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Don't jump ship!
New approaches in teaching mental health to undergraduates

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Introduction

Mental health teaching on undergraduate psychology courses is often structured according to psychiatric diagnoses and categorisations. In this article, we question the value of this approach to teaching and propose an alternative to the tendency for psychology educators to "jump ship" by giving psychiatric rather than consistently psychological explanations of mental distress. We review evidence that psychiatric diagnoses are flawed and unhelpful; briefly outline how the benefits of more consistently psychological formulations and corresponding interventions; discuss recent policy developments which might bear upon mental health teaching; and offer pointers to a range of resources which teachers might find helpful.

What's wrong with psychiatric diagnosis?

Many psychology undergraduates will be familiar with the critiques of psychiatric diagnosis mounted in the 1960s and 1970s. However, there is often much less coverage of more recent research which reveals that diagnostic systems like the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) have been bedevilled by problems of poor reliability and validity (Bentall, 2004; Boyle, 2002; Johnstone, 2000) -- for example different diagnosers may give the same person different diagnoses, and diagnostic criteria vary from system to system (Bentall, 2004).

In the United States, where psychologists are generally paid by clients' health insurers, a DSM diagnosis is required; even though the axial model is argued to better accommodate contextual factors, such a psychosocial stressors and medical problems. Arguably as a result of this lean towards diagnostic categories, North American psychologists have generally been less critical of diagnosis than their British counterparts. Consequently, widely-used North American textbooks (e.g. Davison & Neale, 2003) are typically structured entirely around the DSM and include little critique of such systems. Unfortunately, British texts tend to follow this trend.

One problem of accepting diagnostic categories in this way is that psychological factors are typically invoked only to explain what biology has failed to. For example,

underlying the alleged integration of biology and psychology in the diathesis-stress (the idea that psychosis can be 'triggered' by life events in 'vulnerable' individuals) is the assumption that experiences such as hearing voices are indisputable symptoms of underlying organic pathology. To question such assumptions is *not* to deny that biology can play a significant role in the development and maintenance of psychological distress. Of course, psychological events are simultaneously brain events, but these are correlational rather than necessarily causal relationships. The evidence points to a bi-directional relationship between biology and psychology such that psychology can also influence biology -- even brief cognitive interventions produce measurable biological changes (Wykes & Brammer, 2002).

Researchers find strong associations between ethnicity, gender, social class, sexual abuse and many forms of distress (Johnstone, 2000; Rogers & Pilgrim, 2003; Tew, 2005) which suggests that the brain-body is an open system that cannot be comprehensively understood outside of its social context. Psychiatric diagnoses tend to obfuscate psychological research by individualising distress, forcing it into categories of dubious validity, and then implicitly associating it with underlying biomedical pathologies (Bentall, 2003; Boyle, 2002).

Despite these shortcomings, it seems that many psychology educators import psychiatric assumptions. Indeed, the very notion of an 'abnormal psychology' implies that the psychology of mental health requires a leaving behind of the principles and theories of 'normal' psychology. In contrast, British psychologists have argued that we need to move away from psychiatric diagnosis and embrace a formulation and dimensionally-based approach to mental health problems (e.g. Pilgrim, 2000).

From diagnosis to formulation

In the Society's *Recent Advances in Understanding Mental Illness and Psychotic Experiences* (BPS, 2000), a group of British psychologists of different theoretical orientations, published a consensus report on recent research on psychosis. In it they outlined an approach based on a psychological formulation of an individual's experiences of these mental health problems. It was significant in a number of respects. Firstly, it suggested that psychological understanding was advanced by focusing on particular experiences like hearing voices or having beliefs which were

not shared by others, rather than broad categories like 'schizophrenia'. Secondly, since surveys of the normal population showed that these experiences were not as uncommon as might be supposed, it proposed that these could be understood using normal psychological theories and principles, rather than as representing categorically distinct disease processes. Thirdly, the report advocated a broad-based psychological formulation of these experiences, which would be tailored to fit each individual. This formulation might draw on a range of psychological theories from cognitive to systemic and psychodynamic.

The authors noted that psychological interventions, especially family-based, but also individually focused packages both helped mental health service users to cope with distressing experiences and enhanced their quality of life. In contrast, its review of traditional biological and genetic research noted that, despite years of research and probably because of an over-dependence on diagnostic models, the results were still inconclusive. Perhaps one of the most significant aspects of the report was the emphasis placed on three issues traditionally neglected by psychologists. It argued that discrimination against those with mental health problems should become as unacceptable as racism and sexism. The authors also suggested that training in a psychological perspective should be offered for all staff in NHS mental health services and one of us was subsequently involved in developing a training package based on the report and designed to be delivered in collaboration with service users (Basset et al., 2003). Finally, the report stressed the importance of placing the experiences and perspectives of service users (described as being 'experts by experience') at the heart of a psychological understanding. This last issue is one which has probably had the most impact on mental health services in the UK over the last 15 years and so it is to this that we turn next.

The service user/survivor perspective

Traditionally, the views of users of mental health services (some of whom prefer to call themselves survivors because of their negative experience of mental health services) were rarely sought by researchers and providers probably because they were not seen as rational citizens. However, increasingly, those with personal experience both of mental health problems and services are posing challenges to psychology (May, 2000; May et al., 2003). In the 1980s a number of service user organisations

like Survivors Speak Out (SSO) and later, organisations like the Hearing Voices Network and the Self Harm Network began to be set up (Johnstone, 2000). Peter Campbell (1999), one of the founders of SSO, has noted the diversity of views in the service user/survivor movement -- for example about how critical they are of the 'medical model'. However, there are some shared beliefs: the essential competence of service users; a belief in the value of self-help and collective action; a belief in the possibility of self-organisation by service users; and that people with a diagnosis of mental illness may have special expertise to offer society as a result of their personal experience (and hence are experts by experience). Indeed, mental health service users are now consulted on all NHS mental health policies though this can, at times, seem tokenistic (Campbell, 1999).

The Hearing Voices Network (www.hearing-voices.org) was set up in 1988 and was based on a non-pathologising assumption: that the hearing of voices is a common phenomenon; and that there are a variety of explanations for it, with some service users finding a psychiatric view helpful whilst others find a range of other explanations more beneficial, including psychological, parapsychological, spiritual and other models. The Network drew on research conducted by Dutch social psychiatrist Marius Romme, his colleagues and Dutch voice-hearers (see for example Romme & Escher, 1993, 2000) many of whom coped perfectly well with these experiences without making contact with psychiatric services.

The National Self-Harm Network (www.nhsn.co.uk) was set up in 1994 by people who harmed themselves and was organised around the idea that, rather than being a symptom of some underlying pathology, self-harming was a strategy which people used, often as a way of coping with earlier experiences of abuse or victimisation. This group organised meetings, training workshops and produced resources for service users and professionals (e.g. Dace et al., 1998).

Recent years have seen a growth in research conducted by service users themselves or in collaboration with professionals (Faulkner & Thomas, 2002). For example, the Mental Health Foundation, in its *Strategies for Living* project, employed service user researchers to interview people about the everyday strategies they used to cope with mental health problems (Faulkner & Layzell, 2000). Many service users have also

become experienced trainers and there are many innovative ways in which undergraduate programmes could draw on their expertise (e.g. Tew et al., 2004).

The growing importance of the service user movement is one of the things you won't find in the average abnormal psychology textbook. Another, is the implementation of a range of key British policy initiatives with significant implications for psychological research and the provision of psychological therapy and it is to these that we now turn.

Mental health policy and legislation

The last ten years has seen a number of changes in the delivery of mental health services. The Department of Health has published National Service Frameworks for different specialties (see weblinks) which set new standards for services and highlighted examples of good practice. It has also identified ten essential shared capabilities for the whole of the mental health workforce (Hope, 2004). The National Institute for Mental Health has been set up to support new developments in mental health practice (www.nimhe.org.uk).

Mental health services are now organised into multi-disciplinary teams such as community mental health teams which, in the main, include clinical psychologists. The NHS is now required to provide an early intervention service to those referred with psychosis and many services have out-of-hours, assertive outreach and home treatment teams in order to engage those people who might otherwise lose contact with more traditional services (Sainsbury Centre for Mental Health, 1998). In their 2000 NHS Plan (www.nhs.uk/nhsplan), the government announced that mental health was one of its three priorities, with a corresponding investment of £300 million in mental health services; to finance, amongst other things, the creation of a new workforce of 1,000 graduate mental health workers. It was hoped that the vast majority would be psychology graduates.

The NHS has also undertaken a major review of the effectiveness of psychological therapies (DoH, 2001) which has suggested best practice guidelines, whilst also acknowledging gaps in the evidence base -- much of the research conducted has, for example, been cognitive in orientation and so it was this approach for which there was

most evidence. Recently the National Institute for Clinical Excellence -- which judges the effectiveness of NHS treatments -- announced that individual and family psychological therapies were effective interventions for people with a diagnosis of schizophrenia (NICE, 2002).

Finally, readers of the *Psychologist* will be aware that the government plans to reform the 1983 Mental Health Act in order to broaden the definition of mental disorder, extend compulsory treatment into the community and to allow some psychologists to have compulsory powers (www.parliament.uk/post/pn204.pdf). These proposals have raised a number of concerns within psychology both from professional and service user viewpoints.

Mental health professions have had to adapt to this new policy environment and more recent introductions to clinical psychology like Cheshire & Pilgrim (2004) reflect this. However, it is not only mental health policy and practice which has seen change over recent years. There have also been significant theoretical developments although these, again, are poorly represented in the textbooks.

New theoretical perspectives

As we have already noted, authors from a broadly critical tradition have offered both a resounding critique of the dominant paradigm and some possible ways forward (Bentall, 2003; Boyle, 2002; Johnstone, 2000; Newnes, Holmes & Dunn, 1999, 2001). And many have noted the need for broadening the scope of enquiry to examine the incidences of unusual experiences and psychological distress in the 'normal' population, rather than confining the investigation to individuals who have already received a psychiatric diagnosis. Here we will highlight some additional conceptual resources which those involved in teaching about mental health may find useful.

a) Community psychology

Community psychology (Nelson & Prilleltensky, 2005) offers a means both of investigating the social context of mental health problems and of offering interventions at a community level. The UK Community Psychology website

(www.compsy.org.uk) contains some very useful material including links to community psychology centres around the UK and worldwide.

b) Developing a social perspective

Workers in this tradition (e.g. Beresford, 2002; Tew, 2005) try to counter the individualising emphasis of traditional approaches. The recovery model -- promoting more hopeful views of mental health problems -- has also been influential (Turner-Crowson & Wallcraft, 2002). Recently the Social Perspectives Network (www.spn.org.uk) has been founded by academics, practitioners and service users in order to develop research and promote the incorporation of social perspectives within modern mental health services.

c) Post-structuralism and social constructionism

Some professionals and academics have drawn on alternative frameworks like these in order to critique traditional models in psychiatry and psychology and to explore alternative approaches (e.g. Parker et al., 1995). There are now exciting and innovative conceptualisations of experiences like hearing voices (Blackman, 2001), 'delusions' (Harper, 2004) and difficulties related to sexual abuse (Reavey & Warner, 2003). Psychiatrists interested in these ideas have set up the Critical Psychiatry Network (www.critpsynet.freeuk.com) and have argued for the need to move towards a 'post-psychiatry' paradigm (Bracken & Thomas, 2001).

d) Experimental cognitive psychology and cognitive behaviour therapy.

Those working in the tradition of experimental cognitive psychology have noted how individuals with mental health problems do not necessarily have a *deficit* in thinking, rather a bias (Bentall, 2003). The origins of mental health problems, even ones as 'severe' as the psychoses can thus be located in normal cognitive processes. Another suggestion is that there is no singular causal route that can account for the majority of mental health problems, rather a multitude of social, biological and psychological factors. These empirical studies have informed the therapeutic practice of cognitive behavioural therapy which is guided by empirical observations. The cognitive-behavioural approach advocates making sense of client's perceptions of their thoughts and listening intently to their patterns and systems of sense making. This is done in

order to understand the individual's *active* attempt to make sense of the experience (e.g. perceptual bias, misattribution, shallow processing) in order to understand the cognitive and emotive processes *driving* it (e.g. protection of self-esteem, defence against negative evaluation). Beliefs about the self, the context of the person's life and the emotional distress accompanying the cognitive processes are all recognised and integrated in this approach to therapy.

e) Neuroscience Aspects of contemporary neuroscience (e.g. Damasio, 1994) emphasise how the brain-body system is functionally open to experience and its effects, such that toxic life experiences can become quite literally embodied to create forms of distress. Damasio's work has been invoked to explain the phenomena addressed by diagnoses such as depression (Cromby, 2004).

Useful teaching resources

mhhe

The Mental Health in Higher Education project (www.mhhe.ltsn.ac.uk) aims to facilitate the sharing of ideas and approaches to learning and teaching about mental health across the disciplines in UK Higher Education (Anderson, 2003). Good practice guidance on user and carer involvement in mental health education and training has been produced in partnership with others (Tew et al, 2004). The project plans regional events for mental health educators, and additions to its collection of case studies of learning and teaching are always welcome (several relating to mental health teaching in undergraduate psychology are available on the website).

Psychosis revisited

This is the name of a teaching resource pack (Basset et al., 2003; www.psychosisrevisited.com) which is now available based on the Society's (BPS, 2000) report. Although primarily designed for mental health workers, it has been successfully used with undergraduates and clinical psychology trainees -- the mhhe website includes an example of its use by Mark Hayward at the University of Surrey.

Videos

There is now a good range of resources available which can help to illustrate some of the developments we have discussed in this article and provoke debate. Mental

Health Media (www.mhmedia.com) produce and supply some excellent videos including *Myths about Madness* (which addresses stereotypes about mental health), *Being on a Section* (which explores the effect of being treated compulsorily) and the BBC's Horizon documentary about hearing voices (with contributions from the Hearing Voices Network, Richard Bentall, Patsy Haage, a Dutch voice-hearer, and Marius Romme). Paradogs (www.pinkpink.demon.co.uk/paradogs.html) has produced *Those who are Jesus,* a video exploring the perspective of those diagnosed with 'delusions'. Listen to the Voices (www.listentothevoices.org) have produced an informative video about the Mental Health Bill. *Evolving Minds* is a video exploring the links between psychosis and spiritual experiences (www.undercurrents.org/minds).

Personal experience

First person accounts of mental distress can be invaluable teaching tools. Chipmunka publishing specialises in small books written by service users (www.chipmunkapublishing.com). In addition, the American psychologist Gail Hornstein has assembled a very useful and comprehensive bibliography (www.mtholyoke.edu/acad/misc/profile/names/pdf/Hornstein_Bibliography.pdf).

Online resources

For those wanting to keep up-to-date with current developments the psychminded website (www.psychminded.co.uk) provides a good coverage of news and features and Radio 4's *All in the Mind* has some interesting programmes -- there's a listen-again option on its website (www.bbc.co.uk/radio4/science/allinthemind.shtml). Mind Out for Mental Health's website (www.mindout.net) includes personal accounts of distress as well as links and materials useful in countering negative stereotypes. The US-based MindFreedom website (www.mindfreedom.org) is a useful resource for those wanting to know more about the mental health survivor's perspective on theory and practice. Organisations like Mind, the Sainsbury Centre for Mental Health and the Mental Health Foundation all have their own websites listing materials and publications.

A time for change

In this article we have argued for the need to move the undergraduate teaching of 'abnormal psychology' and mental health away from a narrow diagnosis-based approach and, instead, to consider the implications of recent developments in theory and practice. Rather than simply 'jump ship' and adopt a psychiatric mode of explanation, we feel there is now a need to steer a new course and to move towards a consistently psychological account of mental health problems

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Weblinks

Community psychology in higher education: http://mysite.wanadoo-members.co.uk/cphe/

Department of Health mental health section: http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/fs/en

Guardian Society special report on mental health: http://society.guardian.co.uk/mentalhealth/0,8145,386880,00.html

The Higher Education Academy Psychology Network: http://www.psychology.ltsn.ac.uk

International Centre for the Study of Psychiatry & Psychology http://www.icspp.org/