emotional distress and troubled or troubling behaviours. The form of these expressions of distress is shaped by available resources, social discourses, bodily capacities and the cultural environment, and their core function is to promote emotional, physical and social safety and survival. As adversities accumulate, the number and severity of these responses rises in tandem, along with other undesirable health, behavioural and social outcomes. In the absence of ameliorating factors or interventions, the cycle is then set up to continue through further generations.

Put like this, the outcomes seem hardly surprising. Nevertheless, it is important to have research-based confirmation of this common sense conclusion, because it is fundamentally opposed to the diagnostically-based one. It demonstrates that psychological and emotional distress is, like all human experience, mediated by biology but not in any simplistic sense caused by it. It illustrates the fact that emotional distress and troubling or troubled behaviour are on a spectrum, in which everyone is likely to be impacted by the consequences of social injustice as reflected through taken-for-granted aspects of everyday life, even if they have not experienced specific traumatic events. For the less fortunate or privileged, it illustrates how extreme and disabling circumstances can lead to extreme and disabling responses, in a predictable ratio to damage. It also suggests that there can be ways to escape the cycle, even in the most challenging contexts. The pattern is summarised in diagrammatic form on p.196.

The Foundational Power Threat Meaning Pattern

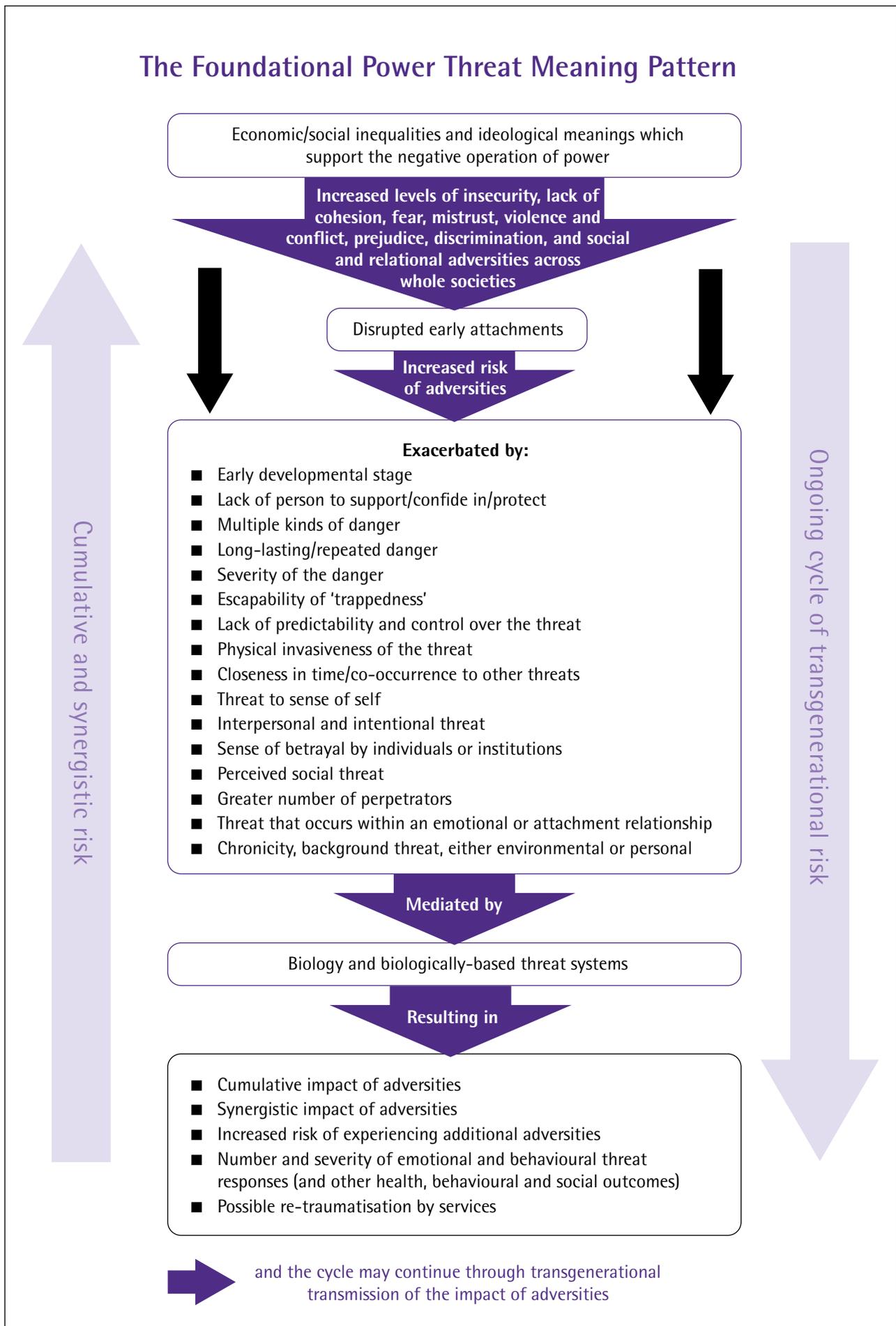


Figure 1: The Foundational Power Threat Meaning Pattern

Comments on the Foundational Power Threat Meaning Pattern

These are population-level trends and not pre-determined individual pathways, and they describe risks not inevitabilities. Nevertheless, the Foundational Pattern has extremely important implications for mental health systems and human services as a whole.

A cumulative and synergistic model of the impact of adversities does not support the individualisation of distress, either medically or psychologically. Instead, it implies the need for action, primarily through social policy, at the earliest possible point, before the destructive and self-perpetuating cycle is set in motion (see examples in Chapter 8).

The origins of the ‘everything’s...’ problem can be clearly seen. The experience of adversities, especially in early years, sets up highly complex, overlapping, meaning-based, cumulative and synergistic patterns in which causality is contingent and probabilistic. The number of possible combinations of response (whether officially designated as ‘pathological’ or not) is almost infinite. The discrete causal pathways implied by psychiatric diagnosis do not and cannot exist in relation to human responses to adversity. Equally importantly, nor can we expect to find psychosocial versions of those pathways in terms of specific event to specific outcome. The Foundational Pattern, then, does not solve the ‘everything’s’ problem. Rather, it acknowledges that *this is how things are*. We believe this is an essential and long overdue recognition.

As already noted, while many people who have been psychiatrically labelled will have experienced both attachment disruptions and specific forms of adversity, even the most loving and secure upbringing cannot provide protection against all threats, especially given a wider context of social inequality. Equally, very few people, whatever their early background, will survive circumstances such as domestic abuse, trafficking, refugee status, chronic physical pain and ill health, multiple bereavement, major natural disaster, war, captivity and so on, without emotional scars. The fewer ameliorating factors in a person’s life (e.g. alternative caregivers; social support; adequate housing; skills and abilities; education; access to resources; appropriate intervention) the smaller the chance of escaping this cycle. However, it is just as important to recognise that each of these possibilities can also be played out positively – perhaps in the form of a caring relative, a particular talent, or a change in social circumstances. With the right kind of support, many people have been able to find a way out from these destructive patterns. We will return to this point later.

We have argued that the Foundational Pattern arises in the context of the negative impacts of power, both immediate and more distant. Along with the work of many others, this analysis suggests that socioeconomic structures influence the social discourses and meanings which serve and shape the interests of various kinds of power, in both its negative and its positive operation. In all these situations, the individual’s distress is likely to be increased in proportion to the extent to which they have assimilated the underlying social norms and discourses, for example, those relating to appropriate gender roles or personal responsibility. As discussed in Chapters 3 and 4, shame is a social emotion, and while a psychiatric diagnosis is sometimes welcomed as offering protection from shame for one’s actions, it can also be experienced as shorthand for a community judgement of: ‘You are a flawed and unacceptable member of the social group.’ Diagnosis can thus set the scene for perpetuating the cycle of traumatising, discrimination and social exclusion.

The Foundational PTM Pattern can be used in combination with an ‘ameliorating factors’

list as a quick checklist to suggest a way of understanding and validating the degree of distress/difficulty in functioning experienced by a particular individual, family, group or community. While we suggest that the PTM Framework and the Foundational PTM Pattern can be used as they stand, they can also be seen as a meta-framework within which existing models and bodies of evidence can be accommodated. Additionally, they can serve as a reference point for identifying gaps in current theory and practice, which very often arise out of insufficient attention to the negative operation of power and its associated ideological meanings. Good practice examples of existing work which is in line with these principles can be found in the Appendices of the Overview publication www.bps.org.uk/PTM-Overview

The next section outlines provisional General Patterns within the Foundational PTM Pattern.

Part 3: Provisional General Patterns arising out of the Foundational Pattern

In this section, we will illustrate how the four main elements of Power, Threat, Meaning and Threat Response can be used to identify patterns and regularities within the overarching Foundational Pattern. These regularities can be understood as more specific examples of *patterns of meaning-based threat responses to power*.

Towards the end of the section, there will be a demonstration of how these provisional, probabilistic, evidenced General Patterns within the Foundational one can serve as a basis for generating personal, group and/or social and community narratives that promote meaning and agency, and along with this, have the potential to create hope, rebuild relationships, and support social action. The PTM Framework and General Patterns can also be used for the more effective fulfilment of the other claimed functions of psychiatric diagnosis, such as indicating interventions, planning services, making administrative decisions, and providing a basis for research (as described in Chapter 8).

Before outlining the General Patterns, it is important to discuss in more detail what might be meant by a 'pattern' in this context, and the similarities and differences between these proposed patterns and the ones that are used to support medical diagnoses.

What is a pattern?

At the most general level, a pattern refers to associations that seem to occur above chance level, amongst whatever phenomena are under consideration. This *meaningfulness* of certain associations can be suggested by, for example, their high frequency of occurrence, by some evidence of causality i.e. antecedent/consequence relationships, and by knowledge of processes which help make sense of them. In Chapter 1, we described how, in medicine, patterns or regularities of this sort in bodily functions, serve as 'templates' to which clinicians try to match an individual's bodily complaints and so gain some understanding of how these complaints have come about and might be alleviated. We also noted that these patterns are at very different levels of complexity and development, providing varying levels of understanding of an individual's problems.

The difficulties of deriving a specific definition of ‘pattern’ in this kind of context are well illustrated in a classic paper on medical diagnosis by Ralph Engle and B.J. Davis published in 1963 but just as relevant today (see e.g. Rosenberg, 2002). The similarities between the aims of medical diagnosis and the aims of alternatives to psychiatric diagnosis mean that the general arguments are relevant to discussion of patterns of emotional and behavioural difficulties as well.

Engle and Davis (1963) describe medical diagnoses as being at different ‘orders of certainty’ reflecting the different characteristics of the patterns they are based on and how ‘certain’ a clinician can be that a patient’s presenting problems ‘match’ any particular general pattern. The first order of certainty includes presentations where the causes are usually very clear and specific and where there is very little variation from person to person or environment to environment. This would include frostbite, crush injuries and some other traumatic outcomes. At the other extreme, at the fifth order of certainty on Engle and Davis’ scale, are constellations of signs and symptoms whose causes are not known and where there is a good deal of variability from person to person. In between are patterns with more or less well-defined links between causes and outcomes and/or more or less variation in individual presentations.

It might be argued that psychiatric diagnoses simply occupy a low point on this scale, but this is not the case. For all the reasons discussed in Chapter 1, the *DSM* and *ICD* clusters on which functional psychiatric diagnoses are based do not reach even Engle and Davis’ lowest order of certainty – constellations of signs and symptoms – although common misuse of the terms ‘sign’ and ‘syndrome’ in discussions of psychiatric diagnosis might suggest otherwise.

Engle and Davis make several important points about general medical patterns and their role in understanding individual problems. First, the patterns and their separation one from another, are always provisional. We can point to some evidence of their validity, but they are never fixed. Second, the patterns are of different types, based on different sorts of evidence, including anatomical changes, causal agents, genetic or biochemical abnormalities and so on. Third, each pattern is underpinned by complex theory and research about the nature of its ‘elements’ and their relationship, and this theory and research, too, is continually being modified. Finally, these patterns have varying relationships to our understanding of an individual’s problems. In some, the match is clear and straightforward, in others it is more open-ended and uncertain.

We have emphasised that the kind of patterns one would expect to find in people’s emotional and behavioural difficulties, their causes and consequences, are very different from the kind of patterns of bodily problems which inform medical diagnosis, and that they are subject to fundamentally different types of causal regularity, and so need to be based on very different theoretical assumptions. However, Engle and Davis’ general points are relevant to the task of describing patterns we can draw on in understanding emotional and behavioural difficulties. Specifically, these regularities will not conform to a single, straightforward definition of ‘pattern’. There can be various kinds of evidence of their validity, including their basis in appropriate theoretical frameworks, frequent occurrence, evidence of cause/effect relationships and knowledge of possible underlying mechanisms, but the patterns, and their boundaries, are inevitably provisional and have an open-ended relationship to the problems of particular individuals or groups. Nevertheless,

the particular patterns we are proposing here are marked by the striking consistency with which their elements emerge from diverse forms of research with population-wide and service user groups. This includes historical and theoretical analyses; demographic, survey, questionnaire, experimental and other quantitative research; qualitative analyses; and, not least, the large body of personal testimonies about distress and unusual experiences. We will return to these themes in the following sections.

Describing meaningful associations: Threat and threat response links

The patterns that can be derived from the PTM Framework and the Foundational Pattern are based on restoring the links between meaning-based threats and meaning-based threat responses.

It is useful to remember that in some situations, these links are readily acknowledged. It hardly needs stating that death of a loved one is experienced as loss and commonly evokes a reaction of grief; absence of attachment figures is experienced as abandonment and leads to anxiety and searching in young children; threat to physical safety results in terror and a fight/flight/freeze reaction; and so on. However, we do not usually ascribe pathology where the immediate psychosocial causal event is obvious. Thus, the temporary madness of grief (weeping, despair, hearing or seeing the person who has died, insomnia, restlessness, inability to concentrate and so on) is not seen as a psychiatric illness even though this constellation of reactions would undoubtedly attract a diagnosis in the absence of an obvious cause. A frantic, weeping, clinging child is not thought to be experiencing a 'disorder' once we realise she has lost her mother in a crowd. A hyperalert, highly anxious soldier is not seen as having suddenly developed a 'mental illness' if he is actually facing combat. Similarly, researchers into 'paranoia' have commented that its well-established links to experiences of bullying, violence, discrimination and unsafe environments render it 'understandable, and, indeed, adaptive' (Shevlin et al., 2015, p.213). In general healthcare settings the link between threatening event and distress (e.g. receiving a terminal diagnosis, difficult childbirth) may also be obvious, although there may be less awareness about the triggering of pre-existing adversities.

Some of these links are acknowledged in psychiatric diagnoses such as 'PTSD', and interestingly, this appears to be part of a growing trend. *DSM-5* (APA, 2013) has re-assigned 'PTSD' from the general category of 'Anxiety Disorders' to a new chapter on 'Trauma and stressor-related disorders', which is described as 'unique within *DSM-5* for requiring the identification of a triggering external event'. It includes 'Reactive attachment disorder', 'Disinhibited social engagement disorder' (in *ICD* this is 'Disinhibited attachment disorder'), 'Acute stress disorder', 'Adjustment disorder' along with other specified or non-specified 'trauma and stressor-related disorders.' 'RAD' is said to develop 'as a result of maltreatment and/or neglect'. Acute stress disorder follows 'exposure to actual or threatened death, serious injury, or sexual violation'. Adjustment disorder 'occurs within a month of a distressing event'. 'Disinhibited attachment disorder' is 'the result of social neglect'. In other words, in all of these diagnoses the 'symptoms' are explicitly described as threat response patterns to psychosocial events and circumstances; indeed, biological causes are exclusion criteria. This new chapter joins the *DSM* and *ICD* one on 'Dissociative Disorders' (including Dissociative Identity Disorder, Dissociative Amnesia,

and Depersonalisation/ Derealisation) as the only place in which ‘disorders’ are explicitly acknowledged as responses to adverse psychosocial events. The trend for framing psychiatric presentations as the consequences of psychosocial adversities, albeit within a ‘disorder’ framework with all its limitations, would have been even stronger had van der Kolk (2014) and colleagues’ detailed proposals for the new categories of ‘Complex trauma disorder’ and ‘Developmental disorder’ to replace many uses of *DSM-IV* diagnoses been accepted.

Similarly, a new category of Complex Post-Traumatic Stress Disorder (Complex Trauma for short) is proposed for inclusion in *ICD-11*. This is defined as ‘*A disorder that may develop following exposure to an event or series of events of an extreme and prolonged or repetitive nature that are experienced as extremely threatening or horrific and from which escape is difficult or impossible (e.g. torture, slavery, genocide, prolonged domestic violence, repeated childhood sexual or physical abuse)*’ (Maercker et al., 2013).

Our argument is that the great majority of the experiences that are described as ‘symptoms’ of ‘functional psychiatric disorders’ (and many other problems, including some examples of criminal behaviour) can be understood in this way, but with no assumption of ‘mental disorder’, once the meaning-based threats have been identified and their links with the protective threat responses restored. The examples above also make it clear that responses need to be described at the level of *function*, not just at the level of behaviours and reactions that have usually been called ‘symptoms’. The function of the child’s crying is to attract the mother’s attention; the function of the soldier’s high arousal is to prepare for fight; the function of suspicious thoughts is to protect from attack; and so on.

As discussed in earlier chapters, a number of factors combine to ensure that these links are obscured in most of what is called ‘mental illness’, as well as in ‘offending behaviour’ and other health and social outcomes. Briefly summarised, these are:

- The threat (or operation of power) may be less obvious because it is subtle, cumulative, and/or socially acceptable. These factors obscure the negative operation of power and thus enable its perpetuation.
- The threat is often distant in time, even though the threat response is still active.
- The threats may be so numerous, and the responses so many and varied, that the connections between them are confused and obscured.
- There may be an accumulation of apparently minor threats and adversities over a very long period of time – particularly in older adults.
- The threat response may take an unusual or extreme form that is less obviously linked to the threat; for example, apparently ‘bizarre’ beliefs, hearing voices, self-harm, self-starvation.
- The person in distress may not be aware of the event(s) or the link themselves, since memory loss, dissociation and so on are part of their coping strategies.
- The person in distress might have become accustomed to disavowing the possibility of a link, because acknowledging it might have felt dangerous, stigmatising, shaming or in some other way unhelpful.
- The disavowing of these links may be encouraged by social discourses of blame, weakness, culpability and so on.
- Mental health professionals are socialised to obscure the link by the application of a diagnosis which imposes a powerful expert narrative of individual deficit and medical illness.

- There is resistance at all levels of society to recognising the prevalence of threats and the negative impacts of power.
- There are many vested personal, family, professional, organisational, community, business, economic and political interests in disconnecting threat from threat response and thus preserving the ‘medical illness’ model.
- The influences above combine to deprive people of a socially shared framework of thought within they can make sense of their own experiences in their own terms.

Cumulatively, these factors help to ensure that such experiences may ‘take place outside the realm of socially validated reality’ and thus become ‘unspeakable’ (Herman, 2001, p.8). This process, which has been described as ‘betrayal blindness’ (Freyd & Birrell, 2013), operates at multiple levels – personal, familial, institutional and societal. In Judith Herman’s words, ‘Repression, dissociation and denial are phenomena of social as well as individual consciousness’ (Herman, 2001, p.9). The impact on the person who is diagnosed can be seen as a form of ‘epistemic injustice’ (Fricker, 2007), a concept which describes the process through which members of marginalised groups are deprived of the social resources to understand their experiences outside of the dominant discourses. This point will be revisited later.

Meanwhile it is important to stress that the relevant sections of *ICD* and *DSM* still conceptualise threat responses as discrete medical ‘symptoms’ or complaints. In contrast, PTM groups them in terms of the main functions they serve, which in turn link to core human needs to be protected, valued, exercise agency and control, find a place in the social group, and so on. These strategies cut across traditional boundaries of ‘normal/abnormal’.

A non-exhaustive list of threat responses is given in Box 2. Everyone experiences or uses these various forms of reaction and behaviour at times, and this is not necessarily a problem. Many of them – such as seeking attachments – are simply part of being human. Thus, they do not always serve the function of protecting from threat, whether they fall into the social categories of ‘normal’ or even desirable (e.g. hard work) or ‘pathological’ (e.g. holding unusual beliefs, hearing voices.) However, especially if they do serve a threat response purpose, they may become problematic in their own right.

Box 2: Functional groupings of threat responses

Regulating overwhelming feelings	E.g. by dissociation, self-injury, memory fragmentation, bingeing and purging, differential memory encoding, carrying out rituals, intellectualisation, 'high' mood, low mood, hearing voices, use of alcohol and drugs, compulsive activity of various kinds, overeating, denial, projection, splitting, derealisation, somatic sensations, bodily numbing
Protection from physical danger	E.g. by hypervigilance, insomnia, flashbacks, nightmares, fight/flight/freeze, suspicious thoughts, isolation, aggression.
Maintaining a sense of control	E.g. by self-starvation, rituals, violence, dominance in relationships
Seeking attachments	E.g. by idealisation, appeasement, seeking care and emotional responses, use of sexuality
Protection against attachment loss, hurt and abandonment	E.g. by rejection of others, distrust, seeking care and emotional responses, submission, self-blame, interpersonal violence, hoarding, appeasement, self-silencing, self-punishment
Preserving identity, self-image and self-esteem	E.g. by grandiosity, unusual beliefs, feeling entitled, perfectionism, striving, dominance, hostility, aggression
Preserving a place within the social group	E.g. by striving, competitiveness, appeasement, self-silencing, self-blame
Meeting emotional needs/self-soothing	E.g. by rocking, self-harm, skin-picking, bingeing, alcohol use, over-eating, compulsive sexuality
Communication about distress, elicit care	E.g. by self-injury, unusual beliefs, voice-hearing, self-starvation
Finding meaning and purpose	E.g. by unusual beliefs, overwork, high moods

The function of specific threat responses will vary from situation to situation and from person to person, although some within-culture commonalities can be expected. This is because, as discussed in Chapter 2, different cultures provide 'symptom pools' or culturally recognised ways of expressing distress. In addition, the same threat response may serve multiple purposes for a single individual. Thus, self-injury may be used simultaneously as self-punishment, communication, and release of feelings. All of these strategies may represent people's attempts – conscious or otherwise – to survive the negative impacts of power and adversity by using the resources available to them. Managing overwhelming feelings and memories is a central survival need in all forms of distress, and is therefore likely to engage a very wide range of threat responses.

Restoring the links between threats and threat responses within the PTM Framework

The PTM Framework offers a structure for restoring the links between meaning-based threats (such as betrayal, abandonment, physical danger) and meaning-based threat

responses (such as hyper-vigilance, self-injury and carrying out rituals). Placing all of these in the wider contexts of power and social/ideological meanings will help us to identify some general, probabilistic and overlapping General Patterns and regularities within the Foundational PTM Pattern.

The template below ('Power Threat Meaning Framework General Patterns Template') may help to illustrate this process. It offers an elaboration of the Foundational Power Threat Meaning Pattern. The main elements of the Foundational Pattern (Power, Threat, Exacerbating/ameliorating factors and Threat responses) have been expanded in order to allow for a more detailed description of their various aspects. 'Mediating biological factors' could include not just biologically-based threat responses, but general factors such as hormonal changes, temperamental factors, the impact of food restriction or sleep deprivation, changes associated with ageing, and so on, along with the consequences of neurodevelopmental conditions, stroke or brain injury if relevant. The addition of 'Meaning and discourse' allows for closer consideration of the characteristic personal and social meanings through which threats may be experienced.

This expanded version of the Foundational Pattern elements can be used to support the identification of evidence-based, but overlapping and contingent, Provisional General Patterns within the Foundational one, as described in the next section 'Provisional General Patterns: Identifying the elements and building blocks.' An adapted version of the template and a guide to using the framework in service, peer support or self-help settings, can be found in Appendix 1 of the Overview publication www.bps.org.uk/PTM-Overview

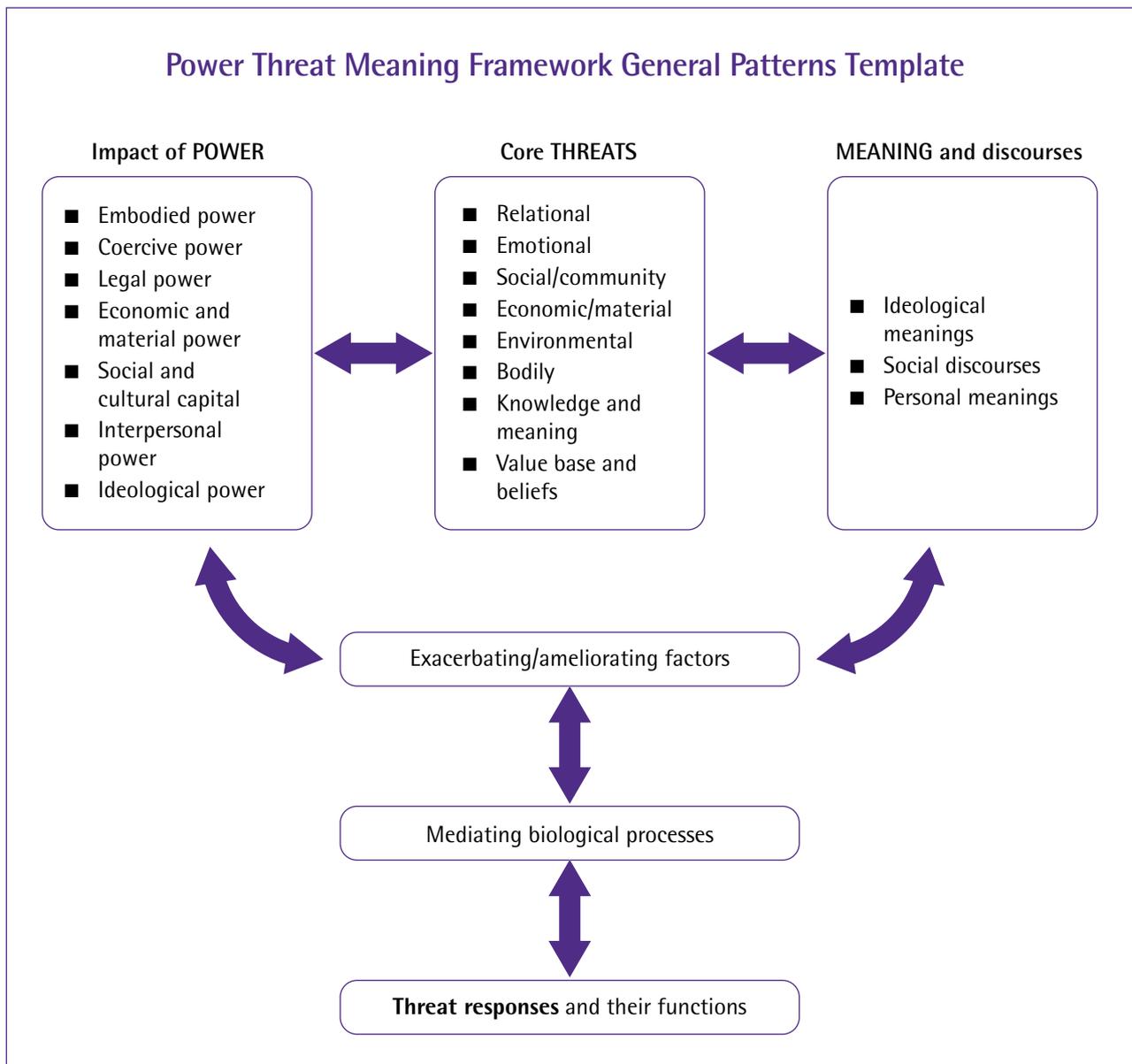


Figure 2

Provisional General Patterns: Identifying the elements and building blocks

This section establishes a preliminary, evidence-based set of building blocks within the four aspects of Power, Threat, Meaning and Threat Response. These building blocks are then used as a basis for outlining General Patterns within the Foundational PTM one.

These lists are not exhaustive, in whatever cultural setting they are used. They are intended to be and to remain open-ended, in order to allow for evolving expressions of distress within particular local and historical contexts. Equally, ongoing research is needed for further confirmation of the validity and practical usefulness of the various elements.

It cannot be over-emphasised that the four aspects of Power, Threat, Meaning and Threat Response are inseparable, conceptually and experientially, although they are considered separately for the purposes of explanation and clarity.

We will now consider each of these four aspects in more detail.

POWER How is Power operating in your life? ('What has happened to you?')

Power can operate positively, in terms of protection, support and access to resources, and also negatively. It is impossible to describe the negative operation of power without at the same time implying both the threat that may result and the meaning that may be intrinsic to the threat. PTM's explicit delineation of the multiple possible sources of power in the life of a child/adult/group/community is central to making coherent sense of people's experiences, and should be the starting point for any understanding of distress or disturbing behaviour.

Power operates through both immediate and more distant factors, mediated through bodily capacities, relationships, social structures, institutions, organisations and everyday interactions. It operates with and without our conscious awareness. As noted in Chapter 4, there is no agreed listing of 'types' of power but the following conveys many aspects of its operation in separate but related spheres:

- **Biological or embodied power** operates both positively and negatively through embodied attributes and their cultural meanings: for example strength, physical appearance, fertility, skin shade and colour, embodied talents and abilities, and physical health and wellbeing.
- **Coercive power or power by force** is inevitably part of war and combat but also involves any use of violence, aggression, threats or greater physical strength, to frighten, intimidate or ensure compliance. Although often negative, coercive power can be used positively, for example, when parents remove young children from danger.
- **Legal power** may also involve coercion, such as power of arrest, imprisonment or hospitalisation. It also refers to a wide range of rules and sanctions which regulate and control many areas of our lives and behaviour, support or limit other aspects of power, offer or restrict choices, protect people's rights, maintain social order, and so on.
- **Economic and material power** involves having the means to obtain valued possessions and services, to control others' access to them and to pursue valued activities. This applies in multiple areas including housing, employment, transport, education, medical treatment, leisure, legal services, safety and security, and privacy.
- **Social or cultural capital** refers to a form of power characterised by a mix of valued qualifications, social identities, knowledge and social connections which can be passed indirectly to the next generation. Increasingly this involves access to and skills in using computers, social media and other new technologies as well as understanding how they can shape our lives, for good or ill.
- **Interpersonal power** Although all forms of power can operate through relationships, this refers more specifically to the power to look after/not look after or protect someone, to help or abandon/leave them, to give/withdraw/withhold love and care, to undermine or support others in the development of their beliefs and identities, and so on.
- **Ideological power** involves control of meaning, language and 'agendas'. It also includes power to create narratives which support particular social and economic interests, to create beliefs or stereotypes about particular groups, to interpret your own or others' experience, behaviour and feelings and have these meanings validated by others, and the power to silence or undermine. It is one of the more hidden forms of power and operates across many areas including the media, advertising, government,

education, the legal system, healthcare, science and research. Social media and the internet have allowed an increasingly pervasive and sophisticated operation of ideological power in ways that are often beyond our knowledge, awareness or skills.

As discussed in Chapter 4, the negative operation of power in these closely related spheres, and the lack of socially valued attributes and resources, can produce challenging and threatening contexts and at the same time limit people's ability to respond to these threats.

THREAT What kinds of threat does it pose? ('How did it affect you?')

Threat describes the risk/dangers that the negative uses of power, as outlined above, may pose to the safety and survival of individuals and/or groups. Since the three aspects of Power, Threat and Meaning are interwoven, a list of threats inevitably implies both their origins and their meanings.

In situations such as natural disasters, the influence of power is more indirect and may be evident through, for example, differing opportunities to take preventative measures beforehand or access material support afterwards. In addition, all of us are vulnerable to experiencing random and unavoidable threats such as unexpected bereavement, accidents or physical ill-health. Here again, power will mainly have its effects through access to support with these life events, and the extent to which our early lives have equipped us to manage their emotional impact.

Core Threats to safety, survival or wellbeing can be conceived of as the opposite of the core human needs outlined earlier, and include:

Relational: e.g. disrupted attachments, abandonment, betrayal, isolation, shaming and humiliation, rejection, hostility, neglect, bereavement, lack of protection, entrapment, threats to boundaries, autonomy/control, self-concept and identity formation, invalidation.

Emotional: feeling emotionally overwhelmed and unsafe.

Social/community: e.g. isolation, exclusion, hostility, social defeat, injustice/unfairness, loss of social or work role.

Economic/material: e.g. poverty, inability to meet basic physical needs, or access basic services for oneself and/or dependants.

Environmental: e.g. lack of safety, physical threat, entrapment, loss of connection with homeland or the natural world.

Bodily: e.g. ill-health, chronic pain, bodily disability, injury, loss of function, physical danger, starvation, exhaustion, bodily invasion.

Knowledge and meaning construction: lack of opportunity, support or social resources to access and use important sources of information and make sense of one's experiences; devaluing of one's own knowledges, understandings and experiences due to unequal power relations; imposition of meanings by social discourses and by more powerful others.

Identity: lack of support to develop one's own identity; loss of social, cultural or spiritual identity; the adoption or imposition of devalued, subordinate or shameful identities relating to oneself or one's social group.

Value base: loss of purpose, values, beliefs and meanings; loss of community rituals, belief systems and practices.

Box 3: Meanings

MEANING – what is the Meaning of these situations and experiences to you? ('What sense did you make of it?')	
Unsafe, afraid, attacked	Trapped
Abandoned, rejected	Defeated
Helpless, powerless	Failed, inferior
Hopeless	Guilty, blameworthy, responsible
Invaded	Betrayed
Controlled	Shamed, humiliated
Emotionally overwhelmed	Sense of injustice/unfairness
Emotionally 'empty'	Sense of meaninglessness
Bad, unworthy	Contaminated, evil
Isolated, lonely	Alien, dangerous
Excluded, alienated	Different/'abnormal'

As already noted, the threatening impacts of the operation of power cannot be understood without attention to their meaning for the individual and/or the social group. The operation of power (e.g. through abuse) does not necessarily imply a lasting threat to the individual (e.g. shame) if s/he has support to shape the meaning of the event (e.g. 'It was not your fault'). Conversely, an attribution of meaning may create a sense of threat even in the absence of current danger, as seen in some instances of suspicious thoughts ('paranoia'). 'Meaning' is thus the thread that holds all the other aspects of the PTM Framework together.

As discussed in Chapter 3, 'Meaning' is understood here as being constituted socially, relationally and personally through both beliefs and feelings, as well as through bodily reactions. Shame, for example, is constituted of both an embodied feeling, and a belief about oneself, as are fear, humiliation, failure, worthlessness, and so on.

At the pre-reflective end, certain meanings ('this person is safe/unsafe'; 'I am protected/in danger') may be biologically primed as part of an evolved response pattern. At earlier developmental stages, meanings may be coded pre-consciously in the form of 'emotional memories' (Gilbert, 2007), images, symbols, bodily reactions and other non-verbal memory forms, and these are sometimes the first or main intimations of unresolved conflicts or adversities. With the development of language and reflective/mentalising ability comes the possibility of appraising and modifying existing meanings and creating new ones, shaped

by social discourses and coded linguistically. However, non-verbal expressions of meaning including dreams, visions, bodily experiences such as tension, pain, discomfort and so on, continue to operate throughout our lives. Meaning can thus be communicated through behaviour, symbols and bodily reactions, as well as verbally. Sometimes these non-verbal or pre-verbal communications are accorded more respect and attention in non-Western cultures, and are thus less likely to be seen as pathology, 'disorder' or madness.

Language-based responses such as imagining, anticipating, ruminating, reflecting, interpreting, evaluating can all interact positively or negatively with other responses. Sometimes people will inadvertently set up reinforcing cycles of meaning which feed back into the threat responses, and create self-fulfilling prophecies. Alternatively, we can use our reflective language-based abilities to create new narratives and meanings that will help free us from these cycles.

THREAT RESPONSES What kinds of Threat Response are you using? ('What did you have to do to survive?')

In Chapter 5, we discussed in detail the role of biology. The following section, however, focuses on embodied reactions which can be thought of more specifically as threat responses.

Faced with threat, human beings can draw upon a spectrum of threat responses in order to ensure emotional, physical, relational and social survival in the face of the negative impact of power. In other words, as emphasised above, these responses perform certain common *functions* which do not necessarily line up with existing 'symptom' descriptions or categories.

In the face of threat, people may call on any combination of these embodied responses (see Boxes 4 to 8) depending on the power resources and cultural meanings available to them. The responses listed first are those that are more pre-reflective and do not necessarily depend upon linguistic or consciously enacted strategies and resources, although they can be shaped by later learning. They may dominate at earlier developmental stages, although they are found throughout the lifespan, and may be more invariant across cultures.

The higher-order social-cognitive capabilities listed later are more dependent upon language and learning, and the person's characteristic pattern of strategies may involve more conscious awareness and selection. These are likely to appear later in developmental terms, to be more open to shaping by local meanings, and hence to be more culture-specific. Importantly, however, there is no absolute distinction between pre-reflective and reflective responses. Equally, there is no implied division into 'positive' versus 'negative' or 'mature' versus 'primitive' responses. All of these responses are adaptive in some circumstances and less so in others, particularly if used with a lack of flexibility.

Responses are conceived in terms of meaningful activity rather than mechanised or unthinking behaviour. This does not mean that the responses are always consciously and deliberately chosen. Rather, it is to emphasise that they arise flexibly, in association with dynamic patterns of complex meaning, rather than automatically by association with stimuli whose meanings are more-or-less constant.

At the pre-reflective end, threat responses may be dominated by biologically-primed meanings/emotional aspects; for example, 'fight' with anger, 'flight' with fear. Distress and the emergence of memories may thus be experienced, particularly in the case of very severe or early adversities, in the form of overwhelming and frightening bodily reactions. However, in practice, responses from the start of the list will frequently draw on elements of language when they are enacted. Likewise, responses from the end of the list, although based on language, learning, discourse, narrative, symbols and self-representations, are always shaped by elements of meaning derived from pre-reflective feelings. In any case, what is reflected upon in one moment can fall into the pre-reflective 'background' of activity in the next. Similarly, a previously obscure meaning can suddenly emerge and become prominent. These shifts in the extent and manner of the reflections and interpretations people make of their own experiences add further layers of complexity and contingency to their response patterns. Additional shaping comes from others' responses, available social meanings, and access to power resources.

A key consideration from an intervention perspective is whether the threat responses are adaptive in their current circumstances. This raises the wider question of how far our attention should be directed towards the responses, and how far towards the circumstances which give rise to them. It also raises the question of who is distressed or disturbed by the threat responses, and why. (NB It is acknowledged that particularly in criminal justice systems and mental health settings, there is a need to consider not just the adaptiveness of the response from the person's perspective, but its legality and potential harm to others).

Whether or not any specific reaction can be considered as a threat response depends on meaning and context; thus, there are many possible reasons for somatic experiences, dissociating, insomnia, using alcohol, isolating oneself, speech delay, and so on, and not all of them are threat-related. Particularly in specialties like Older Adult, Intellectual Disability and Neuropsychology, expressions of distress may be shaped by cognitive and other physical impairments. For example, in ID, some 'behavioural phenotypes' are associated with specific (often rare) neuro-developmental conditions such as Prader-Willi, Lesch-Nyan, Fragile X, etc. People diagnosed with 'autistic spectrum conditions' experience particular neurologically based difficulties, for example, sensory processing, and are very vulnerable to experiencing sensory 'overload' and extreme anxiety, which sets the scene for a range of behavioural responses. These responses can be seen as an attempt to mediate emotional arousal and exert some control over the physical and social environment, over which they often have very little control (Clements, 2005; Grandin, 1984). There is a risk that these behaviours and responses may be seen as just 'part of the condition' rather than attempts to communicate about distress.

Provisional and incomplete lists of threat reactions, described in terms of activated responses not 'symptoms' and running in a rough spectrum from pre-reflective to reflective, can be seen in Box 4, with further examples of threat responses in Boxes 5 to 8.

Box 4: Threat responses

Preparing to 'fight' or attack	'High' or extreme moods; rapid mood changes ('emotional dysregulation')	Carrying out rituals and other 'safety behaviours'
Preparing to 'flee', escape, seek safety	Holding unusual beliefs	Collecting, hoarding
Freeze response	Having unusual visual, olfactory, tactile sensations	Avoidance of/compulsive use of sexuality
Hypervigilance, startle responses, insomnia	Physical sensations – tension, dizziness, physical pain, tinnitus, sensations of heat or cold, exhaustion, skin irritation, gastrointestinal problems and many other bodily reactions	Impulsivity
Panic, phobias	Emotional defences: denying what has happened, idealising people, and so on.	Anger, rage
Fragmented memory encoding	Intellectualisation (avoiding feelings and bodily sensations)	Aggression and violence
Memory suppression (amnesia)	Attention/concentration problems	Suicidal thinking and actions
Hearing voices	Confused/unstable self-image/sense of self	Distrust of others
Dissociating (losing track of time/place; various degrees of splitting of awareness)	Confused/confusing speech and communication	Feeling entitled
Depersonalisation, derealisation	Self-injury of various types	Reduced empathy
Flashbacks	Self-neglect	Distrust
Nightmares	Dieting, self-starvation	Avoiding threat triggers
NEAD ('non-epileptic attack disorder')	Bingeing, over-eating	Striving, perfectionism, 'drive' response
Emotional numbing, flattening, indifference	Self-silencing	Using drugs, alcohol, smoking
Bodily numbing	Mourning, grieving	Overworking, over-exercising, etc.
Submitting, appeasing	Self-blame and self-punishment	Giving up hope/loss of faith in the world
Giving up, 'learned helplessness', low mood	Body hatred	Relational strategies: rejection and maintaining emotional distance; seeking care and attachments; taking on caring roles; isolation/avoidance of others; dominance, seeking control over others; and so on
Protesting, weeping, clinging	Compulsive thoughts	Ruminating, reflecting, anticipating, imagining, interpreting, meaning-making
Suspicious thoughts		
Emotional regression, withdrawal		

Box 5: Examples of threat responses more common in children and young people

Eating/sleeping problems	Hitting, biting
Poor concentration, distractability	Extreme fear of separation
Impulsivity	Phobias
Bed-wetting	Cruelty to animals
Nervous tics, skin picking, etc.	Emotional withdrawal, regression, rocking
Stealing	Truancy
Speech and developmental delay	Poor peer relationships
Bullying others	Sexualised behaviour
Running away from home	

Box 6: Examples of threat responses more common in people with intellectual disabilities

'Self-injurious behaviour': skin-picking, eye-gouging, head-banging, pica

Other 'challenging behaviours' that may be attempts at communication, especially if expressive abilities are limited, such as hitting, biting

Box 7: Examples of threat responses more common in older adults with cognitive impairments

'Wandering', searching for familiar places	Verbal or physical aggression
Repetitive behaviour or questions	Hiding or hoarding objects
Persistent shouting or screaming	Emotional lability
Agitation, restlessness	Disinhibition

Box 8: Examples of threat responses more common in people with a range of neurological impairments

Anxiety	Low mood
Insomnia, fatigue	Emotional lability
Concentration and attention problems	Disinhibition

Provisional General Patterns

The discussion above brings us to the point of illustrating how the ‘building blocks’ within the elements of Power, Threat, Meaning and Threat Response can be loosely grouped together to form Provisional General Patterns within the Foundational Pattern. These patterns are not presented as a definitive and complete set; rather, they offer a starting point for further research and development. In line with the earlier discussion, they do not conform to a single, straightforward definition of ‘pattern’; however, they do represent meaningful research-based associations, and are based on evidence relating to general human functioning, cause and effect links and underlying processes. The relevant bodies of theory and research have been extensively reviewed in previous chapters and are summarised in relation to each pattern in the Appendix.

To repeat the core message from earlier discussions: the experience of adversity sets up highly complex, overlapping, meaning-based, cumulative and synergistic patterns in which causality is contingent and probabilistic. Adversities are often correlated, and the number of possible combinations of response is almost infinite, potentially creating variation from person to person, or within the same person over time, even in the face of similar circumstances. The discrete causal pathways implied by psychiatric diagnosis do not and cannot exist in relation to the responses of agentic, meaning-making human beings to their life struggles. Nevertheless, it is possible to outline some general regularities which emerge from embodied human responses to their social and cultural, material and discursive contexts, rather than from hypothesised biological malfunctions. As we have said, these causal regularities are here conceptualised as *patterns of meaning-based threat responses to power*. For all the reasons described, the understandings of individual or group experiences which draw on these patterns will always be provisional and open-ended.

Since this represents such a major shift from traditional diagnostic thinking, some central points are worth re-emphasising:

The General Patterns do not represent discrete clusters

The General Patterns describe regularities which cut across diagnostic groups and overlap with each other. There is no hard-and-fast boundary between one pattern and another, and nor could there be. Within the PTM Framework this does not present problems of ‘fuzzy boundaries’, ‘co-morbidity’ or ‘disjunctive categories’. *Rather, it acknowledges the irreducible complexity of people’s responses to their circumstances*, the many meanings that the experience of adversities may generate, and the creative range of strategies that may be employed, at various levels of reflective awareness, to survive them.

The General Patterns are not one-to-one replacements for diagnostic clusters

Some of the General Patterns have rough correspondences to existing diagnostic categories – for example, the second one captures some people who attract the diagnosis ‘borderline personality disorder’, the fourth pattern does the same for some people who are diagnosed with ‘schizophrenia’, the fifth corresponds to some diagnoses of ‘depression’, and the sixth describes some people who end up in the criminal justice system with a diagnosis of ‘antisocial personality disorder’. This is because psychiatric diagnoses do, to a very limited extent, reflect common psychosocial response patterns, albeit described in medical terms. *However, as the PTM patterns are based on functions not on*

'symptoms', it is not possible to predict which pattern or combination of patterns might best describe the experiences of a person who has been assigned any specific diagnosis. Equally, each pattern may describe people who have been assigned any one(s) of a range of psychiatric diagnoses, and some who have never been diagnosed at all.

The General Patterns do not offer universal explanations of specific types of 'symptom' or threat response

Each General Pattern includes a range of possible threat responses such as hypervigilance, hearing voices, restricted eating, and so on, grouped in terms of the functions they are serving. Conversely, each type of threat response may appear within several different General Patterns, and may serve a range of different functions. *The patterns attempt to restore links between the meanings of the threats and the functions that the threat responses are serving, not between specific causal events (either biological or psychosocial) and specific psychological outcomes (whether described as 'symptom' or emotion/behaviour).* There can be no universal explanation for why people feel anxious or low in mood, or why they hoard possessions or carry out checking rituals, or why they fear that they are being persecuted and spied on, and so on.

Having said this, the threat responses in each pattern are not simply random or all-inclusive. Threat responses at a more pre-reflective level (e.g. hypervigilance) have the most obvious causal links to the original threats (e.g. physical danger). Threat responses at a more reflective level will be shaped to a greater degree by social learning and social discourses, thus leading to greater variation across cultures. By elucidating the narratives and discourses that are most available within a particular culture, the General Patterns help to identify links between common meanings (e.g. 'It is my fault that I was sexually assaulted') and common functions (e.g. 'I will relieve my guilt by self-injury'). However, these links will always have a degree of provisionality, especially at an individual level.

The General Patterns cut across boundaries of 'normal' and 'abnormal'

The threat responses do not conform to traditional boundaries of what is considered 'normal' vs. 'pathological' – thus, for example, socially-valued attributes such as overwork can sometimes be seen as serving the same functions of self-punishment/avoidance of emotional pain as self-injury. Similarly, the functions of the threat responses cut across the usual service boundaries – thus, addictions and violent or offending behaviour can be seen as survival strategies which serve similar survival purposes to 'delusions' or 'hallucinations', as may over-eating, smoking, risky sexual behaviour, and so on.

There will be patterns within the General Patterns

Within the General Patterns, it may sometimes be useful to consider sub-patterns relating to specific events or circumstances such as domestic violence, rape, homelessness, etc. This is because these events and circumstances may, in a particular social context, be the subject of especially strong meanings and narratives. For example, the social discourse about women as bearing responsibility for sexual assault means that rape very often triggers strong meanings of shame and self-blame. Equally, the social discourse about men as strong and in control means that being the victim of physical violence is likely to trigger dominant meanings about humiliation. In both these examples, we can expect to see common responses which have the function of managing the impact of these dominant meanings;

the woman may keep the rape secret and punish herself by self-injury, while the man may attempt to restore self-respect by counter-aggression. It may be very helpful for people who have experienced these adversities to be informed about these common reactions. *However, there is no universal meaning or unique response in relation to any given set of circumstances, either within or across cultures.* We therefore put forward the sub-patterns related to particular circumstances very tentatively, with a reminder that they overlap with others, and that the strongest regularities will be likely to emerge at a more general level.

The General Patterns will always reflect and be shaped by the ideological meanings that apply within local social, political and cultural contexts

It has been argued that *the expressions and experiences of distress within a given society in a given historical era will be likely, at some level, to reflect a mismatch (perceived or actual) with its values and expectations,* as conveyed through social discourses and ideological meanings. Thus, in modern industrialised societies we might expect common patterns of distress to centre around such themes as struggling to: achieve in line with accepted definitions of success; separate and individuate from one's family of origin in early adulthood; fit in with standards about body size, shape and weight; fulfil wage labour roles; meet normative gender expectations, including those relating to identity and sexual orientation; compete successfully for material goods; meet emotional and support needs within a nuclear family structure; reconcile the values and expectations of having a different culture of origin; bring up children to behave according to received standards; as a child, fit in with educational systems; as an older adult, cope with loneliness; as someone with intellectual or other disabilities, compete in the job market; and so on. Similarly, we might expect to find common patterns of distress relating to the core human needs which are most likely to be threatened by the negative impacts of industrialisation and neoliberalism, such as social exclusion, marginalisation and disconnection. Finally, in Euro-American cultures we might expect to see an increased risk of attracting a diagnosis as a response to experiences that challenge Western concepts of personhood – for example, 'irrational' or non-rational beliefs, unusual spiritual experiences, and experiences such as hearing voices which do not fit with the notion of a unitary self. All of these themes can be recognised in the General Patterns outlined below.

It is recognised that there will be other General Patterns that are more relevant to groups and societies which have a different worldview, albeit one that is increasingly being supplanted by globalisation. For this reason, the list includes some very tentative illustrative suggestions about the functions that some of the 'cultural syndromes' identified in *DSM* and *ICD* may perform when seen from a PTM perspective. The aim is to demonstrate the general principle that the core elements of Power, Threat, Meaning and Threat Response can be found in all groups and societies, although adaptations would be necessary. However, it is emphasised that there is no implication that the PTM Framework should be imposed or exported where it is not needed. Rather, *the intention is to convey a sense of respect for the numerous culturally-specific ways in which individual and community distress is expressed, experienced and healed in the UK and around the globe.*

People will vary in their 'fit' or match to these Provisional General Patterns

Each of the General Patterns describes a spectrum of adversities and responses. Depending on their own unique histories and circumstances, *people may find themselves at any point on the*

continuum, from mild and temporary discomfort to very severe struggles and disabling distress, at any given time and in any given situation. Contrary to the implication of global deficit imparted by a ‘mental illness’ label, no one should be seen as unable to function at all times and in all situations. Equally, we will all inevitably experience extreme forms of distress at some time in our lives, whether we have been psychiatrically labelled or not. Sometimes the operation of power may appear in subtler and socially acceptable guises – for example, through unquestioned assumptions about how ‘normal’ people look, behave, feel, and relate to each other. It may then be harder to detect the roots of less ‘severe’ but common threat responses such as anxiety, panic attacks, and general low mood.

Some people will recognise themselves within a particular pattern or sub-pattern; others will find it helpful to draw on two or more patterns and sub-patterns. This is not a weakness of the patterns but an acknowledgement of the central role of meaning within and across all human responses to adversities, which means that it is impossible to make simple statements about the origins or functions of any given expression(s) of distress. *However, this recognition allows for reinstatement of the human attributes of meaning-making and agency that are excluded within a narrow diagnostic model.* These can be realised through the process of drawing on the General Patterns to develop personal narratives, as discussed in more detail at the end of the chapter.

There will be community versions of the General Patterns

The General Patterns are here conceived as applying mainly to individuals and families, since this is the most familiar lens through which distress is viewed within Euro-American cultures. However, *it is recognised that both within and beyond the UK, we might see patterns describing the traumatisation or denigration of a whole community as a more natural starting point.* This is particularly applicable within contexts of communities affected by war, natural disaster, or large scale loss of culture, identity, heritage, land, language, rituals and belief systems (e.g. Jankovic et al., 2012; Somasundaram & Sivayokan, 2013; Steel et al., 2009). Trauma-informed work increasingly acknowledges the ways in which indigenous groups such as American Indians and Aboriginal peoples are affected by community violence on this scale (see Arthur et al., 2013, and www.preventioninstitute.org).

The community perspective has recently gained credibility in the US, with the recognition that Adverse Childhood Experiences arise within the contexts of Adverse Community Environments. Whole communities may be collectively impacted by structural violence, defined as ‘harm that individuals, families and communities experience from the economic and social structure, social institutions, social relations of power, privilege and inequality and inequity’ (Pinderhughes et al., 2015, p.11). These social contexts foster distrust and erode resilience at multiple levels, affecting all members both directly and indirectly, thus echoing and reinforcing individual patterns of distress (e.g. Rosen et al., 2017). Characteristic patterns of ‘symptoms’ of collective trauma may be experienced at the level of the social-cultural environment (the people), the physical/ built environment (the place) and the economic environment (the availability of resources and opportunities). It is suggested that this needs addressing at multiple levels, which include the development of a new and more hopeful narrative about the community itself (Pinderhughes et al., 2015). It is easy to see how this might apply to UK communities affected by conflict (e.g. Northern Ireland), by the loss of traditional industries and by high levels of deprivation. Such a view is also compatible with a social identity approach, which shows that an important

part of our self-concept derives from perceived membership of social groups (Jetten et al., 2012). This is a possible area for further development of the patterns, perhaps utilising the framework suggested by the Adverse Community Environments research (see Pinderhughes et al., 2015) and/or by adapting part of the PTM Foundational Pattern.

The seven Provisional General Patterns

The discussion up to this point has set the scene for outlining seven Provisional General Patterns within the Foundational Power Threat Meaning pattern. The first General Pattern, 'Identities', is suggested as a useful starting point for everyone, since it is intended to highlight core issues relating to identity, diversity, intersectionality, marginalisation and cultural devaluing, and (where relevant) the ways in which the specific identity of 'mentally ill' may interact with meanings and experiences as a whole.

In keeping with the principle of 'actively engaging threat reactions for protection and survival' rather than 'passively suffering biological deficits', these General Patterns, with the exception of the first, are titled in verb form ('Surviving X threat' rather than 'Suffering from X deficit').

1. Identities.
2. Surviving rejection, entrapment, and invalidation.
3. Surviving disrupted attachments and adversities as a child/young person.
4. Surviving separation and identity confusion.
5. Surviving defeat, entrapment, disconnection and loss.
6. Surviving social exclusion, shame, and coercive power.
7. Surviving single threats.

1. Provisional General Pattern: Identities

This General Pattern is conceptualised as informing and underpinning all the others, and as such can serve as a starting point in working with particular individuals or groups. As with all the General Patterns, the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

Narrative summary of the General Pattern

The PTM Framework demonstrates that distress may be experienced by anyone, including those whose social status is more privileged. Everyone is impacted by the negative operation of power in one form or another, and no one is immune from social and relational adversities. Higher social status can bring exposure to its own characteristic negative operations of power. However, as a generalisation, some identities offer much greater compensatory power, status, control and access to social capital in the face of distress than others, along with more options for support, escape, protection, safety and healing. This is confirmed by the evidence about class, 'race' and gender gradients in mental health, criminal justice and other welfare systems.

This pattern in relation to emotional or psychological distress therefore often, but not always, describes someone whose identity, or aspects of whose identity, has subordinate or devalued status. This includes many people of minority status (for the purpose of this document, within the UK, although worldwide they may be a majority). It may also describe the experiences of a majority in a given society, and as such, may be an inescapable part of many people's everyday lives. In such cases the pattern may be even less visible than some of the other patterns and more accepted as culturally normal. The devalued identity may relate to ethnicity, nationality, sexual orientation, gender identity, religion, disability or being defined as 'mentally ill', but it may also relate to much larger groups who identify as female, older, or working-class.

As with all the patterns, occupying several marginalised identities (e.g. Black and disabled; female and poor; gay and 'mentally ill') implies a greater degree of discrimination and threat, and increases the likelihood of experiencing other relational and social adversities, along with physical health problems. Conversely, and protectively, people may experience strong social solidarity within their group and/or have aspects of their identity that are more culturally valued.

As a general rule, all mental health diagnoses are more common in people with devalued identities, especially when they belong to several devalued groups. For example, people from minority ethnic backgrounds living in the UK have much higher rates of both common and severe diagnosed mental health problems than their White British counterparts. This holds whether they were born in the UK or moved to the UK from other parts of the world. It also holds for some White minority groups in the UK such as the Irish. Other marginalised groups, including women, Gypsies and travellers, people with disabilities, people identifying as gay, trans and disabled, and people of any background with low socio-economic status, are more likely to be diagnosed as having both common and severe mental health problems in proportion to their numbers.

Power, Threat, Meaning and Threat Responses within the General Pattern

The Power, Threat, Meaning and Threat Response aspects of this General Pattern commonly include the following:

Power

The person and their social group are likely to have past and ongoing experiences of multiple forms of subordination, exclusion and oppression related directly or indirectly to a devalued aspect of their identity, although this is not true for everyone. These may take the form of chronic background threats (such as living in deprived and unsafe environments or with frequent reminders of the potential for violence or aggression against your group), or of discrimination (in pay and employment, education, housing, transport, healthcare and so on). It may also take the form of numerous encounters with negative stereotypes of your group, of hostility and harassment and of 'micro-aggressions' or multiple, brief daily interactions which often subtly denigrate individuals in relation to their group membership. Harder to detect are potentially traumatic practices which are seen as socially acceptable or even desirable. Devaluing of a social or cultural group also extends to 'hermeneutical' or 'epistemic injustice', in which members are denied the opportunity to make sense of their own experiences due to unequal power relations and lack of shared social resources. All of this may occur in a context of historical and inter-generational oppression of a whole social or cultural group by, for example, warfare, colonialism or in extreme cases, genocide. The negative operation of ideological power may be especially salient given its role in the creation of meaning and identity, norms and standards against which group members' behaviour, character, skills and value may be judged. Ideological power is also closely related to 'hermeneutical injustice' (see above).

Threat

The person (and their family/social/cultural group) within this pattern was and is often faced with core threats resulting from the devaluing of core aspects of their self-concept and identity, including social exclusion and marginalisation within the dominant group, 'othering', physical danger, invalidation, powerlessness, competitive defeat, material deprivation, and loss of bodily integrity, as well as loss or devaluing of social role, community bonds, loss or devaluing of sources of knowledge and understanding, loss of rituals, practices or homeland.

Meaning

The threats are commonly associated with meanings such as: exclusion, shame, humiliation, entrapment, inferiority, worthlessness, powerlessness, and injustice/unfairness.

Threat Responses

The threats, and the meanings they are associated with, give rise to threat responses that are mediated by the body. Threat responses are conceived of as fundamentally protective. Disabling aspects can be minimised and counteracted by other responses which draw on skills, strengths, material, relational and social support, alternative narratives, and other power resources, many of which operate at the more 'reflexive' end of the spectrum. In this pattern, such resources may take the form of social solidarity and awareness of ideological

power, leading to social action. Since all of us occupy a range of identities, we may be able to draw on the advantages offered by more privileged aspects. Threat responses within this pattern are commonly employed to serve the functions:

Regulating overwhelming feelings (e.g. 'high' mood, low mood, hearing voices, use of alcohol and drugs, somatic sensations, rage, bodily numbing, isolation, self-blame, self-injury).

Protection from physical danger (e.g. hypervigilance, fight/flight/freeze, suspicious thoughts, isolation, aggression).

Maintaining identity, self-image and self-esteem (e.g. denial of 'othering' or discrimination, hypervigilance, suspicion, unusual beliefs, perfectionism, aggression, striving).

Preserving a place within the social group (e.g. striving, competitiveness, appeasement, hypervigilance, suspicious thoughts, self-blame, self-silencing).

Protection against attachment loss, hurt and abandonment (rejection of others, distrust, seeking care and emotional responses, submission, self-blame, isolation, appeasement, self-silencing).

Sub-patterns within the General Pattern 'Identities'

Since this General Pattern consists of a large number of often intersecting identities, there is no attempt to provide an exhaustive list of the implications for psychological and emotional distress in each case. Instead, indicative examples of distress in relation to a small subset of identities for which there is the most research evidence are suggested. Additional references providing a starting point for patterns of emotional distress in relation to these and other identities are provided in Appendix 1 along with detailed discussion of links between identities and distress. The intention here is to emphasise that core identities are relevant to the experience and expression of all kinds of distress and troubled or troubling behaviour, and to demonstrate that this awareness must inform the exploration of every individual or group response pattern to adversity.

A more detailed overview of the identity of 'mentally ill' is provided, since by definition it has been applied to, and taken on by, many people in distress or having unusual experiences.

Being identified/identifying as 'mentally ill'

Being ascribed the identity of 'mentally ill' or 'mental/psychiatric patient' is a very powerful act which has been shown to have profound, long-lasting and often negative impacts on many aspects of people's lives, including their psychological or emotional distress. This often includes their physical health, either through indirect effects such as poor diet and lack of access to health care, or through the direct effects of psychiatric medication. Since people whose identities are devalued are more likely to experience adversity and consequent distress, and thus be assigned psychiatric diagnoses, the addition of the devalued identity of 'mental patient' may increase and amplify existing experiences of shame, failure, exclusion and marginalisation.

The 'illness like any other' model of distress is actively promoted in high-income countries and, increasingly, across the globe, and is endorsed by a growing proportion of the general public. Worldwide, this view is associated with increased rather than reduced

stigmatisation, and with social rejection and pessimism about recovery, along with self-stigma and self-blame. The diagnostically-based model of 'mental illness' can be seen as an aspect of the individualism that characterises Western cultures. The promotion of a model based on individual deficit has been argued to serve purposes at individual, social, professional, business and political levels.

The identity of 'mentally ill' has mixed consequences. It may represent relief from guilt and uncertainty, and hope for expert guidance and effective intervention. At the same time, the 'sick role' identity has been theorised as facilitating passivity and a reduced sense of responsibility for one's recovery. Diagnosis has been shown, overall, to incline the person diagnosed to have less optimism about recovery, make less effort to recover, and be more likely to use alcohol to cope, as well as to have lower perceived control over their difficulties and undermining the effects of therapy. Conversely, rejecting one's diagnosis has been linked to better outcomes. However, this may lead to conflict with professionals, and the need to access services and benefits rules out this option for most people.

Self-stigma as a consequence of being designated 'mentally ill' is very widely reported. People may have positive, negative or mixed reactions to being psychiatrically diagnosed, which may change over time. This depends partly on the diagnosis, and labels such as 'schizophrenia' which indicate greater 'severity' are generally experienced as more stigmatising. 'Personality disorder' labels are often reported as the most stigmatising of all due to the implication of a global judgement of madness and badness, and are also known to evoke, or be the consequence of, rejecting attitudes in staff. Diagnoses like 'depression' or 'anxiety disorder' are more likely to be perceived as helpful by service users, for reasons such as relief from guilt and self-blame, access to information and support, and validation of one's distress.

Psychiatric diagnosis has been shown to increase these aspects of the general public's attitudes towards people who have the identity of 'mentally ill': perceived dangerousness; perceived unpredictability; perceived dependency, and lack of responsibility for own actions; perceived lack of 'humanity'; perceived severity of the problem; fear; rejection and desire for distance; and pessimism about recovery.

Discrimination as a result of being designated 'mentally ill' is almost universally reported. This forms a barrier to employment and education, as well as everyday activities such as holidaying and leisure pursuits. These experiences are compounded for people from minority ethnic backgrounds and people with disabilities. Discrimination has a negative impact on seeking help, self-esteem, self-care and social relationships as well as being a source of guilt, shame and concern for family members/carers.

Psychiatric diagnoses facilitate access to important sources of support, both within and outside mental health services. Mental Health and related teams typically offer a range of interventions alongside standard medical ones, including various types of therapy, support with living skills, educational opportunities and building social networks, assessment for housing and employment, and so on. Some people have a good experience of services and find them very helpful. Most people report mixed experiences, both good and bad. On the negative side, psychiatric diagnosis can also set the scene for potentially disabling, coercive and re-traumatising interventions within mental health and related systems, including long-term use of medication, and compulsory admission, seclusion or restraint. The imposition of an expert narrative of 'illness' may undermine people's confidence and ability to make sense of their own experiences.

More subtly, the identity of ‘mentally ill’ may limit people’s expectations of who they can be, what they can achieve, and the kind of life they can hope to live.

Indicative examples of other well-established patterns in distress related to particular identities

Being identified/identifying as female

Girls and women make up around half of those who occupy other devalued identities. In many, if not most, societies, females are represented and treated as inferior or secondary, intellectually, economically and socially. There are variations on this, for example a woman of high social status may be treated as in some ways superior to a man of low social status; some female roles, such as motherhood, may also be highly valued. Overall, however, females as a group are subject to greater control over their bodies and activities than men, are often presented in objectified or sexualised ways, with a very high value placed on their appearance rather than their achievements, and are subject to high levels of harassment, micro-aggressions and violence from men. They are also in the minority in many positions of power and influence, for example in government, the law, industry, science and research. Their situation is complicated by their close, often biological relationships with men and by the taken for granted nature of social structures, practices and relationships in which women’s assumed inferiority is embedded and enacted. There is extensive evidence of the negative impact of all of this on women’s and girls’ mental health across a wide range of presentations including anxiety, low mood, ‘psychosis’, dissociation, sexual problems, sleep problems, post-traumatic stress, eating problems and self-injury.

Being identified/identifying as male

Although ‘male’ is not generally a devalued identity, the privileges associated with it often involve strict boundaries on positive aspects of this identity and devaluing of aspects which challenge these boundaries, especially behaviour and emotional expressions seen as closer to ‘femaleness’. Men who occupy other devalued identities, for example, in terms of socio-economic background or ethnicity will face particular problems in maintaining socially valued aspects of masculinity. All of this, in combination with the threats described in the other provisional general patterns, is reflected in high rates of suicide, violence to others, problematic drug and alcohol use as well as problems with anxiety and low mood.

Being identified/identifying as a member of a minority ethnic group (in the UK)

People from many minority ethnic backgrounds living in the UK have much higher rates of both common and severe diagnosed mental health problems. This holds whether they were born in the UK or moved to the UK from other parts of the world, and has been shown to be related to experiences and perceptions of discrimination and racism, along with numerous other forms of social disadvantage. There are intersections with social class and gender. Specific communities (Turkish, Polish, Romanian, Indian, Pakistani, Ugandan Asian, Somalian, Hungarian and so on) may face their own characteristic patterns of challenge (see Appendix 1 for indicative references.)

Irish people in the UK have a record as poor as, or worse than, many of the main minority ethnic groups living in England in terms of both ‘mental health’ and physical health, and this disadvantage persists into second and third generations.

Being identified/identifying as of African or African-Caribbean heritage (in the UK)

Black people are a minority group in the UK and like many other UK minority groups, face additional hardship and discrimination including being very underrepresented in positions of power and influence. The impacts are partly mitigated by living in close proximity to other Black people. Black people of African and African-Caribbean heritage living in the UK have particularly high rates of diagnoses of ‘psychosis’. This has been shown to be related to generally higher levels of social disadvantage, including poverty, racism and discrimination. Young Black men living in urban environments in the UK have especially high rates of diagnosed ‘psychosis’, including higher rates of ‘paranoia’, which may be attributable to living at the point where multiple forms of disadvantage and discrimination intersect. Historically, the association of ‘schizophrenia’ with Black males and with violence, hostility and paranoia can be traced back to the Civil Rights Movement in the US in the 1960s, when this stereotype started to emerge. The ‘illness’ was previously thought to affect mainly White people and was associated with inability to function rather than violence. The stereotype has survived as shown by the fact that both the public and professionals are likely to over-estimate the likelihood of young Black men being violent. Black men are more likely to be compulsorily admitted to psychiatric hospital and subject to other forms of coercive intervention. Urban environments raise the risk of distress for everyone, but particularly if there are large disparities of income. Living near greater numbers of members of your ethnic group is a protective factor. ‘Paranoia’ is associated with being male, low socioeconomic status, immigration, member of a minority ethnic group, and being a refugee. Studies have associated ‘paranoia’ with feelings including shame, anger, worthlessness, humiliation, entrapment, disconnection, powerlessness and injustice.

Black women living in the UK experience multiple adversities of ongoing racism, poverty and gender inequalities and report high rates of sexual violence and revictimisation. Sexual violence and victimisation are associated with severe depression and traumatisation. Stereotypes of Black women’s strength have been identified as barriers to Black women receiving help from mental health and community services. Black women report being offered medication but not access to counselling or therapy in mental health services.

Being identified/identifying as having an intellectual disability

Particularly those with ‘mild’ ID may experience shame and devaluing, and many seek to distance themselves from others with ID and support services, exacerbating feelings of isolation and ‘difference’. Feelings of ‘stupidity’ are an everyday risk in negotiating the social world. Earlier research from the 1960–1970s referred to attempts to ‘pass as normal’, for example, ‘The Cloak of Competence’, at a high emotional cost to the individual. There may also be shame at having significant ‘impairments’ and experiencing discrimination in a highly individualised, achievement-oriented society, leading to feelings of failure, ‘not good enough’, damaged, etc. This group is also more likely than their peers to have childhood experiences of physical, sexual and emotional abuse and neglect, which may be even less acknowledged than in the non-disabled population.

Appendix 1 gives indicative references for emotional and psychological distress in relation to these and aspects of other identities including Gypsy/Traveller, Irish (in the UK), LGBTQ, Low socio-economic status, Physical disability, and Older Adult.

2. Provisional General Pattern: Surviving rejection, entrapment, and invalidation

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

Narrative summary of the General Pattern

Within the PTM Framework, this describes a broad pattern of relationship threats and threat responses which give rise to core meanings of rejection, entrapment and invalidation. A central survival dilemma is maintaining attachments and relationships versus distrust and fear of rejection, hurt or harm. These situations arise more frequently in power contexts of poverty, social inequality, unemployment, gender inequalities, and war. Common diagnoses are 'borderline personality disorder', 'bipolar disorder', 'dissociative disorder', 'major depressive disorder', 'PTSD', 'alcoholism', and 'psychosis', although not everyone who is assigned one of these diagnoses aligns with this pattern, and these diagnoses are also assigned within other patterns. Poor physical health may compound the person's difficulties. Sometimes there is a history of criminal offences. Like all the patterns, this one may also describe people who have never been formally diagnosed.

Social and cultural discourses about gender roles shape the way in which the threats are experienced and expressed. In many Western cultures, women show a tendency to direct distress inwards and men to direct it outwards, although anger is common in both. Sometimes overt abuse is absent, but emotional neglect, invalidation, criticism and control in early relationships may have resulted in similar threat responses. In service settings, the pattern is most frequently identified in women. This may result from the pathologising of responses such as anger or making demands that are seen as less acceptable in women. It may also relate to the fact that expressing anger inwardly, in line with female socialisation in some cultures, is more likely to result in a mental health referral than expressing anger outwardly in the form of violence to others. Sexual abuse, a powerful synergistic ACE for women, is very common in the early lives of women who are described by this pattern. Sometimes there has been organised abuse. Male veterans of combat may show a slightly different subset of responses (see also sub-pattern 'Surviving Combat').

The pattern describes some women in the criminal justice system, who may self-harm and have unstable lives and relationships. Women in prison report high levels of childhood abuse, domestic violence, and rape. As a generalisation, women are more likely to turn anger inwards into self-harm, eating disorders, etc., and men are more likely to turn it outwards in violence towards others. Women may be using illegal drugs, shoplifting, be involved in prostitution, or, more rarely, committing more serious offences. Their male counterparts are, for reasons related to gender socialisation, more likely to fall into the General Pattern 'Surviving social exclusion, shame, and coercive power'.

Most people with complex histories of adversity also show threat responses (such as flashbacks) to single traumatic events, and thus experience aspects of the pattern of 'Surviving single threats' as well, particularly in relation to men (and women) exposed to

combat. As children they are very likely to have fitted the description of the General Pattern 'Surviving disrupted attachments and adversities as a child'.

Power, Threat, Meaning and Threat Responses within the General Pattern

The Power, Threat, Meaning and Threat Response aspects of this General Pattern commonly include the following:

Power

There has often been prolonged interpersonal maltreatment, abuse, invalidation and neglect in situations of lack of control, dependence, isolation and entrapment. In these situations the person was/is helpless and powerless in the face of emotional and/or physical threat, while often being dependent on the perpetrators for survival. These situations may originate with carers who were not able to facilitate secure early relationships due to their own social, material and personal circumstances, and/or to protect children from exposure to significant abuses of power; and/or they may occur outside the family of origin and/or in adult life. There is likely to have been significant traumatisation and re-victimisation as an adult. Backgrounds include neglectful and/or abusive early relationships; prolonged bullying as a child; domestic violence; combat. Other backgrounds include being a prisoner of war; being a victim of trafficking; survivors of organised sexual abuse; survivors of cults.

Threat

Core threats are rejection, invalidation, abandonment, attachment loss, entrapment, emotional overwhelm/dysregulation, powerlessness, physical danger and bodily invasion, physical ill-health and depletion.

Meaning

The threats are commonly associated with meanings such as: lack of safety, fear, rejection and abandonment, shame, guilt, emptiness, badness and unworthiness, alienation, betrayal, hopelessness, helplessness, and meaninglessness.

Threat Responses

The threats, and the meanings they are associated with, give rise to threat responses that are mediated by the body. Threat responses are conceived of as fundamentally protective. Disabling aspects can be reduced and counteracted by other responses which draw on skills, strengths, material, relational and social support, alternative narratives, and other power resources, many of which operate at the more 'reflexive' end of the spectrum. In this pattern threat responses are often used to serve the following functions, listed in rough order of how commonly they are employed:

Regulating overwhelming feelings (e.g. through dissociation, amnesia, disrupted attention, de-realisation, emotional numbness, bodily numbness, hearing voices, drug and alcohol use, self-harm, impulsivity, somatic sensations, splitting and projection of feelings, rapid changes of mood, unusual beliefs, suicidality).

Protection against attachment loss, hurt and abandonment (e.g. dominance and seeking control,

distrust, vigilance for rejection, rejection of others, isolation/avoidance of others, self-silencing, self-hatred, self-blame, appeasement, compliance).

Seeking attachments (e.g. through idealisation, appeasement, self-blame, seeking care).

Maintaining a sense of control (e.g. anger, dominance, eating habits).

Protection from danger (e.g. hypervigilance, anger and rage, anxiety, suspicious thoughts).

Meeting emotional needs/self-soothing (e.g. using drugs and alcohol, seeking secure attachments, self-injury).

Preserving identity, self-image and self-esteem (e.g. sense of entitlement, projection).

Communication about distress, eliciting care (e.g. self-injury, anger).

Sub-patterns within the General Pattern 'Surviving rejection, entrapment and invalidation'

Sub-patterns within the General Pattern can be seen in relation to the following specific circumstances, among others:

Surviving domestic abuse (women): Women who witness domestic abuse as a child are more likely to be victims of domestic abuse as adults. Additional power issues may be present in the form of financial dependence and lack of alternative housing or support. The constellation of threats and threat responses in women who have survived or who are living with domestic abuse includes anxiety, low mood, fear, guilt, shame, increased risk of suicide, and physical health problems. They may use a range of safety and survival strategies including appeasement, isolation, self-silencing, and using alcohol and drugs. Common meanings, reinforced by the perpetrator, are to do with self-blame and worthlessness. The situation may be perpetuated by realistic fears of retaliation, along with lack of money, social support or alternative accommodation, and sometimes lack of awareness on the part of health and welfare professionals. Less is known about patterns in male victims of domestic abuse, or about abuse within gay or transgender relationships. There may be overlap with 'Surviving defeat, entrapment, disconnection and loss'.

Surviving as a refugee, asylum seeker, trafficked or displaced person: This group has experienced numerous past and present power threats including war, torture, bereavement, persecution and legal battles, along with the loss of family, income, work, homeland, and culture. These pose threats to every aspect of one's relationships, material security and social and personal identity. Meanings include hopelessness, grief, loss, fear, mistrust, isolation, lack of safety, and powerlessness. This may lead to threat responses including low mood, anxiety, nightmares, flashbacks, hopelessness, drug and alcohol use, and hearing/seeing missing relatives. Common diagnoses are 'PTSD', 'depression' and 'psychosis', with the more 'severe' diagnoses being more likely in the face of multiple traumas. There is overlap with 'Surviving single threats' and with 'Surviving defeat, entrapment, disconnection and loss'.

Surviving intergenerational and historical trauma: Work with the families of Holocaust survivors has laid the foundation for an understanding of 'intergenerational trauma' which can affect second and subsequent generations of a family through the psychological and emotional impact of living with trauma survivors. A related concept is historical trauma,

a cumulative emotional wounding across generations caused by subjugating a population, as in colonialism, genocide and slavery in which entire peoples or colonised groups suffer from loss of language, traditions, and other forms of deliberate destruction of their lives and cultures.

3. Provisional General Pattern: Surviving disrupted attachments and adversities as a child/young person

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

Narrative summary of the General Pattern

Within a PTM Framework the pattern describes situations in which the child's early relationships and/or environments were compromised due to a complex mixture of power factors such as intergenerational histories of trauma and adversity, lack of material resources, social pressures and social isolation. A combination of non-violent (e.g. emotional abuse/neglect) and violent (e.g. sexual/physical abuse) trauma may be the most damaging. In more extreme examples, children may be subjected to organised abuse, or they and their families may be refugees or living in a war zone. The pattern can be manifested as 'disorganised attachment', in which an attachment figure is also a source of threat. This is likely to lead to threat responses based on dissociation, 'the escape when there is no escape'. Social discourses about gender roles shape the way in which the threats are experienced and expressed, such that girls may be more likely to react with dissociation and boys with overactivity and inattentiveness. Common diagnoses include 'attachment disorder', 'ADHD', 'oppositional defiant disorder', 'depression', phobias, and 'anxiety disorders', although not everyone within these categories fits the pattern and these diagnoses are also assigned within other patterns. There may also be physical health symptoms and conditions. In older children, the pattern may overlap with 'Surviving separation and identity confusion' or 'Surviving exclusion and competitive defeat as a young person' and there may be a history of criminal offences. Like all the patterns, this one may also describe children and young people who have never been formally diagnosed. As adults, they may be described by any of the other patterns, including 'Surviving rejection, entrapment and invalidation'.

Power, Threat, Meaning and Threat Responses within the General Pattern

The Power, Threat, Meaning and Threat Response aspects of this General Pattern commonly include the following:

Power

These children or young people have frequently been exposed to several or multiple adversities, including neglect, sexual, physical and/or emotional abuse, witnessing domestic violence, bullying, separation from or loss of parental figures (sometimes

through institutionalisation), and in some cases, ritual or organised abuse. More subtle impacts of power may operate through school, social and community environments, familial and social comparisons and expectations, and so on.

Threat

Core threats are physical danger, emotional overwhelm, entrapment, emotional neglect, powerlessness, loss of agency and control, abandonment, identity confusion, physical neglect and bodily invasion.

Meaning

The threats are commonly associated with meanings such as fear, shame, worthlessness, emotional emptiness, abandonment, betrayal, hopelessness, feeling controlled, entrapped and defeated.

Threat Responses

The threats, and the meanings they are associated with, give rise to threat responses that are mediated by the body. Threat responses are conceived of as fundamentally protective. Disabling aspects can be reduced and counteracted by other responses which draw on skills, strengths, material, relational and social support, alternative narratives, and other power resources, many of which operate at the more 'reflexive' end of the spectrum. In this pattern they are often used to serve the following functions, depending partly on developmental stage, and listed in rough order of how commonly they are employed:

Regulating overwhelming feelings (e.g. self-injury, emotional numbness, changes of mood, drug and alcohol use in older children, dissociation, hearing voices, unusual beliefs, somatic sensations, bodily numbness, head-banging, memory gaps, attention and concentration disruptions, reduced empathy, impulsivity, over-activity, de-realisation, anger and aggression).

Protection against attachment loss, hurt and abandonment (e.g. distrust, self-hatred, compliance, making demands, anger, poor peer relationships).

Seeking attachments (e.g. sexualised behaviour, dominance, appeasement and compliance).

Protection from danger (e.g. hypervigilance, anxiety, restlessness, attention and concentration disruption, insomnia, distrust, aggression, biting, phobias).

Meeting emotional needs, self-soothing (e.g. rocking, headbanging, skin-picking, self-injury, rituals).

Communication about distress, elicit care (e.g. self-injury, self-destructiveness, tantrums, aggression and rage, seeking attachments, low mood, somatic sensations).

Maintaining a sense of control (e.g. rage, bullying, aggression, eating problems).

Preserving identity, self-image and self-esteem (e.g. bullying, dominance).

Preserving a place within the social group (e.g. bullying, dominance, appeasement).

Depending on age, there are likely to be developmental impacts on speech, language and behaviour milestones as well as on physical health and development.

Sub-patterns within the General Pattern 'Surviving disrupted attachments and adversities as a child/young person'

Sub-patterns within the General Pattern can be seen in relation to the following specific circumstances, among others:

Surviving witnessing domestic abuse as a child/young person: These children may be particularly likely, especially if boys, to pass on violence (cruelty to animals, aggression and temper outbursts, delinquency, fighting, bullying, threatening, poor peer relationships, disrespect for women, domestic abuse as an adult). This may involve a process of 'identifying with the aggressor'. Alternatively they (mainly girls) may resort to compliance, withdrawal, and feel great responsibility for the abused parent, as shown in high levels of guilt, anxiety, and separation anxiety. Later, adolescents and adults may seek affection through risky and indiscriminate sexual behaviour. The worse the violence in the home, the more severely children are affected.

Surviving sexual abuse as a child/young person: Child sexual abuse can have multiple long-lasting effects in childhood and adulthood, depending partly on exacerbating and ameliorating factors. It is a powerful synergistic ACE for both boys and girls. Girls who have experienced sexual abuse experience more frequent low mood, self-harm, dissociation, cognitive difficulties, numbing, impulsivity, distrust and dissociation than their non-abused female peers, along with lack of friends and troubled sexual relationships in adolescence. The damage is generally more severe if the perpetrator is the biological father, if it involves genital contact, and if there is earlier onset, multiple perpetrators and violence. Child sexual abuse also makes 'hallucinations' more likely, implying a high degree of dissociation (the 'escape when there is no escape') although it is not a specific or unique predictor of such experiences.

Surviving bullying as a child/young person: Bullying can be understood at one level as a process of enforcing group norms within peer groups. In this, it reflects the norms of the school, the media and the wider social environment, so that children who are perceived as deviating from these norms through appearance, socio economic status, ability or disability, gender, sex and sexuality, culture, race and religion are more likely to be targets. Bullying cultures thus have their origins in social and cultural norms, and in a general lack of tolerance for difference. Bullies may also need help; children are more likely to bully others if they have experienced parental maltreatment, especially physical and sexual abuse, and have witnessed domestic violence.

Bullying appears to be particularly common in UK schools. It may include physical and verbal assaults and 'cyberbullying' via social media. While there is no 'typical' recipient of bullying, victims are more likely to belong to groups that are already disempowered and discriminated against in other ways due to their sexuality, ethnicity, or disability.

The impact of bullying is often under-recognised, but can include poor academic performance, low mood, reduced self-worth, anxiety, self-injury and suicide as well as somatic complaints such as headaches, insomnia, stomach aches, and bedwetting. There is also an increased risk of 'psychotic' experiences in adolescence, which may include hearing the voice of the bullies. Longer-term implications for adults, depending partly on exacerbating and ameliorating factors, range from low self-confidence and loneliness, to 'psychotic' experiences. Bullying is a causal factor across a number of forms of distress in

adulthood (see also ‘Surviving defeat, entrapment, disconnection and loss’, and ‘Surviving social exclusion, shame and coercive power’).

Surviving invasive medical interventions as a child/young person: Children who have to undergo repeated, painful and invasive medical interventions may be traumatised, partly because there is some evidence that younger children have a ‘moral’ explanation for health care treatment and interpret medical professionals/parents as intentionally causing them pain as punishment for wrongdoing. The treatment may also involve a degree of ‘entrapment’ or restraint (‘clinical holding’) which, while unavoidable in some circumstances, may exacerbate psychological distress.

Non-Western pattern: *Surviving conflict in Northern Uganda as a young person:* Spirit possession is reported in many cultures worldwide, and is associated with a range of situations, presentations and meanings, some positive, some less so. It does not feature in *DSM*, but is subsumed under ‘trance or possession disorders’, a subcategory of ‘dissociative disorder NOS’ in *ICD-10*. It is sometimes seen as equivalent to the psychiatric concept of ‘psychosis’. One version, ‘cen’, is found in Northern Uganda, where civil war has resulted in widespread brutality and the abduction and forced recruitment of children as soldiers. In this phenomenon, young people report that their identity has been taken over by the malevolent ghost of a dead person. ‘Cen’ has been found to be associated with high levels of war trauma and with abduction, and the spirit was often identified as someone the abductees had been forced to kill.

4. Provisional General Pattern: Surviving separation and identity confusion

As with all the general patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

Narrative summary of the General Pattern

Within a PTM Framework, this describes a pattern that is characteristic of individualistic cultures with a tradition of separation from the nuclear family in late teens/twenties, along with high achievement expectations. A central survival dilemma (reflected in the discourses of the wider culture) is finding a balance between emotional dependence, which may be experienced as trappedness and loss of self, versus separation and individuation, which may be experienced as abandonment and fear of failure. This dilemma commonly becomes acute in teens/early adulthood. Families may be isolated from support and caregivers may be struggling with their own cultural and gender role expectations and/or trauma histories. This may contribute to carer attitudes of protection, control and/or criticism, along with confusing communication styles. Social discourses about independence, striving, hard work, competitiveness and achievement may add pressure to the young person. Identity crises may also occur at other significant life transition points, such as bereavements, job loss, leaving a relationship or reaching a certain age. Common diagnoses are ‘psychosis’, ‘schizophrenia’, ‘anorexia’, ‘bulimia’, and ‘OCD’, although not everyone with these diagnoses fits the

pattern and these diagnoses are also assigned within other patterns. Poor physical health may compound the person's difficulties. For adolescents and young people, there may be overlap with 'Surviving disrupted attachments and adversities as a child/young person'. Like all the patterns, this one may also describe people who have never been formally diagnosed.

Power, Threat, Meaning and Threat Responses within the General Pattern

The Power, Threat, Meaning and Threat Response aspects of this General Pattern commonly include the following:

Power

There has been long-standing difficulty in achieving a balance between dependence and individuation, sometimes starting early in life. There may be a background of parental separation or loss, or of sexual abuse and other traumas. Families of origin may be isolated from support. Social discourses about achievement and independence add pressure to the young person, who may have developed very high expectations of themselves. Western ideals about women's, and increasingly men's, body shapes are transmitted and supported by the media, diet, fashion, magazine and other industries, and set the scene for problematic eating and over-exercising as an expression of distress. (In some countries – e.g. Ghana, Hong Kong and South Africa – control rather than body size may be the dominant theme in restricted eating).

Threat

There are core threats to identity, sense of self and agency, including emotional invalidation. Other threats are abandonment, emotional neglect, rejection, social exclusion and isolation, bodily invasion, and competitive defeat.

Meaning

The threats are commonly associated with meanings such as: abandonment, rejection, worthlessness, shame and inferiority, feeling controlled, invaded, entrapped.

Threat Responses

The threats, and the meanings they are associated with, give rise to threat responses that are mediated by the body. Threat responses are conceived of as fundamentally protective. Disabling aspects can be reduced and counteracted by other responses which draw on skills, strengths, material, relational and social support, alternative narratives, and other power resources, many of which operate at the more 'reflexive' end of the spectrum. In this pattern they are often used to serve the following functions, listed in rough order of how commonly they are employed:

Protection against attachment loss, hurt and abandonment (e.g. through fear of separation; denial/projection of anger and sexuality; compliance; self-silencing; emotional regression; confused identity and boundaries; low mood; anxiety).

Preserving identity, self-image and self-esteem (e.g. through unusual beliefs; self-starvation; anger; rebellion; perfectionism)

Regulating overwhelming feelings (e.g. self-starvation, self-harm, bodily numbing, unusual beliefs, hearing voices, carrying out rituals).

Protection from danger (e.g. through hypervigilance, appeasement).

Maintaining a sense of control (e.g. through rituals and compulsions; self-starvation and bingeing; over exercise).

Seeking attachments (e.g. dependency; compliance).

Preserving a place within the social group (e.g. through perfectionism, striving).

Self-punishment (e.g. self-blame, body hatred, self-harm, low mood).

Communication about distress, elicit care (e.g. through unusual beliefs, hearing voices, confused communications; self-starvation, rituals, low mood).

Finding meaning and purpose (e.g. unusual beliefs, controlled eating).

Sub-patterns within the General Pattern 'Surviving separation and identity confusion'

Sub-patterns within the General Pattern can be seen in relation to the following specific circumstances, among others:

Surviving midlife transitions: Significant distress is sometimes experienced by women facing a change of role after their children have left home, or other aspects of midlife including the death of parents. A similar pattern is sometimes seen in men. In both cases, there may be a drive to fulfil needs that have been denied or set aside through the necessity of meeting social and gender expectations earlier in life. For example, women's sense of identity may have been subsumed by the demands of child-rearing, exacerbated by messages about emotional self-sacrifice and by other social and economic inequalities. Men may be more likely to feel depleted by workplace expectations and the limitations of male socialisation.

Surviving separation within migrant families: Young people from first generation migrant families may experience the dual pressures to individuate according to Western cultural norms as exemplified by their white peers, and to remain in close contact with their families in line with cultural expectations. They may also have to negotiate compromises about styles of dress, use of drugs and alcohol, sexual relationships and so on. This, along with increased likelihood of unemployment and other forms of discrimination, may partially account for reported higher rates of distress including 'psychosis' in some minority ethnic adolescent groups.

5. Provisional General Pattern: Surviving defeat, entrapment, disconnection and loss

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

Narrative summary of the General Pattern

Within the PTM Framework, this describes a broad pattern of threats, both past and present, and threat responses which give rise to core meanings of defeat, entrapment, disconnection and loss. Some degree of sadness, misery, loneliness and anxiety is an unavoidable part of life. However, if current environments are sufficiently long-term, severe and inescapable (e.g. workplace conditions; isolation from one's community; controlling partners; physical health problems; poverty; refugee status), the impact may be profound and disabling, even in the absence of earlier or additional adversities and losses. This pattern of distress is more common in less powerful groups, for example, female, low social class, older age group, minority ethnic, especially in the context of austerity, social inequality and social injustice. These groups are also the most likely to feel the adverse consequences of high unemployment, low wages, poor work conditions, etc. Social discourses about striving, hard work, achievement, competitiveness and success may add to a sense of shame and defeat if these strategies do not succeed. In conditions of austerity and inequality, populations as a whole may experience increased levels of humiliation and shame; fear and distrust; instability and insecurity; isolation and loneliness; feeling trapped and powerless. This applies whatever one's personal background and experience of other adversities. It also affects more affluent members of society even if they are protected from the material impacts.

If 'depression' and 'anxiety' are taken as synonyms for some people who fit this pattern, it is more likely to be identified in women. This may be linked this to the dual trap of lower-paid, less valued work coupled with bearing the main burden of child care. However, one power factor, unemployment, may have a bigger effect on men due to its stronger links with male identities as workers and providers. Social discourses about families, childrearing, women's roles as carers, men's roles as earners and so on feed into expectations, and also set the scene for self-blame if these expectations are not met. Common diagnoses are 'depression', 'clinical depression', 'major depressive disorder', 'anxiety', 'generalised anxiety disorder', 'panic disorder', 'agoraphobia', 'alcoholism'/drug dependency, 'OCD', 'hoarding disorder', 'postnatal depression', 'bulimia', and 'prolonged grief disorder' or 'complicated grief' along with suicidal feelings, although not everyone within these categories fits the pattern and these diagnoses are also assigned within other patterns. Poor physical health or pain and disability may compound the person's difficulties. Like all the patterns, this one may also describe people who have never been formally diagnosed.

Power, Threat, Meaning and Threat Responses within the General Pattern

The Power, Threat, Meaning and Threat Response aspects of this General Pattern commonly include the following:

Power

Within a PTM Framework, this pattern describes people who are trapped in long-term situations of chronic interpersonal/environmental stress and/or social exclusion.

This may include poverty, controlling or unsupportive relationships, social isolation, bereavement, refugee status, workplace stress, unemployment, pain and disability, or child-rearing with insufficient support. At a broader level, it may describe the general impact

of surviving situations of social inequality and injustice and the consequent fragmenting of communities which affects all its members. There may be early histories of disrupted attachments and trauma including loss of a parent, physical and sexual abuse, domestic violence, bullying, criticism or neglect.

Threat

Core threats include entrapment, social exclusion, competitive defeat, loss, attachment loss, loss of agency, loss of access to resources, physical exhaustion and depletion.

Meaning

The threats are commonly associated with meanings such as: helplessness, entrapment, defeat, loneliness, exclusion, lack of trust, self-blame, shame, humiliation, inferiority, unworthiness, and hopelessness. Other meanings may be a sense of alienation, failure, injustice/unfairness.

Threat Responses

The threats, and the meanings they are associated with, give rise to threat responses that are mediated by the body. Threat responses are conceived of as fundamentally protective. Disabling aspects can be reduced and counteracted by other responses which draw on skills, strengths, material, relational and social support, alternative narratives, and other power resources, many of which operate at the more 'reflexive' end of the spectrum. In this pattern they are often used to serve the following functions, listed in rough order of how commonly they are employed:

Protection against attachment loss, hurt and abandonment (e.g. appeasement, compliance, self-silencing, isolating oneself, dependence, 'giving up', exhaustion).

Regulating overwhelming feelings (e.g. withdrawal, avoidance ('agoraphobia'), low mood as a mask for grief, anger and loss, rituals, overwork, depersonalisation).

Self-punishment (e.g. low mood, self-blame, self-harm, suicide attempts, anger).

Maintaining identity, self-image and self-esteem (e.g. striving, competitiveness, self-starvation, perfectionism, body hatred).

Preserving a place within the social group (e.g. appeasement, compliance, dependence, striving, competitiveness, body hatred).

Seeking attachments (e.g. helplessness, weeping).

Meeting emotional needs, self-soothing (e.g. overeating, drug and alcohol use, exhaustion).

Protection from physical danger (e.g. anxiety, panic, phobias, withdrawal, 'agoraphobia', insomnia).

Maintaining a sense of control (e.g. rituals, rumination).

Communication about distress, eliciting care (e.g. self-injury, exhaustion, weeping, helplessness).

Sub-patterns within the General Pattern 'Surviving defeat, entrapment, disconnection and loss'

Sub-patterns within the General Pattern can be seen in relation to the following specific circumstances, among others:

Surviving competitive defeat: Some people demonstrate outward success through a strong achievement and competitive drive, derived from family and social expectations. If perceived expectations are not met, or it is not possible to sustain the drive, or they are suddenly faced with unemployment or other crises beyond their control, there may be threat responses of 'competitive defeat', exhaustion and self-criticism with a sense of failure, shame and hopelessness, and suicidal feelings. These reactions are likely to be more widespread within the general pressures of economic downturn and/or austerity, which have been shown to lead to generally increased levels of humiliation and shame; fear and distrust; instability and insecurity; isolation and loneliness; feeling trapped and powerless. Men may be more vulnerable to these messages and are the most at risk group for suicide. Within this, economically disadvantaged men in mid-life have the highest suicide rates. This may be due to a combination of factors including perceived failure to live up to masculine standards of success and control, in the context of relationship breakdown and socio-economic changes and pressures.

Surviving exclusion and competitive defeat as a young person: Adolescents and young adults in the UK report very high levels of self-harm, body hatred, eating distress, anxiety, misery, drug and alcohol use, etc., in the context of increased pressures to achieve in a more competitive environment, along with constant status comparisons through social media. The 'thin ideal' has resulted in an almost universal pre-occupation with weight in young women. Young men may have a parallel concern with being fit and having a well-defined physique. Austerity and inequality increase the pressures on everyone, and may impact strongly on young people through loss of opportunities coupled with social and economic pressures.

Surviving exclusion and competitive defeat as non-typical or non-conforming: The narrower the range of acceptable ways of being, and the more individualistic and competitive the social norms, the harder it is for people who are non-typical in various ways to find a social role and place for themselves and the more likely they are to experience feelings of failure, inadequacy, shame and exclusion. Some examples include: having an intellectual disability; having the characteristics associated with a diagnosis of Asperger's or autism spectrum disorder; being LGBTQ; having a visible appearance difference; and so on.

Coping with childbirth and childrearing: Sometimes diagnosed as 'post-natal depression'. Childbirth may involve aspects of threat such as entrapment, physical invasiveness, lack of control, loss of previous roles and status and so on, and for some women may re-trigger sexual/physical trauma memories. All of this may be exacerbated by hormonal changes, physical exhaustion, and so on. Longer-term power issues include lack of social support for families, isolated nuclear family structures, coupled with idealised messages about parenthood. Mothers, and sometimes fathers, who have received less than ideal parenting themselves, and/or have experienced earlier adversities and/or who are isolated and living in poverty, and/or are victims of domestic violence, are more likely to experience the emotional and physical demands of parenting as overwhelming and inescapable.

Meanings are likely to include failure and entrapment. Threat responses serve the function of communicating a need for support and reparation, expression of unacceptable feelings, and escape, by means such as low mood, anxiety, intrusive images of harm, 'agoraphobia', self-blame and so on.

Surviving bullying and workplace bullying: Bullying can be understood at one level as a process of enforcing group norms within peer groups. Prolonged bullying in childhood is associated in adults with low mood and low self-worth, difficulties with trust and intimacy in romantic partnerships, shame and lack of confidence, and persistent loneliness. In its more severe forms, it may result in 'psychotic' and other difficulties as an adult, as described under the General Pattern 'Surviving rejection, entrapment and invalidation'. Although adults are, other things being equal, better equipped to deal with bullying than children, workplace bullying is a situation of entrapment and invalidation that is associated with panic attacks, low mood, loss of self-esteem, hyperarousal, avoidance, and physical symptoms such as headaches, insomnia, digestive problems, skin complaints, nausea, and heart palpitations. Bullying is more frequent in business or institutional environments that are primarily based on competition and threat.

Non-Western patterns: *'Brain fag'* in West Africa may be an expression of similar stresses. It is mainly reported by male school and university students and others studying for further qualifications, especially around periods of intensive study, and comprises mental exhaustion, sensations of pain or burning in the head and neck, and blurred vision. The experiences appear to be related to an intense desire to succeed and improve the economic and social standing of oneself and one's family. These pressures arise in the context of rapid social change and globalisation, and create tensions with more traditional values and practices. 'Brain fag' is a diagnosis that appears to be declining in use, with more recently trained psychiatrists applying it relatively rarely in practice. It has also been argued that it is not a true 'culture-bound syndrome' but a notion transported from 19th-century Britain.

The Khwe community in South Africa describes a version of *kufingisisa*, a phenomenon translated as 'thinking too much' which is mentioned in *DSM-5* and recognised in a number of world regions. While this state does not always have negative impacts or connotations for the Khwe, it sometimes refers to intense rumination about the extreme poverty, material deprivation and health concerns faced by this displaced and marginalised community. This is accompanied by feelings of hopelessness and lack of control.

6. Provisional General Pattern: Surviving social exclusion, shame and coercive power

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

Narrative summary of the General Pattern

Within the PTM Framework, this describes someone whose family of origin is likely to have lived in environments characterised by threat, discrimination, material deprivation

and social exclusion. This may have included absent fathers, institutional care and/or homelessness. Within this, caregivers are likely to have been struggling with their own histories of adversity, past and present, often by using drugs and alcohol. As a result of all this, the person's early attachments were often disrupted and insecure, and they may have experienced significant adversities as a child and as an adult, including physical and sexual abuse, bullying, witnessing domestic violence, and harsh or humiliating parenting styles. 'Disorganised' attachment styles are common. Individuals tend to use survival strategies of cutting off from their own and others' emotions, maintaining emotional distance, and remaining highly alert to threat. Social discourses and status comparisons may have imparted a sense of worthlessness, shame and injustice, which may be managed by various forms of violent behaviour. More unequal societies, in which economic inequality increases social competition, allow these dynamics to flourish. This may have a particularly strong impact on disadvantaged men, who have greater incentives than women to compete, achieve and maintain high social status, while being faced with numerous indications of their lack of success and status.

'Paranoia', or suspicious thoughts, is very characteristic of this pattern (although not inevitably, and it is also found in other patterns). It has been shown to have roots in disrupted attachments, domestic violence in family of origin, poverty, institutional care, unsafe urban environments, and experiences of bullying, assault and other physical threats. Minority ethnic status increases the likelihood of experiences of discrimination and exclusion, which may explain the greater incidence of suspicious thoughts ('paranoia') in these groups. 'Paranoia' can thus be seen as a possible response to exclusion and disconnection. Threat responses may include fearfulness, hypervigilance, appeasement, avoidance and self-isolation.

Violence and aggression have been shown to arise from similar roots as 'paranoia'. The two are sometimes, though not always, linked in this pattern, in that threat responses in the form of aggression may be very easily triggered in response to 'paranoia' or perceived danger, especially since the development of reflective abilities may not have been facilitated in early life. Gender socialisation means that men are more likely to direct anger outwards in the form of violence and destructiveness towards others, whereas women have higher rates of self-harm and eating distress. Women with these backgrounds may therefore be more likely to fit the pattern 'Surviving rejection, entrapment and invalidation'. The poverty that is a frequent feature of this pattern is a particularly strong synergistic ACE for both men and women.

While the PTM Framework sees people as able to make choices in their lives, at the same time it acknowledges that these choices are often constrained. Thus, many (though not all) examples of violent and offending behaviour can be understood as survival responses. The pattern is therefore characteristic of a large number of males (and some females) in the criminal justice system (as well as of many people outside it). It has also been argued that 'anti-social personality disorder' is an extreme version of Western cultural stereotypes about dominant men with limited ability to empathise or express emotions.

Common diagnoses for men who are described by this pattern are 'antisocial personality disorder' or 'paranoia', while women are more likely to be diagnosed with 'borderline personality disorder', 'eating disorders', 'bipolar disorder' or 'major depressive disorder'.

Other possible diagnoses are 'alcohol or substance use disorder', although not everyone assigned these diagnoses fits the pattern and these diagnoses are also assigned within other patterns. Like all the patterns, this one may also describe people who have never been formally diagnosed.

Power, Threat, Meaning and Threat Responses within the General Pattern

The Power, Threat, Meaning and Threat Response aspects of this General Pattern commonly include the following:

Power

There have been multiple experiences of the negative operation of almost all forms of power giving rise to multiple social and relational threats and adversities, both past and present. This is commonly exacerbated by being sent to other threatening institutions such as prison. The wider context is one of competitive but economically and socially unequal societies, in which people, especially men, are faced with constant indications of failure and exclusion. Social discourses about gender roles shape the way in which the threats are experienced and expressed. This includes domestic violence, which is facilitated by discourses about male strength, dominance and control.

Threat

The individual (family/social group) within this pattern was and is faced with core threats such as social exclusion and disconnection, physical danger, emotional overwhelm/dysregulation, emotional neglect and invalidation, humiliation, powerlessness, abandonment, material deprivation, and bodily invasion.

Meaning

The threats are commonly associated with meanings such as: fear, shame, humiliation, inferiority, worthlessness, and powerlessness, although there may be limited awareness and acknowledgement of this. Suspicious thoughts have been shown to arise out of feelings of powerlessness, injustice, shame, anger, entrapment, unworthiness and social exclusion. Fear of abandonment, emotional emptiness, emotional numbness, guilt and alienation may also be present.

Threat Responses

The threats, and the meanings they are associated with, give rise to threat responses that are mediated by the body. Threat responses are conceived of as fundamentally protective. Disabling aspects can be reduced and counteracted by other responses which draw on skills, strengths, material, relational and social support, alternative narratives, and other power resources, many of which operate at the more 'reflexive' end of the spectrum. In this pattern they are often used to serve the following functions, listed in rough order of how commonly they are employed:

Preserving identity, self-image and self-esteem (e.g. dominance, feeling entitled, violence, suspicious thoughts, sexual aggression, externalising, hypervigilance, distrust).

Regulating overwhelming feelings (e.g. denial, projection, reduced empathy and reduced

awareness of emotions, suspicious thoughts, dissociation, numbness, somatic experiences, hearing voices, self-harm, drugs and alcohol, impulsivity, rage as a mask for fear, sadness, shame and loneliness).

Protection from physical danger (e.g. suspicious thoughts, distrust, dominance, aggression, hypervigilance, avoidance, self-isolation).

Maintaining a sense of control (e.g. maintain emotional and/or physical distance, use aggression as a defence against shame and humiliation, dominance, violence and threats).

Protection against attachment loss, hurt and abandonment (e.g. appeasement, maintain emotional distance, dominance, suspicious thoughts, violence, sexual aggression, sensitivity to humiliation and shaming, reduced empathy, impulsivity).

Preserving a place within the social group (e.g. aggression, gang membership).

Self-punishment (e.g. self-harm, suicide attempts).

Meeting emotional needs, self-soothing (e.g. drugs and alcohol, eating habits).

Sub-patterns within the General Pattern 'Surviving social exclusion, shame and coercive power'

Sub-patterns within the General Pattern can be seen in relation to the following specific circumstances, among others:

Perpetrating domestic abuse: Domestic abuse can refer to any violent or coercive relationship between adult family members, but most commonly it describes abuse between partners. Domestic abusers, like anyone who has committed a crime or behaved in a violent or coercive way, are accountable for their actions. At the same time, it is important to recognise that certain PTM patterns increase the likelihood that some people will choose to act in this way. Domestic violence perpetrated by men is more common in the presence of unemployment, lower socioeconomic status and financial stress. Early experiences of victimisation and witnessing parental domestic violence also increase the risk of this behaviour in men, but not in women. The level of exposure to violence in childhood is correlated with the severity of abuse inflicted as an adult. Domestic abuse is found in all sections of society, and some male domestic abusers have a profile of higher social status, and fewer or no other violent behaviours. Men described by this pattern sometimes attract diagnoses of 'narcissistic, anti-social or borderline personality disorders', and sometimes abuse alcohol. Less is known about domestic abuse perpetrated by women, although this may be linked to attachment disruptions and early trauma. Little is known about domestic abuse within same-sex and transgender relationships, although there are suggestions that insecure attachments and witnessing domestic violence may be relevant in gay and lesbian perpetrators as well.

Surviving homelessness: Long-term homeless people frequently report poor family relationships, high rates of emotional and physical abuse/violence including domestic violence, institutional care, substance misuse and traumatic brain injury, in a cumulative series of adversities.

Surviving separation, institutionalisation and privilege: People from more affluent backgrounds may show somewhat different patterns of response. The earlier attachment disruptions, victimisation/trauma and the later threat responses may be more limited, subtle, and

seen as socially acceptable or even desirable. Reduced empathy may be masked by social skills, superficial charm and high social status. For example, there has been description of so-called 'boarding school syndrome' among more privileged groups. The sudden loss of attachments at an early age, coupled with the need to survive in a new and possibly threatening or abusive environment, may lead to the development of a superficially confident presentation, which conceals vulnerability, fear and loneliness, even from the person themselves. This is likely to result in later difficulties with trust and intimacy, and (in the case of boys at single sex schools) relating to women. Sometimes, but certainly not always, this pattern is acted out in dominating, bullying or offending behaviour.

Non-Western pattern: Running amok is a pattern of behaviour found in Malaysia and Indonesia among other places. It can take various forms, but in one, a hitherto peaceful man will acquire a weapon and make a frenzied attempt to injure or kill others. The episode frequently ends with the man either killing himself or being killed by others. Malay mythology attributed this behaviour to spirit invasion. It is also widely seen as a way to re-establish one's reputation as a man to be respected and feared, after a perceived slight. Comparisons have been drawn with school shootings in the US, which seem to be linked to male feelings of humiliation, rejection, failure, exclusion, grievance and anger.

7. Provisional General Pattern: Surviving single threats

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

Narrative summary of the General Pattern

Within the PTM Framework, this pattern describes people who have experienced specific threat event(s), either directly or via witnessing harm to others. These may be non-intentional threats such as road traffic accidents, medical procedures, natural disasters, difficult childbirth, bereavement; or intentional such as rape, assault, torture, witnessing or perpetrating acts of war, and so on. The exacerbating factors apply, so that interpersonal and intentional traumas (rape, assault) are likely to have the greatest impact. In the absence of earlier adversity and attachment difficulties, the impact is, on average, less severe. Thus, specific threatening events such as sexual abuse, bullying, assault, difficult childbirth etc. may be survived without lasting distress given the absence of exacerbating factors and the presence of supportive and protective relationships. However there is likely to be at least some initial impact, mediated by the common social meanings of such events.

This pattern is widely recognised in Western settings under the diagnosis of 'PTSD'. The main differences within a PTM Framework are that the pathology implied by the term 'disorder' is avoided and aspects of social context are included. This allows for individual and cultural variation and recognises the centrality of meaning and function across all threat responses. It is important to note that the characteristic 'PTSD' criteria of hypervigilance, avoidance, intrusive thoughts and so on are not universal responses, either cross-culturally or historically (e.g. 'shell shock').

The pattern is also recognised in the trauma literature's distinction between 'single incident' trauma (an unexpected 'one-off' and 'out of the blue' event such as a natural disaster, traumatic accident, terrorist attack or single episode of assault, abuse or witnessing of it) and complex trauma which is cumulative, repetitive and interpersonally generated. Like all the patterns, this one may also describe people who have never been formally diagnosed. The more severe and long-lasting the threat(s), the more this pattern is likely to shade into other General Patterns such as 'Surviving rejection, entrapment and invalidation'.

Power, Threat, Meaning and Threat Responses within the General Pattern

The Power, Threat, Meaning and Threat Response aspects of this General Pattern commonly include the following:

Power

Power may be unrelated (e.g. bereavement from natural causes) or only indirectly related to single traumas. For example, a workplace accident may be caused by machinery, but the wider picture may be one of unsafe working conditions. A natural disaster may be outside human agency but its impact and aftermath (who was best protected? What aid was offered?) is likely to involve aspects of power.

Threat

The traumatic event was a threat to the psychological and/or physical integrity of the person and/or those close to them.

Meaning

The threats are commonly associated with meanings such as: fear, helplessness, isolation, alienation, self-blame, and shame. The last two are especially likely when traumatic events are experienced as highly personalised and intentional and when they are associated with negative cultural meanings. Threats that occur in the context of feelings of betrayal – for example, a war that is perceived as unjust or where others do not recognise the extent of trauma, or hold the person partly responsible – may have a more damaging impact.

Threat responses

The threats, and the meanings they are associated with, give rise to threat responses that are mediated by the body. Threat responses are conceived of as fundamentally protective. Disabling aspects can be reduced and counteracted by other responses which draw on skills, strengths, material, relational and social support, alternative narratives, and other power resources, many of which operate at the more 'reflexive' end of the spectrum. In this pattern they are often used to serve the following functions, listed in rough order of how commonly they are employed:

Regulating overwhelming feelings (e.g. avoiding triggers, drug and alcohol use).

Distraction from/avoidance of overwhelming feelings (e.g. drug and alcohol use, emotional and physical numbness, dissociation, memory gaps, depersonalisation, irritability, rage, self-silencing).

Protection from danger (e.g. fight/flight, hypervigilance, insomnia, rage, flashbacks, nightmares).

Maintaining a sense of control (e.g. hypervigilance).

Self-punishment (e.g. self-criticism, shame, guilt, low mood).

Meeting emotional needs, self-soothing (e.g. drug and alcohol use).

Sub-patterns within the General Pattern 'Surviving single threats'

Sub-patterns within the General Pattern can be seen in relation to the following specific circumstances, among others:

Surviving rape: Rape is known to have a more powerful impact than many other crimes due to its essential elements of terror, humiliation, powerlessness and bodily violation. Common threat responses and meanings include feelings of responsibility and hence self-blame, shame and guilt (especially in women) along with anger, relationship difficulties, and sexual difficulties. A similar pattern in men includes threat responses and meanings of humiliation, denial, repression, shame, powerlessness, low self-confidence, mistrust of adult men, sexual difficulties, negative body image and doubts about one's sexual orientation, along with internalised homophobia. Victims may be low in mood, anxious, fearful, panicky and/or suicidal in the aftermath of the assault, along with experiencing hypervigilance, avoidance, and intrusive thoughts, and may use alcohol or drugs to cope. These meanings are shaped by social discourses about women's and men's roles, male and female sexuality and so on. Many rapes are committed by people known to the victim and may involve the perpetrator's minimisation or denial of what has happened – which in turn may be supported by wider social denial of what has happened. Victims who report the rape may encounter interpretations and legal processes which exacerbate their distress. Rape may also be used as a weapon against the civilian population in war, genocide and other forms of mass violence.

Surviving combat: These responses have long been recognised in forms such as 'shell shock' and were officially recognised with the inclusion of the new concept of 'Post-traumatic stress disorder' in *DSM-III*, following the Vietnam war. If threatening events in combat are characterised by many exacerbating factors, and occur in the context of a history of earlier adversities and attachment difficulties, the threat responses are likely to be more severe, and the pattern may be more typical of 'Surviving rejection, entrapment and invalidation'. It has been argued that the response patterns are essentially similar to those experienced by (mainly) women and children in the private sphere, as a consequence of rape, domestic violence and sexual abuse. War is particularly likely to expose combatants to extreme violence, violation, injury and grotesque forms of death, all of which are known to increase the likelihood of psychological damage to the witness. The survivor may remain in a state of physiological hyperarousal and preparation for threat, with accompanying insomnia, startle responses and irritability. They may experience vivid, fragmented and intrusive memories of combat events in the form of flashbacks and nightmares. They may attempt to manage all this by numbing their feelings and cutting off their perceptions, sometimes to the point of dissociating from their bodies. Drugs and alcohol may also be used to manage feelings of helplessness and terror. As with traumatic events in general, a sense of

betrayal (for example, about the justification for war) increases the damaging impact by shattering the combatants' faith in themselves, other people and the world.

Non Western pattern: *Surviving as a Cambodian refugee:* Khyâl attacks are reported in many Asian and South Asian countries, in which there is a belief in Khyâl, or a windlike substance that flows along with blood throughout the body. Bodily symptoms are frequently attributed to disruption of this flow. Khyâl attacks are characterised by palpitations, dizziness, shortness of breath, joint and neck soreness, tinnitus, headache, and loss of energy. The belief is that khyâl has suddenly started flowing up toward the heart, lungs, and neck. This causes the hands and feet to grow cold, while the upward flow of khyâl and blood potentially stops the heart or bursts the neck vessels. The khyâl exits from ears or eyes, which causes the tinnitus or blurred vision. Cambodian refugees frequently report these attacks. In this group, the attacks are often related to reminders or memories of severe trauma experienced during the Pol Pot regime, including violence, death threats, and witnessing others being tortured or killed.

Part 4: Personal narratives within the PTM Framework

One of the main purposes of the General Patterns is to support the construction of narratives in their various versions, as an alternative to psychiatric diagnoses. 'Personal Narratives' in this sense can encompass individual, couple, family or social networks, depending on the situation and (if relevant) the model of intervention; and narratives may be of any kind, from structured psychological formulations to self-authored personal stories expressed in writing or any other medium. Since verbal or written narratives are the most common and often the most socially-valued form of expression in Western contexts, they are the main focus of this section, although other kinds of narratives (art, music, theatre, poetry, dance, and so on) are equally important and sometimes more helpful and relevant).

First, the issues pertaining to the contexts, forms, structures and functions of narratives, including the particular version that is known as formulation, are discussed.

Narratives – contexts and debates

Within the PTM Framework, the 'personal' meanings which constitute narratives are inseparable from the wider social discourses and ideological meanings from which they emerge; Chapters 2 and 3 offered extensive discussion of the fact that '(a)ll societies have procedures whereby the production of discourses is controlled to preserve the structure and convention of that society' (Hawtin & Moore, 1998, p.91). This connection between personal and social/ideological meaning works both ways. As Sherry Mead and Beth Filson observe, 'Through dialogue, new meaning evolves as we compare and contrast how we have come to know what we know. Our shared stories create communities of intentional healing and hope... When people share their stories without others imposing meanings on them, this creates social change' (Mead & Filson, 2016, p.109). The construction of a narrative through dialogue in this sense is, therefore, much more than an individual story. It is part of reversing the processes which, in the words of survivor Jasna Russo, 'devalue not only our personal stories but also our very ability to understand and make meaning of experiences of our

own'. Instead, there is a need to '...take part in the production of official knowledge about madness and restore our own epistemic existence' (2016, pp.62–61).

It is important to remember that story-telling and meaning-making are universal human capacities, and as such there is an almost infinite number of additional examples of narrative and dialogical practices across the globe. Narratives at the level of the social group may be seen as equally or more valuable in collectivist cultures, where the idea of engaging in one-to-one therapy may be alien and inappropriate and there might consequently be more emphasis on locating emotional distress within the contexts of extended family relationships, ties to village and social network, relationship to house and land, and so on (Bracken, 2002; Somasundaram & Sivayokan, 2013). For example, Davar and Lohokare's (2008) study of faith-based healing centres in India described how people's difficulties were 'woven into a larger narrative about life purpose, spiritual seeking, economic deprivation and social struggles' (quoted in Davar, 2016, p.15). Similarly, meanings may be more typically expressed as patterns within communities as a whole – both in terms of the damage that may have been done to the whole social fabric by war, natural disaster and so on, and in terms of supporting healing through shared community rituals and narratives. This damage is sometimes referred to as 'collective trauma', and as such, a collective response may be seen as more relevant (Somasundaram & Sivayokan, 2013). These perspectives are comparatively under-emphasised in more individualistic cultures, despite the strong evidence about the central importance of relationships and community ties for emotional wellbeing in all societies (Cromby et al., 2012).

Earlier chapters discussed in detail how in Euro-American and Westernised cultures, experiences of distress are likely to be met by a powerful dominant narrative of medicalisation. However, as also discussed, narratives can be restorative and healing as well as limiting. This is a prominent theme in the lives of many former service users and in survivor-led movements. Thus, the emerging field of Mad Studies 'centres the knowledges of those deemed mad' in scholarship, theories, research and practice, as a way of resisting diagnostic and biomedical thinking (LeFrancois, 2016, p.v). Survivors/campaigners such as Jacqui Dillon and Rufus May concur that '...many accounts of recovery seem to be about a decolonising process' of 'reclaiming their experience in order to take back authorship of their own stories'. These new stories can transform discourses of deficit into ones of strength and survival, as part of 'our right to define ourselves; the right to find our own voices' (Dillon & May, 2003, p.16). This includes seeing your experiences as valid and meaningful; putting them in a wider context of social justice; joining together with others; and sometimes finding a new purpose that emerges out of suffering (Dillon & May, 2003).

It is important to acknowledge that distancing yourself from dominant expert narratives and constructing new ones, if that is your choice, is not a quick, easy or complete solution (Romme et al., 2009). This is partly because the discourse of medicalisation is so deeply embedded in our social institutions, theories, practices and everyday lives. It may be very hard to free oneself from the internalised stigma of diagnosis. Long-standing forms of distress may not disappear although it may be possible to find ways of living alongside them (as described in some of the early recovery literature). Healing from some of the consequences of diagnosis – such as the effects of medication – may take months or years, or perhaps never be complete. Struggles with finances, housing, lowpaid employment and so on may continue to dominate daily life. And caution is needed about co-option of

the idea of narrative itself – as seen in pressure to produce an acceptable ‘recovery story’ while leaving basic diagnostic, economic and material structures unchanged. Critiquing this trend, Lucy Costa and co-authors (2012) note that ‘It is now commonplace for mental health organizations to solicit personal stories from clients – typically, about their fall into and subsequent recovery from mental illness. These stories function to garner support from authority figures such as politicians and philanthropists, to build the organizational “brand” regardless of program quality, and to raise operating funds during times of economic constraint’ (p.86). The authors warn that these ‘sanitised’ accounts, backed up by disclosures from well-known public figures, function ‘to further solidify hegemonic accounts of mental illness’ (p.87).

A similar cautionary note is needed about the growing trend for ‘narrative-based medicine’ as a framework for a holistic, empathic understanding of a patient’s physical illness and its meaning for him or her (Greenhalgh & Hurwitz, 1999). While this approach may have much to offer general medical practice, it cannot justify analogies between physical ill-health and ‘mental illness’ (see Chapter 8 for discussion of the problematic ‘parity of esteem’ agenda). The medicalised ‘illness’ narrative is not simply another story that someone might be offered in relation to emotional distress or troubled/troubling behaviour, and its continued use by professionals raises questions of ethics as well as evidence.

Despite all the caveats above, there is still the possibility for approaches based on narrative, relational, dialogical and social justice principles to allow for what psychiatrist Judith Herman calls the ‘restorative power of truth-telling’ (Herman, 2001, p.181). This can provide a means for the person to locate their suffering within a wider social context, and replace exclusion and self-blame with a sense of compassion and community. In a jointly authored article, psychiatrist Philip Thomas and survivor Eleanor Longden concur that ‘Just as the self can be undone and dehumanised by brutality and isolation it can be renewed and remade through solidarity and connection with others through narrative’ (Thomas & Longden, 2013, p.4). These dialogues require, in Herman’s words, ‘a committed moral stance. The therapist... must affirm a position of solidarity with the victim. This does not mean a simplistic notion that the victim can do no wrong; rather, it involves an understanding of the fundamental injustice of the traumatic experience and the need for a resolution that restores some sense of justice’ (Herman, 2001, p.135). There are obvious resonances with community psychology’s emphasis on the core values of liberation, empowerment and social justice (Orford, 2008); with formulating within social inequalities and community psychology perspectives (Hagan & Smail 1997a, 1997b; McClelland, 2014); with the liberation psychologies of Latin America (Afuape & Hughes, 2016; Burton & Kagan, 2011); and with the process of ‘conscientisation’, or developing critical consciousness about the impact of societal structures on wellbeing, in which there is a shift from ‘You are to blame for your circumstances and you must individually solve your problems with my expert help’ to ‘Certain social arrangements maintain particular groups in powerful and powerless positions, so let’s act together to change them’ (Nelson & Prilleltensky, 2010).

Using Personal Narratives within the General Patterns

The PTM Framework is not intended to replace existing narrative and dialogical practices, or to re-package human abilities into professionally-owned skills. The longer-term aim is to

make the PTM Framework an optional resource accessible to all. In the meantime, some initial thoughts about translating the PTM Framework into practice are offered below. Further resources, materials and good practice examples can be found in the Appendices of the Overview publication.

The General Patterns provide a basis for developing personal narratives which fulfil more effectively the helpful functions of diagnosis as reported by service users, such as giving an explanation, having distress validated, facilitating contact with others in similar circumstances, offering relief from shame and guilt, and suggesting ways forward. A personal narrative drawing on the PTM Framework aims to promote understanding and influence/agency within the person/family/social network by: increasing awareness about the origins, both local and more distant, of experiences of distress; identifying and demystifying the influence of social discourses and ideological meanings; restoring the links between meaning-based threats and functional threat responses; facilitating the relinquishing of narratives of stigma, shame and deficit; opening up alternative ways of living with/resolving emotional pain; increasing access to power and resources; increasing influence and agency within inevitable biological, psychological, social and material constraints and local cultural assumptions; and creating or co-creating a new and more hopeful narrative that supports and enables all the above. In narrative therapy evaluative terms, narratives informed by a PTM Framework are more likely to be ‘thick’ stories which increase influence and choice (Harper & Spellman, 2014). Appendix 1 of the Overview publication suggests a template that may be useful in guiding this process www.bps.org.uk/PTM-Overview

As described earlier, Personal Narratives within a PTM or any other framework need to include two important additions to the information in the General Patterns (see Appendix 1, Overview publication). These are:

- The power resources available to the person and their social group, which moderate the negative impacts of power, convey a message of hope and resilience, and provide the basis for support and moving forward. In other words, we need to ask the question: ‘What are your strengths?’ (What access to Power resources do you have?)
- A summary of the evolving story, narrative, hypothesis or ‘best guess’ which integrates Power, Threat, Meaning and Threat Responses through the meanings they have to the person and their family/social network/community, and the strengths and resources that they can draw on. In other words, we need to work out ‘What is your story?’

Clearly, power can be used in helpful (experienced as protective, enabling, supportive) as well as unhelpful (experienced as threatening, entrapping, invalidating) ways. Even the most disempowered individual/family and the most devastated community will have at least some access to sources of influence and resistance, which are more or less the opposite of the negative actions of power, as illustrated by Hagan and Smail’s process of ‘Powermapping’ (Hagan & Smail 1997a, 1997b). These may encompass:

- Secure early relationships;
- Supportive current partners, family and friends;
- Social support and belonging;
- Access to material resources/cultural capital/education/ and so on;
- Access to information/alternative perspectives;
- Positive/socially valued aspects of identity;

- Skills/abilities – intelligence, resourcefulness, determination, talents;
- Bodily resources – appearance, strength, health;
- Belief systems – faiths, community values and so on;
- Community practices and rituals;
- Connections to the natural world.

This may enable individuals, families and groups to draw upon some of the following resources and strategies in response to threat:

- Regulating emotions by releasing/expressing/processing feelings (e.g. writing, exercise, talking therapies, body therapies, creativity and the arts, compassion-focused approaches, mindfulness, meditation);
- Self-care – e.g. nutrition, exercise, rest, alternative therapies;
- Using healing attachments/relationships for practical and emotional support, protection, witnessing, validation;
- Finding meaningful social roles and activities;
- Values and spiritual beliefs;
- Other culturally-supported rituals, ceremonies and interventions;
- Supporting each other in campaigning, activism;
- Creating/finding new narratives/meanings/beliefs/values/‘survivor missions’.

Narrative use in current practice

There is already a rich range of narrative, dialogical and formulation-related practices to build on, each of which has characteristic strengths and limitations. Within services, this includes psychological formulations from various theoretical perspectives (Corrie & Lane 2010; Johnstone & Dallos, 2014); narrative therapy (e.g. White, 2000; and see Appendix 9 of the Overview publication www.bps.org.uk/PTM-Overview); the Tidal Model (Barker & Buchanan-Barker, 2005); reflecting teams (Anderson, 1991); Open Dialogue (e.g. Seikkula & Arnkil, 2006; and see Appendix 10 of the Overview publication) and many others. Narrative approaches to emotional healing developed mainly outside services include the ‘constructs’ or personal understandings about voice-hearing from the Hearing Voices Network (Romme & Escher, 2000; and see Appendix 11 of the Overview publication); other resources developed by the Hearing Voices Network (e.g. The Maastricht interview); Intentional Peer Support, a form of peer storying and ‘becoming part of each other’s narratives’ (Mead & Filson, 2016); the ‘Tree of Life’ approach initially developed in southern Africa (Ncube-Millo & Denborough, 2007) and now used in various settings including intellectual disabilities and young people (Denborough, 2008). Others have found art, poetry, painting, music, literature, sport, yoga and so on helpful in addition to, or instead of, counselling and therapy. Examples include the use of music technology to explore notions of masculinity with young offenders (Clemon, 2016); and film-making with young refugees and asylum-seekers (Clayton & Hughes, 2016). See also the Shared Voices and MAC-UK projects in Appendices 13 and 14 of the Overview publication www.bps.org.uk/PTM-Overview

Within this work, the concepts of testimony and witnessing may often be more relevant than those related to formal therapeutic intervention. Alec Grant (2015) has argued that all mental health professionals need to ‘...develop increasingly more sophisticated levels

of narrative competence. ...This term refers to the capacity for human beings to deeply absorb, interpret, and appropriately respond to the stories of others. Such close attention facilitates methods for addressing users' existential issues around inner hurt, despair, hope... By carefully attending to context, nuance and difference within and between people's experiences of distress, narratively competent practice is helpful in engaging people who use mental health services in a recovery process through which they are able to re-story their lives' (Grant, 2015, p.52). This process of 'narrative re-storying' (Grant et al., 2015) is closer to the 'professional artistry' of reflective practice than to the dominant technical/rational model of medicine (Schon, 1987). The implication is that 'narrative competence' should inform every aspect of professionals' interactions with service users. This aligns with the principles of the Open Dialogue approach in which the shared dialogue is not a way of deciding on the intervention, but is itself the intervention and the means through which change can occur. Many service user/survivor accounts have illustrated the power of this process (Coleman, 2017; Grant et al., 2015; Longden, 2014; Romme et al., 2009; Waddingham, 2013).

The PTM Framework does not aim to supplant these existing practices, and clearly, The Personal Narrative template (see Appendix 1 of the Overview publication) is not the only way of structuring a narrative, although it may have particular uses in some settings. Rather, the aim is to raise awareness about the aspects that existing narrative and formulation practices may under-emphasise. These are:

- The entrapping effect of the dominant narrative of psychiatric diagnosis and its wider context of meta-narratives about science.
- The contradictions inherent in combining psychiatric diagnostic narratives with psychosocial ones.
- The role of social discourses, especially those about gender, class, ethnicity and the medicalisation of mental distress, and how these discourses can support the imposition of others' meanings.
- The impacts of coercive, legal, and economic power.
- The nature and impact of power inequalities in psychiatric settings.
- The prevalence of abuse of interpersonal power within relationships.
- The role of ideological power as commonly expressed through dominant narratives and assumptions about individualism, achievement, personal responsibility, gender roles, and so on.
- The mediating role of biologically-based threat responses.
- The importance of function over 'symptom' or specific problem.
- The role of social learning and power resources in shaping threat responses.
- Culture-specific meanings, belief systems and forms of expression.
- Self-help and social action along with, or instead of, professional intervention.
- The importance of community narratives, values and spiritual beliefs, to support the healing and re-integration of the social group.
- Recognition of the varied, personal and provisional nature of all narratives and the need for sensitivity, artistry and respect in supporting their development and expression, whatever form they take.
- A meta message that is normalising, not pathologising (either medically or psychologically): 'You are experiencing an understandable and indeed adaptive reaction to threats and difficulties. Many others in the same circumstances have felt the same'.

This analysis suggests that narratives of all kinds will be more holistic, helpful, healing, empowering and evidence-based if they draw on all aspects of the Power Threat Meaning Framework, as above.

Personal narratives and psychological formulation

Psychological and psychotherapeutic formulations are one kind of narrative, and a narrative approach obviously has implications for the development of formulations.

Although training courses and some textbooks tend to describe formulation as if it is an event or ‘thing’, it is perhaps more accurate to see it as a process, an aspect of a shared exploration between two or more people, that has no definite end point. This is captured in the definition ‘a process of ongoing collaborative sense-making’ (Harper & Moss, 2003, p.8). The development of this personal story or narrative has been described as ‘a way of summarising meanings, and of negotiating for shared ways of understanding and communicating about them’ even though this can never be a final or ‘true’ account (Butler, 1998). In contrast to psychiatric diagnosis, psychological formulation approaches all expressions of distress with the assumption that ‘...at some level it all makes sense’ (Butler, 1998, p.2). In other words, it represents a fundamentally different way of thinking about emotional distress, not just an additional activity or skill.

Psychological formulation as outlined in the Division of Clinical Psychology (DCP) (2011) *Good Practice Guidelines* already fulfils some of the criteria for narratives as listed above. Importantly, it is conceived of as an alternative to, not an addition to, psychiatric diagnosis: ‘Best practice formulations... are not premised on psychiatric diagnosis. Rather, the experiences that may have led to a psychiatric diagnosis (low mood, unusual beliefs, etc.) are themselves formulated’ (DCP, 2011, p.17). This is particularly relevant in mental health settings, although formulation is also used to provide a holistic understanding within Intellectual Disability, Older Adult, Neuropsychology and Health services, where a medical or neurodevelopmental condition will often be the main focus of intervention. The *Guidelines* recognise the damaging impacts of adversity, discrimination, deprivation and inequality (pp. 14, 18, 20) and the potentially traumatising and re-traumatising role of services (p.20). It is recommended that psychological formulations include ‘...a critical awareness of the wider societal context within which formulation takes place’ (p.20). It is noted that switching attention from individual deficits to ‘injuries inflicted by a damaging environment... may... constitute a form of “demystification”, bringing with it a significant degree of relief’ (Hagan & Smail, 1997a, cited in DCP, 2011, p.20). There is recognition that psychological formulation itself is only one way of constructing narratives, and that it is influenced by Western assumptions about internal causation, individualism and self-actualisation (p.18). Finally, respect, collaboration and reflexivity are urged in the process of co-constructing formulations (p.30). Many of these principles are echoed in a core text from counselling psychology, Corrie and Lane’s (2010) *Constructing stories, telling tales: A guide to formulation in applied psychology*, which emphasises the role of narrative and story-telling across the usual divisions of Psychology and the arts, and indeed in all human societies. The text offers helpful reflections about the definitions, uses, professional contexts, accuracy, evaluation and ownership of formulation.

The Personal Narrative template can be seen as another possible format for structuring

psychological formulations with individuals, families and teams. More broadly, it is hoped that the PTM Framework will enrich the theory and practice of psychological formulation in whatever form it is currently used, and help to minimise some of the inherent risks of individualising, cultural insensitivity, imposing 'expert' views, and downplaying the causal role of adversities, both relational and social (DCP, 2011). This is an evolving field, and there are some interesting examples of formulating in relation to political and societal issues such as young people's 'sexting', debates about nuclear weapons, and the impact of legal processes on refugees (see *Clinical Psychology Forum*, 2017, no. 293). Others are discussing ways of ensuring that formulations are culturally sensitive and appropriate (e.g. McInnis, 2017).

The DCP *Good Practice Guidelines* (2011) make an important distinction between psychiatric formulation – an addition to a psychiatric diagnosis – and psychological formulation – an alternative to a psychiatric diagnosis (p17). It is probably not a coincidence that formulation, and debates about its role, have achieved growing prominence in the wake of the challenges to psychiatric diagnosis (e.g. Craddock & Mynors-Wallis, 2014). Now that formulation – in its psychiatric version – has become a core competency for all mental health and related professions (Skills for Health, 2016), extra vigilance is needed to promote, protect and develop those aspects of formulation and formulating that offer an alternative to medicalisation and psychiatric diagnosis.

Evaluating narratives and formulation

We have noted that the more variation across individuals and environments within the General Patterns, the more open, varying and provisional will be the personal narratives derived from them. We have also argued that this variation and overlap across the patterns is inevitable, since it arises from the highly contingent and synergistic nature of causality in human affairs, from the multiplicity, complexity and interacting nature of the factors involved, and from our roles as meaning makers and active agents in our lives. There can, therefore, never be one final, accurate and truthful account of the origins and meanings of someone's difficulties. Drawing from a psychoanalytic tradition, Stephen Frosh (2007) warns about the impossibility of ever reaching a final personal narrative that 'makes sense' because:

The human subject is never a whole, is always riven with partial drives, social discourses that frame available modes of experience, ways of being that are contradictory and reflect shifting allegiances of power as they play across the body and the mind (p.638).

More generally, Bebe Speed (1999) has emphasised the combination of uncertainty and regularity which characterises personal narratives:

I can tell many stories about myself, who I am and the different selves or parts of me which are called forth in my interactions with others [but how] I behave and feel in any context is not random, but patterned. My life is not a fiction... Clients and I construct together some account of what's going on. It won't be the only one possible, the truth about the situation... There will be other versions of their situation that I (not to mention other therapists) and they together could have constructed that would also have had some fit and been relatively adequate to their situation (Speed, 1999, p.136).

This raises an important question: In what sense, if any, can a narrative or formulation be said to be ‘true’, accurate, or in current terminology, ‘evidence-based’?

The issue of evidence has been addressed more directly in relation to formulations, which differ from ‘narratives’ in a more general sense because they are defined by their explicit basis in established theory and bodies of evidence (DCP, 2011). Formulation-based practice is, in essence, a way of tailoring this evidence to the individual, with formulations serving as ‘the lynchpin that holds theory and practice together’ (Butler, 1998, p.2). In other words, ‘formulations can best be understood as hypotheses to be tested’ (Butler, 1998, p.2). Since developing and testing hypotheses is the heart of evidence-based practice (Sackett, 2002), it makes little sense to argue that formulations, either individually or as a whole, ‘lack validity’. The validity of a particular formulation, or hypothesis, is tested out in practice and modified accordingly; and the strength of the formulation, or hypothesis, depends partly on the strength of the evidence it draws upon. This process will always involve a degree of uncertainty and provisionality.

In addition, in the case of both formulations and of narratives in general, we can reflect on how *useful* they are, from our different positions as professionals, service users, or simply people experiencing distress. Following Speed, we can think about how good a fit the new narratives have with actual lived experience, and the extent to which they enhance and enrich our lives or limit and diminish them – in other words, whether they ‘make change conceivable and attainable’ (Schafer, 1980, p.42) through providing a ‘healing theory’ (Meichenbaum, 1993, p.204). This usefulness depends on a different kind of ‘truth’, at least as experienced by the client, from that sought through ‘evidence-based practice’. We are all familiar with the experience of suddenly reaching a new insight – whether through self-reflection, conversation, or a more formal process of therapy. This is illustrated by some client reactions to suggested formulations of their difficulties (Redhead et al., 2015):

‘I think that sort of opened my eyes sort of, oh my goodness, that’s what I’m doing. I really am doing that, and it’s really not helping me. It’s almost like algebra in school, it clicks all of a sudden’ (p.459).

‘It all just made sense. I got it (the formulation), because it was true. It seemed true to me anyway’ (p.459).

Further experiential confirmation of the accuracy of a formulation came in the form of an emotional shift, and a sense of being able to move forward:

‘My thoughts were all floating around at random, it was like a sort of storm inside my brain. But the diagram kind of took the pressure off. . . understanding it all was just like, phew, the storm was gone’ (p.460).

‘I think if you know the reason something’s happening, it automatically becomes more controllable. I could take control’ (p.462).

This was contrasted with the intuitive reaction to a formulation that did not feel true and was therefore not useful:

‘She was way off then, even suggesting it was down to my mum having a bad spell and me seeing her when she wasn’t feeling good. And it was just like, no.’ (p.461).

In the case of both formulations and narratives, then, it is not enough to demonstrate that the theory underpinning them is sound, or that the facts of the person's life are historically accurate. It is possible for these requirements to be met and for the formulation to be experienced as unhelpful or inaccurate. One would hope that formulations grounded in established evidence would be more likely to bring about this experience of 'fit', but we cannot assume that this would be the case. Indeed, there is an opposite danger of shoehorning clients' experiences into a theory that is held too rigidly. People may also find elements of competing narratives useful, depending on the situation (Leeming et al., 2009). This is why client responses (which, ironically, are rarely considered in investigations into the validity of formulations; Johnstone, 2013) must be central to the evaluation of personal narratives and formulations.

The issue may become clearer by exploring Donald Spence's distinction between 'narrative truth' and 'historical truth'. He defines narrative truth as 'the criterion we use to decide when a certain experience has been captured to our satisfaction...that a given explanation carries conviction. Once a given construction has acquired narrative truth, it becomes just as real as any other truth' (Spence, 1982, p.31). In fact, he argues that, for the person concerned, narrative truth may have priority over historical truth 'because we are able to contain an unfinished piece of reality in a meaningful sentence' (p.137); in other words, to help someone to see things in a new way, which may help them to construct new meanings. These effects will be enhanced if interpretations have properties such as consistency, coherence and comprehensiveness. The notion of meaning is central here, because as Spence points out, psychotherapeutic work is based on theories about the *meanings* of situations and actions, not (as in the natural sciences) about more objectively verifiable events and processes. This is why the narratives constructed in therapy 'to an important extent... remain independent of facts' (p.292).

Formulations and related practices within therapeutic contexts can thus be seen as occupying a bridging position between narratives of science and narratives of subjectivity and personal meaning. While drawing on the established evidence-base, formulation also 'requires a kind of artistry that also involves intuition, flexibility and critical evaluation of one's experience... a balanced synthesis of the intuitive and rational cognitive systems' (Kuyken, 2006, p.30). This encourages us to adopt a more open and respectful attitude to non-clinical narratives – in other words, to the enormous range of stories that we may be presented with as clinicians, or that we may construct and live by as human beings. To give an example: elements of service users' narratives may be completely implausible, in terms of conventional evidence (for example, a belief that they are being tormented by the voice of the devil). In such situations, therapy often consists of a slow process of negotiating a different, less disabling narrative, which is equally unproven and unprovable – perhaps that the 'devil' is really a manifestation of unresolved abuse by a perpetrator who used the same words. Or perhaps the person may be able to draw on a different metaphor from within their own cultural belief system. In time, this new story may acquire narrative truth, and may thus help to open the person up to new ways of understanding and managing their distress.

What does the PTM Framework add to these complex issues? The argument is that it, along with the General Patterns that can be outlined by applying this lens, supports the claim that formulations and personal narratives informed by this perspective can be *evidence-based*. This applies in two important senses.

Firstly, as above, it has always been the case that best practice formulations are evidence-based in the sense of drawing on existing bodies of knowledge. The additional element that PTM supplies is a theoretical basis for grouping embodied, meaning-based threat responses into General Patterns. These higher-level patterns, underpinned by extensive theory and research, support the construction and content of specific formulations or hypotheses and put them on a firmer evidential footing. This ‘clustering’ is what psychiatric diagnosis claims, but fails to offer within its own terms – i.e. to provide support for the assumption that people with a certain diagnosis have something important in common, which derives from shared aetiology and suggests treatments targeted at known underlying dysfunctions. By abandoning the search for the kind of biological patterns needed to support medical diagnosis in favour of the very different approach needed to understand human behaviour and experience, we have been able to provisionally identify broad, meaning-based regularities which can serve a parallel purpose for formulations, but which draw on very different concepts of causality and shared aetiology.

Secondly, since the General Patterns are primarily organised around meanings – personal, social and cultural – they can be used to identify common patterns of meaning that may underpin particular narratives, whether those narratives are presented formally as formulations, or whether they arise informally as individual, family or group stories. Thus the PTM Framework’s evidence about meaning-based patterns can help us to locate personal narratives within broader cultural meanings and discourses, and to identify and support the construction, where necessary, of more helpful and empowering ones which make sense within the person’s own belief systems and which are likely to be experienced as having ‘fit.’ This may be supported by an existing evidence base, but we are also free to work (as the Hearing Voices Network www.hearing-voices.org and National Paranoia Network <http://www.nationalparanoianetwork.org> do) within any framework of reference that is meaningful to the person, in the knowledge that a mismatch with historical and scientific facts is not a barrier to constructing new and liberating narrative ‘truths’. The PTM Framework thus has the potential to make narratives and formulations more evidence-based, in both the conventional sense and in the sense of facilitating the construction of ‘narrative truth’.

Conclusion

In concluding, it is important to emphasise these points:

- The core purpose of the PTM Framework is to outline a conceptual and intellectual resource that will take us beyond diagnostic and medicalised thinking and practice in relation to emotional distress, unusual experiences and troubled or troubling behaviour.
- The PTM Framework does not depend on any one theoretical orientation. Rather, it draws on general principles and evidence to present a fundamentally different perspective with the potential to enrich current theory and practice, as well as suggesting new ways forward.
- There can be no one-to-one replacements for existing psychiatric categories or terminology. The PTM Framework suggests a more fundamental shift in thinking which poses a challenge to all aspects of current diagnostically-based theory and practice, and applies across boundaries of ‘normal’ and ‘abnormal’.

- The suggested General Patterns are provisional and incomplete and will inevitably change in response to further research and practice-based evidence.
- A main aim of the PTM Framework is to restore the aspects that are marginalised and obscured by current diagnostically-based practice: the operation of power, the links between threats and threat responses, the wider social, political and cultural contexts; and the meaning-making and agency of those who are struggling to survive within their embodied personal, social, socio-economic and material environments.
- Narratives in the broadest sense can offer, and in many settings and cultures already do offer, a rich and meaningful alternative to psychiatric diagnosis. This Framework suggests ways of supporting, conceptually, empirically and practically, the construction and co-construction of narratives, both within and beyond service settings.

In the next chapter, we discuss the feedback from our service user/carer consultancy group on the main elements of the PTM Framework.

Chapter 7: Service user consultation and feedback

As part of the process of developing the PTM Framework, we consulted with a group of service users/survivors and carers. Eight people were invited to one-to-one meetings in order to give feedback on the development of the framework from the perspective of their own lived experiences of mental health difficulties and their contact with services. Their comments were then used to refine the framework further.

In this section, we summarise the consultation process, which was implemented in line with the principles of the DCP Experts By Experience Position Statement and Strategy (2017), and the feedback that emerged from the consultation. We end with some thoughts about how to develop the framework further into a resource with the potential to increase service user/survivor and carer knowledge, empowerment and control in relation to the difficulties they may have encountered in their lives.

The consultants

In order to get feedback from different perspectives, we approached people who had collectively experienced a range of psychological, emotional or behavioural difficulties in childhood and/or adulthood, and had been assigned a range of diagnoses. Because they were asked to read material in advance and discuss it in detail, we did not contact anyone who was currently very distressed or would otherwise have found this process too difficult.

Consultants were recruited through informal service user and professional networks, aiming for diversity in terms of gender, age, ethnicity, and socioeconomic status. One person was known to a project member through their campaigning work but most of the others had not been exposed to critical perspectives in any detail. This meant that although we did not have advance knowledge about their views on psychiatric diagnosis, we were able to recruit people with a range of perspectives. For the most part, potential consultants were contacted by someone who already knew them and asked if they were interested in participating; two of them declined.

Our group consisted of eight people, four women and four men, with an age range of 21 to 54. Five are White British, two are of African Caribbean descent and one is of a non-British nationality which they preferred not to be specified for the purposes of the project. Seven of them are or had been psychiatric service users, one had been prescribed antidepressants and referred for psychological treatment via physical health services, and one was also a carer for a relative who was a service user. Most of the consultants had been given more than one diagnosis, including: 'borderline personality disorder', 'PTSD', 'bipolar disorder', 'bipolar disorder-2', drug induced psychosis, 'depression', 'schizophrenia', anxiety, and at risk mental state/sub-threshold 'psychosis'. The carer's relative had been given a diagnosis of 'manic-depression'. It is important to note that although consultants were invited to think about the framework in terms of their experiences (see below) they were not asked to describe their personal stories or their journeys through mental health services. Therefore, although they generally grounded their views in their own experiences (with

some sharing more than others), it is not possible or appropriate for us to provide detailed personal or psychiatric histories.

Consultation process

Potential consultants who had expressed an interest in participating were sent a summary of the PTM Framework in its state of development at that point, along with an explanation of the purpose of the consultation and a request to meet for one to two hours. Once they had given their agreement, they were sent more detailed information about the framework and were asked to read this in advance.

The consultations were carried out by three members of the project group, and a clinical psychologist not otherwise connected with the project. If consultants agreed, the discussion was recorded.

Using the advance information on the core elements of Power, Threat, Meaning and Threat Response as a focus, consultations were generally structured around the following headings:

- Thinking about how your problems /difficulties came about, got better or worse, does this framework make any sense of your experiences?
- Which parts of the framework make most sense, which least sense?
- Did you think/have you ever thought about your experiences in this way? Would it have made any difference if you had?
- If these aspects had been addressed when you first had contact with psychiatric services, would it have made any difference?
- Could you tell us any more about how you were thinking and feeling about the situations and experiences we've talked about – what they meant to you?
- What has it been like to take part in this discussion?

Not all interviews could be recorded but detailed notes were also taken. Consultants were paid a fee and any expenses incurred. Following the meetings, the feedback was written up by the interviewers and was also examined independently by a member of the project team, in order to organise it into themes relating to the main interview headings. Consultants were sent a draft of the chapter to check for accuracy and invited to give any additional thoughts on the framework or the consultation process if they wished. They were also given the opportunity to provide feedback on the final version of the framework document if they wished.

Feedback on the PTM Framework

General relevance of the core elements of the PTM Framework

We have referred to the consultants as A,B,C,D, E, F, G and H. Consultants were unanimous in their view that, overall, the framework's elements of Power, Threat, Meaning and Threat Response were very helpful and relevant in making sense of their experiences. This way of summarising the aspects was described as 'simple yet clever at the same time' (A); making an 'enormous' amount of sense, 'very strong and useful' and 'really, really helpful' (B); as 'a major step forward' and as making 'absolute' sense (C). Other general helpful aspects included the fact that the PTM Framework did not assume pathology; its potential to

facilitate discussion; to summarise complex strands of experience in a non-stigmatising way; and to create a sense of permission to disclose ‘unmentionable’ events. It was suggested that the PTM Framework also had implications for social activism and challenging the status quo, as well as explaining some of the beneficial effects of medication in terms of moderating reactions to threat and helping to regulate emotion.

More specifically, several consultants highlighted the importance of making the operation of power explicit and central to all experiences of distress:

The most helpful aspect has been the power, and had this been up for discussion it would have changed the course of what happened...for me (E).

[The] power part of the framework is the fulcrum of it (F).

These are things that are at play every day but especially if you are caught up in systems which are power-heavy or rely on power dynamics to establish the status quo, such as psychiatry, mental health [systems] (H).

Another consultant (C) reported that they had not previously considered the influence of power in the ‘joined up way’ it was set out here, and described their sense of intrigue in reading the information and applying it to their own situation.

Although they were not asked to share their personal experiences, consultants did name various ways in which power had operated in their lives, and how it had contributed to their contact with mental health services and to ongoing distress. As well as relationship traumas, the consultants reported struggles with physical disability, poor housing, violent neighbourhoods, welfare systems, racial discrimination and poverty.

The list of the various kinds of threat was also seen as very helpful, particularly in highlighting the potentially damaging impact of events or behaviour which might otherwise be seen as ‘normal’. This aspect of the framework also provided a context for exploring one’s responses to ‘threats’ and was seen as potentially useful in learning protective responses. And, while consultants were very aware of the impact of different kinds of meaning, the framework was seen as facilitating discussion of meaning, including aspects which might be very threatening and overwhelming, rather than having meaning imposed on them (see below).

What difference might the PTM Framework have made?

In discussing what difference the PTM Framework might have made both generally and on first contact with mental health services, consultants emphasised four possible areas: preventing or making more difficult the imposition of others’ meanings; giving ‘permission’ to speak about certain life experiences; encouraging more positive and helpful coping responses; and, partly as a result of this, potentially fostering a quicker ‘recovery’.

Consultants spoke frequently about the damaging impact of having others’ meanings imposed on their feelings and behaviour within mental health services:

Meaning to what was going on was given by medics to my detriment and [any resistance] resulted in being labelled as a troublemaker. As a direct consequence I started to not trust people’ (E).

Medicalisation of their experiences was experienced as a particularly damaging imposition of meaning:

...absolutely everything I had to say, including that the drugs were making things worse, [staff] made me, and more specifically my brain, the problem, rather than my traumatic experiences (F).

Others spoke of having internalised a sense of having a 'faulty brain' and of feeling as if they had 'failed' when the medication did not help (A); of being told, contrary to their own views, 'you are ill, which is why you feel bad' (G) and of services 'implicitly reinforcing' the fear that they had an intractable, biological illness (C). One consultant (A) reported feeling so demoralised and disempowered by these negative meanings that when a doctor eventually told them that recovery was possible, they did not believe him.

Consultants saw the PTM Framework as helping to prevent or minimise this process mainly through making it more likely that they would be asked and feel they had permission to speak about their life experiences and their responses to them:

...(feeling) that it's okay to talk about these things, it's okay to tell people about them... to name them... If you believe that it's not okay to even have a conversation about it, you can't ask someone else to help you deal with it' (B).

It would have felt like a weight off my shoulders to feel that the person I was talking to was recognising the things... that were predominantly the cause of my problems... somebody hearing me say, 'I have absolutely had the sharp end of the stick in certain power-related situations, in certain threat-related situations...' That would have been an incredibly helpful alternative to what did happen (C).

Consultants saw the processes of meaning-making and permission to speak as being linked, and as offering the potential for avoiding diagnosis, accessing more appropriate intervention, adopting more adaptive coping responses and feeling more positive about oneself:

In response to feeling powerless, because of this invalidation and nobody else understanding, I began to drink, it became something daily, it numbed me, I did not have to think... (E).

I'd love to have come across this [framework] at first and not been given drugs. Everything could have been so different. But did I need the 'band-aid' then? If drugs were given consciously, very short term and then stopped – that would have really changed things for so many of us too (D).

If I had had this PTM Framework earlier on it would have changed things, in terms of how I would be treated, diagnosed, but also the recovery journey. Because when you are unwell not only you are dealing with that [being unwell] but also all of this, the threats, the power, othering. So there is no time and space to become well... If this PTM Framework had been used in my first admission, as a way of thinking about what brought this person to this place, the challenges (unemployment, relationships, life events, lack of sleep), the context, and allowed time and recognised power... maybe people won't be diagnosed. (H).

I can guess I would have felt stronger afterwards. To be able to see a professional... Ask me, genuinely, about any problems I'd had, power related situations or threat related situations... [and] telling me 'these are absolutely valid things to be hugely unhappy about and very valid things to have suffered because of' (C).

Consultants also spoke about how this kind of PTM Framework could have helped them identify and clarify aspects of their life they might not otherwise have focused on; demystified their experiences; and helped them feel validated, normal, reassured and less alone in their struggles. They also felt it could have improved their engagement with services, helped to avoid mental health crises, identified positive strategies beyond medication use, and ensured more appropriate interventions. One Consultant (G) thought the PTM Framework could have fostered an approach which would be 'less reactionary, less just fighting fires'; another (F) spoke of the difference a PTM Framework like this could have made to the trajectory their life took, and another (B) of their sense of grief that had a PTM Framework like this been available at the time, they might not have lost so many years of their life to mental health problems.

Limitations of the framework

Consultants were clear that they were highlighting possible limitations within a general context of positive responses to the PTM Framework. Four main areas were raised: language and conceptual complexity; possible additional threat responses; the risk of imposing another professional model; and the need for wider cultural change if the PTM Framework is to have an impact. One consultant (C) pointed out that the PTM Framework could be problematic for people who might prefer a diagnosis which did not explore their personal history, and seemed to provide clear-cut answers rather than the more complex picture suggested by the PTM Framework.

In relation to language, some consultants suggested that the term threat might itself be threatening to some people, especially if it was used about future events, perhaps making them seem more powerful and alarming. It was suggested that 'threat' might be reserved for past or current circumstances, but that terms such as conflicts or challenges might be more appropriate in talking about the future. It was also suggested that 'threat' could imply an active stressor and might not adequately capture the absence of something, for example as in neglect. 'Meaning' was also seen as a complex area to discuss, since it encompasses the meaning of the 'symptoms' themselves as well as of the threatening experiences.

Although we anticipate different versions of the PTM Framework being used for different groups and purposes, we deliberately gave the consultants quite a detailed written description. As we had expected, then, the issue of accessibility, for example, for service users with limited intellectual capacity or in varying states of emotional distress, was raised (although only by one consultant).

One consultant suggested additions to the list of threat responses including:

- somatic/physiological reactions (gastrointestinal problems, difficulty regulating body temperature);
- sleep disturbances (nightmares, insomnia, feeling unsafe to go sleep, waking up with panic attacks);

- emotional flattening (depression, numbing, feeling indifferent to people and events).

Some consultants, although positive about the framework overall, queried its ability to create real cultural change and highlighted the danger of it becoming yet another imposed professional model, thus reinforcing existing hierarchies and limiting service users' ability to find their own explanations:

So I think 'brilliant!', but I wonder how effective will it be at effecting a culture change. How do you make [professionals] sit down and understand someone's meaning of life, what does a good life mean to you? This needs to be heard, we must shift things at the wider level (H).

To some extent I dislike the idea of a model at all, though, another framework, however loose, to look at things in terms of. We each have our own truth and each situation is so different. I feel talking and really listening to one another, person to person on an equal basis, would actually be best... But a lot of people's careers, earnings, training programmes etc and the social hierarchy and ways the whole medical system is set up would be thrown out of whack by this. It would never happen.... (D).

Consultants also made suggestions about presenting and implementing the PTM Framework, including:

- using visuals to present such complex material in a more accessible way;
- condensing all of the material into a simpler document for use within services;
- inserting a clearer opening statement about the purpose of the framework;
- providing concrete examples of the operation of power;
- emphasising the dynamic nature of the concepts of power, threat and meaning;
- emphasising that the framework is a guide, and the need for flexible and sensitive use across different groups;
- emphasising collaborative use of the PTM Framework.

Reflections on the process

Overall, the process of consultation was very positively experienced and consultants were pleased to have taken part. Although it had touched on painful feelings, some consultants also felt the process had been very enlightening and had encouraged questioning and critical thinking:

All that has been covered here would change many people's experiences and it has exceeded my expectations. Reflecting on these areas was an eye-opener to all that I was managing at the time... It has been emotional, emotive not distressing, and it has taught me a lot (E).

Taking part in this has made me question... other aspects of power, the wider context, and made me want to ask more questions. I think [this framework] will bring up more positives than negatives. I think it's valuable because I'm not a fan of diagnoses, I'm a fan of 'let's help people have the kind of lives they want to have' and I can see this [framework] very much working to have a discussion on what is really valuable to someone (H).

Incorporating the feedback

We are very grateful to the consultants for sharing their comments and expertise. We were encouraged to hear their very positive endorsement of the PTM Framework as a helpful and effective way forward with the potential to address many of the problems of the current diagnostic approach.

We incorporated the consultants' feedback as follows:

- Making additions to the list of threats and threat responses.
- Emphasising the dynamic and interactive nature of the core elements of the PTM Framework.
- Clarifying the nature and purpose of the framework throughout, by means of summaries and bullet points.

While we were pleased that the consultants grasped the nature and relevance of the core concepts so readily, their feedback reinforced the need for user-friendly versions of the PTM Framework. As explained in the Introduction, the longer-term aim is to supplement this document with a range of accessibly-written summaries and resources so that its ideas can be made available to all. We see the PTM Framework as a knowledge resource and as a work in progress. It is our hope that the ideas within it will be freely adapted and developed in whatever way is most helpful to individuals and groups, whether professional, service user/self-help, or general public. In this way we hope to counter the risk of simply producing another 'expert' body of professional knowledge. Future materials will include the suggestions made by the consultants, such as concrete examples of the operation of power, alternative language uses where appropriate, a strong emphasis on flexible and collaborative use of the ideas, illustrative graphics, and so on. Co-producing these and other materials is a priority for the next stage of the project.

Chapter 8: Ways forward

Overview

This final chapter addresses the last of the four questions posed in Chapter 2 in relation to the development of alternatives to psychiatric diagnosis:

‘What are the implications – therapeutic, social, ethical, legal – arising from adopting non-diagnostic approaches and how might we address them?’

Such a major shift in policy, practice and thinking will take many years to develop and to embed fully, and we make no claim to be providing a complete answer. Nor are we making formal Division of Clinical Psychology or British Psychological Society policy or practice recommendations; rather, we are exploring the various possible implications of the PTM Framework in these areas, in the hope that they might be taken forward in future projects and documents. We aim to demonstrate that there can be, and in many cases already are, non-diagnostic alternatives in all the areas outlined above and we will comment on the PTM Framework’s compatibility with and potential contribution to these initiatives. After briefly outlining the general social, political and economic context, we will discuss these principles and practices under nine main headings: 1. Public health policy. 2. Mental health policy. 3. Service principles. 4. Service design, commissioning and outcomes. 5. Access to social care, housing and welfare benefits. 6. Therapeutic interventions. 7. The legal system. 8. Research. 9. Use of language.

Overall, we endorse a Human Rights approach as outlined in the Convention on the Rights of Persons with Disabilities (UN General Assembly, 2008). This landmark document reinforces the requirement for UN Declaration of Human Rights (1948) to apply to people who can be described as having psychosocial disabilities (but see also section on the social model of disability) and whose rights are particularly likely to be denied. The Human Rights model goes further than a social model in that it considers that diversity and difference are part of humanity and should be valued, not rejected. Therefore, persons with disabilities are entitled to an equal and full range of civil, political, economic, social and cultural rights and opportunities. The CRPD has been ratified by the UK and is legally binding. It is thus a potentially powerful mechanism for challenging coercive, abusive and discriminatory practice.

Further to this, a recent United Nations report strongly endorsed ‘the public health and social justice imperatives for addressing the social determinants of health’ (UN, 2017). It states that ‘To take full account of the evidence around the determinants of mental health, the right to those determinants must expand beyond inequities, discrimination and the physical environment to reflect the documented importance of healthy psychosocial environments... That includes developing public policies that promote non-violent and respectful relationships in families, schools, workplaces, communities and health and social services’ (p.16). It considers that there is a human rights imperative to ‘move beyond individualized responses towards action on a range of structural barriers and inequalities’ (p.16), since ‘Reductive biomedical approaches to treatment that do not adequately address contexts and relationships can no longer be considered compliant with the right to health’ (p.17).

We fully support the United Nations Special Rapporteur's conclusion that 'The urgent need for a shift in approach should prioritize policy innovation at the population level, targeting social determinants and abandon the predominant medical model that seeks to cure individuals by targeting "disorders"' (UN, 2017, p.19).

We want to acknowledge that there are many innovative service user/survivor projects operating outside mainstream health and welfare organisations which already promote these principles (see examples in Appendices 2 to 14 of the Overview publication; see also BPS, 2017), although detailed descriptions are beyond the remit of this document.

Although we have tried throughout the document to avoid medicalised language, the term 'mental health' is so widely used in services, policy documents, reports and so on, that it is difficult to avoid. There are also, at the moment, few satisfactory alternatives. We will therefore use the term in places, while noting some of the issues it raises.

Introduction

The medicalisation of emotional and psychological distress is deeply entrenched within existing systems. Psychiatric diagnosis and/or its general underlying assumptions are not only used within mental health services, as a basis for care pathways and clusters, record-keeping, commissioning and planning, but also in the criminal justice system and the welfare system. Diagnosis is used to make decisions about eligibility for services and benefits, assessment of risk, and judgements about responsibility for criminal actions. Most psychiatric research is predicated on diagnostic categories, as are grant applications and NICE guidelines. Therapeutic models and interventions are often based on diagnosis. Most professional training is structured around these categories, as are textbooks and training modules. Public health documents use diagnostic language, as do mental health charities and campaigning groups. Perhaps most influential of all is media coverage, which uncritically reproduces the diagnostic perspective even as it deplores the stigma it evokes.

Part of the appeal of psychiatric diagnosis, and a reason for its survival, is that it seems to provide simple answers to complex questions about causation, need/eligibility, and responsibility, along with their administrative consequences. We have argued that diagnosis does not, in fact, answer these questions in a remotely adequate way. If it did, we would not see regular re-defining of the basis of care pathways (unlike in general medicine, where a legitimate medical diagnosis often performs this task satisfactorily); or irresolvable disputes about whether high profile lawbreakers are or are not 'mentally ill'; or the recent decision by the National Institute for Mental Health in the US not to fund studies based on diagnostic categories (Insel, 2013). Nor would calls for 'treatment' for the growing epidemic of mental health problems be so disconnected from attention to the social causal factors and policies driving it.

As we have emphasised throughout this document, it is impossible to separate out the emergence and experience of mental distress from wider society and culture and associated forms of power. Replacing the diagnostic model with a non-diagnostic understanding of emotional and psychological distress and troubled or troubling behaviour will inevitably force us to face up to some of the complexities that diagnosis has obscured. This, as Bessel van der Kolk has noted, will be challenging. 'Academic laboratories are funded to study particular disorders... If you say that your disorder is

part of a larger picture, which includes elements from several other diagnoses, then you'd have to rearrange your lab, your concepts, your funding, and your rating scales' (van der Kolk, quoted in Wylie, 2010, p.14). The implications go further than that: we will need to grapple with a whole new set of problems and dilemmas, with major implications for public health policy, social inequality, and social justice.

It is important to note that *none of the models, interventions or examples in this chapter and in the good practice examples in the appendices to the Overview publication is put forward as an ideal, complete or unproblematic solution*. Rather, we have attempted to demonstrate how we can move towards non-diagnostic practice in a whole variety of ways, while acknowledging the risks of marginalisation, compromise and co-option. Sometimes we are in a position to build on and change existing practices and systems from within, as illustrated in the examples given in Appendices 2 to 10 in the Overview publication. Sometimes there will be the opportunity for more fundamental changes in practice and policy, as illustrated in Appendices 11 to 14 in the Overview publication. We take the view that both these strategies are needed in order to achieve a collective shift towards a non-diagnostic paradigm. We also believe that there needs to be a range of alternatives to diagnostic vocabulary, rather than a unilateral replacement of one system or set of terms with another. Thus, personal narratives may be the best starting point for individual intervention, but for purposes such as research or welfare claims, a validated 'problem list' phrased in ordinary language terms could be a flexible and appropriate alternative (Kinderman, 2014). Most importantly, we recognise the need for survivor-led and other alternatives outside the current system. All these changes must be based on fundamentally different way of thinking about distress, or else, despite good intentions, they will simply lead to variations or modifications of medicalisation and the 'DSM mindset.' In the words of one survivor: 'The incredibly transformative and far-reaching potential of our collective knowledge is no doubt one of the reasons why we continue to be denied spaces and resources for working and theorising on our own' (Russo, 2016, p.60). It is our hope that the PTM Framework will be a resource for survivors as well as professionals '...as we set out on the journey towards developing our own model of madness' (Russo, 2016, p.60).

Social, political and economic context

In the UK, the annual economic cost of mental health problems is roughly £105 billion a year – equivalent to the cost of the entire NHS (NHS England, 2016a). This is partly made up from the loss of 70 million working days a year, the leading cause of sickness absence (Mental Health Foundation, MHF, 2015). Mental health problems constitute the largest burden of 'disease' at 28 per cent of the total, or 4.5 per cent of GDP (MHF, 2015). An estimated £14 billion per year is spent on mental health care in the UK (Parsonage & Naylor, 2012).

These figures are fairly well known. Much less discussed is the fact that mental health services, as currently configured, are of very limited effectiveness in 'treating' these conditions. Figures are hard to find, but the percentage of people who can be said to have 'recovered' after their time in mental health services, in the usual medical sense of being free of 'symptoms' and returning to a previous state of health, seems to be very low (Drury, 2014) and may be worse than rates achieved in the non-medical 'moral treatment' of the early and mid-19th century (Warner, 2004). In fact, many surveys have found that people

in ‘developing’ countries which do not rely on modern psychiatric facilities or drugs have higher rates of recovery (overview in Warner, 2004). Of even greater concern is the fact that mental health services may overall, and despite the best intentions of their staff, be more likely to create disability than reduce it, by prolonging the natural course of people’s difficulties (Whitaker, 2010). Thus, a recent survey of ‘mood and anxiety disorders’ in Australia, England, Canada and the US found that far from reducing the prevalence and impact of these difficulties, increases in treatment provision were associated with the opposite effect (Jorm et al., 2017).

In this context, the PTM Framework has important public policy implications. These can be summarised as follows: First, reducing economic and social inequality is probably the single most effective step we can take to improve the mental health of the population (as well as bringing many other benefits). Second, such a reduction would have the biggest impact on groups who have less power because of class, age, ethnicity, sexuality and/or gender; these are also the groups which experience proportionately more mental distress. Third, we need to recognise the profound psychological, educational, occupational, social, and economic impact and cost of adversities of all kinds, especially ones occurring early in life. Fourth, this implies that child protection and support for families and early years development is of central importance in prevention. Fifth, psychiatric medication is a major public health concern on its own. Sixth, since globally mental health is undermined most often by warfare, resolving conflict at this level may be the most important international priority for mental health (and for many other reasons). All of these priorities will be obscured and undermined by continuing to frame emotional and psychological distress in diagnostic terms.

Worldwide, some of these factors are already recognised. National guidelines on childhood adversities from Australia note:

Trauma is not simply an individual misfortune. It is a public health problem of major proportions. The costs of unrecognised and untreated complex trauma are enormous. This is not only in terms of reduced quality of life, life expectancy and lost productivity, but in ‘significant increases in the utilization of medical, correctional, social, and mental health services’. In 2007 alone, the cost of child abuse to the Australian community is conservatively estimated to be at least \$10.7 billion, and is almost certainly far higher. (Blue Knot Foundation, 2012, p. xxviii).

A similar policy re-orientation is evident in reviews from the US. A health economic summary from the Perryman Group, an economic and financial analysis firm, concluded:

...child maltreatment is pervasive in the United States and ranks as one of the nation’s most pressing public health and social concerns (The Perryman Group, 2014).

The Adverse Childhood Experiences (ACE) studies (see Chapter 4) conclusively confirm the public health costs of unaddressed adversity in terms of the human suffering borne by victims and their families; the economic costs borne by society; the social costs borne by society; and the intergenerational transmission of childhood adversity borne by future society. Although the studies originated in the US, recognition of the impact of ACEs is also found in recent UK policy documents. For example, a study of the impact of ACEs in England (Bellis et al., 2014) found that reducing ACEs could lead to significant reductions

in violence, substance abuse and imprisonment, among other outcomes. The role of ACEs is referenced in 'Better Mental Health for All' (Faculty of Public Health, 2016) and in Royal College of Psychiatrists (2013) 'Whole-person care: From rhetoric to reality'. The Welsh Adverse Childhood Experiences study (Ashton et al., 2016) similarly found that people who had experienced four or more ACEs were five times more likely to suffer from low mental wellbeing of various kinds, while the 'Well-being of Future Generations (Wales) Act' (2015) has set helpful frameworks for reducing ACEs across Wales. The Scottish Public Health Network (2016) report 'Polishing the diamonds' gives a detailed overview of the harms and costs caused by ACEs in Scotland. Collectively, the three reports call for co-ordinated action at multiple levels in order to implement early years interventions, reduce harmful behaviours, and strengthen communities.

Welcome as these reports are, the issues are more fundamental than tackling a range of specific adversities as such. These events and situations arise within broader political and economic contexts of poverty, inequality, social injustice, and the many interests that drive and benefit from this status quo. ACEs are known to be related to deprivation, with the experience of four or more ACEs being reported by 4.3 per cent in the least deprived quintile and 12.7 per cent in the most deprived quintile (Bellis et al., 2014). Epidemiological research into the impacts of economic inequality makes a strong argument for addressing this as a fundamental cause of multiple undesirable social, behavioural and health outcomes (Wilkinson & Pickett, 2009). These points are strongly made in a briefing paper on 'The Psychological Impact of Austerity' (Psychologists Against Austerity, 2015) which identifies five 'austerity ailments' of humiliation and shame; fear and distrust; instability and insecurity; isolation and loneliness; and being trapped and powerless. Its recommendations are: Social policy should work towards a more equitable and participatory society, to facilitate individual wellbeing, resilient places, and strong communities. It is crucial that policy makers and service developers consider the psychological impacts of current and future policies. Creating the conditions for wellbeing and resilience directly helps to prevent distress in the short and long term, both saving resources and reducing suffering.

Regrettably, economic inequality and associated levels of discrimination and disadvantage in the UK show no sign of reducing. This trend is accompanied by, and closely connected to, austerity measures, spending cuts and (in England) fragmentation and privatisation of health and social care services which is undermining their ability to respond at the very time they are most needed. Indeed, health care staff are increasingly experiencing the same pressures as their clients. This inevitably undermines their ability to provide the secure, reliable therapeutic relational base that has consistently been shown to be essential to good outcomes (Priebe & McCabe, 2006). A narrow focus on achieving targets and reducing costs increases the risk that staff will become active or passive participants in harmful and abusive practices. The key message from the Francis report was that 'it should be patients – not numbers – which counted' (Francis, 2013, p.5).

Public health policy

To what extent have these important epidemiological findings been recognised in UK public health policy?

David Harper (2016) has made a strong case for a preventative public health approach; a

parallel to the improvements in sanitation which stopped cholera epidemics in the 19th century. Using our extensive knowledge about the causal influences in mental distress, psychologists and other mental health professionals could advocate for changes to policy and legislation much as physicians and health campaigners have done in relation to smoking. This might involve engaging policymakers both directly and indirectly through think tanks and the media and working with local authorities and other agencies. It needs to be paralleled by a shift in the priorities of research funders from aetiology and treatment (which, in relation to 'depression' attracted £2.71 million and £1.05 million respectively in 2015) to prevention (£0.3 million) (Harper, 2016). Rather than directing further funding into hypothesised biological causal factors, we need to address the known and extensively documented psychosocial roots of psychological distress in its various presentations.

The Marmot review (Marmot, 2010) is quoted in the Five Year Forward plan for Mental Health (NHS England, 2016a) and contains the most explicit warnings about the human and economic cost of failing to act on health inequality, and the need to put wellbeing, not just economic growth, at the heart of policy (p.17). It builds on the work of the WHO 'Commission on social determinants of health' (2008) which concluded that 'the social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that gave rise to them: inequities in power, money and resources'. The Executive Summary's blunt summary is that 'Social injustice is killing people on a grand scale'.

This leads Marmot to state that 'action is required across all these social determinants of health and need to involve all central and local government departments as well as the third and private sectors. Actions taken by the Department of Health and the NHS alone will not reduce health inequalities' (p.19).

The Marmot review is based on the general principle of 'proportionate universalism'; in other words, rather than targeting resources at groups such as the 'mentally ill', '... actions must be universal with a scale that is proportionate to the level of disadvantage' (p.16). The resulting six policy objectives are consistent with a PTM Framework: Give every child the best start in life; Enable all children, young people and adults to maximise their capabilities and have control over their lives; Create fair employment and good work for all; Ensure healthy standard of living for all; Create and develop healthy and sustainable places and communities; Strengthen the role and impact of ill-health prevention. Despite this, the most recent UCL Institute of Health Equity (2015) review of the Marmot indicators found that increasing numbers of people are experiencing poverty and ill health even though unemployment is falling. The number of households in England unable to afford an acceptable standard of living had risen steadily from nearly a fifth to a quarter, and over half of all poverty is now found in working households.

The 2012 Health and Social Care Act transferred public health in England to Local Authorities, although it remains the responsibility of the NHS in Scotland, Wales and Northern Ireland. A new body, Public Health England, sits within the Department of Health and aims to create greater alignment across the NHS, public health and social care, with a stronger focus on the prevention of ill-health. Its objectives will be taken forward by directors of public health at local governmental levels.

The new structure of public health bodies in England may provide more of an opportunity

to focus on the social context of psychological distress, and to build on a range of well-evidenced interventions to improve public mental health (e.g. Division of Clinical Psychology, 2014a; Friedli, 2009; Newton, 2013; Taylor et al., 2007) including promoting better quality of life in neighbourhoods (Biglan & Hinds, 2009). This would be timely as public mental health has been seen as a recent government priority (e.g. Public Health England, 2015). Boardman and Friedli (2012) have identified a number of ways in which Health and Wellbeing Boards can, through commissioning, increase mental health recovery through public health strategies in areas such as housing, transport, employment, leisure activities, the built environment, and so on. They emphasise that ‘recovery connects the personal with the political and is concerned with social justice, individual rights, citizenship, equality and freedom from prejudice and discrimination’ (Boardman & Friedli, 2012, p.8). Inexplicably, given the evidence presented in this document, most public health departments do not routinely include a mental health specialist, and nor is this area necessarily covered in their professional training.

Overall, then, and taken in conjunction with the ACE surveys, there are signs of a growing recognition of the need to take a public health approach to mental distress in order to address its root causes. Some public health reports have made explicit links between distress and inequality, austerity and social injustice, although this message has not always been taken on board in terms of national economic policy. However, with the exception of the Marmot review, the recommendations – in Australia, the US and the UK – are largely directed at specific consequences such as unemployment, poor housing and so on rather than the political policies that drive these inequalities. Even when these reports are assessed in their own terms, a recent All-Party Parliamentary Health Group (APHG) report found that ‘tackling the wider determinants of health has been disappointing’ (APHG and Health Foundation, 2016, p.40).

A limitation of all the overviews, even the most hard-hitting ones authored by Marmot and by Wilkinson and Pickett, is the use of diagnostic language, which helps to obscure the links between social hardship and emotional distress even as they are being discussed. In addition, there is little discussion of inequalities of power and privilege arising from, for example, gender or ethnicity, or of the processes which might link these to emotional distress and troubled behaviour. The unquestioning adherence to an underlying medical orientation in which outcomes are still conceptualised in terms of ‘illnesses’ means that one of the biggest public health issues, the extent to which psychiatric drugs actually create and perpetuate disability over the long term (see ‘Medication’ below), is not discussed at all. This urgently needs to be addressed, given the massive rise in their use (‘anti-depressants’ prescriptions in England rose by 7.2 per cent from 2013–2014 to 57 million; ‘antipsychotics’ prescriptions rose from 9.7 to 10.5 million in the same period (Health and Social Care Information Centre 2015 figures reported at <http://cepuk.org/2015/04/10/latest-prescription-data-shows-consumption-psychiatric-drugs-continues-soar>). The total amount spent on all psychiatric drugs, adjusted for inflation, rose from £544m in 1998 to £881m in 2010 (Ilyas & Moncrieff, 2012). As has also been documented in the US (Whitaker, 2010) this trend corresponds with an increase, rather than decrease, in the numbers of people claiming disability benefits (Viola & Moncrieff, 2016).

Mental health policy

This section takes a more detailed look at examples of mental health policy documents with reference to the extent to which they do or do not address the implications of a PTM Framework. The key documents that will be considered are: ‘2010–2015 Government Policy: Mental Health Service reform’ (Department of Health, 2015a); ‘Five Ways to Wellbeing’ (Aked et al., 2008); ‘The Five Year Forward View for Mental Health: Mental Health Task force report’ (NHS England 2016a); ‘Implementing the Five Year Forward Plan’ (NHS England, 2016b); ‘Confident Communities, Brighter Futures’ (New Horizons, 2010); ‘No Health without Mental Health’ (Department of Health, 2011b); ‘Future in Mind’ (NHS England, 2015); and ‘Better Mental Health for All: A public health approach to MH improvement’ (Faculty of Public Health, 2016) and ‘Mental health and new models of care’ (Naylor et al., 2017). Since they overlap significantly, they will be considered as a group. The documents all apply to England, except for ‘Five ways to wellbeing’, although policies relating specifically to Scotland, Wales and Northern Ireland will be referenced where relevant.

As noted above, the public health arguments are closely linked to those for tackling social inequalities, and the case for both is made in a number of recent mental health policy documents, including a Government-commissioned report ‘Whole Person Care’ (Royal College of Psychiatrists, RCP, 2013); the ‘Five year Forward View for Mental Health’ (NHS England, 2016a); ‘Better Mental Health for All: A public health approach to Mental Health Improvement’ (Faculty of Public Health, 2016); and ‘Bringing Together Physical and Mental Health: A new frontier for integrated care’ (Naylor et al., 2016). For example, ‘Whole Person Care’ states that *‘There must also be widespread recognition of the social and cultural factors affecting mental health, such as exclusion, trauma, abuse, domestic and other violence, and other social and inter-personal stress. Social policy on poverty, employment, violence, parenting and body image issues, to name but a few, are just as important for achieving parity as efforts to reform healthcare’* (RCP, 2013, p.59). The ‘Five Year Forward View’ concurs: *‘Finally, we have placed a particular focus on tackling inequalities. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination... To truly address this, we have to tackle inequalities at local and national level’* (p.3). ‘Better Mental Health for All’ similarly talks in terms of ‘serious mental health disorders like schizophrenia’ but also emphasises that *‘Understanding and addressing inequality is part of creating a mentally healthier society... Evidence is now emerging that there is a strong contextual effect for material factors, with higher levels of wellbeing in more equal societies’* (pp.17–18). Additionally, it notes that the economic downturn since 2008 is likely to result in *‘an increase in mental health problems including depression, possible lower levels of wellbeing, more suicides and suicidal behaviours, increased domestic violence and child neglect with associated impact on child mental health and wellbeing, and an increase in drug and alcohol dependency’* (p.27). ‘No Health without Mental Health’ aims to reduce *‘...the social and other determinants of mental ill health across all ages, and the inequalities that can both cause and be the result of mental health problems including, for example, social isolation, particularly among older people.’* In other words, all the documents recognise that mental health difficulties arise within contexts of social hardship and inequality.

Another common feature is the need for action and intervention at a whole community level in order to address these multiple causal factors. The ‘Five Year Forward View’ notes that *‘helping people lead fulfilled, productive lives is not the remit of the NHS alone. It involves*

good parenting and school support during the early years, decent housing, good work, supportive communities and the opportunity to forge satisfying relationships. ‘2010–2015 Mental Health Reform’ echoes this: *‘Mental health can be influenced by things like having good relationships and meaningful work, housing and feeling part of a community... So to make improvements to mental health, we’ll need action from many different areas of government’*.

However, the policy documents are less clear about how these important aims might be achieved. For example, the ‘Five Year Forward View’ talks about ‘Creating mentally healthy communities’ but is less clear how ‘local mental health prevention plans’ will achieve this. The implementation document (NHS England, 2016b) focuses almost entirely on recommendations for mental health services, rather than outlining a wider remit of liaison and action across communities. Similarly, it is not clear how easy or possible it will be to ‘build resilience and a safe secure base’, or carry out ‘violence and abuse prevention work with young people’, as recommended by New Horizons (2010), especially within the economic context that is acknowledged at the beginning of their report. As discussed below, there are also likely to be numerous reasons why it is hard for many individuals to ‘Be active’ and ‘Keep learning’ as recommended in the government-commissioned report ‘Five Ways to Wellbeing’ (Aked et al., 2008).

The overall emphasis in the documents is on managing the impact of existing policy rather than challenging it in a more fundamental way. For example, rather than questioning the imposition of the housing benefit cap, the ‘Five Year Forward View’ suggests that the Department of Work and Pensions should ensure that the right levels of protection are in place for people with mental health problems who require specialist supported housing.

The documents all acknowledge the importance of taking preventative action in early years, based on research about attachment and adversities. ‘Future in Mind’ (NHS England, 2015) has a particularly helpful emphasis on *‘improving access for parents to evidence based programmes of intervention to support and strengthen attachment, avoid early trauma, build resilience and improve behaviour’* and *‘ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to the services that they need, including specialist mental health services’*. The concept of trauma-related reactions is only partly assimilated, and elsewhere, the references tend to be to the ‘epidemic’ of one in 10 children aged 5 to 16 who are said to have a ‘diagnosable problem’ (‘Five Year Forward View’), the need for teachers to identify these emerging ‘illnesses’ and so on, and for greater access to services to ‘treat’ these ‘medical’ conditions. The Coalition Government’s pledge in March 2015 to provide £1.25 billion of new funding for children’s mental health services was, while welcome, unaccompanied by any discussion about what model might form the most appropriate basis for these services, given the likely nature of the difficulties that their clients would be presenting with.

In relation to interventions for adults, there is only very patchy acknowledgement of the need to address trauma, adversity and social contexts. Scotland has made the most progress here. Its Mental Health strategy 2012–2015 includes addressing psychological trauma as a priority in primary care and mental health services, and encourages trauma training for staff (Scottish Government, 2012). Scottish national guidance on psychological therapies (NHS Education for Scotland, 2015) includes a section on ‘complex traumatic stress disorders’ and the three-stage trauma model in the Adult section, and on complex trauma and sexual trauma in the Child section. In a recent and ambitious project, NHS Education for Scotland has been commissioned to develop and deliver a multi-level trauma-informed framework

for organisations, trainers, staff, and people affected by trauma, based on the assumption that understanding trauma and its impact is everyone's business (see nes.scot.nhs.uk). In England, the Department of Health has made routine enquiry about abuse mandatory in mental health settings, and evaluations show some shifts in practice (McNeish & Scott, 2008). 'Tackling Child Sexual Exploitation' rec 52 (Department of Health, 2015b) makes a brief reference to the need to '*...train staff on trauma-informed approaches to care in MH services*'. The Department of Health in England is due to set up a programme looking at the implications of the ACEs research, and trauma-informed practice is being promoted in the prison service (as described below).

Apart from these encouraging examples, increasing access to 'treatment' for 'mental illness' is the main thrust of all UK mental health policy. These interventions are said to need to be offered faster ('Five Year Forward View'); on a par with the response to physical health problems ('No Health Without Mental Health'); to groups excluded from treatment – 'mothers', 'offenders', 'BAME', 'older people' ('Five Year Forward View' and '2010–2015 Mental Health Reform'); and more widely (thus the IAPT programme was provided with £400 million between 2011 and 2015 to improve access to psychological therapies). Quality and effectiveness should be ensured by offering '*timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment*' ('No Health without Mental Health.'). There is promised a significant increase in access to counselling for Children and Young People and people with diagnoses of 'serious mental illness' and 'personality disorder' through the next phase of the IAPT programme ('Implementing the Five Year Forward Plan').

Clearly there is much to welcome in these principles and plans, but calls for better access to MH services fail to acknowledge the extent to which diagnostically-driven practice can reinforce and actively obscure the disconnect between social contexts and distress, downplay the need for care that acknowledges the impact of adversities, and may be disabling and re-traumatising in its own right. There is little detailed consideration of the ways in which inequalities of power and privilege arising from subordinate or devalued identities profoundly influence both the nature of adversities and people's responses to them. This absence contributes to the de-contextualised approach evident throughout the agendas and recommendations.

A contrast can be drawn with the World Health Organisation Office for Europe document on 'Mental health, resilience and inequalities' (Friedli, 2009) which states much more bluntly: '*...levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing... both health-damaging behaviours and violence... may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status... current economic and fiscal strategies for growth may also be undermining family and community relationships: economic growth at the cost of social recession*' (pp.iii–iv). It continues: '*A preoccupation with individual symptoms may lead to a 'disembodied psychology' which separates what goes on inside people's heads from social structure and context. The key therapeutic intervention then becomes to 'change the way you think' rather than to refer people to sources of help for key catalysts for psychological problems: debt, poor housing, violence, crime. There is a need to think more critically about the relative contribution to mental wellbeing of individual psychological skills*

and attributes (e.g. autonomy, positive affect and self-efficacy) and the circumstances of people's lives: housing, employment, income and status. This also involves recognizing that "happiness", "positive thinking" and "trust" are not always adaptive responses' (p.7).

In conclusion, there is general acceptance within current UK mental health policy that social adversities are both cause and consequence of mental distress, and that intervention needs to take place at a societal as well as individual level, even if the details are sketchy and fall short of challenging the governmental policies that underpin inequality and injustice. At the same time, these progressive ideas are, if these documents are taken as typical, undermined by unquestioned assumptions of medicalisation. Social factors are 'related' to mental health problems rather than being at their root. Emotional distress is conceived as 'illness' to be 'treated' rather than intelligible response to life circumstances. The prevention of adversities is less of a priority than the need to increase access to 'treatment'. More mental health services are promised, but the appropriateness of the diagnostic model on which they are based is not open to question or dispute. Despite recognition of ACEs as causal factors in distress, there is no discussion about the need to orient standard interventions (IAPT, Early Intervention, crisis teams, liaison psychiatry and so on) so that they acknowledge the impact of these adversities. Consideration of issues relating to 'race' and culture is also notable by its general absence. Finally, as discussed below, attempts to reduce stigma are undermined by reliance on the concept of 'mental illness.'

Parity of esteem

This new agenda will undoubtedly become increasingly influential in the coming years, and merits separate consideration. The Health and Social Care Act 2012 recognised the Secretary of State's duties in relation to both physical and mental health, and provided the basis for what has become known as the principle of 'parity of esteem' for mental health. This principle informs 'No Health Without Mental Health' (Department of Health, 2011b), the mental health strategy for England, and the work of the NHS Commissioning Board. It was further reinforced by the Coalition Government's aim to put mental health on a par with physical health (Royal College of Psychiatrists, 2013).

The term 'parity of esteem' essentially means valuing mental health equally with physical health. When compared with physical healthcare, the aim is to have equal access to the most effective and safest care and treatment; equal efforts to improve the quality of care; the allocation of time, effort and resources on a basis commensurate with need; equal status within healthcare education and practice; equally high aspirations for service users; and equal status in the measurement of health outcomes <http://www.rcpsych.ac.uk/policyandparliamentary/whatsnew/parityofesteem.aspx>

As part of working towards these aims, a Government-commissioned report called for 'Whole person care' across health care settings (Royal College of Psychiatrists, 2013). The report recognises (quoting the ACE studies among others) the strong relationship between mental and physical health problems and their common origins in a range of social adversities, and hence the need to tackle them across disciplinary and organisational boundaries. This was a core theme of the 'Five Year Forward View' (NHS England, 2016a) which argues for integrating mental and physical health care, as does the report 'Better Mental Health for all': *'Historically, there has been a disconnect within healthcare of the mind and body, but it is now understood that this is an arbitrary separation; mental health and physical health*

are fully integrated and codependent. The mind and body are intrinsically linked on a physiological level (p 12)... The silo approach to public health, in which physical health is considered independently of mental health, no longer makes sense (Faculty of Public Health, 2016, p.14). One of the suggested solutions is the commissioning of liaison psychiatry teams across acute, secure, primary care and community settings, for all ages. By 2020/2021 it is intended that all acute hospitals will have liaison psychiatry teams, representing a significant expansion in jobs (NHS England, 2016b). The joint King's Fund and Royal College of Psychiatrists report 'Mental health and new models of care: Lessons from the vanguard' (Naylor et al., 2017) describes ambitious plans for rolling out multispecialty community providers (MCPs) and primary and acute care system models (PACS) across most of England. The report justifies this by various examples of people with complex needs – for example, those who might suffer both a chronic physical health condition and 'depression'. The unstated assumption is that the 'depression' is a separate illness that needs independent expert management from a new, usually medically-qualified team member. The list of 'vanguard' projects described in the report suggests that the recommendations are being widely translated into practice, mainly by employing consultant psychiatrists in service settings that have not usually been part of their remit.

These arguments and service developments need careful examination. It is undoubtedly true that mental health services are seriously under-resourced and underfunded. Co-locating physical and mental health services in primary and community care could help to encourage more integrated ways of working (NHS England, 2016b). Breaking down artificial service barriers between mental and physical health settings and social care is highly desirable. Physical health services will clearly be improved by paying more attention to people's psychosocial needs, but this would be better met through more holistic training for existing staff, and/or support and supervision from relevant professionals such as counsellors or health psychologists. Thus, while the need for parity of esteem in the form of resources in all these areas can be endorsed, it should not be conflated with justifying the expansion of the medicalisation of distress, given the striking lack of an evidence-base or achievement of good overall outcomes (Drury, 2014). Indeed, the evidence suggests that this will actually be harmful. These developments are particularly unwarranted given, although possibly related to, increasing challenges to medicalisation within mental health services themselves.

As we have emphasised throughout this document, psychological and emotional distress is not the same kind of problem as medical illness even if they co-exist, have synergistic effects, and share some common roots arising out of adversities. This is not to deny that useful work happens within these new liaison and consultancy teams, as within any mental health team. However, with mental health now a declared priority for all political parties, uncritical promotion of the 'Parity of Esteem' agenda represents a major risk not only of reinforcing medicalisation within mental health services but of embedding inappropriate or damaging interventions even more widely into health and social care systems as a whole. A similar process has been observed in the US with the controversial Mental Health Reform Act 2016, sometimes known as the Murphy Bill. It couples the call to integrate mental and physical health with a more emphasis on coercive interventions and less on peer support and trauma-informed care.

Part of the problem may lie in the language of 'mental health' itself. While the term may

be seen as more acceptable than ‘mental illness’, the two are dependent on each other for their meanings. As discussed under ‘Language use’ (below), different terminology is essential in order to open up new, more effective ways of practising.

Independent, voluntary, self-help and survivor-led services

While it is beyond the remit of this document to offer an overview of non-statutory, voluntary, self-help and survivor-led services and organisations, it is important to note that many of them offer extremely valuable support, which may be based on non-medical and non-diagnostic approaches. Examples are given in *Understanding Psychosis and Schizophrenia* (BPS, 2017). The Appendices in the Overview publication of the Framework describe some particularly impressive projects (see Appendices 11–14).

Anti-stigma campaigns

Discrimination refers to various forms of unequal treatment and exclusion from full participation in society arising from a person’s membership of a particular group, such as people who have been psychiatrically labeled. Stigma describes negative social attitudes towards these people, which are often internalised into a sense of shame and difference. Both are a major barrier to recovery (Corrigan & Kosyluk, 2013; Pyle & Morrison, 2014), and some people describe stigma and discrimination as more disabling than their original difficulties (Schulze & Angermeyer, 2003).

Anti-stigma campaigns such as the current UK ‘Time to Change’, supported by the two main UK mental health charities MIND and Rethink Mental Illness (www.time-to-change.org.uk), typically focus on stigma rather than discrimination – (the latter including societal barriers to employment, education, discriminatory legislation about benefits and housing, and so on). The campaigns are almost universally based on the ‘mental illness is an illness like any other’ strategy which attempts to persuade the public to think in terms of biologically based, medical illnesses, a message often reinforced by high-profile celebrities. However, this approach has consistently been shown to increase, rather than decrease, prejudice, fear and pessimism about recovery (Angermeyer et al., 2011; Kvaale et al., 2013; Read et al., 2006; Read, Haslam & Magliano, 2013) both in the UK and worldwide. A 2013 review of the relationship between attitudes and causal beliefs about ‘schizophrenia’ ‘psychosis’ or ‘mental illness’ in 16 countries found that bio-genetic causal beliefs were strongly related to negative attitudes while the opposite holds for psycho-social beliefs (Read, Haslam & Magliano, 2013). A meta-analysis of this same body of research concurs that ‘medicalisation’ of human distress via ‘biogenetic explanations’ increases pessimism about recovery and perceived dangerousness (Kvaale et al., 2013).

Stigmatising attitudes are less common in low and middle income countries, which may partially account for higher recovery rates there. For example, an overview of attitudes towards people who met the criteria for ‘major depression’ in 34 countries showed that stigma and discrimination was worse in high income countries than in poorer ones (Lasalvia et al., 2016). The researchers explained this in terms of the more widespread promotion of biomedical model explanations which have ‘proved to be extremely damaging’ and are ‘responsible for unwarranted and destructive pessimism about the chances of recovery’ (p.6). Service users who espouse biological causal beliefs are less

optimistic about recovery, make less effort to recover, and/or are more likely to use alcohol to cope (Birchwood et al., 1993; Kemp et al., 2014; Read, 2007). Mental health professionals who hold bio-genetic causal beliefs may be less empathic towards their clients (Lebowitz & Ahn, 2014).

A central component of efforts to improve what is referred to as ‘mental health literacy’ (or ‘knowledge and beliefs about mental disorders which aid their recognition, management or prevention’ Jorm et al., 1997) is to teach people to recognise common ‘mental illnesses’ as defined in biomedical terms. This too, however, has been shown to lead overall to more negative attitudes (Angermeyer et al., 2004; Read et al., 2006; Read, Haslam & Magliano, 2013). For example, studies of our readiness to see certain behaviours as ‘schizophrenic’, show that such labelling is positively related to perceived: dangerousness; unpredictability; perceived lack of ‘humanity’ and responsibility for actions; fear, rejection and desire for social distance; and pessimism about recovery (Angermeyer et al., 2004; Angermeyer & Matschinger, 2005; Kingdon et al., 2008; Magliano et al., 2003, 2011; Martinez et al., 2011; Wright et al., 2011). Conversely, experimental studies that put forward psychosocial causal explanations have been consistently shown to improve attitudes (Kvaale et al., 2013; Read et al., 2006, 2013).

Some service users have expressed doubts about the messages of anti-stigma campaigns. As one person put it: ‘The trouble with anti-stigma campaigns... is that on the one hand they accept the illness model, then try to change public perception about it. But we need to get rid of stigma at source by getting rid of unhelpful diagnoses. If we had an accurate version of humans which pinpointed the central question as “what can we do about human suffering?” then we’d be on our way to ending stigma once and for all!’ (cited in Beresford et al., 2016, p.25). In the light of the evidence that the ‘illness like any other’ approach is neither evidence-based nor effective, the more useful way forward would be a public campaign about the limitations of the diagnostic model and the availability of alternatives, accompanied by a change of focus to campaign against the very real discrimination faced by people who have been psychiatrically diagnosed. Accessible public-facing documents such as *Understanding bipolar disorder* (BPS, 2010) and *Understanding psychosis* (BPS, 2017) have done much to spread the message that experiences often seen as ‘psychosis’ are ‘common experiences which can be a reaction to trauma, abuse and deprivation. Calling them symptoms of mental illness, psychosis or schizophrenia is only one way of thinking about them, with advantages and disadvantages’ (BPS, 2017, p.6).

Summary

Current mental health policy has many important strengths. Its equally significant limitations can be traced back to a failure to question, and thus offer genuine alternatives to, the medicalisation of emotional distress with all its consequences. Situating these services within the NHS, which is primarily designed to address bodily problems and disease processes, contributes to this confusion. Peter Kinderman has argued that since ‘mental health and well-being is fundamentally a psychological and social phenomenon, with medical aspects... not... a medical phenomenon with additional psychological and social elements, it follows that the correct place for mental health care is within the social care system’ (Kinderman, 2014, p.94). He believes that both community and residential support for psychological and emotional distress should be under local authority control

(as is already the case with some but not all intellectual disability, older adult and child services, and a small number of mental health services) and suggests that: ‘In such a world, people would default to a *psychosocial explanatory model*, and the disease model of mental disorder would be redundant’ (p.17). Interestingly, the idea of locating mental health services within local authorities was discussed when the NHS was first set up in 1948, but ultimately rejected on the grounds that research was about to deliver breakthroughs in the medical treatment of these ‘illnesses’ (Kinderman, 2014).

Service principles

Trauma-informed approaches

The evidence about the impact of adversities has been most widely implemented in the US, where both the concept of ‘trauma-informed care’ and the ACE studies originated (Sweeney et al., 2016). The US has developed national policy in this area through the National Centre for Trauma-Informed Care established by SAMHSA (Substance Abuse and Mental Health Services Administration), which defines the approach as follows:

‘A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.... When a human services program takes the step to become trauma-informed, its entire organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.’ (SAMHSA, 2015).

According to comprehensive Australian guidelines (www.blueknot.org.au), trauma-informed systems, whether mental health, physical health, social care, intellectual disability, public health and prevention, forensic, probation, prisons, child welfare, child protection, substance abuse, or education, recognise that:

- The effects of complex (cumulative, underlying) trauma are pervasive, and if unresolved, negatively impact mental and physical health across the lifespan.
- The majority of people treated by public mental health and substance abuse services have trauma histories.
- Child abuse, in all its forms, and chronic neglect, are the key antecedents of complex trauma, although they are not the only causes.
- When unresolved, complex trauma causes ongoing problems, not only for those who experience it, but for their children (intergenerational effects) and society as a whole (Blue Knot Foundation, 2012, p.xxviii).

Similar guidelines and practice examples have been developed in British Columbia (Arthur et al., 2013).

From a PTM Framework perspective, the trauma-informed model has much to offer. It also has risks and limitations, including:

- Conceptualising the approach as an alternative explanation for ‘schizophrenia’, ‘bipolar disorder’, ‘ADHD’ and so on, perhaps by reducing adversities to the status of a ‘trigger’ and thus retaining diagnostic categories and thinking.

- Retaining medical language and thus avoiding a fundamental challenge to medicalisation – for example, proposals for new categories of *Complex Post-Traumatic Disorder* or ‘*Developmental Trauma Disorder*’ (van der Kolk, 2014) or the proposed addition of *Complex Post-Traumatic Stress Disorder* to *ICD-11*. An example of this kind of assimilation can be seen in recent work on the causal role of trauma in ‘psychosis’ (Johnstone, 2009).
- Using ‘trauma’ as a de-contextualised shorthand which, rather like diagnosis, can obscure the horrific nature of the events and situations it refers to.
- Lack of clear theoretical thinking resulting from using the term ‘trauma’ for both cause and effect.
- Framing awareness of the impact of adversity in a simplistic and reductionist way; for example, ‘All mental health problems are caused by trauma’ or ‘Sexual abuse causes voice-hearing’.
- Overlooking the more chronic, insidious and ongoing aspects of the negative operation of power, such as inequality, discrimination, denial of opportunities, social exclusion, imposition of ideological meanings, and so on, in favour of a focus on specific abuses committed by individual perpetrators (Burstow, 2003).
- Focusing on individual consequences of the negative impact of power, while neglecting the preventative, public health and social policy implications.
- Using the trauma literature to support the expansion of psychiatric models into physical healthcare and other human welfare systems, on the basis that physical ill health shares common roots with ‘mental illness’ (see Parity of esteem, above).

We believe that these risks can be minimised by viewing the trauma-informed approach from a PTM perspective. Not everyone in mental health and related services has experienced specific identifiable traumatic events, and conversely, not everyone who has done so will experience lasting damage or need professional support. However, we are all, in some aspects of our lives, subject to the negative impacts of power. As we have argued in Chapter 4, the term ‘adversity’, defined to include continuous or repeated negative experiences which are embedded in people’s lives and relationships and in the discourses, structures, practices and material conditions of our social world, may capture this better than the terms ‘trauma’ or ‘abuse.’ With these caveats, we believe that the trauma-informed approach has many consistencies with the PTM Framework.

Recent work in the US recognises the need to pay equal attention to Adverse Community Environments – the roots of Adverse Childhood Experiences – in order to prevent an accumulation of adversities and intergenerational cycles of poor health outcomes (Pinderhughes et al., 2015). Sometimes referred to as historical or intergenerational trauma, community trauma is not just the aggregate of individuals in a neighbourhood who have experienced trauma from exposures to violence, but is ‘the product of the cumulative and synergistic impact of regular incidents of interpersonal, historical, and intergenerational violence and the continual exposure to structural violence. Structural violence refers to harm that individuals, families and communities experience from the economic and social structure, social institutions, social relations of power, privilege and inequality and inequity that may harm people and communities by preventing them from meeting their basic needs’ (p.22). It can ‘break social ties, communality, and undermine previous supportive resources’ (p.11). The ‘symptoms’ can be manifested in the social-

cultural environment (the people), the physical/built environment (the place) and the economic environment (the availability of resources and opportunities). Rather than focusing all interventions at the individual, within a broadly medical framework, it is argued that there is a need to address the consequences of community trauma as they are manifested in the breakdown of social networks, social relationships and positive social norms across the whole community. Cumulatively, this erodes people's resilience and leads to vicious circles of increasing distrust and fragmentation. Ideally these strategies build on local or indigenous knowledge, expertise and leadership (see examples in Pinderhughes et al., 2015). Clearly, there are useful lessons here for UK public health policy.

Implementing awareness of the causal role and impact of adversities in services (adult, older adult, forensic and criminal justice, child and adolescent, addictions, neuropsychology, intellectual disabilities and physical health)

The basic principles of trauma-informed services are 'safety', 'trustworthiness', 'choice', 'collaboration' and 'empowerment' (Fallot & Harris, 2009) along with attention to cultural, historical, and gender issues (SAMHSA, 2015). These principles are implemented through:

- a shift from 'caretaking' to 'collaborative' ways of working;
- movement from an illness/symptom-based model to one of skills acquisition;
- replacement of the core question 'What's wrong with you?' with 'What happened to you?' (Blue Knot Foundation, 2012, p.14).

The PTM Framework suggests, as discussed in Chapter 6, that the question 'What has happened to you?' can be expanded into 'How has Power operated in your life?' and should be supplemented with 'How did it affect you?' (What kind of Threats does this pose?) 'What sense do you make of it?' (What is the Meaning of these situations and experiences to you?) and 'What did you have to do to survive?' (What kinds of Threat Response are you using?)

In the US, the principles of trauma-informed practice have been applied to projects in fields as diverse as schools, homelessness hostels, refuges, parenting support programmes, parent and child clinics, juvenile offending, and a range of innovative community and public health interventions (www.acesconnection.com; SAMHSA, 2015; <http://communityresiliencecookbook.org/tastes-of-success>). There are also trauma-informed projects and services in Canada, Australia and New Zealand (Sweeney et al., 2016; www.asca.org.au). However, all these mental health systems are as a whole still strongly biomedically-based.

As described above, trauma-informed care is in its infancy in most parts of the UK (Sweeney et al., 2016). One exception is the Clinical Link Pathway for Trauma in the Adult Mental Health Service in Tees, Esk and Wear Valleys NHS Foundation Trust, which is designed for people whose distress arises from trauma irrespective of their diagnosis or cluster (described in Appendix 7 in the Overview publication. See also Appendices 2, 4, 5 and 6). The literature is, however, becoming more widely known, as seen in the citing of the ACE studies in recent health policy documents above. Another encouraging

development is the commissioning of a large-scale, two-year project ‘Beyond Violence’, led by US psychologist, Stephanie Covington, to develop a trauma-informed approach for women who have committed criminal offences (Covington, 2013, 2015). The ambitious aim is to introduce this approach to all UK prisons and prison staff. Progress will be assessed against principles of trauma awareness and gender responsiveness.

A central message of this approach is that awareness of the causal impact of adversities is needed across all human welfare systems, and hence that there needs to be a far greater degree of integration and collaboration across them. High levels of trauma and adversity are found not just in mainstream ‘mental health’ services for children, adults and older adults, but in people with addictions (Brown et al., 2013), people with intellectual disabilities, including but not limited to physical and sexual abuse (Keesler, 2014; Sequeira & Hollins, 2003; Sinason, 1992); people who have committed criminal offences (Miller & Najavits, 2012); and people with traumatic brain injuries and other neurological problems (Bay & McLean, 2007; Buckingham & Daniolos, 2013; Hunt et al., 2004).

As described in Chapter 6, the trauma-informed approach has two linked aspects: ensuring that systems as a whole are based on awareness of the prevalence and impact of adversities; and offering interventions aimed directly at processing the emotional effects of those adversities. The latter are typically based on the three-stage trauma model, consisting of Safety/Stabilisation through attention to safety in current social and relational contexts, education about the impact of trauma, and acquiring coping and self-regulation skills; Processing of memories and emotions through a range of possible therapies, often including Compassion focused therapy (Lee & James, 2012); and Integration, or reconnecting with one’s life and relationships (Blue Knot Foundation, 2012; Briere & Scott, 2013; Courtois & Ford, 2015; Herman, 2001; McFetridge et al., 2017). Trauma-focused therapies emphasise compassionate and validating therapeutic relationships within which earlier attachment violations can be repaired. Community support resources such as helplines and organisations, crisis services, safe respite and accommodation, are also an important part of the recovery process.

Translated into practice, the specific implications for services include:

- All staff, including administrative and support workers, need to have training and education in facts, figures and interventions in relation to adversities, and in the three-stage model. This should incorporate issues of culture and diversity.
- The creation of new adversity-informed curricula across professions, possibly including a much greater amount of shared training.
- All parts of services (e.g. CAMHS, Older Adult, Intellectual Disability, Early Intervention, Assertive Outreach, Crisis Resolution and Home Treatment, Dementia Care, Rehabilitation, Forensic, Addictions, ‘Eating Disorder’ and ‘Personality Disorder’ units, all clusters and pathways, as well as general Health settings) need to recognise the shared causal factors in distress in their respective populations.
- Given this recognition, there should be much less fragmentation into specialist teams (EI, AO, CRHTT, etc.) with all the inevitable risk of communication breakdowns and inconsistent intervention plans.
- Adversities should be identified as early as possible in a person’s contact with services, including in CAMHS work. Although Routine Enquiry is Department of Health policy, staff still report reluctance to act on this, mainly because of lack of confidence in how

to respond to disclosures. Responding Effectively to Violence and Abuse Briefing 2 (Scott et al., 2015a) puts forward a number of recommendations about how to support Routine Enquiry through training, supervision and audit.

- All staff should be trained in Stage 1 stabilisation work and a proportion of staff from across ‘mental health’ and related disciplines should be trained in Stage 2 trauma processing work (with some exceptions; e.g. dementia care).
- All staff need to have what has been described as ‘narrative competence’ (Grant, 2015, p.52): ‘the capacity for human beings to deeply absorb, interpret, and appropriately respond to the stories of others’.
- There needs to be service-level awareness of the potentially re-traumatising impact of interventions, especially when coercive and involuntary. This is most likely to apply to admissions, sectioning, use of medication and ECT but can also apply to therapies and other interventions (as discussed below) as well as to routine practices such as giving personal care, and so on. Thus, narratives, formulations and therapies which are not offered sensitively and reflectively may be experienced as disempowering, invalidating and/or pathologising (Division of Clinical Psychology, 2011, and see Supporting Safe Therapy at <http://www.supportingsafetherapy.org/clients>).
- Professionals need to be securely supported and valued within organisations that provide them with safe attachments, so that they can meet others’ emotional needs. Staff who do not have access to supervision, are subject to constant pressure from job insecurity, re-organisations, target cultures and so on, will not be able to tolerate or work with the high degree of distress associated with acting as witnesses to the consequences of trauma and adversity. They will be at risk of burnout and/or acting in insensitive, invalidating or actively re-traumatising ways (Francis, 2013; Onyett, 2014).
- Active collaboration with service users is needed at all levels of the organisation, and support for/links with service-user led organisations, support groups and so on is essential. There should be positive welcoming of service-user trainers and staff with personal experience of mental health difficulties.
- Physical environments should be safe and welcoming, and should minimise the possibility for re-traumatisation due to factors such as mixed sex wards, lack of privacy, exposure to others’ disturbed behaviour, and so on.
- All aspects of the service should ensure maximum opportunity for choice, control and informed consent.
- Close collaboration is needed with local agencies such as the police, domestic violence services, refuges, charities, and others working with abuse.
- Partnership with, and learning from, non-statutory organisations such as the Hearing Voices Network is also essential.

These recommendations are supported by surveys. For example, research in the UK found that survivors of violence and abuse described the most important components of services as offering Routine Enquiry in primary care, in children’s services, in Child and Adolescent Mental Health Services (CAMHS), and in community services – particularly those dealing with drug and alcohol issues; staff in these services having good training and support and being able to make direct referrals to specialist services in both the statutory and voluntary sector; group and peer support being readily available for male and female survivors of all types of abuse; some non-hospital based crisis/respite provision available specifically for

survivors; and services knowing about, talking to, and coordinating with each other (Scott et al., 2015b).

Many of these recommendations are part of existing policy and practice. For example, in services for people with intellectual disabilities, the idea of having a secure attachment to the ID service as a whole, independent of any other specific interventions, has gained currency and seems to make sense for ‘difficult to reach’ or ‘revolving door’ service users. Empowering practice, referred to variously as person-centred planning or personalisation, is widely promoted, although there is a danger that the only change is in the language used. Funding for self-advocacy for organisations such as People First needs more consistent support. Systemic approaches are increasingly used in ID services (e.g. Baum & Lynggaard, 2006). These avoid reliance on diagnostic categories and (at best) promote a more reflective and reflexive stance, which fits well with an examination of the operation of power in relationships at every level. There have recently been calls to implement trauma-informed perspectives in this field in recognition of the high prevalence of adversities in the client group (Keesler, 2014).

In general medical settings, the impact of traumatic events (e.g. burns, difficult childbirth) and of interventions themselves (e.g. receiving a terminal diagnosis; undergoing an operation) is increasingly recognised. There is also awareness that staff themselves may be traumatised by their work – for example, attending a road traffic accident as a paramedic or a failed attempt to resuscitate a baby. Much of this awareness is event-specific, rather than a full recognition of the longer-term adverse contexts that may contribute to physical health conditions, harmful behaviours and unhealthy lifestyles. Psychiatric liaison teams may be called to advise if a medical event such as a heart attack leads to severe distress, but this is likely to be viewed as the ‘trigger’ of an underlying psychiatric ‘disorder’ or ‘illness.’ The patient thus risks acquiring a psychiatric diagnosis in addition to a physical health one. Compassion-focused therapy, strengths models and narrative approaches are very popular in physical health settings, and provide opportunities for introducing trauma-informed perspectives, as does indirect work by health psychologists through training, team formulation, etc.

An emerging body of evidence suggests that interventions based on trauma-informed principles are effective in reducing low mood, trauma reactions, self harm, suicidality and revictimisation (Briere & Scott, 2013; Courtois & Ford, 2015). There are also indications that trauma-informed care may help to reduce general ‘mental health symptoms’, increase coping skills, improve physical health, and lead to shorter inpatient stays (Sweeney et al., 2016). Group therapy based on these principles is particularly effective at reducing shame, blame and isolation, as well as low mood and suicidality (Lau & Kristensen, 2007; and see Appendix 5 in the Overview publication). Embedding trauma-informed formulation within inpatient and community services has been shown to lead to significant reduction in service user distress ratings and increase in self-management skills in a large MH Trust (Araci & Clarke, 2016). Trauma-informed environments have been found to reduce levels of restraint and seclusion on an inpatient ward (Arthur et al., 2013) and to be more effective than routine care in women’s substance abuse and mental health services (Veysey & Clark, 2004). At the level of primary prevention, both national (see section on Social, political and economic context above) and international research provides powerful evidence that community projects of various kinds can substantially reduce the

many negative health, educational and social consequences of adversities (examples at www.acestoohigh.com; <http://communityresiliencecookbook.org/tastes-of-success>). Detailed research-based guidance on trauma-informed practice in the UK can be found in McFetridge et al. (2017); from Australia in Blue Knot Foundation, 2012 (available at www.blueknot.org.au); and from Canada in Arthur et al. (2013).

The principles of PTM-informed non-diagnostic care which acknowledges the causal impact of adversities are potentially consistent with five other current trends, depending to some extent on how they are defined and implemented. These will now be described.

The social model of disability

The UN Convention on the 'Rights of persons with disabilities' represents a move away from seeing people with disabilities as objects of charity and medical treatment, and towards one of citizens with rights, who can make decisions about their lives based on their free and informed consent, and are active members of society. The Convention is thus based on a social model of disability, seeing it as resulting from '*...the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others*' (UN General Assembly, 2008, Preamble). In other words, disability is a complex phenomenon which reflects not just the person's characteristics, but also barriers relating to transport, employment, negative attitudes and many other factors.

Although service users frequently advocate much greater attention to people's social circumstances and to wider societal issues, they have expressed mixed views about the social model of disability as an alternative to a medical one. Some appreciate the human rights perspective and welcome the chance to link with the wider disability movement, while others do not want to take on an identity of impairment, and resent the implications of permanence (Beresford et al., 2016). From a PTM perspective, psychological distress is seen as originating in expected and understandable responses to adversity, and thus the language of survival strategies is more appropriate than that of disability. However, the emphasis on reducing societal barriers for people who frequently experience states of emotional distress is a very helpful one.

Recovery

The notion of 'recovery' has been re-defined over the last 20 years or so. As used in general medicine, it often means having a condition successfully treated and returning to a previous state of health. The rarity of this outcome in standard psychiatric practice is seldom discussed. An exception can be found in the writing of David Whitwell, a psychiatrist who over a period of 20 years came to believe that '*...the recovery promised by medical treatment is a myth; held out as a goal, but rarely attainable*' (Whitwell, 2005, p.ii). Attempting to find former 'mental health' service users who might fit this definition, he set up a study in which he invited his medical colleagues to put forward names of people whom they considered to have 'recovered' in this sense. After a 9-month search, only 13 could be identified, and at interview, all of them turned out to have significant ongoing difficulties – many of which they attributed to their contact with the mental health services (Whitwell, 1999).

Recovery is now defined as ‘a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles.’ This definition, emerging from service users/survivors themselves, contrasts with the more traditional definitions of ‘clinical recovery’ (Slade & Longden, 2015). Rather, recovery is conceptualised as a way of living a satisfying, hopeful, and meaningful life, as defined by the individual, even within the fluctuations and limitations caused by states of distress (Anthony, 1993). The movement has its roots in service user descriptions of their journeys through ‘a transformative process in which the old self is gradually let go and a new sense of self emerges’ (Deegan, 2001). It emphasises personal stories rather than diagnoses: ‘The starting point of recovery-oriented services is to encourage the person to tell their story... We should therefore give the use of narrative accounts the central place in the practice of recovery that it deserves’ (ImROC, 2014). Recovery-oriented services should be based on the key recovery principles identified by Repper & Perkins (2003) – hope, control, and access to ‘opportunities to build a life beyond illness’.

This new definition of ‘recovery’ has become the guiding vision for mental health services in the UK and beyond. The ImROC programme (Implementing Recovery through Organisational Change) was established by the Department of Health in England in 2008 to help services become more recovery-oriented (Shepherd et al., 2009). ‘Recovery Colleges’ are based on an educational model and use co-production to develop and deliver courses to students who are a mixture of service users and staff (co-learning). The emphasis is on providing an environment where people can develop their own understanding of mental health issues and how best to manage them (Perkins et al., 2012).

Despite these important principles, there is widespread service user/survivor and professional suspicion that the philosophy has been subverted by a Government agenda of getting people off benefits and into jobs, rather than expanding their life chances (Beresford et al., 2016; McWade, 2016). There is little sign of the recovery model replacing the traditional medical one in service delivery; rather, there are reports of re-labelling teams and services as ‘recovery-oriented’ with no accompanying change in philosophy or attitudes. At its worst, the rhetoric has been seen as providing a justification for discharge from or closing down services. Medical language retains its dominance, and in practice, personal narratives do not replace diagnostic categories (Beresford, 2016; Harper & Speed, 2012; Pilgrim & McCranie, 2013; and see <https://recoveryinthebin.org/>). The movement can perhaps also be seen as a way to avoid difficult questions about why ‘clinical recovery’ is so rare, by devolving responsibility for ‘recovery’ back on to service users themselves.

A recent report focusing mainly on ‘psychosis’ attempts to reclaim some of the original vision by promoting evidence-based principles including: Recovery is best judged by the person living with the experience; Many people with mental health problems do recover, in the sense of taking up their lives again; and diagnosis is not a robust foundation (Slade & Longden, 2015). It notes that some people make a positive and beneficial choice not to accept their diagnosis and to find support outside mental health services, and that it should not be a requirement to be formally diagnosed and engaged with mental health services in order to access entitlements. Reviewing the evidence, the authors conclude that ‘the unquestioning use of mental illness diagnoses as if they are un-contested and capture meaningful and invariant individual-level diseases is difficult to justify, and may have harmful consequences’ (p.19).

Wellbeing

There is a similar ambiguity in the widespread promotion of Wellbeing, common to all the mental health policy documentation, and enshrined in England in Health and Wellbeing boards which co-ordinate health strategies at a local level. The increasing popularity of this concept implies recognition of the social determinants of mental health, that all of us can experience less than optimal states of mind, and all of us can take some steps to change this. As noted in 'Psychological health and wellbeing' (Tai et al., 2009) this perspective can offer a helpful and inclusive alternative to a 'disorder' model, and as such 'may help unify a number of policy drivers. Importantly, it could give an ethos or frame for commissioning services, including the development of more appropriate measurements or metrics focussing on social and functional rather than symptomatic outcomes' (p.5). One implication is that CAMHs interventions with traumatised children need to go beyond standard courses of medical or CBT 'treatment' for those meeting diagnostic criteria for 'mental illness' (p.13). This sets the scene for a broader recommendation that 'Mental health care is better located within a social, not medical, framework' (Tai et al., 2009, p.5).

A slightly different message emerges from 'Five Ways to Wellbeing' (Aked et al., 2008), a health promotion initiative that aims to change people's behaviours in order to enhance their wellbeing, defined as comprising two elements; 'feeling good' – (happiness, contentment, enjoyment, curiosity and engagement) and 'functioning well' – (experiencing positive relationships, control over life, sense of purpose). The individual is encouraged to do this through five key actions: Connect; Be active; Take notice; Keep learning; Give. However, the explicitly individual focus (since 'actions oriented at the societal or governmental level would not be applicable to changes that the individual has capacity to make in their own life') is problematic. Individual wellbeing cannot be achieved if the social factors that lead to its absence are unaddressed, and the implication of personal responsibility for the impact of wider structural factors is concerning.

Person-centred care and co-production

Person-centred care views service users, their families and professionals as equal partners in making decisions about care (de Silva, 2014). It supports people to develop knowledge and skills to manage their health and make informed decisions about their health care (Health Foundation, 2014) through a range of approaches including shared decision-making, self-management and personalised care planning (Coulter & Collins, 2011). However, at least in mental health systems, these desirable aims have yet to overcome the pervasive reality that 'When the client is compliant, shared decision making is a virtue; when there is disagreement about treatment, the client "lacks insight" and shared decision making is a risk' (Drake & Deegan, 2009).

Embedding shared decision-making into care pathways, systems, workforce attitudes and behaviours in order to promote choice and shared decision-making in healthcare is a major challenge, and there is still a long way to go (Foot et al., 2014; Health Foundation, 2014). This may be aided by greater engagement of staff, service users and carers in the design and evaluation of services (Social Care Institute for Excellence, 2012). Experience-based co-design (EBCD), for example, uses the experience of the care pathway to plan service improvement (Bate & Robert, 2006; Tsianakas et al., 2012).

A related concept is co-production, in which practitioners, service users and families

share power in the design and delivery of services (Slay & Stephens, 2013). ‘Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbors. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change’ (Boyle & Harris, 2009). This is a way of thinking about power, resources, partnerships, risks and outcomes, rather than a model of service provision as such (Needham & Carr, 2009) and is a core principle of mental health policy (e.g. NHS England, 2016b). As with person-centred care, significant systemic change will be required to enable co-produced mental health care to become a reality (Shepherd et al., 2009). Shepherd and colleagues (2010) identified 10 organisational challenges including improving the quality of experience, user-led training, and employment of Experts by Experience (EBEs) in the workforce, for example, as Peer Support Workers.

The broad aims of person-centred care and co-production are highly desirable. However, there is limited research into either of these approaches, and thus little evidence about their impact or effectiveness (King’s Fund, 2013). The extent to which co-production, and respect for diversity and choice in understanding and managing mental health problems, will be able to challenge or provide alternatives to traditional diagnostic-based models and practice is not yet clear, and these potential challenges and conflicts of interest are so far undiscussed in the literature.

Peer support

In mental health settings and beyond, people have been coming together to support each other in adverse circumstances for centuries (Davidson et al., 2012). Seebohm et al. (2010) suggest that peer support and self-help groups are both characterised by mutual aid and reciprocity, as indeed are many service user groups. Peer support can be offered on a one-to-one or group basis, and different terminology may be used by different marginalised groups which reflect their own histories of community organisation. For example, Seebohm et al. (2010) document the tradition of self-help within Black communities, in an article exploring the different ways in which the terms ‘self-help’, ‘peer support’ and ‘service user groups’ are used and understood (Faulkner & Kalathil, 2012). It is only in the last couple of decades that the term has begun to be used in relation to something more intentional and sometimes interventionist in nature (Repper & Carter, 2011; and see project examples at <http://www.peerworker.sgul.ac.uk>).

In its most natural form, peer support is simply support exchanged between people who share something in common: they are entering into something on a more or less shared, or equal, basis. Sometimes called self-help or mutual support, peer support can emerge wherever service users come together: in inpatient wards, day centres and drop-ins and in organised service user groups. It reflects a natural human tendency for people with something in common to share experiences and help each other. Adverse circumstances, such as inpatient admissions, can create a sense of camaraderie which may be more supportive than the official treatment on offer (Faulkner & Layzell, 2000; Walsh & Boyle, 2009).

In its more recent version, ‘Intentional Peer Support’ (IPS) has been used within a recovery approach to describe the engagement of people with lived experience in helping others to progress in their recovery journey. IPS has its roots in the US with the work of

Shery Mead, a peer consultant who defines it as ‘peer support with a purpose – that of supporting one another in moving towards the life we wish to lead’ (Mead, 2003). Its central aim is to build mutual relationships within which we can ‘explore the events in our lives and the stories we create out of them’ (Mead & Filson, 2016, p.109). As has been emphasised throughout the document, seeking to understand what has happened to people rather than asking what is wrong with them allows the creation of new stories that may challenge existing beliefs about guilt, shame and ‘illness.’ As Mead and Filson (2016) note, this contradicts many of the basic principles of statutory services. Nevertheless, they believe that these dialogues, connections and relationships ultimately have the power to create social change.

However, like the concept of ‘recovery’ before it, there is a risk of peer support being co-opted by mental health services into a service-led intervention, despite its origins in grassroots mutual help and activism (see Penney & Prescott, 2016). People with lived experience may be employed within services to provide peer support to service users, sometimes as one member of a team with a role that can be poorly defined. Thus, peer support can mean many different things to many different people. Some of this is about language but some is about ethos and values, and the possibility that we may be using the same words to describe quite different things. In the scoping review by Mind (2013), the following broad categories were identified:

- Self-help groups;
- Mutual peer support;
- Intentional peer support;
 - recovery based;
 - non-recovery based;
- Peer mentoring;
- Online peer support.

Mind (2013) summarised the core principles as: mutuality, respect, a non-judgmental approach, inclusivity, and equality. They also emphasised the value of being peer- or user-led and independent (of statutory services). Since this work, many other organisations have identified values and principles behind peer support, for example, Together for Mental Wellbeing (Basset & Faulkner, 2010; Basset et al., 2010; Faulkner & Basset, 2010), and the newly-funded ENRICH research project based at St George’s, University of London. It becomes all the more important to define these terms in a context of increasing individualisation. The move towards statutory funding and research interest (based on conventional outcomes such as hospital readmission) may leave grassroots service user self-help, activism and leadership unfunded and unsupported at a time when they are needed more than ever.

The principles and ethos behind service user or peer-led peer support are the source of its particular strengths; the challenge is how to retain them and remain true to the origins of peer support when introducing it into services. At the basis is a non-diagnostic and personal story approach to understanding people’s mental distress – not something that can easily fit into contemporary mental health services without some degree of culture change.

These trends are all, to varying extents, undermined by a core aspect of service provision which will now be discussed: coercion.

Coercion

One of the most controversial aspects of mental health services is coercion, or the legal powers that enable mental health workers to enforce compulsory detention, compulsory intervention ('treatment') and compulsory restraint and seclusion.

Broadly, there are three circumstances when this happens. First, 'mentally disordered' offenders may be compulsorily detained in forensic mental health services, where the balance between coercion and forming therapeutic relationships is particularly problematic (Miles, 2016). Second, people diagnosed with mental health problems, who have not committed a criminal offence, may be detained or treated against their wishes, under various sections of the Mental Health Act (Mental Health Act, 1983/2007). Third, in Scotland since 2005 and in England and Wales since 2008, people who have been in hospital under some sections of the Mental Health Act may be required to comply with 'supervised treatment' in voluntary interventions in community settings via Community Treatment Orders, and may be brought back into hospital if they do not do so. Conditions may include attending medical appointments and taking medication.

People with diagnoses of 'psychosis' or 'anti-social personality disorder' are treated more coercively – the former in acute mental health services and the latter in forensic mental health services. The other group subject to raised levels of coercion is those who are profoundly depressed and actively suicidal. It is also well-established that Black people, especially young African or African Caribbean men, are disproportionately likely to be subjected to forced detention and medication (Mental Health Act Commission, 2009).

As well as these overt uses of legal powers, there can be what has been described as a 'spectrum of pressure' (Szmukler & Appelbaum, 2001) consisting of *Persuasion*: for example, someone may be reminded of the consequences of not cooperating in the past; *Leverage*: for example, where a professional might express disappointment or disapproval about the service user's choices or wishes; *Inducements*: where, for example, someone may be offered advantages in exchange for compliance; and *Threat*: where the service user may be told that if they do not agree with the plan voluntarily, they will be subject to forced intervention anyway.

Libertarian critics have argued that as long as the involuntary detention and treatment is possible, genuine voluntary contact becomes meaningless (Szasz, 1970). Thus, the threat of coercion may overshadow all of a service user's interactions with the mental health system, however supportive individual professionals are, and may incline them to conceal their real feelings and needs. In practice, service user accounts of entering hospital informally suggest that the common use of threat of coercion means that many are, in effect, 'pseudo-voluntary' (Rogers, 1993). The ever-present possibility of coercion also undermines the philosophies of person-centred care, co-production, and recovery, although this is rarely acknowledged.

Just as worrying is the extent to which coercive interventions are experienced as both traumatising and re-traumatising. These events are widespread in inpatient settings (Freuh et al., 2005) and the shock of being detained, restrained, put in seclusion, forcibly medicated or given ECT against your will cannot be overestimated. People report feeling terrified, humiliated, shamed, degraded, and abused, with a lasting impact on their trust of mental health professionals (Johnstone, 1993; May, 2001; Meyer et al., 1999). Thus,

one person described her detention as ‘a source of profound feelings of humiliation and shame, as well as a source of a deep sense of failure, unfairness/injustice and stigmatisation... it was an immensely scarring experience... something that I experienced as a brutal assault on my identity’ (Poursanidou, n.d.). Researchers have acknowledged that ‘There is abundant evidence that the experience of... coercive treatments is often psychologically traumatic in a manner that is consistent with the broader definition of trauma’ (Lu et al., 2011, p.73). Such experiences, along with frequently-reported incidents such as physical or sexual assault, bullying, verbal abuse, and witnessing fellow patients being treated in the same way (Freuh et al., 2005), are highly likely to repeat earlier experiences of being powerless, abused, hurt and controlled, as noted in the literature on trauma-informed care.

Coercion is thought to be warranted, by professionals and others, on two broad grounds: people’s alleged failure to recognise their need for treatment, and thus act in their own interests, and/or the need to protect third parties. Together these two points are captured in the phrase ‘risk to self or others’. The cultural association of madness with irrationality and the idea of certain experiences and actions as symptoms of an underlying illness rather than meaningful responses to adversity, can also make coercive interventions seem like a reasonable response. At any one time, about 20,000 people are being detained in psychiatric hospitals against their will (Kinderman, 2014). It is a matter of great concern that the number of compulsory admissions has risen steeply over the last 30 years (Health & Social Care Information Centre, 2013) and that the use of CTOs has far outstripped initial projections (Care Quality Commission, 2016). The government-funded OCTET randomised control trial (Burns et al., 2013), the third of its kind, found that CTOs did not reduce re-admissions of people with a diagnosis of ‘psychosis’ and concluded, in line with the previous trials, that their use did not justify ‘the significant curtailment of patients’ personal liberty.’ Another potentially worrying trend is the drive for early intervention in ‘psychosis’. While some EI teams work within a strongly psychosocial model, there have also been arguments for enforced medication for those deemed to be at risk of developing ‘psychosis’, thus increasing their exposure to the adverse effects of medication for difficulties that may never develop (Bentall & Morrison, 2002; Miller & McGlashan, 2003).

Clearly, the use of coercion raises significant ethical concerns, given that people diagnosed with mental health problems are the only group subject to compulsion in the absence of committing a crime (Pilgrim, 2012; Pilgrim & Tomasini, 2012). With only a very few exceptions (i.e. in the case of some transmissible diseases, or emergency treatment if someone is unconscious, or if they are a suspected terrorist) there is no legal right to act in this way towards those without a psychiatric diagnosis. People retain the right to refuse treatment for physical illnesses, even if this puts their health at risk. We do not compulsorily intervene in examples of self-injurious behaviour such as smoking. Nor do we force people to take preventative medication to avoid relapses of physical health conditions. Moreover, the whole argument for coercion is predicated on the assumption that the enforced ‘treatments’ are indeed beneficial, when the evidence shows that people may have very sound reasons for refusing them, both in terms of their immediate effects and in terms of their long-term impact on physical and mental health.

From a PTM perspective, these discriminatory and often re-traumatising practices are predicated on and justified by the underlying assumptions of psychiatric diagnoses. The

BPS has argued that intervention decisions should be based on someone's capacity to understand them, rather than on whether they have a psychiatric diagnosis (BPS, 1999). Similarly, Peter Kinderman has argued that 'A more coherent and fair approach would be to agree to take decisions on behalf of other people if they are unable to make decisions for themselves, regardless of whether they have a diagnosis' (Kinderman, 2014, p.11). This could be implemented within the general principles of Powers of Attorney, Advance Decisions and of the Mental Capacity Acts (2005, England and Wales; 2016, Northern Ireland) or the Adults with Incapacity (Scotland) Act (2000), without assuming that receiving a 'mental disorder' diagnosis necessarily removes decision-making capacity, and ideally, without reference to the hypothesised presence of a 'mental disorder' at all.

The United Nations has gone further, with a call from the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment for a ban on forced psychiatric interventions including drugs, ECT, psychosurgery, restraint and seclusion (Méndez, 2013). A subsequent UN report noted that despite the emphasis of the Committee on the Rights of Persons with Disabilities on full respect for legal capacity and the absolute prohibition of involuntary detention based on impairment and the elimination of forced treatment, this position is not consistently upheld in human rights frameworks (UN, 2017). As a result, 'the denial of legal capacity frequently leads to deprivation of liberty and forced medical interventions, which raises questions not only about the prohibition of arbitrary detention and cruel, inhuman or degrading treatment, but also the right to health' (p.8). The report notes that while it will take time to change practice, 'Coercion in psychiatry perpetuates power imbalances in care relationships, causes mistrust, exacerbates stigma and discrimination and has made many turn away, fearful of seeking help within mainstream mental health services' (p.15). Moving beyond diagnostic thinking is essential in order to have a rational debate about the issues.

Mental Health Services commissioning, access, design and outcomes

Service commissioning and access

Commissioning arrangements vary in different specialties and different parts of the UK. Any discussion about commissioning of mental health services in England raises the question of to what extent payment by results is a productive and meaningful way of planning, running and funding services. There is a particularly poor fit with mental health work, where the link between a diagnosis and a standard intervention (e.g. hip replacements for arthritis) simply does not exist, because no two people with a given psychiatric diagnosis have the same needs. The same disadvantages apply as to managerialism and the target culture in general, i.e. introducing 'gaming' or incentives to play the system, undermining professional experience and intuition, increasing defensive practice, and taking the focus away from direct care towards time-consuming and expensive administrative tasks (Drury, 2014; Boyle, 2011). Opening up services to market forces speeds up the demoralizing process of constant change, along with fragmentation of services, and managing, monitoring and measuring at the expense of actual work with service users (Verhaeghe, 2012). Instead, 'We need to recognise the vital human factor in services: the element of relationship building that is required before real change can happen on the ground, and which is completely antithetical to the business of measuring, standardising and rewarding' (Boyle, 2011, p.634).

Some general principles in relation to commissioning are illustrated with particular reference to AMH services in England.

In England, the general context of commissioning has shifted towards primary care, local authorities, and local community needs. Since the 2012 Health and Social Care Act, health services in England have been commissioned by Clinical Commissioning Groups (CCGs). These in turn are informed by local Health and Wellbeing Boards, statutory bodies with representatives from social services, children's services, the public health department and others such as police, fire and ambulance services. The general aim is to integrate mental health care, physical health care and social care, such as linking GP services with wider community and social services, by bringing together clinical commissioning groups and local councils to develop a shared understanding of the health and well-being needs of the community. This Joint Strategic Needs Assessment (JSNA) forms the basis of a strategy for action. This is intended to include action on the social determinants of health and health inequalities as they apply within local communities. Some HWB boards have included targets based on the 2010 Marmot Review 'Fair Society, Healthy Lives'.

The Boards are designed to enable joint commissioning and integrated services across health and social care, joined-up services between the NHS and local councils, and stronger democratic legitimacy and engagement. This integration makes a great deal of sense within a trauma-informed and PTM Framework, given the co-existence and common roots of so many physical, emotional and social problems. It could be expanded to include other services such as education at various levels and third-sector organisations. Routinely informing local schools, churches, parent groups, colleges and employers about key mental health issues in the area could also help to develop community-based approaches.

Individual CCGs and NHS Mental Health Trusts negotiate together about which services will be commissioned and what entry criteria will be used. They are expected to set up services within which National Institute for Health and Care Excellence (NICE) guidelines, which are largely based on psychiatric diagnostic categories, can be met. In addition, the Department of Health issues implementation frameworks based on governmental strategy. However, in practice there is considerable variation due to local needs, and services are not always based on diagnostic categories. A recent survey of 15 Trusts in the north of England (Allsopp, 2017) found that in practical terms, diagnosis was neither necessary nor sufficient in commissioning decisions or establishing service entry criteria. Instead, services may be designed for particular groups such as military veterans, or the homeless; they may be needs-led, such as inpatient, rehabilitation, IAPT or psychological therapies; or they may be problem-specific, such as psychosexual clinics, or alcohol/substance abuse. Even where services are described in broadly diagnostic terms, such as 'Personality disorder' or 'Eating disorder', the actual entry and exclusion criteria often depend as much on severity ratings as on these categories. Thus, services typically rely on qualifying statements such as 'distressing hallucinations or delusional beliefs of sufficient intensity and frequency' or 'mild or moderate social and/or functional impairment'. In Early Intervention teams, the requirement may be explicitly based on not currently meeting diagnostic criteria, but on experiencing certain 'symptoms.' Similarly, acceptance into CMHTs is typically decided by qualifiers such as 'severe and persistent' or 'complex and enduring' or 'causing substantial disability.' One Trust explicitly stated: 'Decisions on whether someone should be accepted for services are based on their health and social care needs as a whole and not on diagnosis

alone'. In other words, and contrary to what is sometimes claimed, service commissioning and entry criteria do not have to rely on diagnostic categories, either partially or wholly, and in practice, frequently do not do so. The same is true of forensic services, where risk is likely to be the deciding factor. Where diagnoses are mentioned, they appear to function largely as a proxy for levels of severity or risk, or for the likelihood of benefiting from particular professional competencies.

As discussed under 'Access to social care, housing and welfare benefits' below, the implication is that it would be relatively simple to replace medical terms with non-medical ones such as 'experiencing temporary and enduring or regularly occurring severe mental distress', with no assumption that these states constitute an 'illness'.

In general, then, the HWB board structure in combination with flexibility within commissioning practices allows for a change of emphasis towards seeing emotional and behavioural difficulties as needing input from a combination of public health, social care and psychotherapeutic services rather than medical ones, and setting up services not based on diagnostic categories. An example is seen in a project promoting psychologically-informed environments in hostels for the homeless in Lambeth. A combination of NHS, LA and charitable funding allowed psychologist Emma Williamson and her team to introduce psychological principles into all aspect of the hostels' functioning, leading to significant reductions in emotional distress, drug and alcohol use and criminal behaviour and increased ability to maintain tenancies (Williamson & Taylor, 2015).

Similarly, education, social services and the criminal justice system do not rely on diagnosis for planning and commissioning, but on the identification of problems, level of need, and the evidence-base for available services, none of which has to be diagnostically-based. National/Regional surveys of any or all of the dimensional constructs discussed above can be used to determine the need for a range of services within a given locality or region.

Within the PTM Framework, the boundaries suggested by diagnostic groupings, however they are defined, do not exist, and as described below, very different service design principles are implied.

Assessing general levels of need in a population

As is often already the case, determining the overall level of need in a given population should take into consideration levels of poverty which, statistically, is the strongest predictor of mental health problems, partly through its impact on rates of violence, trauma and abuse (Read, 2010; Read, Johnstone & Taitimu, 2013) and also through the many other processes discussed in Chapter 4. The surveys (above) of the prevalence of ACEs in England, Scotland and Wales, give a more detailed picture. As described at the start of the chapter, ACEs have been used in Australia and the USA to estimate lifetime costs of childhood adversity. The Foundational Pattern (Chapter 6) could also be adapted for various general purposes at a population or community level such as estimating the lifetime cost of adversities; estimating the likely prevalence of complex mental health problems in a given population; planning the most effective prevention strategies; informing health strategies and priorities; and so on. The population-based Adult Psychiatric Morbidity Surveys which are carried out around every seven years also provide important information linking demographic information to mental distress (see NHS Digital <https://digital.nhs.uk>). Allsopp and Kinderman (2017) have pointed out that even

within existing *DSM* and *ICD* classification systems, the psychosocial codes that document neglect, abandonment, homelessness, poverty, discrimination and so on, could be used for the more systematic collection of information about the social determinants of mental health problems.

In England, the REVA (Responding Effectively to Violence and Abuse) project has used Department of Health data to map the relationship between violence, abuse and mental health presentations. Similarly to the ACE studies, they found strong and consistent relationships, with people in the 'extensive physical and sexual abuse' group about 15 times more likely than those with little experience of violence and abuse to meet the criteria for three or more mental disorders (Scott et al., 2015c). They recommend that 'Commissioners of both health and crime related services need to be acutely aware of the links between interpersonal violence, abuse and mental health and the related needs of the population and fund accordingly rather than just on the basis of either criminal justice outcomes or health outcomes' (Scott et al., 2015a, p.9). Similar points about commissioning are made in 'Commissioning services for women and children who are victims of violence: a guide for health commissioners' (Department of Health, 2011a) and 'Securing excellence in commissioning sexual assault services for people who experience sexual violence' (NHS England, 2013). Identification of need does not guarantee funding, but may at least help to indicate where the priorities lie and how the money will be best spent.

It has been argued that commissioning incentives need to change so that community-based preventative initiatives are also rewarded (Harper, 2016).

Service design: Clustering and care pathways

In England, Care Packages and Pathways, a model for grouping adult and older adult service users with similar needs, was introduced in 2012. The Mental Health Clustering Tool, partly based on HONOS (Health of the Nation Outcome Scales) is used to match individual service users to the most appropriate cluster. Higher clusters within the 3 broad categories of 'non-psychotic', 'psychotic' and 'organic' represent greater severity, levels of need and disability. Each of the 20 'care clusters' suggests packages of appropriate evidence-based interventions, based on NICE and other approved guidelines. Each cluster represents a different pricing tariff and review period, with pricing reflecting the amount of time and resources likely to be needed to care for a person categorised under that cluster. This is then costed for contracting purposes via Payment by Results. The aim is to enable commissioners, service managers and providers to determine what care is needed, who is needed to deliver it, how much it will cost, and how services can be designed to deliver the packages efficiently and effectively. Versions have also been developed for Child and Adolescent, Intellectual Disability and Forensic services (Cohen-Tovée, 2012).

CPP has been found to be unsatisfactory on a number of grounds. The clusters cut across diagnoses in a tacit admission that these categories do not (unlike in general medicine) provide a valid basis for grouping similar problems together or indicating treatment. As a result, clusters consist of a confusing mixture of diagnostic categories and levels of need/severity/complexity (mild, severe and so on.) Although they are not solely diagnostically-driven, there is a diagnostic division between clusters 1 to 8 (excluding 'psychoses') and 10 to 17 (people with 'psychoses.')

In addition, since evidence as summarised by NICE is based

on diagnoses, each cluster suggests a very complex mix of possible interventions with little cluster specificity. This selection of recommendations, while containing useful elements, is open to all the criticisms about current hierarchies of knowledge, limitations of RCTs, lack of applicability to real-life settings, and marginalisation of service user feedback and experience. About 10 per cent of service users do not fit clearly into any cluster (Cohen-Tovée, 2012) and practitioners report making arbitrary decisions about where to place them. Finally, it is clear from this document (and from existing practice) that there can be no such thing as a specific prescribed care package for a specific individual, whichever cluster they fall under. Needs can only be decided on the basis of individual assessment and will be different for each person regardless of cluster or diagnosis.

Further confusion arises when clusters are translated into practice. In England, AMH services are now grouped into pathways. Sometimes these are based on clusters, or combinations of clusters; sometimes they are based on diagnosis; and sometimes the solution is something in between, or is based on a new set of designations altogether. In addition, each pathway may be further divided into early intervention, acute care, complex care, and so on. What these attempts have in common is that none of them work satisfactorily in practice. People's difficulties and needs cut across these new groupings just as much as across diagnostic ones. Arbitrary decisions have to be made about which 'symptoms' trump other ones, and expertise is fragmented across the service.

Cohen-Tovée (2012) has suggested ways in which the CPP model, despite its limitations, can be used to commission psychological services based on need and biopsychosocial formulation rather than on diagnosis. The Division of Clinical Psychology (DCP, 2013a) subsequently contributed to work matching recommended psychological interventions to clusters. It proposed a three-level framework consisting of Generic interventions, Condition-specific interventions and Complex interventions, defined as follows:

'Generic interventions... are targeted at populations of people (e.g. people with mental distress) where broad psychological principles from generic psychological theories are applicable to large groups of people. This level covers low intensity interventions within the IAPT framework. Condition-specific interventions... involves the application of specific psychological theories for the amelioration of specific conditions (e.g. cognitive therapy for depression), and encompasses manualised treatment approaches. This level covers the high intensity interventions with the IAPT framework. Complex/Multi-modal interventions... involves the application of theories which go beyond addressing a specific condition/diagnosis, and allow for a more detailed understanding of the personal meaning of experiences. Practitioners at this level may be working in an integrative approach, calling upon different theoretical perspectives as appropriate' (DCP, 2013a).

The DCP suggests that these three levels of intensity can operate across clusters (and diagnoses) and can be matched to the skill levels of staff, with the highest level being driven by individual formulations.

The PTM perspective suggests a modified and simpler version of these principles (applicable slightly differently in Health settings, where the intervention itself may be the current and unavoidable cause of a traumatic reaction; and in Dementia Care, Neuropsychology and other services which work with cognitive impairment.) Shared narratives or formulations based on PTM principles would not be reserved for the highest

level but would be the starting point for everyone. The next step, ‘Generic interventions’, would encompass Stage 1 education and stabilisation skills, along with attention to financial, material and social circumstances, offered to all service users in whatever combination was helpful to them. This would include group or individual strategies for particular problems or difficulties described in non-medical, ordinary language terms such as ‘Coping with anxiety’ or ‘Unusual beliefs’ or ‘Low mood’ or ‘Eating Distress’ or ‘Flashbacks’ and so on. Stage 2 in-depth therapeutic interventions, group or individual, would then be offered to those who wished to use them, including trauma-processing work if appropriate. Some of these interventions could be based on the experience of particular adversities (e.g. groups for survivors of sexual abuse or domestic violence). Stage 3 Integration would, like Stage 1, be a core aspect of all professional roles. At all stages there would be attention to financial and social needs, and close links with self-help and voluntary organisations. At no point would a diagnostic category be necessary. A possible model is seen in the Clinical Pathway for Trauma at Tees Esk and Wear Valleys NHS Foundation Trust (Sweeney et al., 2016; and see Appendix 7 in the Overview publication).

The suggested model is not one of pathways or clusters, but of a ‘menu’, in which everyone will make a personal selection from a wide range of ‘starters’, and most will then make a further choice from a more indepth selection of ‘main courses.’ An example of this kind of structure in MH inpatient services is provided in Clarke (2015).

Electronic records

Every person using health care systems will have an electronic record (ECR) containing clinical information, care and outcome data. If there is no space for non-diagnostic ways of describing people’s difficulties, such information will not be taken into account in analyses and service decisions. Michael Berger (2013) and Ben Donner (2014) have discussed some of the complex implications for psychological models and approaches. Berger suggests, for example, that there are various ways of extracting information from free-text input such as formulations (Berger, 2013, Appendix 1). However, much work remains to be done on incorporating psychological, as well as psychiatric, aspects of care into the electronic records (BPS, 2011) although some recording systems, such as Rio, provide a space for formulations as well as for diagnoses. There is no reason in principle why this should not be available in all systems.

Service outcomes

An outcome measure is a measure of the quality of care, judged at the end point of the intervention. ‘Outcomes are the results people care about most when seeking treatment, including functional improvement and the ability to live normal, productive lives’ (The International Consortium for Health Outcomes Measurement (ICHOM) www.ichom.org). Information about outcomes is needed in order to commission and plan the most effective services, evaluate interventions, identify shortfalls and gaps, establish which interventions are appropriate for which problem, and develop local and national benchmarks for best practice. The NHS Outcomes Framework (NHS Outcomes Framework, 2014) sits alongside the outcomes frameworks for adult social care (Department of Health, (2013) and public health (Public Health England, n.d.). PROMS are patient reported outcome measures; PREMS are patient reported experience measures; and CROMS are clinician rated outcome measures.

A follow-up document to the 'Five Year Forward View for Mental Health' recommends a combination of national and local measures, with the latter used flexibly to reflect the needs and priorities of the local population (NHS England and NHS Improvement, 2016). In AMH, and due to apply in the longer-term to child and adolescent mental health, intellectual disabilities, forensic and perinatal mental health as well, it emphasises that social outcomes and personal life goals such as employment, education and housing status may be more meaningful than a more limited focus on 'treatment' and 'symptom' outcomes. Its definition of the term 'Expert by experience' includes 'mental distress is a meaningful human experience, and... it is for the individual to make sense of their own experiences within the context of their personal story' (p.22). No specific outcome measures are suggested, or exist, to assess the degree to which this is respected, especially in relation to a possible preference for non-diagnostic understandings. Presumably, though, there could in principle be a local CQUIN (Commissioning for Quality and Innovation) target for such an outcome, given a sufficiently forward-looking organisation.

Overall, then, it is increasingly recognised that outcomes in mental health and related services expressed in terms of 'symptom reduction' do not necessarily relate to social or functional outcomes, i.e. the ability to live your life. This implies dimensional rather than categorical approaches, based not on diagnostic categories but on the levels of functioning and well-being that are most relevant to service users. Dimensional measures allow for the fact that 'milder' mental health difficulties, such as anxiety, can be just as disabling as more 'severe' ones. They also fit with a broader shift within mental health service policy from an emphasis on 'treatment' to reduce 'symptoms', to a more holistic approach which takes into consideration well-being, recovery, personal goals, social functioning, and quality of life.

There is a large range of non-diagnostic outcome measures to choose from (see examples in NHS England and NHS Improvement, 2016). The GAF Global Assessment of Functioning (GAF), is a 0 to 100 scale for recording the overall impact of 'symptoms' on social and occupational function. *DSM-IV* also included (in the 'For further study' section) two other dimensional measures: The Global Assessment of Relational Functioning (GARF), and The Social and Occupational Functioning Assessment Scale [SOFAS] scale (Goldman et al., 1992), which looks at social and occupational functioning rather than 'symptoms'. The GAF, GARF and SOFAS all have high levels of inter-rater reliability (Hilsenroth et al., 2000), and are quick and easy to administer. There is a measure that replaced GAF in *DSM-5*, the WHO Disability Assessment Schedule (WHODAS 2.0), which assesses 'Cognition, Mobility, Self-care, Getting along, Life activities and Participation'. This too has excellent reliability and functionality (WHO, 2016).

Another possibility is the use of dimensional Quality of Life (QoL) measures (Connell et al., 2014), already frequently used in general health settings. Some of these QoL measures have been explicitly developed as an alternative to, or extension of the diagnostic focus on symptoms and categorisation (Hogan, 2003; Department of Health, 2011b). Possibilities here include the World Health Organization Quality of Life Instruments (Skevington et al., 2004) and the Assessment of Quality of Life instruments (Richardson et al., 2013). In the Intellectual Disability field, there have been various attempts to develop outcomes relevant to the goals and aspirations of service users, for example, goal-attainment scaling; the Ridgeway Routine Outcome Measure (Weston et al., 2011).

Given the evidence that emotional distress and troubled or troubling behaviour arise in response to adversities, relevant outcome measures should be designed accordingly. For example, PROMS have been developed in conjunction with women and children who have been victims of violence. These cover areas such as Being Healthy; Staying Safe; Enjoyment and Achievement (Department of Health, 2011b). Similarly the Supporting Survivor Outcomes (SSO) tool has been developed in conjunction with mental health service users who are survivors of violence and abuse. It includes a range of measures that apply both to service users and to the services themselves, both statutory and voluntary (Scott et al., 2015d). The SSO goes beyond 'clinical' outcomes to encompass other important aspects of functioning and wellbeing that may be negatively impacted by violence and abuse.

A further possibility is to focus not only on what is missing/wrong but to assess what is *needed* (Thornicroft, 2003), and to allocate and evaluate services on that basis. Such a focus has the obvious advantage of addressing whether or not a particular service is able to address the need(s) in question. The Camberwell Assessment of Need (CAN) (Phelan et al., 1995), which can be administered at varying levels of detail/complexity, addresses 22 domains of social and health needs. Although more often used to assess the needs of people who have already entered a service, it could also be used as part of the process of determining who should receive the service in the first place. It has been adapted for specific groups with mental health problems, such as older people, people with intellectual difficulties, and mothers and pregnant women. It can also be used to assess the perspectives of service user, family member and staff.

Given the recent emphasis on Wellbeing and Recovery, there is a growing literature on how to assess outcomes in these terms. Some recommendations for relevant outcomes include the extent to which service users feel they have achieved their personal goals; have an increased sense of hope, control and opportunity beyond illness (sic); have a better quality of life; and are being supported by staff (ImROC, 2014). The briefing lists a range of suitable assessment measures, including relevant PROMS, PREMS and Quality of Life instruments. Any or all of the above measures could be used or adapted for the purposes of deciding access level and type of need in relation to mental health services. In fact, such decisions are not necessarily based on diagnosis at present, as already discussed.

Social return on investment (SROI) is a technique that allows commissioners to calculate the overall social benefit of investment in a service, beyond the immediate service outcomes. These measures are particularly important given evidence about the impacts of adversities across all areas of health, welfare, education, and the criminal justice system (www.sroi-uk.org). From a public health perspective, measures of general wellbeing may be just as important as those related to the prevalence of specific 'disorders'. 'Better Mental Health for All' (Faculty of Public Health, 2016) lists a range of sources of data on community measures of factors such as social isolation, social capital and connectedness, life satisfaction, and so on.

In summary, the outcomes literature has already moved some distance away from 'symptom' reduction and diagnostically-based measures in recognition of the fact that these have little meaning in terms of people's everyday goals and lives. Instead, there is a welcome emphasis on designing outcomes based on what service users actually value most, including some useful measures about the impact of the adversities that bring people into services in the first place. However, medical terms have not disappeared; for

example, recovery measures use the language of illness alongside non-medical terms like wellbeing. In general, there is little recognition that outcomes may actually be worsened by interventions based on inappropriate medicalisation; that receiving a diagnosis may itself have caused or compounded distress; or that ‘illness’ narratives are not the only kind.

Access to social care, housing and welfare benefits

Local Authorities and government departments make gatekeeping decisions about whether people are eligible for welfare benefits, social care services and housing. It is essential that non-diagnostic approaches do not restrict access to these much-needed resources. However, as with mental health services, assessments of eligibility and rights do not have to be, and are not always, diagnostically-based.

In the current system, eligibility and rights are based on a number of fairly imprecise concepts. For example, social care funding under the Care Act 2014 will be granted if adults have needs due to a ‘physical or mental impairment or illness’ which prevents them achieving two ‘outcomes’ which have ‘a significant impact on the adult’s wellbeing’. The terms ‘physical or mental impairment or illness’ are not further defined within the legislation.

Welfare benefits because of inability to work are based on a ‘Work Capability Assessment’ which assesses how ‘health conditions, illnesses and disabilities’ impact on day to day functioning. GPs and other relevant professionals need to confirm this condition, illness or disability. Applicants then need to outline how this affects their ability to manage certain situations including ‘learning to do tasks’, ‘awareness of hazards and dangers’, ‘coping with changes’, ‘going out’, and ‘coping with social situations’. A face-to-face assessment then follows. Specific benefits such as PIP (Personal Independence Payment – the replacement for Disability Living Allowance) are granted if it is accepted that the individual has a ‘long-term health condition or disability and difficulties with activities related to daily living and or mobility’.

The Equality Act (2010) states that ‘a person has a disability if he or she has a mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities’ (p.4). ‘Mental Impairment’ is not defined: ‘The term... should be given its ordinary meaning’ and ‘it is not necessary for the cause of the impairment to be established, nor does the impairment have to be the result of an illness’. However, the guidance does then go on to say ‘a disability can arise from a wide range of impairments which can be... mental health conditions with symptoms such as anxiety...and mental illnesses such as depression and schizophrenia’.

Housing is provided by the local authority for people who are in ‘priority need’. One of the reasons you may be in priority need is if you are considered to be ‘vulnerable’ which in turn may be ‘as a result of old age, mental illness or handicap’.

In summary, it is clear that the current systems of rights and welfare entitlements is not based on specific qualifying diagnoses, but on a handful of problematic constructs, the central of which is ‘disability’, which is further defined by reference to ‘Mental impairment, illness and condition’. These function in a straightforward binary fashion; they are either present, or they are not. If they are present, then other, more complicated matters largely concerned with ‘functioning’ are considered. If the constructs are considered not to

apply, then any further processes of analysis is pointless. Policy appears to be based on the assumption that ‘illness’, ‘condition’, and ‘impairment’ are relatively interchangeable and refer to versions of the same thing. If people can prove the presence of these through professional confirmation, they will be able to gain basic entry into a system that will further assess the relevant functioning (e.g. ability to work, ability to achieve outcomes, ability to carry out tasks, the way that inadequate or non-existent housing impacts on the ‘illness’). The system will then also provide money, support or alternative housing and give people the right not to be discriminated against and to have access to the same facilities as everyone else.

At the moment, professionals who are reluctant to diagnose do manage to assist people to obtain support and benefits by a process of omission – neither saying that someone does have a specific diagnosis/impairment/disability, or that they do not. If a CMHT makes a referral to a local authority for a care act assessment, for example, saying that someone is hearing voices and that this is linked to traumatic experiences and having a significant impact on their functioning, then the care act assessment will proceed with no great consideration of, or further reference to, any ‘impairment’. Crucially, there is usually an unquestioned assumption that anyone who receives the services of a CMHT has a ‘mental impairment’.

The situation is very similar with regard to welfare benefits. A note may be required by a doctor that someone is too ‘ill’ to work, but the details that are written within the note are not central. If a professional has filled out a disability benefit form with a detailed description of the impact on daily functioning, the benefit decision makers will again in all likelihood assume that ‘impairment’ and ‘disability’ are present because, in their view, anyone receiving the service of a mental health team has a mental health problem which is a disabling impairment. While the underlying assumptions are still medically-based, there is no need to invoke any specific psychiatric diagnosis.

Given that diagnostic terms are largely irrelevant to the decision making process once the presence of a ‘mental health condition’ has been confirmed by a professional, it would be relatively simple to replace medical terms with non-medical ones. For example, we could deploy something like: ‘Experiencing temporary and enduring or regularly occurring severe mental distress’. GPs already do something similar when they sign sicknotes confirming that someone is suffering from a non-specific condition such as ‘stress’ or ‘exhaustion’. ‘Severe’ could also necessitate ‘enduring’ or ‘regularly occurring’, to exclude people where the distress is very fleeting. However, there should be no assumption that these states constitute an ‘illness’ that is permanent and unremitting; as Slade and Longden (2015) point out, people can be not just ‘in remission’ but ‘well’. They also recommend that it should be possible to record disagreement with one’s diagnosis on claim forms without jeopardising entitlements. The same terms and procedures could also be used to confirm vulnerability in relation to social care and housing needs.

The strategies above are still predicated on a deficit based system, under which people have to define themselves as ‘incapable’, ‘impaired’ or ‘different’ in order to receive certain rights and supports. A more radical alternative is the idea of a universal basic income, which replaces means-tested welfare with a single, universal payment that every citizen is entitled to. One of its aims is to ensure that all citizens have a better chance of accessing the basic resources to cope with periods of extreme distress without needing to demonstrate that they

are ‘impaired’. A report by Psychologists for Social Change (2017) concluded that the UBI has potential for improving psychological health and wellbeing and reducing emotional distress and is likely to have a significant impact on the social determinants of mental health and on the five psychological indicators of a healthy society, namely security, connection, meaning, trust and agency. There have been trials of this idea in Canada, Finland and India. There are current projects in Utrecht and several other Dutch towns, and schemes are under discussion in Scotland, Canada and Switzerland. However, depending on factors such as the level of income that is allocated and how the scheme is funded, it could turn out in practice to be much less progressive than it appears (Recovery in the Bin, 2017).

This idea links with the growing field of ‘Asset based community development’ (ABCD) both in the UK and internationally (www.abcdinstitute.org). By focusing on assets instead of deficits (‘Shifting from what’s wrong to what’s strong’) the task changes from assessing disability and need, to the question of how to build communities that genuinely welcome people who are most marginalised, and how to use their gifts and talents. In such a system, mental health service users and others facing particular struggles are seen as active citizens rather than passive recipients of care, and they are assisted to offer all they can to communities, rather than asked for descriptions of what they can’t do. Despite the ever-present danger of devolving responsibility for the impact of social adversities down to its victims, this movement may have useful lessons for social policy.

A recent survey found much support among service users for a universal rights, asset-based perspective as an alternative to the humiliating requirement to demonstrate enough impairment to access essential financial support (Beresford et al., 2016). Interviewees also suggested that a benefits system based on a social not a medical model would challenge rather than compound the hostility and discrimination towards people who use mental health services, and that valuing their goals and contributions would open up voluntary work as a valid option without the fear of losing benefits (pp.53–54). The universal right to a basic income could remove much of the fear, shame and desperation that is caused when people are forced to depend on welfare.

Educational support

Children who have special educational needs can access extra support through assessment by a SENCO (Special Educational Needs Co-ordinator) on behalf of the local authority. This is based on reports from relevant others, such as teachers or GPs, who know the child. Diagnosis is not essential to the process, since the decision is mainly based on a functional assessment of communication skills, social or emotional difficulties, and so on. Various forms of support may be made available as a result, including an EHC plan which brings the child’s education, health and social care needs into a single, legal document. The assessment may or may not include a diagnosis (physical or mental) but there is no assumption that children with special educational needs necessarily have a ‘disability’ as well. There is therefore scope for making recommendations on the basis of problems rather than mental health diagnoses (Department for Education, 2014).

Therapy and therapeutic interventions

Not everyone wants or needs formal therapy. For many, the most essential ingredients will be non-specific factors such as staff who can offer a consistent, supportive, trusting

relationship rather than therapy as such, along with ordinary life solutions such as meaningful activity, social groups, job opportunities, practical support, help with housing and benefits, and so on. Others will continue to find the best forms of support in non-statutory and service-user-led organisations, including culture-specific and community projects. Within statutory services, emphasis on individual therapy as the main or ideal mode of intervention needs to be balanced with encouragement for more ‘bottom-up’ rather than expert-driven ‘top-down’ approaches, such as supporting the development of self-help and peer support groups. The PTM Framework suggests, as community psychologists have argued for many years, that this should include looking at people’s experiences of power and powerlessness in relation to both the immediate circumstances of their lives (work, education, housing, social networks, etc.) and the more distant ones (economics, politics, and culture; Tew, 2005). As noted above, we also need to acknowledge that psychotherapy, like any intervention, can be carried out in ways that are unhelpful, re-traumatising and even abusive (Barlow, 2010; Jarrett, 2008).

From a PTM perspective, the problem is that therapy is too often superimposed upon the basic ‘disorder’ model of medical positivism, and thus secondary or subordinate to it. Thus, we have brand name therapies for ‘borderline personality disorder’, ‘psychosis’ and so on. While these may have useful aspects, the disempowering messages of a psychiatric diagnosis can undermine the helpful aspects of therapy (Honos-Webb & Leitner, 2001). In fact, there is evidence that different models of therapy tend to produce broadly similar outcomes (Luborsky et al., 2002; Paley & Lawton, 2001). This is likely to be because the therapeutic alliance, based on core therapeutic conditions of empathy, warmth and authenticity, has repeatedly been identified as the most important aspect and agent of change in any therapy (Sparks et al., 2008). The suggestion of a core set of attitudes is supported by the finding that experienced therapists from different theoretical orientations resemble each other more closely than novices trained within the same approach (Luborsky et al., 2002). The most effective therapists seem to be those who work hardest to maintain a good therapeutic relationship (Okiishi et al., 2003) and the best outcomes are found when there is ‘fit’ between the therapeutic approach and the client’s theory of change and subjective meanings (Robinson, 2009; and see Appendix 3 in the Overview publication).

This research strongly suggests that attention to the quality of the therapeutic relationship should transcend ‘brand wars’ in which approaches which are the best fit with the current biomedical and research paradigms are championed at the expense of others which are based more on narrative, dialogue, relationship and evolving meanings. In other words, research and training should change its focus to ‘empirically-supported relationships’ rather than ‘empirically-supported treatments’ (Paley & Lawton, 2001). The implication is that ‘therapies are co-created... therapies cannot be boxed, copyrighted or manualised before the patient is seen’ (Crittenden, 2006, p.113). The trauma-informed model similarly argues that therapists need to function primarily as attachment figures who can offer reparative witnessing, processing and healing (Crittenden, 2006; Herman, 2001). Trauma-informed therapy is relatively new within the UK (Sweeney et al., 2016) although in Scotland, the Matrix, a guide to delivering evidence based psychological therapies, includes a section on Complex PTSD (NHS Education for Scotland, 2015). However, from a PTM perspective, a range of therapeutic models can be of use if seen within a wider PTM Framework. For example, although CBT has been criticised for its individualistic

assumptions (Moloney & Kelly, 2008; Proctor, 2008), it can be practised in a way that acknowledges the central role of relationship factors and social factors (Gilbert, 2004; Hagan & Donnison, 1999; Strong et al., 2008) as well as intersectionality with gender and 'race' (Haarmans et al., 2016). Even in its simpler forms, it may offer useful tools and strategies in Stage 1 Stabilisation work.

The PTM perspective also implies the need for much greater emphasis on, and integration of, a social inequalities perspective within therapy (Smail, 2001). Some examples were given in Chapter 2 under 'Social Justice Approaches' and include feminist therapy (e.g. Watson & Williams, 1992); narrative approaches (see Appendix 9 of the Overview publication); and other therapeutic approaches informed by community psychology and its core values of liberation, empowerment and social justice (McClelland, 2013). Well-known examples of putting these principles into practice include Hagan and Smail's Power-mapping (Hagan & Smail, 1997a and 1997b, and see Appendices 8, 13 and 14 in the Overview publication) and Sue Holland's work with inner city women (Holland, 1995). Work has also been undertaken to embed this perspective within therapeutic models including CAT (Brown, 2010) and CBT (Hays & Gayle, 2006). Another welcome development is a randomised control trial into Open Dialogue across four NHS trusts, led by University College London (<http://www.nelft.nhs.uk/open-dialogue-pilot>.)

Intercultural therapy (Kareem & Littlewood, 2000; Thomas, 1992) is a rapidly expanding field, offering holistic and non-European perspectives that may be missing from more traditional therapies. For example, African Centred Therapy is based on the philosophy of Ubuntu, or the interrelatedness of all humanity, the universal life force, and the capacity for self healing, and is practised with an awareness of all forms of oppression <http://www.pattgifttherapy.org/therapies/> Integrated examples are emerging: for example, Family Constellations work draws on Zulu worldviews and Western existential traditions in order to address intergenerational trauma (Cohen, 2006). More broadly, the discipline of Indigenous Psychology supports culturally appropriate healing as a reaction to the hegemony of Western psychological theories and practices (Dudgeon & Bray, 2016). Therapists trained in Western models are urged to respect, inform themselves about and work alongside their clients' indigenous belief systems (Sue & Sue, 2008).

As described above, the three-stage model of Safety/Stabilisation, Processing, and Integration, offers an over-arching structure for therapeutic interventions within services. Within this, a wide variety of therapies, supports and strategies can be offered on a non-diagnostic basis. Stage 1 may be achieved through a personalised combination of strategies such as soothing and self-care, grounding, mindfulness, meditation, exercise, compassion-focused therapy (Gilbert, 2013), visualisation, and so on, as well as more orthodox CBT skills (McFetridge et al., 2017). Specific strategies and interventions for living with hostile voices or unusual beliefs, managing mood swings, coping with dissociation, and so on may also be useful. In line with the recognition of the impact of adversities on the body, body-oriented therapies are increasingly seen as ways to promote integration, along with creativity through art, music and dance (Blue Knot Foundation, 2012; van der Kolk, 2014). Stage 2 may be achieved through a range of individual and/or group therapies within services, or peer/self-help groups outside services. Stage three, integration, encourages reconnecting with people, meaningful activities, and communities, and rebuilding of lives in line with one's goals and values.

The shared development of a story, narrative or formulation, guided by the PTM Framework, can serve as a starting point which will evolve throughout the person's contact with services.

IAPT (Improving Access to Psychological Therapies)

Recent moves to co-opt therapies and therapists for overtly political aims such as getting people off benefits and back to work, are difficult to reconcile with therapeutic principles. This, along with siting Improving Access to Psychological Therapies (IAPT) workers in Jobcentres, is one of the more controversial aspects of the IAPT programme. The redefinition of employment as a positive 'clinical' outcome is at odds with the evidence that insecure and poorly paid jobs are a cause of, not a cure for, emotional distress (Butterworth et al., 2011). A recent report suggested that unemployment is being rebranded as a psychological deficit, with psychological interventions being introduced to promote more 'positive' attitudes and behaviour in benefit claimants (Friedli & Stearn, 2015, and see also Chapter 2). The BPS has expressed serious concerns about these developments (BPS, 2016a). In February 2017 the BPS joined with other psychology organisations in a call to the Government to suspend its benefits sanctions system, because of impacts like 'destitution, hardship, widespread anxiety and feelings of disempowerment' (BPS, 2017).

The IAPT project as a whole has been described as perhaps 'the biggest shift in policy in UK mental health service provision in the last 50 years (Radhakrishnan et al., 2012, p.37). In 2006, a Centre for Economic Performance report put forward the tautologous argument that 'crippling depression and chronic anxiety are the biggest causes of misery in Britain' (p.1). This reification of states of human misery lent itself to a manualised and diagnostically-based approach to distress which has attracted criticism (e.g. Marzillier & Hall, 2009). Despite optimistic predictions, and as a model for a large-scale response to distress, the results overall have been disappointing. Analysis of referrals which ended in 2015–2016 suggests that around 44 per cent of people assessed as suitable for the IAPT service, completed their scheduled treatment and that around 50 per cent either declined the treatment offered or discontinued it.¹ Analysis of outcomes in 2016 suggests that around 27 per cent of those entering treatment and who meet criteria for 'caseness', reach 'reliable recovery'; around 28 per cent 'move to recovery'. These are defined by test scores at treatment sessions rather than by longer term follow-up and may involve relatively small changes. The outcomes for those who 'finish a course of treatment' – defined as attending at least two treatment appointments – are better, with around 49 per cent 'moving to recovery' and 46 per cent achieving 'reliable recovery'. (Community and Mental Health team, Health and Social Care Information Centre, 2016, 2017)². However, the outcomes of all those who enter treatment, whether or not they continue, provide a clearer picture of the acceptability and efficacy of the programme as a whole. These figures also have to be considered alongside the possibility of 'spontaneous remission' or recovery without treatment. For example, a recent meta-analysis (Whiteford et al., 2013) suggested rates

¹ Several other types of reason are given for ending a referral in this group, including transfer to another or a non-IAPT service, death, or unknown. Hence the figures here do not add to 100 per cent.

² No data are available on the proportion of people who enter IAPT treatment 'at caseness', only for those who 'complete a course of treatment'. We have applied the latter figure to those who enter treatment because there is no reliable evidence that in therapy services generally the two figures are systematically different in one way or the other (Whiteford et al., 2013).

of ‘spontaneous remission’ from ‘depression’ of 23 per cent within three months, 32 per cent within six months and 53 per cent within 12 months, in groups broadly comparable to those accessing IAPT services. Another important comparison is with pre-IAPT services such as primary care or voluntary organisation counselling. Here again, the figures are not reassuring: costs appear to be lower and outcomes to be better, compared to IAPT (Timimi, 2015).

Similar concerns of acceptability and efficacy may apply to the next stage of the project, IAPT SMI (Serious Mental Illness), unless these lessons have been learned. Investment in psychosocial interventions for people with diagnoses of ‘bipolar disorder’, ‘psychosis’ and ‘personality disorder’ is very welcome, but the proposed roll-out of IAPT for these categories of ‘severe mental illness’ risks reinforcing an individualistic, diagnostic model with insufficient attention to the known causal effects of social policy and social and relational adversities. Instead, practitioners will be required to demonstrate fidelity to NICE guidelines for these ‘disorders’, with all the problems that are discussed below under ‘Research’. We have provided an example of delivering IAPT in a way that is less likely to fall into these traps (see Appendix 2 in the Overview publication).

Psychological formulation

As discussed in Chapter 6, the PTM Framework provides a set of principles and a possible structure for the co-construction of narratives and formulations, whether at an individual/family or team level. The General Patterns provide previously-missing summaries of the evidence-base for the regularities that can inform specific formulations. We hope that this will enrich the theory and practice of all varieties of narrative and help to minimise some of its inherent risks – for example, of individualising, cultural insensitivity, imposing ‘expert’ views, and downplaying the causal role of adversities, both relational and social (DCP, 2011). We also hope that this document, and future publications based on it, will serve as a resource for the construction of personal narratives by anyone who wishes to do so, whether in contact with services or not.

Psychological formulation can be defined as the process of co-constructing a hypothesis or ‘best guess’, drawing on research and theory, about the origins of a person’s difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them. From a formulation-based perspective, the work of every mental health professional should be based on the principle that however unusual, confusing, risky, destructive, chaotic, overwhelming, frightening or apparently irrational someone’s thoughts, feelings and behaviours are, there is a way of making sense of them. These principles are fully in keeping with a PTM Framework.

In the UK, formulation has the advantage of familiarity within services, several professions who claim it as a core competency, and a small but growing amount of research and evaluation supporting its benefits (Araci & Clarke, 2016; Berry et al., 2009; DCP, 2011). It is now a core skill for all mental health and related professions in the revised Mental Health Core Skills Framework (Department of Health, 2017). Formulation is used by all Adult Mental Health, Child and Adolescent and Forensic clinical psychologists and also provides a more holistic understanding within Intellectual Disability, Older Adult and Health settings, where a medical or neurodevelopmental condition may be the main focus of intervention (DCP, 2011). As such it is well-placed as a platform for promoting

alternatives to functional psychiatric diagnoses within existing systems. The Division of Clinical Psychology recommends it as one, but not the only, alternative to functional psychiatric diagnosis (DCP, 2013b, p.9). The DCP ‘Good practice guidelines for the use of psychological formulation’ (2011) make an important distinction between psychiatric formulation – an addition to a psychiatric diagnosis – and psychological formulation – an alternative to a psychiatric diagnosis (p17). The practice of team formulation is increasingly common in adult mental health services, and to a lesser extent, in Older Adult (Dexter-Smith, 2015), Intellectual Difficulty (Ingham, 2015), Child and Adolescent (Milson & Phillips, 2015), forensic (Lewis-Morton et al., 2015) and Health (Cole, 2013) settings (see Appendix 4 in the Overview publication).

Feedback from service users suggests that while formulation is often experienced as increasing understanding and trust, as empowering, as a relief, and as enabling them to move forward (Redhead et al., 2015), it can also be experienced as saddening, frightening or overwhelming (Chadwick, Williams & Mackenzie, 2003; Morberg Pain, Chadwick & Abba, 2008). Offering a formulation-based understanding of one’s difficulties can feel less legitimate than a diagnostic one (Leeming et al., 2009). Best practice principles for the process of formulating emphasise the importance of collaboration; being respectful of service users’ views about accuracy and helpfulness; using ordinary and accessible language; taking a non-blaming stance; and including strengths and achievements (DCP, 2011, pp.29–30). Professionals are expected to take a reflective stance which reduces the risk of using formulation in insensitive, non-consenting or disempowering ways (DCP, 2011, p.21). We need to know more about the acceptability of both individual and team formulation to service users, along with the possible impacts on measures such as use of medication, number of admissions, recovery rates and so on (Cole et al., 2015). We also need to be aware that since psychological models inevitably draw from wider societal discourses, formulations can be used, whether intentionally or not, to mystify and reinforce entrapment as well as to enlighten and empower (Grant, 2015; Johnstone, 2013). Formulation itself is a Western concept that may make little sense within different cultural settings (DCP, 2011, p.18).

It is probably not a coincidence that formulation, and debates about its role, have achieved growing prominence in the wake of the challenges to psychiatric diagnosis (e.g. Craddock & Mynors-Wallis, 2014). Vigilance is needed to promote, protect and develop those aspects of formulation and formulating that run counter to medicalisation and psychiatric diagnosis. This includes the risk of re-packaging narrative and meaning-making, which are universal human activities and attributes, into uniquely professional skills.

The main purpose of psychological formulation aligns with the key message of this document: to restore the meaning in madness and distress, on the basis that these experiences are, ultimately, understandable human responses to unbearable situations. As already noted, this position does not align in any simple way with professional background, and members of the Critical Psychiatry Network have joined with clinical psychologists to urge ‘Drop the language of disorder’ in favour of a narrative or formulation-based approach (e.g. Kinderman et al., 2013; Timimi, 2014).

Medication

The question ‘Is there a role for medication?’ is frequently raised in response to critiques of diagnosis. The short answer is that psychiatric drugs will continue to have an important

role in alleviating many people's distress, and everyone should be offered the opportunity to make an informed choice about what works best for them. However, the broader picture is, as noted in a recent UN Special Rapporteur report on the right to health, of 'a bias towards first-line treatment with psychotropic medications, in spite of accumulating evidence that they are not as effective as previously thought, that they produce harmful side effects and, in the case of antidepressants, specifically for mild and moderate depression, the benefit experienced can be attributed to a placebo effect' (UN, 2017, p.6).

Informed choice depends on receiving comprehensive and accurate information in the first place, and the mode of action of psychiatric drugs needs to be understood and explained differently. The PTM Framework is consistent with psychiatrist Joanna Moncrieff's contrasting descriptions of the 'disease-centred' and the 'drug-centred' models of drug action. Medication development and use in general medicine often aims to reverse, partially reverse or compensate for, the assumed biological causes of disease and bodily symptoms (e.g. replacing the body's insulin supply, destroying cancerous tumours, killing bacteria, and so on). This 'disease-centred' model, while not always applicable in medical practice, does not apply at all within psychiatric practice because the diagnostic clusters give us no information about biological causes. Rather, the action of psychiatric drugs conforms to the 'drug centred' model, in that they have a range of general effects such as sedation or emotional blunting on both 'normal' and 'abnormal' states of mind (Moncrieff, 2008). In fact, claims that the drugs correct 'chemical imbalances' are rapidly being retracted by senior figures in the field (Pies, 2014). A more accurate analogy is drinking alcohol as a relief for anxiety in social situations, rather than, say, insulin to restore a physiological deficit. The PTM Framework suggests another analogy: intense grief after the death of a partner may be greatly relieved by short-term use of medication to aid sleep, but we would not describe this as 'treatment' for a 'disease'. Neither the PTM Framework nor the drug-centred model of action justify telling people that psychiatric drugs are essential to prevent or treat 'illness', or pressurising or coercing them into taking them against their will.

The drug-centred model acknowledges that the abnormal brain states induced by psychiatric drugs may be experienced as helpful by some people in some circumstances. Some service users have described being better able to cope with overwhelming anxiety or hostile voices. Others have described a difficult trade-off between beneficial and unpleasant effects (Carrick et al., 2004). Many have testified to unbearable feelings of emptiness, dread and agitation which may be worse than the difficulties for which the drugs were prescribed (Moncrieff et al., 2009). The problem is that although psychiatric drugs may help to control feelings and behaviour, this comes at a price, because they also block the systems that regulate engagement, motivation, pain, and pleasure (van der Kolk, 2014, p.225–227). Similarly, while these drugs can sometimes enable access to therapy or be of help in the initial stabilisation stage, they can also hinder longer-term therapeutic work by cutting off access to emotions and impairing motivation. Van der Kolk (2014) summarises the pros and cons of different classes of psychiatric drugs in working with people who have experienced adversities and traumatic events, and recommends a careful negotiation to determine what might be most helpful in particular situations. The principles of drug-centred prescribing are outlined in Yeomans et al. (2015).

Further implications of drug use within a PTM Framework are:

- Misleading terms like ‘antipsychotics’, ‘anti-depressants’ and ‘mood stabilisers’ should be abandoned since they do not describe the mode of action, and help to set the scene for automatic prescription in response to certain difficulties.
- Professionals urgently need up-to-date information about the emerging evidence of limitations and harms potentially caused by all classes of psychiatric drugs, and to receive training on the use of medication within a drug-centred model. This applies not only to psychiatrists, GPs and psychiatric nurses, but, as suggested in the 2008 NIMHE report ‘Medicines management: Everybody’s business’, to all professionals who work in settings where psychiatric medication is used. Any of these people may be inadvertently giving inaccurate messages or failing to challenge poor practice (NIMHE, 2008).
- Psychiatric drugs should be prescribed on the basis of fully informed choice, with service users as equal partners in the decisions (Deegan, 2007, 2010).
- Support to come off psychiatric drugs needs to be routinely available within mental health services, through information leaflets, professional advice, support groups and so on.
- Particular disquiet have been expressed about psychiatric drug use in Intellectual Disabilities to sedate, manage and control people (Public Health England, 2015). Similarly, the misuse and overuse of neuroleptics in Older Adults with dementia for the control of behaviour has been the subject of a Department of Health report (Bannerjee, 2009). In both these relatively less powerful populations, prescribing is common even in the absence of any psychiatric diagnosis, existing cognitive impairments are likely to be exacerbated, and lives may be shortened. This is a matter of urgent concern.

Adoption of these principles would be likely to lead to substantial reduction, and hence cost savings, in the use of psychiatric drugs, whether prescribed by GPs or psychiatrists. Even greater savings can be envisaged in the future, given the growing amount of evidence that all classes of psychiatric drugs may be less effective than has been assumed (e.g. Bentall, 2009; Kirsch, 2009; Moncrieff, 2015) and may actually increase disability over the long term (Viola & Moncrieff, 2016; Whitaker, 2010) up to and including brain degeneration and early death (Hutton et al., 2014). There is a curious reluctance to acknowledge the implications of the fact that prescribing rates are consistently far higher in areas of social deprivation, and the paradox that this massive influx of drugs does not appear to reduce the numbers of people diagnosed with ‘mental illness’ and claiming disability benefits in these communities; if anything, the trend runs in the opposite direction (Jorm et al., 2017; Viola & Moncrieff, 2016).

An encouraging recent development is the Norwegian Ministry of Health’s commitment to setting up psychiatric beds for people who want medication-free interventions, or to withdraw from medication. The first such unit has opened in Tromsø, with more to follow (Whitaker, 2017). This move has been influenced by the Open Dialogue’s successful use of reduced, short-term or no medication in ‘psychosis’ and its consistently better long-term outcomes (see Appendix 10 in the Overview publication).

The legal system

We have already discussed some aspects of the legal system within mental health services (see section on ‘Coercion’). However, diagnostic thinking is deeply embedded throughout

the legal system. As well as the law relating to mental health practice and services, this includes the criminal justice system, notably in relation to the ‘insanity defence’ and pleas of diminished responsibility; family and other civil courts, for example in relation to decisions about parenting or personal injury; and tribunals, where decisions may be made on detention, risk, and conditions of release. In line with this, requests for Court or Tribunal reports often ask for judgements about a person’s diagnosis or whether they have a ‘mental illness’ (Kinderman, 2014). The influence of diagnostic thinking partly reflects the cultural reach of medicalisation. It also reflects the fact that the legal system deals with questions of rationality, responsibility and justifiable coercion, of why people behaved in particular ‘abnormal’ ways, how they are likely to behave in future and what should happen to them as a result – questions that psychiatric diagnosis and the assumptions which surround it can seem to answer.

However, as we have seen, psychiatric diagnoses cannot explain or predict people’s actions or address questions of responsibility. Nor can diagnostic or non-diagnostic approaches answer moral questions about what *should* happen to people, whether they should be deprived of their liberty, ‘punished’ or ‘treated’. These issues are partly recognised within the legal system. For example:

- Although there are variations across jurisdictions, the law does not generally depend on particular diagnostic systems or criteria or even on diagnosis itself. However, the use of terms such as ‘mental disorder’, ‘mental disease’, ‘mental illness’ and ‘recognised medical condition’ does tend to suggest the question ‘Which disorder/disease/illness/medical condition?’ This was made explicit in the English Law Commission’s discussion paper on ‘Insanity and Automatism’ (Law Commission, 2013), where the Commission stated that its proposed defence of ‘not criminally responsible by reason of recognised medical condition’ would have to involve a diagnosis of a recognised medical condition.
- There is a strong assumption that ‘mental disease, disorder, illness’, and so on, can *cause* people to behave in certain ‘abnormal’ ways. However, the Scottish Law Commission’s discussion paper on ‘Insanity and Diminished responsibility’ (Scottish Law Commission, 2003) recognised that simple, direct concepts of causality were inadequate for explaining people’s actions and that the law must take account of mediating thoughts, feelings and psychological states. They suggested instead the concept of a ‘connecting link’ between a ‘mental disorder’ and criminal conduct. Although this still retains the idea of a ‘mental disorder’ or ‘mental illness’ influencing people’s behaviour, it could allow other forms of explanation.
- Within the justice system, it is the Court’s responsibility to make judgements on the basis of evidence presented, so that links between diagnoses of mental disorder and particular actions are not taken for granted.

All of this suggests that, in practice, the operation of the law does not necessarily require diagnosis or explanations based on it. Similarly, diagnoses are not obviously relevant to the questions actually posed by the law within the criminal justice system, mental health services, family courts and tribunals. These questions include capacity to give consent and make important personal decisions, capacity to parent, or manage finances; questions of extent of psychological harm, for example, from an accident; questions of cause in relation to socially unacceptable and apparently inexplicable actions; of how far someone

understands the meaning and likely outcomes of their actions and of their degree of control over their emotions or behaviour. There are also questions of the need for and availability of appropriate care, and the consequences of not providing it; questions of risk, that is, how someone is likely to behave in the future, and of appropriate consequences or interventions. Questions like these can be and already are being addressed without reference to diagnosis (see below).

The idea of addressing legal questions outside of a medicalised framework is not new. In 1973, in its evidence to the Butler Commission on ‘Mentally Abnormal Offenders’, the BPS strongly criticised the legal assumption of ‘mental disease’ as a cause of some offending behaviour. It also criticised the legal dichotomy between rational people, who appeared to be responsible for their own decisions and in control of their actions, and the person ‘behaving in an apparently unmotivated, unnatural or irrational manner and who is deemed unable to exercise full control over his actions, decisions or will’ (BPS, 1973, p.332). Pointing out the need to consider external influences – current events, past experiences – on all behaviour, and the social nature of judgements of abnormality, irrationality and responsibility, the BPS suggested the adoption of a continuum-based developmental model and questioned the concept of criminal responsibility and the distinction between ‘mentally normal’ and ‘abnormal’ offenders. The evidence went further in pointing out that these distinctions were partly required to serve the functions of retributive justice, and to allow legal separation of ‘punishment’ and ‘treatment’. This echoes the point we made early in the document, that adopting a non-diagnostic or non-medical approach, can make visible some important social and moral questions that diagnosis, or at least the concept of mental disorder, seemed to answer.

More recently, in relation to psychologists as expert witnesses to the Family Courts, but more widely applicable, BPS guidelines (2016b) emphasise the integration of developmental, psychological, social, relational and neuropsychological evidence through psychological formulation, within a dimensional rather than categorical approach. The guidelines also note that ‘[t]he application of a broad range of psychological theories and principles to specific contexts provides a theoretical framework for valid analysis and prediction’ (p.4). Similarly, Peter Kinderman (2015) has argued that alternatives to diagnoses for court reports on mental health tribunals are already available, and more useful. Thus, descriptions of individual problems can replace diagnoses; psychological and other relevant theories can help explain complex behaviour and give a basis for assessing risk; and non-diagnostic formulations can provide a basis for professional guidance which is evidence based and tailored to the individual. A summary designed to inform courts and judges about the role of adversities in criminal behaviour, along with detailed suggestions for language and court procedures that avoid re-traumatising people, is available in SAMHSA (2013). The PTM Framework can provide an additional resource for analysis and prediction, and we would argue that its explicit linking of threats and threat responses may be particularly useful in forensic and other legal settings.

Research

Diagnostic categories are often defended as necessary for research. It is true that researchers need to use methods which are consistent across researchers, institutions, countries and so on, but this is only useful if those methods are reliable and valid. Since

this is not the case for many functional diagnostic categories, their use may not only lead to confusing and contradictory results but may actively obstruct research progress.

Unfortunately, diagnostic categories continue to be used partly because of institutional inertia, and maintained through self-sustaining cycles. Thus, researchers use them because otherwise high impact factor journals will not publish the results, then research evaluators such as the National Institute for Health and Care Excellence (NICE) see that the research literature is organised by such categories and so base their guidelines on these ‘conditions’; research funders then focus on particular categories and this then influences how researchers go about their work.

In fact, NICE guidelines in their full versions do acknowledge the serious conceptual and methodological problems with diagnosis, but the Quick Reference Guides then make recommendations despite the lack of validity of these concepts as starting points (Midlands Psychology Group, 2010). The Critical Psychiatry Network submitted a comprehensive critique to the stakeholder consultation for the ‘ADHD’ guidelines, and received the response that: ‘...we are unable to dismiss the diagnosis as we would then be left without a guideline to undertake’ (cited in Midlands Psychology Group, 2010), perhaps illustrating the self-sustaining cycle mentioned above. NICE guidelines, despite their non-mandatory status, can exert a powerful influence on Care Packages and Pathways, and on the interventions that organisations offer and the standards against which they are evaluated. In the process, diagnostic terms become further reified and embedded in research and services, and subtleties (such as the evidence that the therapeutic relationship is as or even more important than the specific therapeutic intervention), are eroded and replaced by standardised packages of care for people whose needs simply do not fit them. Clinical psychologists (and others) who are involved in drawing up these guidelines may need to challenge these diagnostic assumptions and their consequences more openly, as well as being appropriately cautious about how far to be directed by them in research and practice (Court et al., 2016).

Perhaps most importantly, service users/survivors need to be centrally involved in the production of knowledge about their experiences (Sweeney, 2016). There has been some increase in service user influence on, and collaboration with, conventional research, and correspondingly some progress towards valuing experiential knowledge and balancing the marginalising effects of positivist discourses (Beresford, 2016; and see discussion in Chapter 2). However, numerous factors limit the likelihood of survivor-led studies being seen as acceptable in conventional methodological, funding and outcome terms, especially, as above, if they are framed in non-diagnostic language (Sweeney, 2016). There is still a long way to go before service users/survivors can take the lead in their own research and produce their own knowledge, although the emerging discipline of Mad Studies offers an important new platform (Sweeney, 2016).

Because diagnostic categories serve so many functions (see Chapter 1) it is unlikely that we will be able to develop a single approach that will fulfil them all. Progress has been hampered while researchers and clinicians await the emergence of such an alternative. However, it is now time to accept that it will be better to have a range of approaches more closely aligned to their functions, for example, epidemiology, therapy efficacy, service planning, the law and so on. In this section, therefore, we will examine some alternative research strategies which are not based on diagnostic categories. We will show,

firstly, that there is a need to reinvigorate research methods which already have a place in psychological research traditions, and secondly, a need for development of newer methods to address some newer questions. However, simply identifying these approaches is not enough. Perverse incentives to continue using diagnostic categories will need to be eliminated. This means that researchers, journals, funders and evaluators of research such as NICE need to demonstrate support for and acceptance of other approaches. Here, professional bodies like the BPS could lead the way.

Alternative approaches from well-established (but often under-used) psychological research traditions

Many successful areas of Psychology are those where researchers have been able to conceptualise phenomena and develop valid constructs which can be measured reliably, ideally from a number of vantage points (e.g. self-report, experimental methods using more observable measures, etc.) and which are transparent enough to be used by different groups of researchers; for example, Seligman's (1972) construct of learned helplessness or the construct of hearing voices. This has enabled the study of particular psychological processes; some of this research has been called experience-based or complaint-based, as advocated by Persons (1986) and adopted by Richard Bentall and colleagues, and uses a dimensional rather than categorical approach. Kinderman (2014) has argued for validated 'problem lists.' Use of the ordinary language descriptive term 'hearing voices' has been very productive in the large body of research emerging out of the Hearing Voices Movement (Longden, 2017). These and other considerations could inform non-diagnostic research in a number of areas.

For example – within epidemiological and aetiological research we could do some or all of the following:

- Use population data already collected on particular experiences or 'symptoms' (from e.g. 'Psychiatric Morbidity' Surveys).
- Link this to information on social circumstances (e.g. adverse events like childhood sexual abuse, discrimination and so on).
- Devise realistic thresholds (e.g. develop an empirically-based analysis of what levels of problematic experiences and distress are statistically unusual and functionally distressing or disabling in the general population rather than relying on decisions by committees).
- Consider the implications of an approach informed by person-specific formulations rather than disorder-specific formulations.
- Employ network analysis of complaints/experiences (e.g. Fried et al., 2016).
- Use ordinary language descriptions like 'Hearing voices', or validated 'problem lists' as a starting point.

As we have seen in previous chapters, some of this has already been done, for example, through the ACE studies and other population-level research. However, as we noted, this still tends ultimately to retain diagnostic assumptions.

Therapeutic efficacy and evaluating therapeutic change

Even within the current mainstream approach to research, there is a recognition that high quality research is not dependent on higher level diagnostic categories but rather includes measures of specific outcomes or of 'symptoms' which may be assessed across a range of studies. In researching therapeutic change we need to consider this and also the following:

- If randomised controlled trials are used then the ‘number needed to treat’ criterion should also be used – that is, how many people would need to receive the experimental condition for one person to gain a benefit they would not have obtained from receiving the control condition. This statistic is still infrequently used – one study found that only four out of 100 randomly selected papers published in the APA’s Journal of Consulting and Clinical Psychology between 2000–2008 utilised this statistic (Shearer-Underhill & Marker, 2010). This can be supplemented by the ‘number needed to harm’ criterion to enable an even-handed analysis.
- The use of single person (‘case’) design approaches (Barkham et al., 2010).
- The use of a range of methods including theory-building ‘case’ studies, single person designs and multiple outcome measures (Barkham et al., 2010).
- The use of measures which enable measurement of individually-tailored outcomes – for example, Shapiro’s Personal Questionnaire (Shapiro, 1961): the client is asked to describe, in their own words, a particular problematic experience or ‘complaint’ (or ‘symptom’ within a diagnostic framework). Each complaint is then given a simple rating scale and so the client can be asked to give a rating over the course of an intervention (e.g. Barkham et al., 1989).
- The use of goal-based measures and solution-focused therapy rating scales (e.g. George et al., 1999). Scaling questions can be used to evaluate progress towards desired goals, confidence in maintaining progress and so on.
- The use of other psychotherapy process measures, for example, of rapport or significant therapy events.
- Bear in mind that single standard outcomes are unlikely to be appropriate across all research because we are addressing complex patterns of behaviour in context and because different people will value different outcomes. While this may limit comparisons across large numbers of studies, it may also allow more useful comparisons.
- In recognition of the complexity of therapy process and outcome, use a combination of quantitative and qualitative methods.
- Adopt a transtheoretical approach focusing on change processes rather than brand name therapies (Wampold & Imel, 2015).
- Further develop methods for the evaluation of the much wider range of interventions now available both within and separate from statutory services, in joint work with service users, carers and professionals.

Developing newer paradigms

As we have emphasised, one of the problems with utilising current measures of ‘symptoms’ or ‘complaints’, whether within or outside a diagnostic framework, is that they treat problematic experiences in a decontextualised manner – they tend to strip the experiences of their personal, social and cultural meanings. In contrast, some analyses of particular mental health idioms suggest ways in which we might return to more ordinary language understandings of mental health. Thus Barke et al. (2000) have explored the meaning of ‘nervous breakdown’ in the 20th century, while Kaiser et al. (2015) have investigated the idiom of ‘thinking too much’. In addition Horwitz and Wakefield have analysed historical changes in how we have understood both sadness and fear (2007 and 2012 respectively).

Pluralistic inter-disciplinary research could help develop multi-perspective descriptions and explanations of other idioms and experiences; more socially and culturally contextualised understandings could be developed by drawing on social, community and cross-cultural psychology as well as on other disciplines such as sociology and anthropology, and on accounts from distressed people themselves. In line with this, survivor researchers within the 'Mad Studies' movement have called for the opportunity to develop their own non-diagnostic research methodologies and frameworks within which their voices and experiences can be valued and heard (Russo & Sweeney, 2016).

In thinking more contextually about therapeutic efficacy we might consider the implications of viewing psychotherapy as a socially-situated healing practice (Wampold & Imel, 2015) rather than in terms of the 'drug metaphor' underlying current psychotherapy RCTs (Stiles & Stiles, 1989).

Trish Greenhalgh (2016) has identified a range of research methods from the narrative tradition which could provide a much wider perspective for health research. Although these are aimed mainly at physical health, they do not require diagnoses and are equally applicable to psychological and emotional distress. The methods include traditional single person ('case') studies; individual accounts of 'illness' captured through qualitative interviews; study narratives of a health care organisation or system that forms the institutional context for individual experience and treatment; cultural/historical narratives within which particular 'illness' stories are embedded, for example the meta-narratives of subordinate groups and/or displaced communities; analyses of policy discourses which involve particular framings that drive action or justify inaction; and analyses of the multi-voiced narratives of online communities and social movements. Greenhalgh argues that these methods can be used in combination with more traditional measures of population health status to produce cross-country comparisons for health issues that are strongly influenced by cultural contexts, as well as to better understand people's health-related experiences and lifestyle choices and to inform the design and evaluation of interventions aimed at influencing these.

At least some of this is already underway. A good illustration is a recent Samaritans report into the higher rates of suicide of disadvantaged men in midlife (Wyllie et al., 2012). Combining interviews with theory and evidence from a range of disciplines, including Sociology, Psychology, Economics and Gender Studies, the researchers were able to 'get behind the statistics' to reveal a picture of how feelings of defeat, entrapment and worthlessness are produced within a specific social, economic and cultural context, with important messages for policy and practice. This was not based on diagnostic categories. As well as supporting developments like these, the PTM Framework suggests an urgent need for more research, using a variety of methods, on psychological aspects of the operation of power and on the nature and impact of experiences of powerlessness. It is essential that this research does not recreate individualistic understandings. The framework also suggests the need for research on how this can be incorporated into intervention and into the design, implementation and evaluation of social policy aimed at reducing distress and supporting wellbeing.

These and other developments require different research questions, different research methods, and (often) different researchers. Thus, the kinds of research questions often asked currently are overdetermined by the kinds of research methods privileged by

research funders, while the questions themselves privilege often biological research into aetiology over research on interventions and prevention (MQ, 2015, pp.7–8) and fail to involve service users in the co-production or initiation of knowledge. Ironically, this imbalance may be supported by the failure of diagnostically-based biological research to produce positive results (see Chapter 5), suggesting the need for more (biological) research into causes and discouraging attempts at primary prevention.

What language do we use instead of diagnostic terms?

In the introduction to the document we briefly considered the issue of language and terminology. In this chapter, we have made a number of suggestions for the purposes of research, commissioning and so on. We end by returning to this question, especially in relation to everyday usages, because changing medicalised language is perhaps the most fundamental and important next step which must underpin all the others. This goes much further than exchanging one disputed or stigmatising term for another. Rather, it implies replacing the whole discourse about what is called ‘mental health’. ‘Discourse’ refers to organised and often unquestioned ways of speaking and using language which shape and transmit knowledge and the practices that depend on it (Foucault, 1979, 1980). Discourse is never used in a vacuum but always depends for its comprehensibility on other usually unarticulated statements which ‘carry deeply entrenched convictions and explanatory schemas fundamental to the dominant form of making sense of the world in any given period’ (Sawicki, 1991, p.104). So, as we described in Chapter 3, changing language is not simply about using alternative vocabulary, but opens up new ways of thinking, experiencing and acting. Until this happens, we will simply continue to reproduce existing practices in slightly different, but equally unsatisfactory, forms.

It is for these reasons that there have been various attempts to outline alternative language uses, from both professional (DCP, 2014b) and service user/survivor (Wallcraft & Michealson, 2001) perspectives. Trauma-informed guidelines have similarly suggested a shift from ‘symptom’ to ‘adaptation’, ‘disorder’ to ‘response’ and so on (Arthur et al., 2013, p.24). BPS publications ‘Understanding bipolar disorder’ and ‘Understanding psychosis’ have acknowledged the debate and encouraged service user choice of terminology (BPS, 2010, 2017). However, this is a complex issue, with no single answer. Instead, we suggest a range of non-medical terms and phrases which may be suitable for different purposes and circumstances. In other words, instead of a ‘new dogma’ we need ‘sensitive diversity in language’ (Beresford et al., 2016, p.27). At the same time, we recognise that medicalised language will not change overnight; that developing new language uses is an evolving process that can only happen in tandem with a general shift in thinking about distress; that existing terminology will still be used – and therefore need to be used by others – for some current practical purposes such as access to services, or finding relevant literature and self-help groups; and that some people will continue to find diagnostic terms a useful shorthand description of their problems on a day-to-day basis.

Most importantly, we support individuals’ right to make their own choice of terminology. At present, this right typically works one-way only: those who want their difficulties defined in diagnostic terms are unlikely to be denied this. The corresponding right, to refuse psychiatric labels, or even to be informed about debates and limitations, is rarely if ever offered. In fact, in many mental health, criminal justice and other welfare settings it may

be unwise and unsafe for service users to reject their diagnosis in favour of alternative understandings.

At the same time as affirming people's right to describe their difficulties as they wish, we affirm the equally important principle that professionals, researchers, trainers, lecturers, charities, policy-makers and others involved in the mental health field should use language and concepts that have some claim to be descriptively accurate and evidence-based. Because psychiatric diagnosis does not meet these standards, it follows that it can no longer be considered professionally, scientifically or ethically justifiable to present psychiatric diagnoses as if they were valid statements about people and their difficulties. To draw an analogy from psychiatric history, once it becomes clear that terms like 'wandering womb' are mistaken, no professional should be offering – let alone imposing – them. The demise of current categories has been predicted by senior UK psychiatrists Paul Bebbington (see Introduction) and Robin Murray, who has said he expects 'schizophrenia' to become as obsolete as 'dropsy' (2017). Existing terms will probably survive in ordinary language use for some time, since it takes a while for lay terminology to catch up, but these can no longer be professionally-sanctioned concepts.

But as we have emphasised, it is not simply diagnostic terms which need to change. If we are truly to think and act differently, the many language uses that imply, support and perpetuate the current model (patient, symptom, diagnosis, psychopathology, illness, disease, disorder, prognosis, remission and so on) also need to change. Three principles are suggested in the DCP *Guidelines on Language for professional documents* (DCP, 2014b):

1. Where possible, avoid the use of diagnostic language in relation to the functional psychiatric presentations (e.g. 'extreme mood swings' not 'bipolar disorder'; 'suspicious thoughts' not 'paranoia').
2. Replace terms that assume a diagnostic or narrow biomedical perspective with psychological or ordinary language (e.g. 'problem' not 'symptom'; 'intervention' not 'treatment').
3. In situations where the use of diagnostic and related terminology is difficult or impossible to avoid, indicate awareness of its problematic and contested nature (e.g. in an introductory note).

These principles can also be applied more generally. For example, researchers often use medicalised language such as illness, symptoms, and psychopathology unnecessarily. This not only continually reconstructs a problematic view of reality, it distracts attention from researchers' descriptions of what they are actually studying and risks losing valuable knowledge about people's experiences. This is not to suggest that researchers should not infer concepts or processes. The evidence presented here, however, suggests that these will be more valid if they reflect social contexts and relationships as well as individual behaviour and experiences. 'Dissociation', for example, refers to a functional, context-dependent process engaged in both by individuals and larger social groups.

We have noted, however, that there is no entirely satisfactory substitute for terms like 'mental illness', 'mental disorder' or 'mental health', and we have in some places found the latter term unavoidable in this document. Nor will there ever be an adequate single replacement word or phrase, since the range of thoughts, feelings and actions that can lead to a psychiatric diagnosis encompasses almost every human experience, arises out of a complex multitude of contingent causal factors, and ultimately depends on local social and cultural judgements. One solution is to adopt a range of interchangeable, non-medical terms and use the one(s) which are the best fit for particular circumstances or usages. In

this document we have alternated between emotional/psychological distress, problems, emotional difficulties, unusual experiences, and troubled or troubling behaviour. The DCP Language Guidelines suggest ‘emotional distress, mental distress, severe mental distress, extreme state, psychological distress’.

As we have described in this chapter, access to services, benefits, housing and so on can be, and to some extent already is, determined on the basis of a professional endorsement that a person is experiencing severe psychological distress which impacts on daily functioning, or some synonym of this. For more specific purposes, non-medical problem descriptions such as ‘hearing hostile voices’ or ‘suspicious thoughts’ or ‘very low mood’ or ‘feeling suicidal’ or ‘self-harming’ can, as we have suggested, be a useful starting point for research and clinical work, or as a basis on which to offer specific interventions, develop literature or set up support groups. Service design and commissioning can similarly be based on needs, specific population groups or problem categories rather than on diagnosis. Clustering terms such as ‘complex trauma’ are already used in some service settings and pathways (Sweeney et al., 2016) and, even bearing in mind our cautions about the term ‘trauma’, are more relevant to people’s actual problems and needs than current diagnostic groupings. Even if current systems demand that a diagnosis is recorded, *DSM-5* and the proposals for *ICD-11* allow for options such as ‘Acute stress disorder’, ‘Adjustment disorder’, ‘Dissociative disorder’ or ‘Complex trauma’ that acknowledge psychosocial rather than medical causes, and are on the whole less stigmatising than terms such as ‘schizophrenia’ which they may replace (see Chapter 6). Some computerised records allow space for a brief formulation-type summary – typically as well as diagnosis, but possibly instead of one in the future.

The issues in relation to everyday language use are also complex. One of the more difficult dilemmas for those who have been psychiatrically labelled is how to describe distress to others in a concise way that makes one’s struggles seem reasonable and understandable. The many disadvantages of psychiatric diagnosis may be offset by their function of legitimising and (apparently) explaining distress to friends, family, employers and other lay people. As discussed by Leeming et al. (2009), narratives and formulations may seem to provide insufficient defence against attributions of shame or weakness, and because of the complex information they contain, are not appropriate for all purposes. The titles of the provisional General Patterns are probably not suitable for explaining distress to others, although adapted versions may be acceptable to some people (e.g. ‘I am experiencing/struggling with/living with the effects of violence and neglect/abuse and trauma/loss and deprivation’).

A balance may need to be found between verbs – more accurate, but also lengthier – and nouns. We have used the example of grief at various points. Because this is a universally-experienced form of distress, a phrase such as ‘bereavement reaction’ is generally understood to refer not to a disease or specific condition that someone ‘has’, but to a recognised emotional process, another way of saying ‘I am grieving.’ Public education might help to bring us to the point where it is understood that phrases such as ‘Trauma reaction’, ‘Separation difficulty’, ‘Attachment problems’, ‘Identity conflicts’, ‘Social exclusion’ or ‘Severe threat response’ refer to similar processes of surviving the impact of life events and adversities. There should also be room for conceptualisations like ‘Spiritual crisis’. Some service users want to reclaim the word ‘madness’, as in the ‘Mad Pride’ movement, while others definitely do not (Beresford et al., 2016).

These examples are not precisely-defined psychological (still less medical) concepts, but that is the point; as we have argued, patterns of human responses to adversity do not and cannot fall into neat categories. If we want shorthand ways of conveying the responses of people struggling with adversities, then these are better captured by ‘fuzzy concepts’ – in philosophical terms, categories that are open, inexact and yet still useful and meaningful in context, as many examples of everyday language are (Haack, 1996). Interestingly, the existence of lay versions of psychiatric language, such as ‘stress’ or ‘nervous breakdown’ suggests that general terms or fuzzy concepts like ‘emotional/psychological crisis/breakdown’ could serve as acceptable substitutes for the current pseudo-medical ones (Barke et al., 2000). It will no doubt be objected that these are not precise categories, but nor are the ones they replace. The crucial question is whether they are precise enough for their intended purposes. It is clear that they could be – and moreover, without the many disadvantages of diagnosis and the identity of ‘mentally ill’.

A fundamental problem is, as noted in the Introduction, the failure to find a midpoint between what has been called the ‘brain or blame’ dichotomy (Boyle, 2013). In other words, ‘As a society, we seem to find it hard to find a middle ground between “You have a physical illness, and therefore your distress is real and no one is to blame for it” and “Your difficulties are imaginary and/or your or someone else’s fault, and you ought to pull yourself together”’ (Johnstone, 2014, p.2). Public health information about the limitations of current models is urgently needed. The PTM Framework offers, instead, the resources to avoid this trap by constructing non-diagnostic, non-blaming, de-mystifying stories about strength and survival. In doing this, it opens up the possibility of replacing diagnosis with a range of ordinary language descriptions of these universal human experiences.

Conclusion

As we noted at the beginning of this chapter, there is no simple, perfect or easy way to move beyond the diagnostic thinking that permeates current theories, practices, institutions and social and political discourse. We have suggested that change needs to happen in multiple ways and at multiple levels, both within and outside ‘Mental Health’ and its related systems. In all these domains, but particularly in the former, there is the ever present danger of ‘co-option’ in which professionally, socially or politically challenging ideas are assimilated by dominant groups and ‘water[ed] down... so they become nonthreatening and ineffective’ (Boyle, 2013; Penney & Prescott, 2016, p.35). We are not suggesting that this is necessarily done in a planned or even conscious way. However, as we saw in Chapter 1, there are many factors supporting the persistence of diagnostic thinking, and attempts to move beyond it often retain many of its basic assumptions. This is apparent for example in the National Institute of Mental Health’s RDoC project, with its starting assumption that ‘Mental disorders are brain disorders’, as well as more generally in the presentation of aspects of social relationships and circumstances as ‘life events’ or ‘stressors’ which trigger underlying ‘vulnerabilities’. We have argued that some of this arises from the underlying influence of positivism which facilitates a default position of medicalisation. Several aspects of the PTM Framework have the potential to point the way beyond diagnostic thinking. The PTM Framework’s emphasis on the negative operation of different forms of power – material, symbolic and discursive – and the threats this can create, challenges a view of ‘social context’ as a series of quantifiable events or stressors;

the explicit linking of threats and threat responses restores meaning, function and intelligibility; and the emphasis on embodiment, evolved adaptations to threat, and the reciprocal interaction of experience and biology, allows a role for biology which is very different from theories about 'faulty' genes or biochemistry. We hope that this will make it easier to maintain a focus on embodied persons acting meaningfully in complex social and cultural contexts, to direct prevention towards the circumstances of people's lives, and to move beyond the damaging 'brain or blame' dichotomy.

However, the issues relating to the development and implementation of alternatives to diagnostic thinking and medicalisation will not be resolved without the driving force of those who have been ascribed a psychiatric diagnosis. This needs to be backed up by a sea-change in messages to the general public about alternatives to the narrative of medicalisation. We hope that our PTM Framework will be a contribution to these aims.

Appendix

EVIDENCE TO SUPPORT THE GENERAL PATTERNS

Research evidence in relation to each of the proposed Provisional General Patterns is presented below. A number of points should be borne in mind:

- All the General Patterns draw on the extensive body of evidence that constitutes the Foundational Pattern, as referenced throughout this document. In addition, each General Pattern draws from evidence that suggests regularities within the Foundational Pattern.
- These bibliographies are not intended as comprehensive records of all the relevant literature relating to each General Pattern, but as an indication of some of the main summaries, meta-analyses and literature reviews.
- Due to the dominance of diagnostic assumptions, much of the evidence we have adduced below is expressed in these terms. This has obvious limitations, and in citing such studies, we do not endorse the categories they assume. However, if taken as a proxy for common experiences and expressions of distress and viewed through a PTM lens, the studies can be used to suggest the regularities of meaning and function which are the central elements of the Patterns.
- In many cases, research dating back several decades testifies to the widespread recognition of these General Patterns in Western cultural contexts, although there may be variations in some of its current manifestations. Older references are therefore as relevant as more recent ones.
- This is not intended as a complete or definitive set of patterns but as a starting point for further research into, and delineation of, regularities in the experience and expression of distress which can inform theory, practice and personal narratives. We welcome feedback from research, clinical practice and personal testimony on this ongoing development process.

THE FOUNDATIONAL PATTERN

The General Patterns all emerge and draw from the body of evidence that constitutes the Foundational Pattern, and are thus supported by it. This evidence is summarised throughout the document, and especially in Chapter 4. The overviews below also offer summaries.

Adversities

Economic, social and relational adversities can happen to people at any point in their lives and are a permanent feature of some people's lives. However, adversities experienced in childhood can exert a disproportionate influence on mental and physical health. Key bodies of research are to be found in the Adverse Childhood Experiences studies and related literature. The Adverse Childhood Experiences (ACE) study, conducted by the Centers for Disease Control and Prevention and Kaiser Permanente, involved over 17,000 participants from a US health insurance plan, and is thus one of the largest investigations ever conducted into the association between childhood maltreatment and later-life health and well-being. Data were collected over two years between 1995 and 1997, with

the participants followed up over a period of 15 years. Participants were scored from 0 to 10 as to whether they had experienced specific adverse relational and family events. Subsequent research has investigated a wider range of adversities, personal, social and environmental. The results document strong and significant relationships between ACEs and a wide range of adult mental and physical health, social and behavioural problems, social and economic costs, and early mortality. High ACE scores are significantly correlated with 'depression' and 'mood disorders', 'anxiety disorders', 'psychosis', 'PTSD', substance abuse, attempted suicide, hallucinations, and the use of neuroleptic medications, multiple sex partners, and increased likelihood of becoming a victim of sexual assault or domestic violence. ACEs were shown to increase the risk of substance abuse, interpersonal violence, and criminal offending. They are also related to physical health problems including liver disease, chronic pulmonary obstructive disease, heart disease, autoimmune disease, and lung cancer. Overall, ACEs are the most preventable cause of 'serious mental illness' and of drug and alcohol abuse. ACEs are transmitted intergenerationally, with enormous personal, social and economic costs.

Other adversities subsequently measured by the National Child Traumatic Stress Network include sexual assault/rape, serious injury/accident, illness/medical trauma, physical assault, kidnapping, natural disaster, forced displacement and extreme interpersonal violence, along with war/terrorism and political violence. These adversities are also associated with lower educational and occupational performance and higher use of medical, social and welfare services.

The impact of ACEs has been shown to be cumulative and synergistic. The more ACEs someone accumulates beyond a single one, the more likely they are to experience mental health problems in adulthood, in a roughly stepwise increase that often shows a marked acceleration at four or more ACEs. In addition, certain ACEs appear to have a synergistic impact – in other words, their combined effect is greater than the sum of their individual effects. In women, a particularly strong synergy seems to occur with childhood sexual abuse, with growing up in economic hardship a close second. In men, growing up in economic hardship appears to set up the most powerful synergy, along with childhood sexual abuse. Parental depression and anxiety and parental drug use exert synergies in both men and women. The younger the age, the more damaging the impact. Social discourses about gender roles seem to shape the way in which adversities are experienced and expressed; for example, that girls may be more likely to react with dissociation and boys with overactivity and inattentiveness.

The researchers hypothesise that ACEs have their effect by increasing risk factors such as smoking, excessive drinking, overeating and self-injury, which can be understood as ways of coping with the emotional impact of the trauma; and by the impacts of childhood trauma on the developing brain and body, causing deregulation of physiological processes including the stress response. Chapter 5 on 'Biology' explores these complex mechanisms and their relational, material and social contexts in more detail.

These childhood adversities are often experienced, and responses to them shaped, in a more general context of social disadvantage and inequalities of power which also have strong and established links with a wide range of mental health diagnoses, partly through providing a context within which adversities multiply. The impact of adversities is then passed down the generations. Within developed industrialised societies, economic

inequality further facilitates the occurrence and prevalence of all varieties of adversity. Recent research in the US has started to investigate the relationship between patterns of Adverse Community Experiences, as found in communities that are highly affected by structural violence and deprivation, and individual distress.

The ACE studies and related evidence are discussed here:

- Arthur, E., Seymour, A., Dartnall, M. et al. (2013). *Trauma-informed practice guide*. British Columbia Centre of Excellence for Women's Health. Available from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- Hughes, A., Bellis, M.A., Hardcastle, K.A. et al. (2017) The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *Lancet Public Health*, 2, e356–366.
- Pinderhughes, H., Davis, R. & Williams, M. (2015). Adverse Community Experiences and resilience: A framework for addressing and preventing community trauma. Prevention Institute, Oakland, CA.
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www.acestudy.org

www.cestoohigh.com

www.blueknot.org.au

www.CANarrative.org

Overviews of the general literature on the impacts of adversities can be found at:

- Friedli, L. (2009). *Mental health, resilience and inequalities*. Copenhagen, Denmark: World Health Organization.
- Herman, J.L. (2001). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books.
- Kezelman, C.A. & Stravropoulos, P.A. (2012). *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*. Milsons point, NSW: Blue Knot Foundation. www.blueknot.org.au
- Marmot, M. (2010). *Fair society, healthy lives: Strategic review of health inequalities in England post 2010*. London: IHE.
- Psychologists against Austerity (2015). *The psychological impact of austerity: A briefing paper*. Author. Available from <https://psychagainstausterity.files.wordpress.com/2015/03/paa-briefing-paper.pdf>
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- van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York: Viking.
- Wilkinson, R. & Pickett, K. (2009). *The spirit level: Why more equal societies almost always do better*. London: Allen Lane.

www.traumacenter.org

Overviews of causal factors in 'mental health' in general are provided in:

- Bentall, R.P. (2004). *Madness explained: Psychosis and human nature*. London: Penguin.
- Cromby, J., Harper, D. & Reavey, P. (Eds.) (2013). *Psychology, mental health and distress*. Basingstoke: Palgrave Macmillan.
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PROVISIONAL GENERAL PATTERNS

1. Identities.
2. Surviving rejection, entrapment, and invalidation.
3. Surviving disrupted attachments and adversities as a child/young person.
4. Surviving separation and identity confusion.
5. Surviving defeat, entrapment, disconnection and loss.
6. Surviving social exclusion, shame, and coercive power.
7. Surviving single threats.

1. Provisional General Pattern: Identities

This General Pattern is conceptualised as informing and underpinning the other six General Patterns and their variations. The evidence cited below relates to an indicative list of identities among many other possible examples.

Distress may be experienced by anyone, including those whose social status is more privileged. However, as a generalisation, some identities offer much greater compensatory power, status, control and access to social capital in the face of distress than others, along with more options for support, escape, protection, safety and healing. This pattern therefore often, but not always, describes someone whose identity, or aspects of whose identity, has subordinate or devalued status. This may relate to ethnicity, nationality, sexual orientation, gender identity, religion, disability or being defined as ‘mentally ill’, but it may also relate to much larger groups who identify as female, older, or working-class. Occupying several marginalised identities (e.g. Black and disabled; female and poor; gay and ‘mentally ill’) implies a greater degree of discrimination and threat, and increases the likelihood of experiencing other relational and social adversities, along with physical health problems. Conversely, and protectively, people may experience strong social solidarity within their group and/or have aspects of their identity that are more culturally valued.

As a general rule, all mental health diagnoses are more common in people with devalued identities, especially when they belong to several devalued groups. Being ascribed the identity of ‘mentally ill’ may increase and amplify existing experiences of shame, exclusion and marginalisation, as well as being a significant source of stigma and discrimination in itself. The identity of ‘mentally ill’ is therefore considered in detail.

The general impacts of marginalisation, devaluing and discrimination

- Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford: Oxford University Press.
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Intersectionality

- McManus, S., Scott, S. & Sosenko, F. (2016). *Joining the dots – the combined burden of violence, abuse and poverty*. DMSS Research and Heriot Watt University report for Agenda.
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- Weber, L., Madden, M. & Hyde, J.S. (1998). A conceptual framework for understanding race, class, gender and sexuality. *Psychology of Women Quarterly*, 22, 13–32.

Social identity, health and wellbeing

- Haslam, S.A., Jetten, J., Postmes, T. et al. (2009) Social identity, health and well-being: An emerging agenda for applied psychology. *Applied Psychology: An International Review*, 58(1), 1–23 (and other papers in this Special Issue).
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Sub-patterns

Being identified/identifying as 'mentally ill'

Stigmatising effects of psychiatric labels in the UK and worldwide

- Angermeyer, M. & Matschinger, H. (2005). Labeling – stereotype – discrimination: An investigation of the stigma process. *Social Psychiatry and Psychiatric Epidemiology*, 40, 391–395.
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- Kvaale, E., Haslam, N. & Gottdiener, W. (2013). The 'side effects' of medicalization: A meta-analytic review of how biogenetic explanations affect stigma. *Clinical Psychology Review*, 33, 782–794.
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- Read, J., Haslam, N. & Magliano, L. (2013). Prejudice, stigma and 'schizophrenia'. In J. Read & J. Dillon (Eds.), *Models of madness: Psychological, social and biological approaches to psychosis* (pp.157–177). London: Routledge.

Discrimination against people who have been psychiatrically labelled

- Gonzales, L., Davidoff, K.C., Nadal, K.L. et al. (2015). Microaggressions experienced by persons with mental illnesses: An exploratory study. *Psychiatric Rehabilitation Journal*, 38(3), 234–241.
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High rates of physical health problems in people who have been psychiatrically labelled, including the effects of psychiatric drugs

- De Hert, M., Detraux, J., van Winkel, R. et al. (2012). Metabolic and cardiovascular adverse effects associated with antipsychotic drugs. *Nature Reviews Endocrinology*, 8, 114–126.
- Naylor, C., Parsonage, M., McDaid, D. et al. (2012). *Long-term conditions and mental health: The cost of co-morbidities*. London: The King's Fund.

Personal reactions to being psychiatrically labelled

- Callard, F. (2014). Psychiatric diagnosis: The indispensability of ambivalence. *Journal of Medical Ethics*, 40(8), 526–530.
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- Coleman, R. (2017). *The Ron Coleman story*. Author. Retrieved from <http://www.workingtoorecovery.co.uk/ron-coleman/the-ron-coleman-story.aspx>
- Hayne, Y.M. (2003). Experiencing psychiatric diagnosis: Client perspectives on being named mentally ill. *Journal of Psychiatric and Mental Health Nursing*, 10, 722–729.
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- Romme, M., Escher, S., Dillon, D. et al. (Eds.) (2009). *Living with voices: 50 stories of recovery*. Ross-on-Wye: PCCS Books.
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- Rachel Waddingham’s blog at <https://www.madinamerica.com/2013/08/does-language-matter/http://psychdiagnosis.weebly.com/stories-of-harm.html>
- www.openparadigmproject.com
- www.madinamerica.com/category/personal-stories/

Being identified/identifying as female

Worldwide, females are often represented and treated as inferior or secondary, intellectually, economically and socially. There is extensive evidence of the negative impact of all of this on women and girls’ mental health across a wide range of presentations.

- Bates, L. (2014). *Everyday sexism*. London: Simon & Schuster.
- Fine, C. (2011). *Delusions of gender*. London: Icon Books.
- Freeman, D. & Freeman, J. (2013). *The stressed sex: Uncovering the truth about men, women, and mental health*. Oxford: Oxford University Press.
- Gavey, N. (2005). *Just sex? The cultural scaffolding of rape*. London: Routledge.
- House of Commons Women and Equalities Committee (2016). *Sexual harassment and sexual violence in schools*. London: House of Commons.
- Lafrance, M.N. (2009). *Women and depression: Recovery and resistance*. London: Routledge.
- Nicolson, P. (2015). *Gender, power, and organisations* (2nd edn). Hove: Routledge.
- Oram, S., Khalifeh, H. & Howard, L.M. (2016). Violence against women and mental health. *The Lancet Psychiatry*, Available online 15 November 2016, ISSN 2215-0366, [http://dx.doi.org/10.1016/S2215-0366\(16\)30261-9](http://dx.doi.org/10.1016/S2215-0366(16)30261-9).
- Salter, M. (2012). Invalidation: A neglected dimension of gender-based violence and inequality. *International Journal for Crime and Justice*, 1, 3–13.
- Ussher, J.M. (2011). *The madness of women: Myth and experience*. Abingdon, Oxon: Routledge.
- Valenti, J. (2016). *Sex object*. New York: Harper Collins.
- World Health Organization (2000). *Women’s mental health: An evidence based review. Department of mental health and substance dependence*. Author: Geneva.
- World Health Organization (2005). *WHO multi-country study on women’s health and domestic violence against women: Summary report of initial results on prevalence, health outcomes and women’s responses*. Author: Geneva.
- World Health Organization (2013). *Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines*. Author: Geneva.

Being identified/identifying as male

Although 'male' is not generally a devalued identity, the privileges associated with it often involve strict boundaries on positive aspects of this identity and devaluing of aspects which challenge these boundaries, especially behaviour and emotional expressions seen as closer to 'femaleness'. This is reflected in high rates of suicide, violence to others, problematic drug and alcohol use as well as problems with anxiety and low mood.

- Addis, M. (2008). Gender and depression in men. *Clinical Psychology Science and Practice*, 15, 153–168.
- Archer, J. (Ed.) (1994). *Male violence*. London: Routledge.
- Classen, T.J. & Dunn, R.A. (2012). The effect of job loss and unemployment duration on suicide risk in the United States. *Health Economics*, 21, 338–350.
- Connell, R. (2005). *Masculinities* (2nd edn). Cambridge: Polity.
- Emslie, C., Rridge, D., Ziebland, S. et al. (2005). Men's accounts of depression: Reconstructing or resisting hegemonic masculinity? *Social Science and Medicine*, 62, 2246–2257.
- Frosh, S., Phoenix, A. & Pattman, R. (2002). *Young masculinities: Understanding boys in contemporary society*. London: Palgrave.
- Schrock, D. & Schwalbe, M. (2009). Men, masculinity and manhood acts. *Annual Review of Sociology*, 35, 277–295.

Being identified/identifying as a member of a minority ethnic group (in the UK)

People from minority ethnic backgrounds living in the UK have much higher rates of both common and severe diagnosed mental health problems than White British people. This holds whether they were born in the UK or moved to the UK from other parts of the world, and has been shown to be related to experiences and perceptions of racism, along with numerous other forms of social disadvantage. Indicative examples are given below. Specific communities (Turkish, Polish, Romanian, Indian, Pakistani, Ugandan Asian, Somalian, Hungarian, etc.) may face their own characteristic patterns of challenge.

- Brown, L.S. (2009). Cultural competence: A new way of thinking about integration in therapy. *Journal of Psychotherapy Integration*, 19(4), 340–353.
- Comas-Díaz, L. (2011). Multicultural approaches to psychotherapy. In J. Norcross, D. Freadheim & G.I. Vandenboss (Eds.) *History of psychotherapy: Continuity and change* (2nd edn). Washington, DC: American Psychological Association.
- Fearon, P., Kirkbride, J., Morgan, C. et al. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: Results from the MRC AESOP Study. *Psychological Medicine*, 36(11), 1541–1550.
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- Kposowa, A.J., Tsunokai, G.T. & Butler, E.W. (2001). The effects of race and ethnicity on schizophrenia: Individual and neighborhood contexts. *Race, Gender & Class*, 9(1), 33–54.
- Littlewood, R. & Lipsedge, M. (1997). *Aliens and alienists: Ethnic minorities and psychiatry* (3rd edn). London: Routledge.
- Morgan, C. & Hutchinson, G. (2010). The social determinants of psychosis in migrant and ethnic minority populations: A public health tragedy. *Psychological Medicine*, 40, 705–709.
- Rogers-Sirin, L., Ryce, P. & Sirin, S.R. (2014). Acculturation, acculturative stress, and cultural mismatch and their Influences on immigrant children and adolescents' well-being. In R. Dimitrova et al. (Eds.) *Global perspectives on well-being in immigrant families* (pp.11–30). New York: Springer.
- Series authored by The Change Institute (2009), published by Department for Communities and Local Government, on *Understanding Muslim ethnic communities*. www.changeinstitute.co.uk
- Greater London Authority (2009) series on *Communities in London*. Greater London Authority, City Hall.

Irish people in the UK have a record as poor as, or worse than, many of the main minority

ethnic groups living in England in terms of both ‘mental health’ and physical health, and this disadvantage persists into second and third generations.

Fitzpatrick, M. & Newton, J. (2005). Profiling mental health needs: What about your Irish patients? *The British Journal of General Practice*, 1, 55 (519), 739–740.

Leavey G. (1999). Suicide and Irish migrants in Britain: Identity and integration. *International Review of Psychiatry*, 11, 168–172.

Leavey, G., Clarke, G., King, M. et al. (1997). Health research on the Irish in Britain: Invisible and excluded. *Psychiatric Bulletin*, 21, 739–740.

Mind Factsheet. Irish people in Britain. Available from <http://www.lemosandcrane.co.uk/dev/resources/Mind%20-%20The%20mental%20health%20of%20Irish%20people%20in%20Britain.pdf>

Reid-Galloway, C. & Stewart, G. (2001). Mental health of Irish-born people in Britain. London: MIND.

Being identified/identifying as a person of African or African-Caribbean heritage

Black people of African and African-Caribbean heritage have particularly high rates of diagnoses of ‘psychosis’. This has been shown to be related to generally higher levels of social disadvantage, including poverty, racism and discrimination. African Caribbean men are over-represented in acute and secure psychiatric settings and receive more coercive interventions. They are also over-represented in the criminal justice system. Young Black men living in urban environments have especially high rates of diagnosed ‘psychosis’ including higher rates of ‘paranoia’, which may be partly attributable to stereotypes about violence – although living in a majority Black neighbourhood seems to be a protective factor. Black women experience multiple adversities of ongoing racism, poverty and gender inequalities and report high rates of sexual violence and revictimisation.

Boast, N. & Chesterman, P. (1995). Black people and secure psychiatric facilities: Patterns of processing and the role of stereotype. *British Journal of Criminology*, 35(2), 218–235.

Boydell, J., van Os, J., McKenzie, K. et al. (2001). Incidence of schizophrenia in ethnic minorities in London: Ecological study into interactions with environment. *British Medical Journal*, 323, 1336–1338.

Bresnahan, M., Begg, M.D., Brown, A. et al. (2007). Race and risk of schizophrenia in a US birth cohort: Another example of health disparity? *International Journal of Epidemiology*, 36(4), 751–758.

Das-Munshi, J., Bécaries, L., Boydell, J.E. et al. (2012). Ethnic density as a buffer for psychotic experiences: Findings from a national survey (EMPIRIC). *British Journal of Psychiatry*, 201, 282–290.

Heinz, A., Deserno, L. & Reininghaus, U. (2013). Urbanicity, social adversity and psychosis. *World Psychiatry* 12(3), 187–197.

Janssen, I., Hanssen, M., Bak, M. et al. (2003). Discrimination and delusional ideation. *British Journal of Psychiatry*, 182(1), 71–76.

King, C. (2016). Whiteness in psychiatry: The madness of European misdiagnoses. In J. Russo & A. Sweeney (Eds.) *Searching for a rose garden* (pp.69–76). Ross-on-Wye: PCCS Books.

Kirkbride, J.B., Errazuriz, A., Croudace, T.J. et al. (2012). Incidence of schizophrenia and other psychoses in England, 1950–2009: A systematic review and analysis. *PLoS One*, 7(3), e31660.

Metzl, J.M. (2010). *The protest psychosis: How schizophrenia became a black disease*. Boston: Beacon Press.

Neighbors, H.W., Trierweiler, S.J., Ford, B.C. et al. (2003). Racial differences in DSM diagnosis using a semi-structured instrument: The importance of clinical judgment in the diagnosis of African Americans. *Journal of Health and Social Behavior*, 44(3), 237–256.

Prins, H., Backer-Holst, T., Francis, E. et al. (1993). *Report of the Committee of Inquiry into the Death in Broadmoor Hospital of Orville Blackwood and a review of the deaths of two other Afro-Caribbean Patients*. Big, black and dangerous? The Special Hospitals Service Authority.

Read, J., Johnstone, L. & Taitimu, M. (2013). Psychosis, poverty and ethnicity. In J. Read & J. Dillon (Eds.), *Models of madness: Psychological, social and biological approaches to psychosis* (2nd edn, pp.191–209). London: Routledge.

Rosen, C., Jones, N., Longden, E. et al. (2017). Exploring the intersections of trauma, structural adversity, and psychosis among a primarily African-American sample: A mixed-methods analysis. *Frontier Psychiatry* 8(57). doi: 10.3389/fpsy.2017.00057

Sharpley, M., Hutchinson, G., McKenzie, K. et al. (2001). Understanding the excess of psychosis among the African-Caribbean population in England. *British Journal of Psychiatry*, 178(40), 60–68.

Being identified/identifying as a Black woman

Bryant-Davis, T., Ullman, S.E., Tsong, Y. et al. (2010). Struggling to survive: Sexual assault, poverty, and mental health outcomes of African American women. *American Journal of Orthopsychiatry*, 80(1), 61–70.

Crenshaw, K.W. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43, 1241–1299.

Holland, S. (2011). Psychotherapy, oppression and social action: Gender, race and class in black women's depression. In R.J Perelberg & A.C. Miller (Eds.) *Gender and power in families* (pp.256–269). London: Karnac.

hooks, b. (1999). *Ain't I a woman: Black women and feminism*. Boston: South End Press.

Jones, L.V. & Guy-Sheftall, B. (2015). Conquering the Black girl blues. *Social Work*, 60(4), 343–350.

Jones, L.V., Hopson, L., Warner, L. et al. (2015). A qualitative study of black women's experiences in drug abuse and mental health services. *Journal of Women and Social Work*, 30(1), 68–82.

McNeish, D. & Scott, S. (2014). *Women and girls at risk. Evidence across the life course*. Barrow Cadbury Trust, Lankelly Chase Foundation & The Pilgrim Trust. Retrieved from <http://lankellychase.org.uk/wp-content/uploads/2015/12/Women-Girls-at-Risk-Evidence-Review-040814.pdf>

Sciolla, A., Glover, D.A., Loeb, T.B. et al. (2011). Childhood sexual abuse severity and disclosure as predictors of depression among adult African-American and Latina Women. *Journal of Nervous and Mental Disease & Volume*, 199(7), 471–477.

Being identified/identifying as having an intellectual disability

Particularly those with 'mild' ID may experience shame and devaluation, and many seek to distance themselves from others with ID and support services, exacerbating feelings of isolation and 'difference' in a highly individualised, achievement-oriented society. This group is also more likely than their peers to have childhood experiences of physical, sexual and emotional abuse and neglect.

Grandin, T. (1984). My experiences as an autistic child and review of selected literature. *Journal of Orthomolecular Psychiatry*, 13, 144–174.

Keesler, J.M. (2014). A call for the integration of trauma-informed care among intellectual and developmental disability organizations. *Journal of Policy and Practice in Intellectual Disabilities*, 11(1), 34–42.

MENCAP (2007). *Death by indifference*. London: Author.

Sequeira, H. & Hollins, S. (2003). Clinical effects of sexual abuse on people with learning disability: Critical literature review. *British Journal of Psychiatry*, 182, 13–19.

Sinason, V. (1992). *Mental handicap and the human condition*. London: Free Association Books.

Taylor, J.L. & Knapp, M. (2013). Mental health and emotional problems in people with intellectual disabilities. In J.L. Taylor, W.R. Lindsay, R.P. Hastings & C. Hatton (Eds.) *Psychological therapies for adults with intellectual disabilities* (pp.1–14). Oxford: Wiley-Blackwell.

Being identified/identifying as a Gypsy or Traveller

This group has poorer emotional wellbeing and physical health.

Department of Health (2004). *The health status of gypsies and travellers in England*. London: Department of Health Publications.

Race Equality Foundation (2008). The health of gypsies and travellers in the UK. *Better Health Briefing Paper 12*. Race Equality Foundation.

Being identified/identifying as lesbian, gay, bisexual, trans and/or queer (LGBTQ)

Higher rates of diagnosed ‘mental health’ problems have been found in people identifying as LGBTQ.

- Almeida, J., Johnson, R.M., Corliss, H.L. et al. (2009). Emotional distress among LGBT youth: Influence of perceived discrimination based on sexual orientation. *Journal of Youth and Adolescence*, 38(7), 1001–1014.
- Burton, C.M., Marshal, M.P., Chisolm, D.J. et al. (2013). Sexual minority-related victimization as a mediator of mental health disparities in sexual-minority youth: A longitudinal analysis. *Journal of Youth and Adolescence*, 42(3), 394–402.
- Lehavot, K. & Simoni, J.M. (2011). The impact of minority stress on mental health and substance use among sexual minority women. *Journal of Consulting and Clinical Psychology*, 79(2), 159–170.
- Lewis, N.M. (2009). Mental health in sexual minorities: Recent indicators, trends, and their relationships to place in North America and Europe. *Health and Place*, 15(4), 1029–1045.
- Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697.

Being identified/identifying as an older person

Older people are particularly likely to experience sadness, despair, anxiety and loneliness, as a result of social isolation, poverty, discrimination, loss of partners, friends and family through bereavement, and poor physical health including chronic pain, chronic conditions such as diabetes and cardio-vascular problems, and disability. Some are victims of elder abuse. This is exacerbated, particularly in the UK, by loss of extended family structures, along with cultural messages that place less value on age, wisdom and experience.

- Cattan, M., White, M., Bond, J. et al. (2005). Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. *Ageing and Society*, 25, 1, 41–67.
- Dover, S. & McWilliam, C. (1992). Physical illness associated with depression in the elderly in community based and hospital patients. *Psychiatric Bulletin*, 16, 612–13.
- Drentea, P. & Reynolds, J.R. (2012) Neither a borrower nor a lender be: The relative importance of debt and SES for mental health among older adults. *Ageing Health*, 24(4), 673–695.
- Keyes, C.L.M. (2004). The nexus of cardiovascular disease and depression revisited: The complete mental health perspective and moderating role of age and gender. *Ageing and Mental Health*, 8(3), 266–274.
- Mental Health Foundation (2015). *Fundamental facts about mental health. Section 2.1.4, Older Adults*. Author. Available from <https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf>
- Ostir, G.V., Markides, K.S., Peek, M.K. et al. (2001). The association between emotional wellbeing and the incidence of stroke in older adults. *Psychosomatic Medicine*, 63, 210–215.
- Serby, M. & Yu, M. (2003). Overview: Depression in the elderly. *Mount Sinai Journal of Medicine*, 70(1), 38–44.

Being identified/identifying as low socio-economic status

- Baumburg, B., Bell, K. & Gaffney, D. (2011). *Turn to us: Benefits stigma in Britain*. London: Elizabeth Finn Care.
- Chase, E. & Walker, R. (2012). The co-construction of shame in the context of poverty: Beyond a threat to the social bond. *Sociology*, 47, 739–754.
- Cromby, J. & Harper, D. (2009). Paranoia: A social account. *Theory and Psychology*, 19, 335–361.
- Farah, M.J., Shera, D.M., Savage, L. et al. (2006). Childhood poverty: Specific associations with neurocognitive development. *Brain Research*, 1110, 166–174.
- Fell, B. & Hewstone, M. (2015). *Psychological perspectives on poverty*. York: Joseph Rowntree Foundation.
- Fujiwara, T. & Kawachi, I. (2008). A prospective study of individual level social capital and major depression in the United States. *Journal of Epidemiology and Community Health*, 62, 627–633.

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Being identified/identifying as physically disabled

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Provisional General Pattern: 2. Surviving rejection, entrapment and invalidation

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

There has often been prolonged interpersonal maltreatment, abuse, invalidation and neglect in situations of lack of control, dependence, isolation and entrapment. In these situations the person was/is helpless and powerless in the face of emotional and/or physical threat, while often being dependent on the perpetrators for survival. These situations arise more frequently in power contexts of poverty, social inequality, unemployment, gender inequalities, and war. Common diagnoses are 'borderline personality disorder', 'bipolar disorder', 'dissociative disorder', 'major depressive disorder', 'PTSD', substance and alcohol abuse, and 'psychosis', although not everyone who is assigned one of these diagnoses aligns with this pattern, and these diagnoses are also assigned within other patterns. There is overlap with 'Surviving single threats', particularly in relation to men (and women) exposed to combat. In service settings, the pattern is most frequently identified in women. It describes some women (or less often, men) in the criminal justice system. There is overlap with the pattern 'Surviving social exclusion, shame and coercive power' and with 'Surviving single threats'. Like all the patterns, this one may also describe people who have never been formally diagnosed.

The pattern may describe some people diagnosed with 'personality disorder'

Overview in Chapter 13, 'Disordered personalities?' In J. Cromby, D. Harper & P. Reavey (2013). *Psychology, mental health and distress*. Basingstoke: Palgrave Macmillan.

Extensive *DSM-IV* field trial work was carried out by Herman, Perry, van der Kolk and others in relation to the proposal for a new category of 'Disorders of Extreme Stress, Not Otherwise Specified' or 'Complex trauma reaction' for short. Their definition of Complex trauma reaction is:

A psychological injury that results from protracted exposure to prolonged social and/or interpersonal trauma in the context of dependence, captivity or entrapment (a situation lacking a viable escape route for the victim), which results in the lack or loss of control, helplessness, and deformations of identity and sense of self. Examples include people who have experienced chronic maltreatment, neglect or abuse in a care-giving relationship, hostages, prisoners of war, concentration camp survivors, and survivors of some religious cults. Particularly if it occurs in childhood, at the hand of caregivers, may lead to attachment problems, boundary confusion, difficulty regulating emotions, profound mistrust and shame, attention and concentration problems, dissociation, disturbed body image, behavioural lack of control, disturbed self-concept and identity.

The researchers found that the 'Complex trauma' pattern described many, but not all, of those diagnosed with 'Borderline personality disorder'.

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- Work from a psychoanalytic perspective also identifies a similar pattern, albeit described in diagnostic terms: summary in Bateman, A. & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalisation-based treatment*. Oxford: Oxford University Press.

Feminist critique argues that the responses and behaviours diagnosed as 'borderline personality disorder' can be seen as understandable responses to entrapment, invalidation, abuse and disempowerment, expressed in ways that challenge female gender socialisation (anger, self-harm and so on) and are thus more likely to attract a diagnosis if seen in women. This pattern is located within the broader context of power interests including denial of the prevalence and impact of domestic abuse and sexual abuse, and the effect of combat – the former disproportionately experienced by women, and the latter disproportionately experienced by men.

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The pattern may describe some women within the criminal justice system

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The pattern often leads to dissociation as a key coping response, sometimes diagnosed as a 'dissociative disorder'

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Sub-patterns

Surviving domestic abuse

The threat responses in women who have survived or who are living with domestic abuse include anxiety, low mood, fear, guilt, shame, increased risk of suicide, and physical health problems. Less is known about domestic abuse in gay and transgender partnerships or where the victims are male.

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Surviving as an asylum seeker, refugee, trafficked or displaced person

Asylum seekers, refugees and trafficked or displaced persons have usually experienced many extremely threatening events and major losses, in addition to ongoing poverty, insecurity and the stress of legal processes. As a result of these cumulative adversities, they may meet the criteria for a range of psychiatric diagnoses, including 'psychosis'. There may be overlaps with 'Surviving single threat(s)' and with 'Surviving rejection, entrapment and invalidation.'

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Surviving intergenerational and historical trauma

Work with the families of Holocaust survivors has laid the foundation for an understanding of 'intergenerational trauma' which can affect second, third and subsequent generations of a family through complex relational and possibly epigenetic processes. A related concept is historical trauma, in which entire peoples or colonised groups suffer from loss of language,

traditions, genocide, and other forms of deliberate destruction of their lives and culture. There is evidence that these effects can also be passed down the generations.

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Duran, E., Duran, B., Brave Heart, M.Y.H. et al. (1998). Healing the American Indian soul wound. In Y. Danieli (Ed.) *International handbook of multigenerational legacies of trauma* (pp.341–354). New York: Plenum.

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Kellerman, N.P.F. (2013). Epigenetic transmission of Holocaust trauma: Can nightmares be inherited? *The Israel Journal of Psychiatry and Related Sciences* 50(1), 33–39.

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Provisonal General Pattern: 3. Surviving disrupted attachments and adversities as a child/young person

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

The pattern describes situations in which the child's early relationships and/or environments were compromised due to a complex mixture of power factors such as intergenerational histories of trauma and adversity, lack of material resources, social pressures and social isolation. Children who are exposed to trauma and adversities, especially in the context of abusive, insecure or neglectful early relationships, may be given diagnoses such as 'attachment disorder', 'ADHD', 'oppositional defiant disorder', 'depression', 'phobias', 'eating disorders' and 'anxiety disorders', among others. There may also be physical health symptoms and conditions. In older children, the pattern may overlap with 'Surviving separation and identity confusion' or 'Surviving exclusion and competitive defeat as a young person' and there may be a history of criminal offences. Like all the patterns, this one may also describe people who have never been formally diagnosed.

The pattern draws partly on Van der Kolk et al.'s field trial for *DSM-IV*, which proposed a diagnosis of 'Developmental Trauma Disorder' for children and young people showing the indications of the proposed diagnostic category in Adults of 'Complex Trauma'. The first stage summarised the findings from 130 studies reporting on more than 100,000 children and adolescents worldwide. A validated rating scale based on data from 350 children was then developed in order to demonstrate that the average of three to eight co-morbid diagnoses applied to traumatised children could be replaced with one single term clearly indicating the common origin of their difficulties in 'a combination of trauma and compromised attachment'. The main criteria were: Exposure to multiple or prolonged adverse events; Affective and Physiological Dysregulation; Attentional and Behavioral Dysregulation; Self and Relational Dysregulation; Post-traumatic Spectrum Symptoms

lasting at least six months; and Functional Impairment in various domains. The causal events included 'Witnessing or experiencing repeated and severe episodes of interpersonal violence, and significant disruptions in primary caregiver, separation from primary caregiver, or exposure to severe and persistent emotional abuse'.

van der Kolk, B.A. (2005). Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5), 401–408.

A combination of non-violent (e.g. neglect, emotional abuse) and violent interpersonal (e.g. sexual abuse, physical abuse) trauma may be particularly damaging.

Kisiel, C.L., Fehrenbach, T., Torgersen, E. et al. (2014). Constellations of interpersonal trauma and symptoms in child welfare: Implications for a developmental trauma framework. *Journal of Family Violence*, 29, 1–14.

Other overviews

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Sub-patterns

Surviving witnessing domestic violence as a child/young person

These children may be particularly likely, especially if boys, to pass on violence (cruelty to animals, aggression and temper outbursts, delinquency, fighting, bullying, threatening, poor peer relationships, disrespect for women, domestic abuse as an adult). Alternatively they (mainly girls) may resort to compliance, withdrawal, and feel great responsibility for the abused parent, as shown in high levels of guilt, anxiety, clinging and separation anxiety. Later, adolescents and adults may seek affection through risky sexual behaviour. The worse the violence in the home, the more severely children are affected.

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Surviving sexual abuse as a child/young person

Child sexual abuse can have multiple long-lasting effects in childhood and adulthood, depending partly on exacerbating and ameliorating factors. It is a powerful synergistic ACE for both boys and girls. Girls who have experienced sexual abuse experience more frequent low mood, self-harm, dissociation, cognitive difficulties, numbing, impulsivity, distrust and dissociation than their non-abused female peers, along with lack of friends and troubled sexual relationships in adolescence. The damage is generally more severe if the perpetrator is the biological father, if it involves genital contact, and if there is earlier onset, multiple perpetrators and violence. Child sexual abuse also makes ‘hallucinations’ more likely, implying a high degree of dissociation (the ‘escape when there is no escape’) although it is not a specific or unique predictor of such experiences.

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Surviving bullying as a child/young person

Bullying can be understood as a process of enforcing group norms within peer groups. In this, it reflects the norms of the school, the media and the wider social environment, so that children who are perceived as deviating from these norms through appearance, socio-economic status, ability or disability, gender, sex and sexuality, culture, race and religion are more likely to be targets. Bullying cultures thus have their origins in a general lack of tolerance for difference. Bullies may also need help; children are more likely to bully others if they have experienced parental maltreatment, especially physical and sexual abuse, and have witnessed domestic violence.

The short-term impact of bullying can include poor academic performance and heightened absenteeism, low mood, low self-esteem, anxiety, self-injury and suicide as well as headaches,

insomnia, stomach aches, and bedwetting. It may also lead to ‘psychotic’ experiences such as hearing the voice of the bullies. Relational bullying is more common amongst girls and physical victimisation is more common amongst boys. Bullying is a causal factor across a number of forms of distress in adulthood (see also Surviving defeat, entrapment, disconnection and loss, and Surviving social exclusion, shame and coercive power.)

Overviews:

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- Schreier, A., Wolke, D., Thomas, K. et al. (2009). Prospective study of peer victimization in childhood and psychotic symptoms in a non-clinical population at age 12 years. *Archives of General Psychiatry*, 66(5), 527–536.
- Spandler, H. (2001). *Who’s hurting who? Young people, self-harm and suicide* (2nd edn). Gloucester: Handsell Publications.
- United Nations Children’s Fund (UNICEF) (2014). *Hidden in plain sight: A statistical analysis of violence against children*. Author. Retrieved from http://files.unicef.org/publications/files/Hidden_in_plain_sight_statistical_analysis_EN_3_Sept_2014.pdf
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- Wolke, D., Lereya, S.T., Fisher, H.L. et al. (2014). Bullying in elementary school and psychotic experiences at 18 years: A longitudinal, population-based cohort study. *Psychological Medicine*, 44(10), 2199–2211.

Surviving invasive medical interventions as a child

Children who have to undergo repeated, painful and invasive medical interventions may be traumatised, partly because there is some evidence that younger children have a ‘moral’ explanation for healthcare treatment and interpret medical professionals/parents as

intentionally causing them pain as punishment for wrongdoing. The treatment may also involve a degree of ‘entrapment’ or restraint (‘clinical holding’) which, while unavoidable in some circumstances, may exacerbate psychological distress.

Bibace, R. & Walsh, M.E. (1981). Children’s conceptions of illness. *New Directions for Child and Adolescent Development*, 14, 31–48.

Surviving conflict in Northern Uganda as a young person

A version of spirit possession, ‘cen’, is found in Northern Uganda, where civil war has resulted in widespread brutality and the abduction and forced recruitment of children as soldiers. In this phenomenon, young people report that their identity has been taken over by the malevolent ghost of a dead person. ‘Cen’ has been found to be associated with high levels of war trauma and with abduction, and the spirit was often identified as someone the abductees had been forced to kill.

Neuner, F., Pfeiffer, A., Schauer-Kaiser, E. et al. (2012). Haunted by ghosts. *Social Science and Medicine*, 75(3), 548–554.

Provisional General Pattern: 4. Surviving separation and identity confusion

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

This General Pattern describes separation problems and identity confusion, often accompanied by other adversities. It is characteristic of individualistic cultures with a tradition of separation from the nuclear family in late teens/twenties, along with high achievement expectations although it may be present at earlier and later life stages. Social discourses about independence, striving, hard work, competitiveness and achievement may add pressure to the young person. Common diagnoses are ‘psychosis’, ‘schizophrenia’, ‘anorexia’, ‘bulimia’, ‘OCD’, although not everyone with these diagnoses is described by the pattern and these diagnoses are also assigned within other patterns. In adolescents and young people, there may be overlap with General Pattern ‘Surviving disrupted attachments and adversities as a child/young person.’ Like all the patterns, this one may also describe people who have never been formally diagnosed.

The pattern may describe some people diagnosed with ‘schizophrenia’, ‘psychosis’ or ‘first episode psychosis’, especially younger adults

Overviews and some supporting literature can be found in:

Cromby, J., Harper, D. & Reavey, P. (2013). *Psychology, mental health and distress*. Basingstoke: Palgrave Macmillan.

Harrop, C. & Trower, P. (2003). *Why does schizophrenia develop at late adolescence? A cognitive developmental approach to psychosis*. Chichester: John Wiley & Sons.

Johnstone, L. (1999). Do families cause schizophrenia? In C. Dunn, C. Newnes & G. Holmes (Eds.) *This is madness: A critical look at psychiatry and the future of mental health services* (pp.119–134). Ross-on Wye: PCCS Books.

- Johnstone, L. (1993). Family management in 'schizophrenia': Its assumptions and contradictions. *Journal of Mental Health, 14*, 255–261.
- de Sousa, P., Varese, F., Sellwood, W. et al. (2014). Parental communication and psychosis: A meta analysis. *Schizophrenia Bulletin, 40*, 756–768.

Combinations of low care and high control appear to be particularly damaging:

- Alanen, Y.O. (1997). *Schizophrenia: Its origins and need-adapted treatment*. London: Karnac Books Ltd.
- Doane, J.A., West, K.L., Goldstein, M.J. et al. (1981). Parental communication deviance and affective style. *Archives of General Psychiatry, 38*, 679–715.
- Goldstein, M.J. (1984). Family factors that antedate the onset of schizophrenia and related disorders. *Acta Psychiatrica Scandinavica, 71*(S.319), 7–18.
- Rosenthal, D. (1963). *The Genain quadruplets*. New York: Basic Books.
- Read, J. & Gumley, A. (2008). Can attachment theory help explain the relationship between childhood psychosis and adversity? *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis, 2*(1), 1–35.
- Martindale, B.V., Bateman, A., Crowe, M. et al. (2000). *Psychosis: Psychological approaches and their effectiveness – putting psychotherapies at the centre of treatment*. London: Gaskell, The Royal College of Psychiatrists.
- Scott, R.D. (1973a). The treatment barrier: Part 1. *British Journal of Medical Psychology, 46*(1), 45–55.
- Scott, R.D. (1973b). The treatment barrier: Part 2. The patient as an unrecognized agent. *British Journal of Medical Psychology, 46*(1), 57–67.

The pattern may describe some people diagnosed with 'eating disorders', especially younger adults

Self-starvation, purging and bingeing may sometimes express similar themes, within a general culture of emphasis on women's (and increasingly men's) body size, shape and weight. These cultural pressures are particularly strong in Western societies, and are spreading further along with industrialisation. Eating distress in women (and increasingly in men) is complicated by gendered and often contradictory messages about role expectations, which lead to an increased need to exercise control over one's body, weight and eating patterns.

- Overview in Chapter 12, 'Distressed bodies and eating' in Cromby, J., Harper, D. & Reavey, P. (2013). *Psychology, mental health and distress*. Basingstoke: Palgrave Macmillan.
- All Party Parliamentary Group on Body Image (2012). *Reflections on body image*. London: All Party Parliamentary Group on Body Image and Central YMCA.
- Bordo, S. (1996). Anorexia nervosa: Psychopathology as the crystallisation of culture. In A. Garry & M. Pearsall (Eds.) *Women, knowledge and reality; explorations in feminist philosophy* (pp.388–418). New York: Routledge.
- British Psychological Society (in press). *Understanding eating disorders: How psychological struggles can manifest as eating problems*. Leicester: Author.
- Dallos, R. (2001). ANT – Attachment narrative therapy: Narrative and attachment theory approaches in systemic family therapy with eating disorders. *Journal of Family Psychotherapy, 12*(2), 43–72.
- Evans, P.C. (2003). 'If only I were thin like her, maybe I could be happy like her': The self-implications of associating a thin female ideal with life success. *Psychology of Women Quarterly, 27*(3), 209–214.
- Gordon, R. (2000). *Eating disorders: Anatomy of a social epidemic*. Oxford: Blackwell.
- Malson, H. (2009). *The thin woman: Feminism, post-structuralism and the social psychology of anorexia nervosa*. London: Routledge.
- Nasser, M., Katzman, M.A. & Gordon, R.A. (Eds.) (2002). *Eating disorder and cultures in transition*. London: Routledge.
- Orbach, S. (1978). *Fat is a feminist issue*. London: The Hamlyn Publishing Group Ltd.

- Troisi, A., Massaroni, P. & Cuzzolaro, M. (2005). Early separation anxiety and adult attachment style in women with eating disorders. *British Journal of Clinical Psychology*, 44, 89–97.
- Vogel, E.A., Rose, J.P., Roberts, L.R. et al. (2014). Social comparison, social media, and self-esteem. *Psychology of Popular Media Culture*, 3(4), 206–222.

The pattern may describe some people diagnosed with 'obsessive compulsive disorder', especially younger adults

- Doron, G., Moulding, R., Nedeljkovic, M. et al. (2012). Adult attachment insecurities are associated with obsessive compulsive disorder. *Psychological Psychotherapy*, 85(2), 163–178.
- Doron, G., Sar-El, D., Mikulincer, M. et al. (2012). Experimentally-enhanced attachment security influences obsessive compulsive related washing tendencies in a non-clinical sample. *Electronic Journal of Applied Psychology*, 8(1), 1–8.
- Ivarsson, T. (2008). Obsessive-compulsive disorder in adolescence. In H. Steele & M. Steele (Eds.) *Clinical applications of the adult attachment interview* (pp.213–235). New York: The Guilford Press.
- Ivarsson, T., Granqvist, P., Gillberg, C. et al. (2010). Attachment states of mind in adolescents with obsessive-compulsive disorder and/or depressive disorders: A controlled study. *European Child & Adolescent Psychiatry*, 19(11), 845–853.
- Lochner, C., du Toit, P.L., Zungu-Dirwayi, N. et al. (2002). Childhood trauma in obsessive-compulsive disorder, trichotillomania, and controls. *Depression and Anxiety*, 15(2), 66–68.
- Mathews, C.A., Kaur, N. & Stein, M.B. (2008). Childhood trauma and obsessive-compulsive symptoms. *Depression and Anxiety*, 25(9), 742–751.
- Yarbro, J., Mahaffey, B., Abramowitz, J. et al. (2013). Recollections of parent-child relationships, attachment insecurity, and obsessive-compulsive beliefs. *Personality and Individual Differences*, 54, 355–360.

Sub-patterns

Surviving mid life transitions

- Brinig, M.F. & Alan, D.W. (2000). 'These boots are made for walking': Why most divorce filers are women. *American Law and Economics Association*, 319, 126–169.
- Gannon, L.R. (1999). *Women and aging: Transcending the myths*. London: Routledge.
- Johnstone, L. (2000). *Users and abusers of psychiatry: A critical look at psychiatric practice*, Chapter 5, Women's and men's role problems and psychiatry (2nd edn, pp.100–129). Hove, New York: Routledge.
- Kalmijin, M. & Poortman, A.R. (2006). His or her divorce? The gendered nature of divorce and its determinants. *European Sociological Review*, 22, 201–214.
- Lafrance, M.N. (2009). *Women and depression: Recovery and resistance*. London: Routledge.
- Rotermann, M. (2007). Marital breakdown and subsequent depression. *Health Reports*, 18, 33–44.
- Stoppard, J.M. (2000). *Understanding depression. Feminist social constructionist approaches*. London: Routledge.

See also the extensive literature on women's role problems summarised in Chapter 4.

Surviving separation within migrant families

Separation from one's family of origin may be a particularly difficult transition if there are contradictions between cultural family values and the values of the dominant social group.

- Bourque F., van der Ven, E. & Malla, A. (2011). A meta-analysis of the risk for psychotic disorders among first- and second-generation immigrants. *Psychological Medicine*, 41(5), 897–910.
- Cantor-Graae, E. & Selten, J. (2005). Schizophrenia and migration: A meta-analysis and review. *American Journal of Psychiatry*, 162(1), 12–24.
- Coid, J.W., Kirkbride, J.B., Barker, D. et al. (2008). Raised incidence rates of all psychoses among migrant groups: Findings from the East London first episode psychosis study. *Archives of General Psychiatry*, 65(11), 1250–1258.

- Fearon, P., Kirkbride, J., Morgan, C. et al. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: Results from the MRC AESOP Study. *Psychological Medicine*, 36(11), 1541–1550.
- Gupta, V., Johnstone, L. & Gleeson, K. (2007). Exploring the meaning of separation in second generation young South Asian women in Britain. *Psychology and Psychotherapy: Theory, Research and Practice*, 80, 481–495.
- Hwang, W. & Wood, J. (2010). Acculturative family distancing and depression in Chinese American families. *Journal of Consulting and Clinical Psychology*, 78, 655–667.
- Leão, T.S., Sundquist, J., Frank, G. et al. (2006). Incidence of schizophrenia or other psychoses in first- and second-generation immigrants: A national cohort study. *Journal of Nervous and Mental Disease*, 194(1), 27–33.
- Rogers-Sirin, L., Ryce, P. & Sirin, S.R. (2014). Acculturation, acculturative stress, and cultural mismatch and their influences on immigrant children and adolescents' well-being. In R. Dimitrova et al. (Eds.) *Global perspectives on well-being in immigrant families* (pp.11–30). New York: Springer.
- Selton, J., Cantor-Graae, E. & Kahn, R.S. (2007). Migration and schizophrenia. *Current Opinion in Psychiatry*, 20(2), 111–115.
- Series authored by The Change Institute (2009), published by Department for Communities and Local Government, on *Understanding Muslim ethnic communities*. Available from www.changeinstitute.co.uk

Provisonal General Pattern: 5. Surviving defeat, entrapment, disconnection and loss

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

This pattern describes people who are trapped in long-term situations of chronic interpersonal/ environmental stress and/or social exclusion. The broad pattern of threats and threat responses, both past and present, give rise to core meanings of defeat, entrapment, disconnection and loss. This pattern of distress is more common in less powerful groups, for example, female, low social class, older age group, ethnic minority, especially in the context of austerity, social inequality and social injustice. These groups are also the most likely to feel the adverse consequences of high unemployment, low wages, poor work conditions, etc. At a broader level, it may describe the general impact of surviving situations of social inequality and injustice and the consequent fragmenting of communities which affects all its members. Common diagnoses are 'depression', 'clinical depression' or 'major depressive disorder', 'anxiety disorder', 'generalised anxiety disorder', 'agoraphobia', alcoholism/drug dependency, 'OCD', hoarding, 'postnatal depression', 'bulimia', and 'prolonged grief disorder' or 'complicated grief' along with suicidal feelings, although not everyone with these diagnoses fits the pattern and these diagnoses are also assigned within other patterns. Poor physical health or pain and disability may compound the person's difficulties. Like all the patterns, this one may also describe people who have never been formally diagnosed.

Overviews

As described in Chapter 6, Paul Gilbert's theorising has particular relevance within this pattern, as well as having applicability to 'low mood' within other general patterns. He suggests we are primed to feel very distressed by disconnection, social exclusion, and social defeat or 'competitive defeat'. These may result in a change of balance between the posited three main affect regulation systems: (1) threat systems (associated with high arousal and emotions like anger, anxiety and disgust); (2) soothing/affiliative/ emotional regulation systems (associated with feelings of connectedness, safety, and contentment); and (3) drive/excitement systems (associated with rewards and goal-seeking, and feelings

of energy and pleasure). As a result, there may be subjective experiences of loss of pleasure, energy, drive, connection and safety. Sometimes this occurs in the context of over-focus on the achievement and 'drive' system and consequent exhaustion.

In conditions of austerity and inequality, populations as a whole may experience increased levels of humiliation and shame; fear and distrust; instability and insecurity; isolation and loneliness; feeling trapped and powerless. This applies whatever one's personal background and experience of other adversities. It also affects more affluent members of society even if they are protected from the material impacts.

British Psychological Society. (in press). *Understanding depression*. Leicester: Author.

Chandola, T. & Zhang, N. (2017). Re-employment, job quality, health and allostatic load biomarkers: Prospective evidence from the UK Household Longitudinal Study. *International Journal of Epidemiology*, 1–11, doi: 10.1093/ije/dyx150

Cromby, J., Harper, D. & Reavey, P. (2013). *Psychology, mental health and distress*, Chapter 9, 'Sadness and worry'. Basingstoke: Palgrave Macmillan.

Gilbert, P. (2007). *Psychotherapy for counselling and depression* (3rd edn). London: Sage.

Melzer, D., Fryers, T. & Jenkins, R. (2004). *Social inequalities and the distribution of the common mental disorders*. Hove: Psychology Press.

Moussavi, S., Chatterji, S., Verdes, E. et al. (2007). Depression, chronic diseases, and decrements in health: Results from the World Health Surveys. *Lancet*, 370, 851–858.

National Institute for Health and Care Excellence (NICE) (2010). *Depression in adults with chronic physical health problems: The NICE guideline on treatment and management*. London: Author.

Psychologists against Austerity (2015). *The psychological impact of austerity: A briefing paper*. Author. Available from <https://psychagainstausterity.files.wordpress.com/2015/03/paa-briefing-paper.pdf>

Taylor, P.J., Gooding, P., Wood, A.M. et al. (2011). The role of defeat and entrapment in depression, anxiety, and suicide. *Psychological Bulletin*, 137, 3, 391–420.

Wilkinson, R. & Pickett, K. (2009). *The spirit level: Why more equal societies almost always do better*. London: Penguin Books Ltd.

The pattern describes some people diagnosed with 'depression', 'clinical depression' or 'major depressive disorder'. They are more commonly women than men.

Brown, G.W. & Harris, T. (1978). *The social origins of depression*. London: Tavistock Press.

Brown, G.W., Ni Bhrolchain, M. & Harris, T. (1975). Social class and psychiatric disturbance among women in an urban population. *Sociology*, 9, 225–254.

Brown, G.W. (1996). Onset and course of depressive disorders: Summary of a research programme.

In C. Mundt, M.J. Goldstein, K. Hahlweg & P. Fielder (Eds.) *Interpersonal factors in the origin and course of affective disorders* (pp.151–167). London: Royal College of Psychiatrists.

Dryden, C. (1999). *Being married, doing gender: A critical analysis of gender relationships in marriage*. London: Routledge.

Fujiwara, T. & Kawachi, I. (2008). A prospective study of individual level social capital and major depression in the United States. *Journal of Epidemiology and Community Health*, 62, 627–633.

Gilbert, P. (2007). *Psychotherapy for counselling and depression* (3rd edn). London: Sage.

Jack, D.C. & Ali, A. (Eds.) (2010). *Silencing the self across cultures: Depression and gender in the social world*. Oxford: Oxford University Press.

Johnstone, L. (2000). *Users and abusers of psychiatry: A critical look at psychiatric practice*, Chapter 5, Women's and men's role problems and psychiatry (2nd edn, pp.100–129). Hove, New York: Routledge.

Kendler, K.S., Hettema, J.M., Butera, F. et al. (2003). Life event dimensions of loss, humiliation, entrapment, and danger in the prediction of onsets of major depression and generalized anxiety. *Archives General Psychiatry*, 60(8), 789–796.

Lafrance, M.N. (2009). *Women and depression: Recovery and resistance*. London: Routledge.

- Siddaway, A.P., Taylor, P.J., Wood, A.M. et al. (2015). A meta-analysis of perceptions of defeat and entrapment in depression, anxiety problems, posttraumatic stress disorder, and suicidality. *Journal of Affective Disorders*, *194*, 149–159.
- Taylor, P., Gooding, P., Wood, A.M. et al. (2011). The role of defeat and entrapment in depression, anxiety, and suicide. *Psychological Bulletin*, *137*(3), 391–420.
- MacInnes, T., Aldridge, H., Bushe, S. et al. (2014). *Monitoring poverty and social exclusion*. London: Joseph Rowntree Foundation.
- Martin, L.A., Neighbors, H.W. & Griffith, D.M. (2013). The experience of symptoms of depression in men vs women: Analysis of the National Comorbidity Survey Replication. *JAMA Psychiatry*, *70*(10), 1100–1106.
- Mills, C., Zavaleta, D. & Samuel, K. (2014). Shame, humiliation and social isolation: Missing dimensions of poverty and suffering analysis. *OPHI Working Papers 71*, University of Oxford.

Disconnection from one's social group is associated with low mood:

- Cruwys, T., Haslam, S.A., Dingle, G.A. et al. (2014). Depression and social identity: An integrative review. *Personality and Social Psychology Review*, *18*, 215–238.
- Sani, F., Madhok, V., Norbury, M. et al. (2015). Greater number of group identifications is associated with lower odds of being depressed: Evidence from a Scottish community sample. *Social Psychiatry and Psychiatric Epidemiology* *50*, 1389–1397.

Low mood is also one possible response to adversities such as child sexual and physical abuse and witnessing violence as a child

- Schilling, E.A., Aseltine, R.H. & Gore, S. (2007). Adverse childhood experiences and mental health in young adults: A longitudinal survey. *BMC Public Health*, *7*, 30.
- Sitko, K., Bentall, R.P., Shevlin, M. et al. (2014). Associations between specific psychotic symptoms and specific childhood adversities are mediated by attachment styles. *Psychiatry Research*, *217*(3), 202–209.

The pattern describes some people diagnosed with 'hoarding disorder'

One possible response to insecurity and loss is collecting and hoarding possessions, although hoarding may have other meanings and functions as well.

- Division of Clinical Psychology (2015). *A psychological perspective on hoarding: DCP Good Practice Guidelines*. Leicester: British Psychological Society.
- Hartl, T.L., Duffany, S.R., Allen, G.J. et al. (2005). Relationships among compulsive hoarding, trauma, and attention-deficit/hyperactivity disorder. *Behaviour Research and Therapy*, *43*(2), 269–276.

The pattern describes some people who are experiencing long-term reactions to bereavement and loss.

- Bonanno, G.A. (2010). *The other side of sadness: What the new science of bereavement tells us about life after a loss*. New York: Basic Books.
- Davies, J. (2012). *The importance of suffering: The value and meaning of emotional discontent*. New York, Hove: Routledge.
- Horwitz, A.V. & Wakefield, J.C. (2012). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. New York: Oxford University Press.

Sub-patterns

Surviving competitive defeat

Some people demonstrate outward success through a strong achievement and competitive drive, derived from family and social expectations. If perceived expectations are not met, or it is not possible to sustain the drive, or they are suddenly faced with unemployment or other

crises beyond their control, there may be threat responses of ‘competitive defeat’, exhaustion and self-criticism with a sense of failure, shame and hopelessness, and suicidal feelings.

Men may be more vulnerable to these messages and are the most at risk group for suicide. Within this, economically disadvantaged men in mid-life have the highest suicide rates. A recent Samaritans report suggests that this can be understood as a combination of factors including perceived failure to live up to masculine standards of success and control, in the context of relationship breakdown and socioeconomic changes and pressures.

- Brownhill, S., Wilhelm, K., Barclay, L. & Schmied, V. (2005). ‘Big build’: Hidden depression in men. *Australian and New Zealand Journal of Psychiatry*, 39, 921–931.
- Classen, T.J. & Dunn, R.A. (2012). The effect of job loss and unemployment duration on suicide risk in the United States. *Health Economics*, 21, 338–350.
- Gilbert, P., McEwan, K., Bellew, R. et al. (2009). The dark side of competition: How competitive behaviour and striving to avoid inferiority are linked to depression, anxiety, stress and self-harm. *Psychology and Psychotherapy: Theory, Research and Practice*, 82(2), 123–136.
- Jefferis, D.J., Nazareth, I., Marston, L. et al. (2011). Associations between unemployment and major depressive disorder: Evidence from an international, prospective study (the predict cohort). *Social Science and Medicine*, 73, 1627–1634.
- Samaritans (2017). *Suicide statistics report 2017*. Author. Retrieved from <http://www.samaritans.org/about-us/our-research/facts-and-figures-about-suicide>
- Siddaway, A.P., Taylor, P.J., Wood, A.M. et al. (2015). A meta-analysis of perceptions of defeat and entrapment in depression, anxiety problems, posttraumatic stress disorder, and suicidality. *Journal of Affective Disorders*, 194, 149–159.
- Taylor, P., Gooding, P., Wood, A.M. et al. (2011). The role of defeat and entrapment in depression, anxiety, and suicide. *Psychological Bulletin*, 137(3), 391–420.
- Troop, N.A. & Hiskey, S. (2013). Social defeat and PTSD symptoms following trauma. *British Journal of Clinical Psychology*, 52(4), 365–379.
- Wyllie, C., Platt, S., Brownlie, J. et al. (2012). *Men, suicide and society: Why disadvantaged men in mid-life die by suicide*. Samaritans. Retrieved from <http://www.samaritans.org/sites/default/files/kcfinder/files/press/Men%20Suicide%20and%20Society%20Research%20Report%20151112.pdf>

Surviving exclusion and competitive defeat as a young person

Adolescents and young adults in the UK report very high levels of self-harm, body hatred, eating distress, anxiety, misery, drug and alcohol use, etc., in the context of increased pressures to achieve in a more competitive environment, along with constant status comparisons through social media. The ‘thin ideal’ has resulted in an almost universal pre-occupation with weight in young women. Young men may have a parallel concern with being fit and having well-defined muscles.

Overview in:

The Children’s Society (2015). *The good childhood report*. Retrieved from <http://www.childrenssociety.org.uk/what-we-do/resources-and-publications/the-good-childhood-report-2015>

All Party Parliamentary Group on Body Image (2012). *Reflections on body image*. London: All Party Parliamentary Group on Body Image and Central YMCA.

Accordino, D.B., Accordino, M.P. & Slaney, R.B. (2000). An investigation of perfectionism, mental health, achievement, and achievement motivation in adolescents. *Psychology in the Schools*, 37(6), 535–545.

Bardone-Cone, A.M., Wonderlich, S.A., Frost, R.O. et al. (2007). Perfectionism and eating disorders: Current status and future directions. *Clinical Psychology Review*, 27(3), 384–405.

- Bellew, R., Gilbert, P., Mills, A. et al. (2006). Eating attitudes and striving to avoid inferiority. *Eating Disorders*, 14(4), 313–322.
- Ditch the Label (2013). *The cyberbullying report 2013*. Author. Available from <https://www.ditchthelabel.org/research-papers/the-cyber-bullying-survey-2013>
- Evans, P.C. (2003). 'If only I were thin like her, maybe I could be happy like her': The self-implications of associating a thin female ideal with life success. *Psychology of Women Quarterly*, 27(3), 209–214.
- Schweizer, R., & Hamilton, T.J. (2002). Perfectionism and mental health in Australian university students: Is there a relationship? *Journal of College Student Development*, 43(5), 684–695.
- Stice, E., Presnell, K. & Spangler, D. (2002). Risk factors for binge eating onset in adolescent girls: A 2-year prospective investigation. *Health Psychology*, 21(2), 131–138.
- Stowkowy, J. & Addington, J. (2012). Maladaptive schemas as a mediator between social defeat and positive symptoms in young people at clinical high risk for psychosis. *Early Intervention Psychiatry*, 6(1), 87–90.
- Troop, N.A., Allan, S., Treasure, J.L. et al. (2003). Social comparison and submissive behaviour in eating disorder patients. *Psychology and Psychotherapy: Theory, Research and Practice*, 76(3), 237–249.
- Troop, N.A. & Baker, A.H. (2008). The specificity of social rank in eating disorder versus depressive symptoms. *Eating Disorders*, 16(4), 331–341.
- Valmaggia, L.R., Day, F., Garety, P. et al. (2015). Social defeat predicts paranoid appraisals in people at high risk for psychosis. *Schizophrenia Research*, 168(1-2), 16–22.
- Vogel, E.A., Rose, J.P., Roberts, L.R. et al. (2014). Social comparison, social media, and self-esteem. *Psychology of Popular Media Culture*, 3(4), 206–222.

Surviving exclusion and competitive defeat as non-typical or non-conforming

The narrower the range of acceptable ways of being, and the more individualistic and competitive the social norms, the more likely it is that people who are non-typical in various ways will experience feelings of failure, inadequacy, shame and exclusion. Some examples include: having an intellectual disability; having the characteristics associated with a diagnosis of Asperger's or autism spectrum disorder; being LGBTQ; having a visible appearance difference; and so on. This may lead to a variety of threat responses ranging from low mood, low self-worth, anxiety, self-injury, and eating distress to expressions of distress that may be diagnosed as 'psychosis.' Summaries and references relating to some of these aspects of difference are found in General Pattern 'Identities'.

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Coping with childbirth and childrearing

This is sometimes diagnosed as 'postnatal depression.' Childbirth may involve aspects of threat such as 'entrapment', physical invasiveness, lack of predictability, loss of previous roles and status, lack of control, etc., and for some women may re-trigger sexual/physical trauma histories. Mothers, and sometimes fathers, who have received less than ideal parenting themselves, and/or have experienced earlier adversities, and/or are isolated and living in poverty, and/or are victims of domestic violence, are more likely to experience the emotional and physical demands of parenting as overwhelming and inescapable.

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Surviving bullying and workplace bullying.

Bullying can be understood at one level as a process of enforcing group norms within peer groups. Prolonged bullying in childhood is associated in adults with low mood and low self-worth, difficulties with trust and intimacy in romantic partnerships, shame and lack of confidence, and persistent loneliness. In its more severe forms, it may result in 'psychotic' and other difficulties as an adult, as described under the General Pattern 'Surviving rejection, entrapment and invalidation'.

- Hugh-Jones, S. & Smith, P.K. (1999). Self-reports of short- and long-term effects of bullying on children who stammer. *British Journal of Educational Psychology*, 69(2), 141–158.
- Jack, A.H. & Egan, V. (2017). Trouble at school: A systematic review to explore the association between childhood bullying and paranoid thinking. *Psychosis*, 9(3), 260–270.
- Olweus, D. (1993). Victimization by peers: Antecedents and long-term outcomes. In K.H. Rubin & J.B. Asendorpf (Eds.) *Social withdrawal, inhibition and shyness in childhood* (pp.315–342). Hillsdale, NJ: Lawrence Erlbaum.
- Tritt, C. (1997). The relationship between childhood bullying and young adult self-esteem and loneliness. *The Journal of Humanistic Education and Development*, 36(1), 35–44.

Workplace bullying is more frequent in business or institutional environments that are primarily based on competition and threat. It is associated with panic attacks, low mood, loss of self-esteem, hyperarousal, avoidance, and physical symptoms such as headaches, insomnia, digestive problems, skin complaints, nausea, and heart palpitations.

- Bond, S.A., Tuckey, M.R. & Dollard, M.F. (2010). Psychosocial safety climate, workplace bullying, and symptoms of posttraumatic stress. *Organization Development Journal*, 28(1), 38–56.
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'Brain fag' in West Africa

'Brain fag' in West Africa may be an expression of similar stresses. It is mainly reported by male school and university students and others studying for further qualifications, especially around periods of intensive study, and comprises mental exhaustion, sensations of pain or burning in the head and neck, and blurred vision. The experiences appear to be related to an intense desire to succeed and improve the economic and social standing of oneself and one's family. These pressures arise in the context of rapid social change and globalisation, and create tensions with more traditional values and practices. It is a diagnosis that appears to be declining in use, with more recently-trained psychiatrists applying it relatively rarely in practice. It has also been argued that it is not a true 'culture-bound syndrome' but a notion transported from 19th century Britain.

- Ayonrinde, O. (2008). Brain fag syndrome: New wine in old bottles or old wine in new bottles? *Nigerian Journal of Psychiatry*, 6(2), 47–50.
- Ayonrinde, O.A., Obuaya, C. & Adeyemi, S.O. (2015). Brain fag syndrome: A culture-bound syndrome that may be approaching extinction. *British Journal of Psychiatry Bulletin*, 39, 156–161.
- Ebigbo, P.O., Lekwas, E.C. & Chukwuneniyem, N.F. (2015). Brain fag: New perspectives from case observations. *Transcultural Psychiatry*, 52(3), 311–330.

'Kufingisisa' in the Khwe community in South Africa

The Khwe community in South Africa describes a version of kufingisisa, a phenomenon translated as 'thinking too much' which is mentioned in *DSM-5* and recognised in a number of world regions. While this state does not always have negative impacts or connotations for the Khwe, it sometimes refers to intense rumination about the extreme poverty, material deprivation and health concerns faced by this displaced and marginalised community. This is accompanied by feelings of hopelessness and lack of control.

- den Hertog, T.N., de Jong, M., van der Ham, A.J. et al. (2015). 'Thinking a lot' among the Khwe of South Africa: A key idiom of personal and interpersonal distress. *Culture, Medicine and Psychiatry*, 29(3), 357–380.
- Kaiser, B.N., Haroz, E.E., Kohrt, B.A. et al. (2015). 'Thinking too much': A systematic review of a common idiom of distress. *Social Science and Medicine*, 147, 170–183.

Provisional General Pattern: 6. Surviving social exclusion, shame and coercive power

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

The pattern describes someone whose family of origin is likely to have lived in environments characterised by threat, discrimination, material deprivation and social exclusion.

Individuals tend to use survival strategies of cutting off from their own and others' emotions,

maintaining emotional distance, and remaining highly alert to threat. Unequal societies, in which economic inequality increases social competition, allow these dynamics to flourish.

Common diagnoses are ‘anti-social personality disorder’, ‘borderline personality disorder’, ‘narcissistic personality disorder’, ‘paranoia’ and alcoholism/substance abuse along with eating disorders, psychosis, bipolar disorder and major depressive disorder, although not everyone assigned these diagnoses fits the pattern and these diagnoses are also assigned within other patterns. There may be a history of criminal offences. The suspicious thoughts (‘paranoia’) that are characteristic of this pattern (although also found in others) have links to disrupted attachments, domestic violence in family of origin, poverty, institutional care, unsafe urban environments, and experiences of bullying, assault and other physical threats. Suspicious thoughts are also linked to experiences of immigration and racial discrimination. Violence and aggression arise within similar background contexts. In women, the consequences of these backgrounds of victimisation are more likely to be internalised in the form of self-harm and eating distress, and the pattern may be closer to ‘Surviving rejection, entrapment and invalidation’, while men are more likely to direct anger outwards in the form of violence and destructiveness towards others. Like all the patterns, this one may also describe people who have never been formally diagnosed.

Overviews:

- Chapter 13, ‘Disordered personalities?’ In Cromby, J., Harper, D. & Reavey, P. (2013). *Psychology, mental health and distress*. Basingstoke: Palgrave Macmillan.
- Herman, J.L. (2001). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books.
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- Chapter 10 in Wilkinson, R. & Pickett, K. (2009). *The spirit level: Why more equal societies almost always do better*. London: Allen Lane.

See also:

- Bentall, R.P. (2013). Understanding psychotic symptoms: Cognitive and integrative models. In J. Read & J. Dillon (Eds.) *Models of madness: Psychological, social and biological approaches to psychosis* (2nd edn, pp.220–237). Hove: Routledge.
- Berry, K., Barrowclough, C. & Wearden, A. (2008). Attachment theory: A framework for understanding symptoms and interpersonal relationships in psychosis. *Behaviour Research and Therapy*, 46(12), 1275–1282.
- Catone, G., Marwaha, S., Kuipers, E. et al. (2015). Bullying victimisation and risk of psychotic phenomena: Analysis of British national survey data. *The Lancet Psychiatry*, 2(7), 618–624.
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- Read, J. (2010). Can poverty drive you mad? *New Zealand Journal of Psychology*, 39, 7–19.
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- Schore, A. (2003). *Affect regulation and repair of the self*. New York: W.W. Norton.
- Wyllie, C., Platt, S., Brownlie, J., Chandler, A. & Connolly, S. (2012). *Men, suicide and society: Why disadvantaged men in mid-life die by suicide*. Samaritans. Available from <http://www.samaritans.org/sites/default/files/kcfinder/files/press/Men%20Suicide%20and%20Society%20Research%20Report%20151112.pdf>

'Paranoia' or suspicious thoughts

'Paranoia' is associated with being male, of low socioeconomic status, member of a minority ethnic group, immigration and being a refugee. There is an increased risk of 'paranoia' in adults if as children they had insecure or neglectful attachments; witnessed violence, physical attack/assault; or were held captive/threatened with a weapon. Studies have associated 'paranoia' with feelings including shame, anger, worthlessness, humiliation, entrapment, powerlessness, low self-esteem and injustice. It also arises in contexts of income inequality, alienated labour, community mistrust, exploitation, social exclusion and neighbourhood disorder. It is associated with harsh urban environments. African-Caribbeans living in mainly white neighbourhoods experience higher levels of 'paranoia'. Disrupted attachments and resulting low self-esteem pre-dispose to later 'paranoia'. 'Paranoid' reactions seem to be triggered by episodes of low self-esteem and anger, possibly as a way of preserving self-image. 'Paranoid' beliefs are found worldwide, suggesting an underlying evolved threat response possibly mediated biologically by the mid-brain dopamine system which anticipates threats and initiates avoidance behaviour.

Overviews in:

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- Cromby, J. & Harper, D. (2009). Paranoia: A social account. *Theory and Psychology*, 19, 335–361.
- Harper, D. (2011). The social context of paranoia. In M. Rapley, J. Moncrieff & J. Dillon (Eds.) *De-medicalising misery: Psychiatry, psychology and the human condition* (pp.53–65). London: Palgrave Macmillan.

See also:

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- Das-Munshi, J., Bécaries, L., Boydell, J.E. et al. (2012). Ethnic density as a buffer for psychotic experiences: Findings from a national survey (EMPIRIC). *British Journal of Psychiatry*, 201, 282–290.
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- Vassos, E., Pedersen, C.B., Murray, R.M. et al. (2012). Meta-analysis of the association of urbanicity with schizophrenia. *Schizophrenia Bulletin*, 38(6), 1118–1123.
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Violence and aggression

Early environments of attachment disruptions, violence and/or neglect, poverty, witnessing violence, and having parents with substance abuse problems are strongly (although not inevitably) associated with later violent or criminal behaviours, in both men and women,

as are histories of sexual abuse and being taken into care. There are well-established links between harsh or abusive parenting and later delinquency and criminality, and (for men) lack of a father. For this reason, the pattern describes many people in the criminal justice system, especially men, since gender socialisation encourages them to direct anger outwards.

- Allen, J.P., Hauser, S.T. & Borman-Spurrell, E. (1996). Attachment theory as a framework for understanding sequelae of severe adolescent psychopathology: An 11 Year Follow Up study. *Journal of Consulting and Clinical Psychology*, 64, 254–263.
- Ardino, V. (2012). Offending behaviour: The role of trauma and PTSD. *European Journal of Psychotraumatology*, 3, 18968. <http://dx.doi.org/10.3402/ejpt.v3i0.18968>
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- Fonagy, P. (2003). Towards a developmental understanding of violence. *British Journal of Psychiatry*, 183, 190–192.
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- Liotti, G. & Gilbert, P. (2011). Mentalizing, motivation, and social mentalities: Theoretical considerations and implications for psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 9–25.
- McCrary, A., Brito, S.A. & Viding, E. (2011). The impact of childhood maltreatment: A review of neurobiological and genetic factors. *Frontiers in Psychiatry*, 2, 48.
- Miller, N.A. & Najavits, .LM. (2012). Creating trauma-informed correctional care: A balance of goals and environment. *European Journal of Psychotraumatology*, 3, 10.3402/ejpt.v3i0.17246.
- Pfäfflin, F. & Adshead, G. (Eds.) (2004). *A matter of security: The application of attachment theory to forensic psychiatry and psychotherapy*. London and New York: Jessica Kingsley Publishers Ltd.
- Popenoe, D. (1996). *Life without father*. New York: Free Press.
- Webb, R.T., Antonsen, S., Carr, M.J. et al. (2017). Self-harm and violent criminality among young people who experienced trauma related hospital admissions during childhood: A Danish national cohort study. *Lancet Public Health*, 2, e314-22.

‘Paranoia’ in prison populations is linked to experiences of being bullied, witnessing domestic violence as a child, and having been in institutional care, as well as experiencing threats as an adult.

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Sub-patterns

Perpetrating domestic abuse

Domestic abuse can refer to any violent or coercive relationship between adult family members, but most commonly it describes abuse between partners. Domestic abusers, like anyone who has committed a crime or behaved in a violent or coercive way, are accountable for their actions. At the same time, it is important to recognise that certain PTM patterns increase the likelihood that some people will choose to act in this way. Domestic violence perpetrated by men is more common in the presence of unemployment, lower socioeconomic status and financial stress. Early experiences of

victimisation and witnessing parental domestic violence also increase the likelihood of this behaviour in men, but not in women. The level of exposure to violence in childhood is correlated with the severity of abuse inflicted as an adult. Domestic abuse is found in all sections of society, and some male domestic abusers have a profile of higher social status, and fewer or no other violent behaviours. Men within this pattern sometimes attract diagnoses of ‘narcissistic, antisocial or borderline personality disorders’, and sometimes abuse alcohol. Less is known about domestic abuse perpetrated by women, although it may be linked to attachment disruptions and early trauma, social isolation and low self-confidence. Little is known about domestic abuse within same-sex and transgender relationships, although there are suggestions that disrupted attachments and witnessing domestic violence may be relevant in gay and lesbian perpetrators as well.

- Archer, J. (1994). Power and male violence. In J. Archer (Ed.) *Male violence* (pp.121–140). London: Routledge.
- Capaldi, D.M., Knoble, N.B., Shortt, J.W. et al. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse, 3*(2), 231–280.
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- Goldenson, J., Geffner, R., Foster, S.L. et al. (2007). Female domestic violence offenders: Their attachment security, trauma symptoms, and personality organization. *Violence and Victims, 22*(5), 532–545.
- Henning, K. & Holdford, R. (2006). Minimisation, denial, and victim blaming by batterers. *Criminal Justice and Behavior, 33*, 110–130.
- Johnson, M.P. (2008). *A typology of domestic violence: Intimate terrorism, violent resistance and situational couple violence*. Lebanon, NH: Northeastern University Press.
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- McKenry, P.C., Serovich, J.M., Mason, T.L. et al. (2006). Perpetration of gay and lesbian partner violence: A disempowerment perspective. *Journal of Family Violence, 21*(4), 233–243.
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- Swan, S.C. & Sullivan, T.P. (2009). The resource utilisation of women who use violence in intimate relationships. *Journal of Interpersonal Violence, 24*, 940–958.
- Wekerle, C. & Wolfe, D. (1998). The role of childhood maltreatment and attachment style in adolescent relationships. *Development and Psychopathology, 10*(3), 571–586.

Surviving homelessness

Long-term homeless people frequently report poor family relationships, high rates of emotional and physical abuse/violence including domestic violence, institutional care, and substance misuse, in a cumulative series of adversities. About half may have suffered traumatic brain injury, such as a blow to the head during an assault or traffic accident. In addition, strokes, brain cancers, dementias, and damage caused by drug or alcohol use may lead to personality and behavioural changes and problems with concentration and memory.

- Homeless Link (2014). *Brain injury and homelessness: Good practice guidance for frontline services*. Author. Retrieved from http://www.homeless.org.uk/sites/default/files/site-attachments/Brain%20Injury%20and%20Homelessness%20March%202017_0.pdf

Jarrett, C. (2010). Helping the homeless. *The Psychologist*, 23(4), 284–287.

McMillan, T.M., Laurie, M., Oddy, M. et al. (2015). Head injury and mortality in the homeless. *Journal of Neurotrauma*, 15, 32(2), 116–119.

Mental Health Foundation (2015). *Fundamental facts about mental health*. London: Author. Retrieved from <https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf>

Surviving separation, institutionalisation and privilege

People from more affluent backgrounds may show somewhat different patterns of response. The earlier victimisation/trauma and the later threat responses may be more limited, subtle, and seen as socially acceptable or even desirable. Reduced empathy and offending behaviour may be masked by social skills and superficial charm. For example, there has been identification of so-called ‘boarding school syndrome’ among more privileged groups. The sudden loss of attachments at an early age, coupled with the need to survive in a new and possibly threatening or abusive environment, may lead to the development of a superficially confident presentation, which conceals vulnerability, fear and loneliness, even from the person themselves. This is likely to result in later difficulties with trust and intimacy, and (in the case of boys at single sex schools) relating to women.

Schaverien, J. (2004). Boarding school: The trauma of the ‘privileged’ child. *The Journal of Analytical Psychology*, 49(5), 683–706.

Schaverien, J. (2011). Broken attachments: A hidden trauma. *British Journal of Psychotherapy*, 27(2), 138–155.

Duffell, N. & Basset, T. (2016). *Trauma, abandonment and privilege: A guide to therapeutic work with boarding school survivors*. Abingdon: Routledge.

Running amok

Running amok is a pattern of behaviour found in Malaysia and Indonesia among other places. It can take various forms, but in one, a hitherto peaceful man will acquire a weapon and make a frenzied attempt to injure or kill others. The episode frequently ends with the man either killing himself or being killed by others. Malay mythology attributed this behaviour to spirit invasion. It is also widely seen as a way to re-establish one’s reputation as a man to be respected and feared, after a perceived slight. Comparisons have been drawn with school shootings in the US, which seem to be linked to male feelings of humiliation, rejection, failure, exclusion, grievance and anger.

Saint Martin, M.L. (1999). Running amok: A modern perspective on a culture-bound syndrome. *The Primary Care Companion: Journal of Clinical Psychiatry*, 1(3), 66–70.

Provisional General Pattern: 7. Surviving single threats

As with all the General Patterns, this describes a continuum, and the presence of fewer threats and exacerbating factors and more ameliorating and protective ones implies the need for fewer and less disabling threat responses.

This pattern is widely recognised in Western settings under the diagnosis of ‘PTSD’. The pattern is also recognised in the trauma literature’s distinction between ‘single incident’ trauma (an unexpected ‘one-off’ and ‘out of the blue’ event such as a natural disaster, traumatic accident, terrorist attack or single episode of assault, abuse or witnessing of it) and complex trauma which is cumulative, repetitive and interpersonally generated. Reactions to threatening events are more

likely to be severe and long-lasting if there is an earlier history of disrupted attachments and other adversities, in which case there will be overlap with other General Patterns.

- van der Kolk, B.A., Roth, S., Pelcovitz, D. et al. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*(5), 389–399.
- Sitko, K., Bentall, R.P., Shevlin, M. et al. (2014). Associations between specific psychotic symptoms and specific childhood adversities are mediated by attachment styles. *Psychiatry Research, 217*(3), 202–209.
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Sub-patterns

Surviving rape

Common threat responses and meanings include feelings of responsibility and hence self-blame, shame and guilt (especially in women) along with anger, relationship difficulties, and sexual difficulties. A similar pattern in men includes threat responses and meanings of humiliation, denial, repression, shame, powerlessness, low self-confidence, mistrust of adult men, sexual difficulties, negative body image and doubts about one's sexual orientation, along with internalised homophobia. Victims may be low in mood, anxious, fearful, panicky and/or suicidal in the aftermath of the assault, along with experiencing hypervigilance, avoidance, and intrusive thoughts, and may use alcohol or drugs to cope. These meanings are shaped by social discourses about women's and men's roles, about male and female sexuality, and about who bears the responsibility for rape.

- Gavey, N. (2005). *Just sex? The cultural scaffolding of rape*. London: Routledge.
- Hanson, K.R. (1990). The psychological impact of sexual assault on women and children: A review. *Annals of Sex Research, 3*(2), 187–232.
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- Myers, M.F. (1989). Men sexually assaulted as adults and sexually abused as boys. *Archives of Sexual Behavior, 18*(3), 203–215.
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Surviving combat

These responses have long been recognised in forms such as 'shellshock' and were officially recognised with the inclusion of the new concept of 'Post-traumatic stress disorder' in *DSM-III*, following the Vietnam war. If threatening events in combat are accompanied by many exacerbating factors, and occur in the context of a history of earlier adversities and attachment difficulties, the threat responses are likely to be more severe, and the pattern may be more typical of 'Surviving rejection, entrapment and invalidation'.

It has been argued that the response patterns are essentially similar to those experienced by (mainly) women and children in the private sphere, as a consequence of rape, domestic violence and sexual abuse. War is particularly likely to expose combatants to extreme violence, violation, injury and grotesque forms of death, all of which are known to increase the likelihood of psychological damage to the witness. The survivor may remain in a state of physiological hyperarousal and preparation for threat, with accompanying insomnia, startle responses and irritability. They may experience vivid, fragmented and intrusive memories of combat events in the form of flashbacks and nightmares. They may attempt to manage all this by numbing their feelings and cutting off their perceptions, sometimes to the point of dissociating from their bodies. Drugs and alcohol may also be used to manage feelings of helplessness and terror. As with traumatic events in general, a sense of betrayal (for example, about the lack of justification for war) increases the damaging impact by shattering the combatants' faith in themselves, other people and the world.

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Surviving as a Cambodian refugee

Khyâl attacks are reported in many Asian and South Asian countries, in which there is a belief in Khyal, or a windlike substance that flows along with blood throughout the body. Bodily symptoms are frequently attributed to disruption of this flow. Khyal attacks are characterised by palpitations, dizziness, shortness of breath, joint and neck soreness, tinnitus, headache, and loss of energy. The belief is that khyâl has suddenly started flowing up toward the heart, lungs, and neck. This causes the hands and feet to grow cold, while the upward flow of khyâl and blood potentially stops the heart or bursts the neck vessels. The khyâl exits from ears or eyes, which causes the tinnitus or blurred vision. Cambodian refugees frequently report these attacks. In this group, the attacks are often related to reminders or memories of severe trauma experienced during the Pol Pot regime, including violence, death threats, and witnessing others being tortured or killed.

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Chapter 2: Philosophical and conceptual principles of alternatives to psychiatric diagnosis

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Chapter 3 Narrative and meaning

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Chapter 4 The social context

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Chapter 5 Biology

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Chapter 6 Describing patterns within a Power Threat Meaning Framework

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Chapter 8 Ways forward

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