Stressed

A series of blog posts outlining

The Stress & Vulnerability

model in mental health care

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About the author

Stuart Sorensen is a registered mental health nurse with over 25 years experience (both pre and post registration) working in various social care settings. He began working with elderly people as a volunteer in the early 1980s and has since worked in residential and community settings with a wide variety of populations.

Stuart qualified as a registered mental nurse in 1995. In addition to his nursing registration Stuart also holds a diploma in counselling, a diploma in nursing studies and a post graduate diploma in PSI (psycho social interventions). His main interests include working with people with serious and enduring mental disorders, people with personality disorders and those with addictions or with dual diagnoses. He is also particularly interested in issues relating to deliberate self-harm.

Stuart is passionate about the possibility of recovery from mental disorders and much of his clinical and training work has been based around helping people to recover from serious mental disorders such as schizophrenia.

As a trainer Stuart is keen to help staff 'at the coalface' to find a balance between the conflicting (and seemingly impossible) rights of workers, carers and service-users. Based upon his years of experience as a worker and clinical specialist Stuart's training has the feel of reality about it rather than the 'ivory tower' presentations that come from simply reading a book. Stuart understands the difficulties and dilemmas facing workers on the front line because he has faced them too.

Training and consultancy work includes contracts for ARC (Scotland), The Police Complaints Commission for Scotland (PCCS), Impact Health & Social Care Training, The former Commission for Social Care Inspection (CSCI), East Training & Consultancy Ltd., Public Sector Providers, The National Health Service, The Rising Sun Trust, Linkswork and various other, regional and national government, voluntary sector and private sector organisations.

About 'Stressed'

This PDF compilation is comprised of a series of posts that appeared on Stuart's blog in 2010. It is not intended to be a comprehensive or even particularly authoritative reference guide to mental health care. Rather it is a brief introduction to a much larger and infinitely more fascinating subject.

Stressed 1: Outline & contents

Welcome to *'Stressed'*, the blog series on the Stress & Vulnerability model in mental health. As usual I'm posting the proposed outline first. This is likely to evolve as time goes by (that always seems to happen) but it should stick to this basic plan. I hope you find it interesting.

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Stressed 2: What is Stress & Vulnerability?

Let's start by determining what the Stress & Vulnerability model of mental health and disorder is not. It's not new. It's the most recent version of a much more ancient understanding – the idea that stress and life events can cause mental health problems, 'madness' if you will. Ancient texts are rich with stories of people driven mad by events (or as punishments from the Gods).

However, ideas about life events causing mental disorders took second place throughout the last century with the onset of the biomedical model and the near obsessive pursuit of chemical solutions. The rise of industrial psychopharmacology and the assumption that all mental disorders were caused by chemical problems has done much to derail our awareness of what it means to be 'driven mad' by circumstances.

Even as biological explanations were just beginning with tranquilising 'medications' such as chloral hydrate in the early twentieth century the effects of stress upon sanity were demonstrated with startling clarity in the trenches of the first world war. Consider, for example, the following extract from a 1917 medical textbook describing the symptoms of shell shock:

"These afflictions: loss of memory, insomnia, terrifying dreams, pains, emotional instability, diminution of self-confidence and self-control, attacks of unconsciousness or of changed consciousness sometimes accompanied by convulsive movements resembling those characteristic of epileptic fits, incapacity to understand any but the simplest matters, obsessive thoughts, usually of the gloomiest and most painful kind, even in some cases hallucinations and incipient delusions – make life for some of their victims a veritable hell."

(Smith GE & Pear TH 1917)

We can see that the symptoms of anxiety, depression and psychosis were very common among soldiers who were not otherwise prone to insanity or so far as we know biologically deficient. These were ordinary men forced to endure extraordinary trauma and they reacted accordingly.

My own experience of mental health care clearly demonstrates that people who are exposed to extreme trauma develop symptoms of mental disorder ranging from anxiety and depression to full blown psychosis. They present with obsessions and hypochondriasis, hallucinations and thought disorders, delusions, mood disorders and a host of other distressing problems. And yet often these are people who showed no hint of psychiatric problems until circumstances dealt them more stress than they knew how to cope with.

It's important to be clear at this point….

Stress is what happens – not how we react to what happens. How we react is our own affair. It's a response to the stress that the world throws at us. It is vital that this is clear because the whole stress & vulnerability model depends upon this distinction.

Stress is what happens to us.

Our reactions to stress are what psychiatrists call symptoms.

I make this point because many people will describe mental health problems as 'stress' but this is inaccurate. Mental health problems are to do with how we respond to the world. There is no mental disorder called 'stress' but ***reactions*** to stress can be anxiety, obsessions, compulsions, mania, depression, psychosis etc. These symptoms are ***responses*** to stress – not the stress itself.

Once we realise this it becomes easier to see our way through the maze – to understand that our reaction to stressful events is the real problem and that we can choose our reactions. This sometimes takes a bit of training and practice but it can be done – with remarkable results.

One aspect of the stress vulnerability model of mental health and disorder is concerned with isolating the different types of reactions to stress and understanding that some responses are more helpful than others.

However it's not all about circumstances and social situation. The stress and vulnerability model also includes the biological, chemical aspects of who we are. There are real, biological vulnerabilities that can make people more susceptible to mental health problems and to ignore them would be just as silly as the biomedical model's tendency to ignore everything else. The trick is to recognise that there are many types of vulnerability and they all play a part.

Throughout this series we will consider five basic groups or types of vulnerabilities that affect our susceptibility or otherwise to the effects of stress. These are:

Genetics and biology (including illness)

Evidence from family studies, particularly studies involving twins seem to show a strong genetic element (Horobin D. 2001). It seems that one aspect of a person's vulnerability is related to their genetic make-up. However this is not the whole story.

Psychological

How a person thinks about their self or the world around them seems to make a major difference to their level of vulnerability to stress. This is more than simply being optimistic or pessimistic – there are certain thinking methods which help people to cope better than others. Some methods of coping with life's difficulties seem to be more effective than others. People who use effective coping skills seem to deal with stress better than those who do not. They can handle much more stress before they develop symptoms of mental disorder (Warner R. 1994) (Thomas P. 1997) (Warner R. 2000).

Environmental

The way a person deals with stress and the options they have are often related to their environment. Anything from the state of a person's home to the neighbourhood they live in can make a difference. Some neighbourhoods are more relaxed and essentially safe than others. Finance and resources are also included here but they're not the whole story by any means.

Social and cultural

The better a person's social skills the easier it is for them to get other people to help them when things get too tough for them to handle alone. People with lots of supportive friends tend to do better in times of crisis than people with fewer or perhaps no other people to turn to. This is often a function of their social group (how willing those around them are to support the person) and the wider culture in which they live.

Developmental

As human beings develop they change, they adapt and they learn new skills. They also face different challenges at different stages in their lives. Our ability to deal with stressors often depends upon how successfully we have developed and matured from infancy onwards. The same is true of old age. However it's never too late to try new things and even people suffering from advanced dementias can be helped to cope better.

A brief example

The Stress and Vulnerability model holds that our vulnerability factors determine how vulnerable we are to the stresses of life. This means that some people can handle more stress than others but eventually all people, given enough stress can develop mental health problems. A classic example of this relates to the debate about recreational drugs such as cannabis.

It is well known that some people become psychotic as a result of cannabis use whereas others do not. This has led many people to insist that cannabis does not cause psychosis (hallucinations, thought disorders & delusions) because they have never experienced it themselves. However they are being too simplistic. People who argue that cannabis is safe are assuming that everyone is equally vulnerable and so, since they are not affected by it nobody else will be either.

The truth is that people with high vulnerability only need a small amount of a stressor (cannabis is defined as a biological stressor) to push them 'over the edge' so to speak. This is why some people become psychotic and others do not.

This is true of all the vulnerability factors – some people are just more susceptible than others to particular forms of vulnerability.

The trick in dealing with all forms of mental disorders is to help people to decrease their vulnerability but also to change their lifestyle and circumstances so that they can reduce their levels of stress as well. This doesn't mean wrapping people up in cotton wool – nobody ever recovered from anything by being passive. It simply means helping people to 'cut their cloth according to their means'.

Over the coming weeks we'll consider each of the principles mentioned above in more detail. I hope you enjoy this little trip into a genuinely helpful approach to mental health and disorder. This really is the stuff that recovery is built upon.

References

Horobin D. 2001 ***The Madness of Adam & Eve*** Corgi Books, Reading

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Thomas P. 1997 ***The Dialectics of Schizophrenia*** Free Association Books, London

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Stressed 3: The biological (medical) model

The medical (biological) model is the dominant view of mental disorder in Western society. The basic idea is that mental disorders are rooted in physical problems and that they require physical treatments to alleviate them.

To make sense of this we must bear in mind that psychiatrists are trained as medical doctors first. All medical doctors, from General Practitioners to anaesthetists and gynaecologists have been trained to treat physical disorders with physical cures such as medications and surgery. Psychiatrists come from the same basic perspective and psychiatry itself has developed from that same, physical root.

So, according to the biological (medical) model of mental disorder all psychiatric problems are caused by physical imbalances or abnormalities. That's why psychological problems attract physiological treatments such as medications (chemicals used to change physical processes) or even surgery.

It is important to say that most psychiatrists in practice today see the medical model as only a partial explanation for mental disorder. Very few would stick rigidly to the idea that chemistry is everything but none the less this is a very powerful idea and it has a massive impact on mental health care today. In fact the development and supply of psychiatric medications based upon just this idea is a hugely influential worldwide industry in itself.

This is the opposite of the popular view that there is a difference between the 'mind' and the body. Many people, if asked, will insist that mental life is very different from physical life. However these people often do not think through their objections to the basic idea of the medical model.

Most people accept that hallucinogenic drugs like magic mushrooms and LSD affect perception. Drugs such as cannabis and ecstasy affect mood and substances such as amphetamine (speed) can cause psychological problems such as paranoia as well as major emotional problems relating to anger and anxiety. These are psychological problems caused by physical (chemical) changes. If we accept that these things happen we must also accept that physical changes cause psychological and emotional difficulties.

Personally I'm always intrigued when people who use substances like cannabis, ecstasy or amphetamine tell me that their drug of choice doesn't affect them psychologically. Clearly this cannot be the case or why on earth would they bother taking them? The fact is that people take recreational substances precisely because they affect mental and emotional life.

The medical model tells us that the fabled 'mind:body' split does not exist. Both are part of the same, single system. That is why physical interventions are used to make psychological and emotional changes. That is the essence of the biomedical model of mental disorder.

After all – if the problem wasn't assumed to be caused by dodgy chemistry then what would be the point of giving chemicals in the form of medications to 'fix' it?

Stressed 4: The social model

Many people argue that the social model is the opposite of the traditional medical model. Whereas the medical model places the cause of problems in affected person (the biologically 'ill' or physically 'disabled' individual) the social model is interested in the way that society at large reacts to people. It places responsibility for people's problems as much in the lap of society as it does in the lap of the person themselves.

This does not mean that social perspectives deny the effects of physical or chemical processes such as drug use or disability. Rather it maintains that many of the problems people face are caused and/or maintained by social pressures. The argument is that my problems aren't caused by the fact that I have no legs or that I hear voices but rather by the fact that society is organised in such a way that people with no legs cannot use services or that voice-hearers are stigmatised.

A good example might be the London underground service (the tube). Originally the vast majority of tube stations were accessible only by stairs which, of course, meant that wheelchair users couldn't access the platforms and so couldn't use the tube. Is this problem caused by their disability or is it caused by the fact that society ignores the needs of many citizens?

The social model argues that society has a responsibility to all – not just to those with a particular set of attributes. It is because of social model concerns that so many tube (and other) stations have now been fitted with mechanical lifts large enough to accommodate wheelchairs. It's a social solution to a problem that arguably needn't be thought of as 'medical' at all. People may well have physical differences but the real impact of those problems is caused by the way that society responds to them. This is why we have laws governing discrimination and ensuring fair access to services and employment.

In terms of mental health and disorder (the real focus of this blog) the social model argues that the way society responds to people who are psychologically different is the real problem. The social stigma surrounding mental disorders can be an effective barrier to inclusion, employment, insurance, housing and many other aspects of our society that other people take for granted. The effect of such exclusion and alienation on self-esteem and life opportunities is well known to be extremely detrimental.

There's an interesting (and relatively recent) illustration of the difference between the social model and the biological (medical) model that we discussed in the previous entry. Until recently homosexuality was thought to be a mental disorder. This took all responsibility away from the larger society and so if gay men and lesbians were unhappy that was thought to be a function of their disorder. Today in UK society most people see homosexuality as no more than an individual trait. It's not illness – it's just a part of a person's larger identity. Social stigma has reduced dramatically and presumably will disappear completely within another decade or so.

By taking homosexuality out of the medical model and placing it within a social model context many (although admittedly not all) problems with discrimination have been solved by social attitudes changes. Now if someone is depressed and

also happens to be homosexual we deal with their depression without sticking medical labels upon their sexuality.

A large part of the change we have seen in recent decades has been due to the influence of the 'gay pride' movement and there is a direct similarity between the way that gay and lesbian people previously were seen in our society and the suspicion that surrounds people diagnosed with mental disorders today. Because of this the 'mad pride' movement has taken some very direct lessons from the gay movement and mad pride events are becoming increasingly common in Britain today.

It will be interesting to see what happens to the stigma around people who hear voices or who believe that they can commune with unseen entities over the next few decades. After all if it's OK for priests, pastors and faith healers to hear and talk to their Gods, angels and guides and it's acceptable for mediums to commune with the 'spirits', why should it be any different for people who believe that they can talk to the Martians?

Perhaps the only real difference between the priest, the madman, the shamanic healer and the medium is social acceptance.

Stressed 5: Merging the two

So far in this series we've looked at two basic models that seek to explain mental health and disorder. We considered the medical model that places the root of disorder in the physical body and the social model that identifies social problems as the root cause.

Both these models have their advantages but neither is sufficient on it's own. What we really need is a way to think about (and deal with) mental health problems that acknowledges more than just a single cause. The possibility of a genetic or chemical characteristic in people diagnosed with certain mental disorders doesn't mean that there are no other factors to be considered as well. Similairly, social drift or other such problems don't remove the possibility of biological issues. Both the social and medical models are limited (at least in their pure forms) because both exclude the knowledge and understandings of the other.

The 'stress and vulnerability' model encompasses both these paradigms and more. Beginning with the basic premise that distress results from stress we concern ourselves with the various types of stressor that create problems and also the different factors affecting vulnerability. Some people are more vulnerable to stress (or particular types of stress) than others.

There are five basic types of stressor. One of these is 'biological' which corresponds to the medical model. The social model is covered by two others – the 'social' and 'cultural' stressors. Additionally the model includes 'psychological' stressors and 'developmental' stressors. Developmental stressors can variously be seen as biological or socio-cultural as well depending upon the exact nature of the stressor.

Put simply then the five stressor types are:

Biological;
Social;
Cultural;
Psychological;
Developmental.

Some people are very susceptible to stress whereas others are not (although even the strongest among us has limits). Not only that but different people have different types of susceptibility. One person may be very susceptible to psychological stress but biologically robust whereas another might be quite the opposite. This degree of susceptibility to stressors is what we mean by vulnerability.

So according to the 'stress and vulnerability' model distress or disorder is what happens when the stress we face is greater than we can cope with. Let's look at a few simple examples….

The biological stressor of drug misuse can tip biologically vulnerable people into mental disorder of various kinds whereas others who are less vulnerable to biological stressors may be unaffected.

A person with marked social vulnerability might develop problems after rejection whereas another, less gregarious individual might take it in their stride.

A person with a strong 'internal locus' of self esteem might take criticism with a pinch of salt but find themselves extremely vulnerable to psychological stressors such as self reproach or guilt.

Some people are so vulnerable to a range of stressors that they seem to be distressed or mentally disordered 'all the time'. Traditional psychiatry has assumed that this must be because they simply 'are' mentally ill people whereas the social model holds that they are constantly treated unfairly by others. Stress and vulnerability holds that they need help to deal with their stressors across any or all of the five groups.

This leaves us with two basic tasks.

1. Work on reducing stress levels and help the individual to learn how to manage their own stressors;

2. Help people to reduce their vulnerabilities across any or all of the five basic types of stressor.

Recovery happens when a person's stress reduces, their coping ability increases or both to the extent that they can handle life without becoming more disordered than the average person.

In the next part of this series we'll begin to examine the stress and vulnerability model in the light of traditional psychiatric diagnosis.

Stressed 6: Diagnosis & the Stress & Vulnerability model

Arguably there are only two possible reasons for using diagnoses at all:

1. The diagnosis should inform treatment;
2. The diagnosis should predict outcome.

A diagnostic category must do either one (or preferably both) of these if it is to have any value. In traditional (medical model) psychiatry some diagnoses are more effective than others according to these criteria. For example a diagnosis of clinical depression does tend to come with relatively reliable treatment options. On the whole the course and outcome of depressive disorders is understood and predictable.

Diagnoses like schizophrenia are far less reliable. The criteria that psychiatrists use to diagnose schizophrenia are extremely varied and the outcomes vary enormously from person to person and even continent to continent.

The very word 'diagnosis' literally means 'through knowledge' and yet the diagnosis of major psychotic disorders reflects very limited knowledge. Treatment for people diagnosed with schizophrenia is extremely variable and it takes much more than diagnosis to determine what treatment to offer.

The fact that we can name a set of symptoms does not necessarily mean that we understand them. For example we can correctly name 'gravity' but we don't really understand why things are attracted downwards to the earth. The best we know is that the movement of the earth as it rotates generates a force that we call gravity – why it does so is one of the great mysteries of physics.

To name a phenomenon is not the same as understanding it, especially when (as is the case with diagnosis) there is such disagreement about which diagnosis to apply to which individual. This is why so many people find themselves diagnosed and rediagnosed with disorders such as schizophrenia, bipolar affective disorder, schizotypal personality disorder and more. This process cannot reliably be said either to inform treatment or to predict outcome.

So the 'stress and vulnerability' model is less concerned about diagnosing syndromes or conditions such as 'schizophrenia' as it is with dealing with actual problems, regardless of diagnosis. This doesn't mean diagnosis is ignored – rather that it is not the main focus when dealing with real people. Problems, function and distress are far more important than labels.

In mental health terms this means dealing with three basic types of problem (or 'symptom' if you prefer). The three types of mental health symptom are…

1. Anxiety based problems
2. Depressive problems
3. Psychotic problems

By understanding the vulnerability of the person and the relationship between these three problem groups we can focus upon the experience of the person regardless of diagnostic theories. This allows us to focus on the individual's needs rather than the often theoretical or even ideological concerns of diagnostic nomenclature.

Stressed 7: Stress and vulnerability and Psychosocial Interventions (PSI)

There are various ways to 'use' the Stress & Vulnerability' model to understand and plan mental health care and support. My own preferred approach is to combine the model within a larger 'framework' of 'Psychosocial Interventions' (PSI). This is not the only way to understand mental health interventions and it's important to be flexible to the needs and beliefs of the individual but this is the approach that makes most sense to me.

In PSI we do not reject diagnosis – it can be a useful 'shorthand' in understanding and communication between professionals. But we do acknowledge that it is a 'blunt instrument' that has only limited value. The real understanding comes through 'formulation' – a process that considers cause and effect, vulnerabilities and strengths as well as just symptoms.

We'll devote a seperate post to formulation later. For now it's sufficient to say that it's based upon a thorough assessment not just of the presenting problems or 'symptoms' but also of their development and particular meaning for the service-user. This is important because the more general assumptions of traditional, medical diagnosis tend to sideline the individual's experience in favour of textbook theories that may not always be very relevant in the light of other factors such as culture or psychological 'style'.

However, every approach must have some assumptions underpinning it and PSI is no exception. We simply have different assumptions – ones that hopefully allow us to tailor services more effectively.

Some of these assumptions are……

1. There are many causes of mental disorder.
2. People vary in their vulnerability to mental disorder.
3. Generally speaking people have a part to play in maintaining their own problems.
4. People can learn to manage the majority of problems.
5. Recovery is about coping – not about absence of 'symptoms'.
6. Formulation is vital if we are to understand how problems are maintained.
7. Individualised 'here and now' strategies are at least as important as prescription medicine.

Much of the work with individuals is based on an exploration of their experience. Together we 'unpick' the development of their difficulties, the specific events, thoughts and behaviours that contribute to them and equally specific changes that they can make to alleviate them.

This approach is much more collaborative than traditional, Western psychiatry because it assumes that the individual has at least as much to contribute as the professional. It is also extremely empowering, focussing upon choice and lifestyle rather than passively following 'doctor's orders'.

Of course people do not exist in a vacuum. Actually one of the assumptions of PSI and the stress and vulnerability model is that isolation is inherently damaging. But social groups, as we know, can vary. Not every group is helpful.

So PSI also works with families and others (within confidentiality guidelines) to reduce social vulnerability and enhance coping.

This is not to suggest that families automatically are to blame for an individual's problems. Rather it is an acknowledgement that all people have limits and living with someone diagnosed with a mental disorder can be extraordinarily stressful. It is unfortunate that relatives' normal (and understandable) reactions in these extreme circumstances can also serve to maintain problems. So families and others are encouraged to adopt other, more helpful responses to their situations.

By concentrating upon physical issues like diet, exercise, relaxation, sleep and medication we also address the biological aspect of the stress and vulnerability model. The whole approach combines through various techniques to cover all the stress and vulnerability factors as they apply to the individual concerned.

In my opinion the PSI approach to mental health and disorder is a direct expression of the stress and vulnerability model in practice.

Effectively PSI follows the stress and vulnerability model as the cart follows the horse

Stressed 8: Anxiety

Earlier we talked in general terms about exploring symptoms and making links between people's mental health problems and their thoughts, feelings and behaviours. In this post we'll elaborate on the idea and start to look at the links between the three main symptom groups of anxiety, depression and psychosis, beginning with anxiety.

The point of this exploration is to increase understanding and to point the way to effective intervention. That's the 'informing treatment' principle of formulation that is not always very effective in traditional diagnosis. There is, of course, much more to these issues than can be covered here but this post should at least provide a 'flavour' of what we mean.

One of the basic assumptions of Psychosocial Interventions (PSI) is that symptom groups interact and follow on from each other. This is why PSI is so consistent with stress and vulnerability. Increasingly severe symptoms develop alongside increasing stress.

What follows is a 'model' and like all models it doesn't fit every situation but it allows us to get a sense of the interaction between symptom groups. Let's start with a context, a scenario to illustrate the concept. Let's consider the impact of a 'bad day' on mental health.

Experience tells me that the majority of visitors to my blog are health or social care workers and so I'll try to construct a scenario that most visitors will be able to relate to. Even if you don't work in this field I hope that you will be able to relate it to your own situation……

Imagine what begins as an ordinary working day. You have a full workload and there isn't any spare time but you can cope with it. Actually you got used to this sort of 'capacity functioning' a long time ago. There's not much 'slack in the system' but it's ok – you'll cope.

Then your boss walks up to ask a favour. There's a report that must be finished today. The organisation's funding for next year depends upon it. So the boss has to do it today. Unfortunately that means that you will have to complete the Key Performance Indicator returns that also must be done today. You're more than capable of doing it but you don't have time.

So your boss tells you to get another worker, Bob, to take some of your workload for today to give you time to do the KPI returns.

You ask Bob to do three things and he agrees. Then you get down to business and complete the KPI returns.

Meanwhile Bob gets a call from the hospital. His son has been taken I'll and is on the children's ward. Bob drops everything and goes to the hospital.

At the end of the day your boss returns waving a piece of paper in your face and wanting to know why you had ignored so many client visits. Somehow the commissioners had received several complaints and this was going to damage the organisation's next inspection report.

You explain that Bob was supposed to do those visits whilst you did the KPIs. Your boss calls Bob who, worried about having left work early denies that you ever spoke to him.

Your boss is furious and tells you to appear in his office tomorrow morning at 8:30 sharp. He says you should bring a representative with you.

How do you feel?

It's likely that you'd be worried – one of the 'anxiety' group of emotions. That's appropriate. In fact it's helpful. Anxiety can be thought of as a 'call to action'. It motivates us to act quickly and decisively when danger threatens. It's the evolutionary gift that made our ancestors flee from predators. It's the same force that prompts us to get out of the way of speeding cars when we cross the road.

Unfortunately the anxiety response is there to help us to take physical action – it's not nearly so helpful when the threat requires us to think. That's because the emphasis upon physical movement actually takes away blood and resources from the parts of the brain needed to solve problems. It gets diverted into the muscles instead.

The greater the anxiety the harder it becomes to think clearly. But we'll still try. That's what anxiety is for – it gets us to try to solve problems.

The problem is that many or even most of the problems we face today don't need brute force at all. There's no point running away from an overdue gas bill for example. The skills we need to solve that problem are mental – thinking through how to find the money to pay it. This is why our anxiety response can be such a problem. It was fine for our early ancestors – that's why they evolved it – but it's not really so well suited to life in modern UK.

There's another point about anxiety – it is always concerned with the future. The anxious person is worried that they will not be able to cope with the future. That's why they try to change the likely outcome. They want to change the future – to make it safer and easier to cope with. In this little scenario the prediction is about work and the possibility of disciplinary action or even dismissal.

This future focus is important for our understanding of the relationship between anxiety and depression.

The other common reaction to scenarios such as this is anger fuelled by the injustice of Bob's lies.

Interestingly enough the physiological changes (freeze, flight or fight) we experience when angry are exactly the same as when we're anxious – it's only our perception of the situation that differs. For this reason many people class anger as another of the various 'anxiety based' reactions.

It's the perception of anxiety that we'll turn to next. There are various beliefs (psychologists call them 'anxiogenic' beliefs) people hold that either make them more vulnerable to stress or that make situations seem more stressful than they need to be. These include:

It is terrible if things don't turn out as I want them to;
I need someone or something stronger than myself to rely upon;
If this happens (whatever 'this' is) I won't survive;
I need the approval of other people.

The response is likely to be anger toward the situation in general, Bob or your boss if you have thoughts like:

People who do bad things are bad people who should be punished;
The world should always be fair;
My boss should trust me over other colleagues;
I shouldn't be asked to do my boss' work.

By helping people to reconsider these thoughts we can help them to avoid anxiety before it begins or to manage it before it gets out of control. By helping people to master the physical symptoms of anxiety (physiological arousal) we can help them to keep control of their thoughts and emotions as well as their behaviour. The more the anxiety or anger is allowed to grow out of control the closer we come to other, arguably more serious mental health problems. So an important point here is that good anxiety management skills are vital in maintaining mental health.

However severe the anxiety you would experience in our imaginary scenario another important thing to remember is that you haven't given up hope. You still think there's a chance that you'll survive and that's what your anxiety (or anger) is about.

Stressed 9: Depression

Remember the hypothetical work scenario we introduced in the last post in this series. The possibility of disciplinary action or even dismissal had resulted in an anxiety response as you struggled to find a way out of the situation.

Now I want you to imagine that the situation worsens. You get the sack. Your boss just won't believe your side of the story and it's all become far too serious for Bob to come clean. He's protecting his own job by sacrificing yours.

You won't get a decent reference, you're not getting any younger and the state of the current job market means that the chances of you finding new employment are slim. In short the very thing you predicted (and became anxious about) has happened.

This means you can stop struggling to prevent dismissal – there's no longer anything to prevent. But that's a problem in itself. The temptation here is to give up.

If anxiety involves predicting the future depression is about regretting the past or the present (or both). Where anxiety is about struggle, depression is about defeat. Depressed people tend not to try to make things better because the thing they're depressed about has already happened and cannot be changed.

One way to think about this is to understand the difference between a problem and a fact. Problems can be solved – hence anxiety. Facts are just facts – they cannot be solved. The events of the past are facts, not problems because the past cannot be changed.

There's a clue here. One way to shift depressive thoughts is to help the person shift their focus. Accept the past without getting bogged down in regret and then identify a future task – a problem to solve (how to find alternative work for example). To do this the person will need to overcome some of the thoughts that both create and maintain depression. Thoughts like:

Something that upset me in the past will always upset me;
Unemployed people are worthless people;
If I can't have my old job then life is meaningless;

It's also important to help them to deal with the physiology of depression. If anxiety is characterised by arousal and activity, depression is the opposite. It's a state of physical slowness and lethargy known as physiological de-arousal. The more we give in to it the worse it gets as energy levels deplete. This is why behavioural techniques designed to keep people physically active are so important.

Now here is an interesting point to consider….

Since depression is built upon a foundation of anxiety, the way to beat depression is to return, however temporarily to something akin to anxiety en route to recovery.

Think of mental disorder as a though it was a straight road. There are three main towns in order along the road – anxiety, depression and psychosis. Just like any

other journey along any other road retracing your steps (moving out of disorder) means going back to the places you left behind. So the journey from depression to recovery must take us through anxiety once again. The trick though, is to experience what Freud called 'appropriate' or 'helpful' anxiety rather than the unhelpful, debilitating kind we discussed earlier.

In the next instalment we'll consider what happens if problems worsen and the individual slips further along our imaginary road toward psychosis

Stressed 10: Psychosis

In the last blog post we talked about the progression from anxiety to depression and psychosis as though it was a journey along a straight road. Each of the three symptom 'groups' were said to be towns along the road and people travel along the road visiting them in order.

Clearly there are limitations with such a simple illustration but never the less I want to continue the analogy as we talk about the final symptom group – psychosis.

There are three main kinds of experience (psychiatrists call them 'symptoms') within the psychotic group:

Delusions;
Hallucinations;
Thought disorders.

Let's consider them in turn as we progress further along the road. Previously we discussed the journey from anxiety to depression and we looked at some of the thoughts typically associated with depression. It is these thoughts that we return to now.

By and large depressive thoughts tend to reflect low self esteem. It is these depressive thoughts that some people describe as 'negative self talk', the more or less constant mental chatter denouncing the individual as worthless, useless, a failure, unpopular or without hope or chances. This succession of self-insults is bad enough but it doesn't end there.

There is a step by step progression of these thoughts, becoming more and more insistent and also increasingly convincing until they become delusional.

Delusions are, according to the traditional psychiatric definition, 'fixed, false beliefs that are not amenable to reason'. In other words they are beliefs that are so strongly held that no amount of discussion or persuasion will change the person's mind.

To illustrate the way that delusions form in the mind of a depressed person I'm going to use an example. This isn't the only possible illustration and delusions do vary immensely but it should provide a basic 'sense' of how the process works.

Imagine that the predominant thought in the depressed person's mind is about their own uselessness. That would be a hard thing for anyone to bear. That's why the majority of people have engaged in a form of 'doublethink' from time to time and pretended to themselves and others that someone else is responsible for their little failings. It's just easier that way.

The same is true for people who are seriously depressed. It's easier to believe that we are blameless and that our problems are the result of other peoples' actions. We might even decide that there must be a secret conspiracy – it must be secret because there is so little evidence but it must be true. The only alternative is our own inadequacy and that would be too difficult to bear. If there is no reasonable evidence supporting our belief we'll invent some – and the more

people disagree with us the harder we'll fight to protect our idea – to protect our own self esteem.

This is why it's helpful to know what was going on immediately before the person's psychosis began. This can explain a great deal about the purpose of the psychosis, what it is protecting the person from and how it developed.

In formulation we call this the 'delusional mood' – the person's state of mind as they progressed along our imaginary road from depression to psychosis.

Depending upon the nature of the delusional mood a person may progress to a psychosis characterised by grandeur, paranoia, religiosity or myriad alternative themes and combinations of themes. The delusion mirrors the stresses that the person was exposed to as it developed.

This is why we see situations such as….

1 The rape victim who believes that semen is toxic (a way to justify avoiding the reminder of continued, consensual sexual contact without facing the traumatic memory);

2 The man with low self esteem who believes that terrorists electronically wiped his memory to prevent him using his special powers to save the world from violence.

3 The battered child who as a teenager decides she is the reincarnation of a religious martyr who saw suffering as a gift from God.

I could continue but I imagine the point is made. The delusions serve a purpose and they relate, however symbolically, to a genuine psychological need. The experience isn't always pleasant but it is always possible to see a link so long as we can identify the delusional mood.

Hallucinations are another psychotic symptom. An hallucination is an experience in any of the five modalities (senses) that other people do not experience.

David Jaynes proposed a fascinating theory decades ago. He suggested that voice-hearing was the norm for humans until very recently in our evolution. This, he speculated, is why in ancient literature from the Bible and the Bhagavad Gita to the classical texts of Rome and Greece nobody ever seems to have an idea of their own. Instead the protagonists are guided by the gods or the spirits. Jaynes proposed that these were simply the ancient interpretations of what we now call auditory hallucinations. Psychotic hallucinations were simply an expression of thoughts that are experienced as a voice, vision or other sensory stimuli.

Assuming that this is the case (and it might be) the following facts make a great deal of sense:

1 Delusions and hallucinations are always 'mood congruent' – they mirror our emotions, just like ordinary thoughts do;

2 Although estimates vary widely, up to 15% of the population regularly hear voices and see visions without experiencing any difficulty coping with life. Many of them become religious leaders, mystics and renowned psychic mediums.

3. According to research such as the World Health Organisation's ISOS study psychotic people are much more likely to recover in cultures (unlike our own) where their psychosis is accepted as normal.

4. Some cultures see psychotic episodes as times of development – they are seen as positive experiences.

The precise nature and effects of such psychotic episodes varies enormously. As well as delusions and hallucinations they can lead from psychotic depression or other emotional states right up to hyper mania (very extreme elation) with delusions of grandeur and assurances of 'specialness'. Actually the idea of specialness is a very common factor in the development of all three symptom groups of mental disorder. We do our children no favours by letting them think that they're special. It's far healthier to think of ourselves as 'unique – like everybody else'.

The third symptom group of psychosis is that of 'thought disorders'. This isn't about what we think but about how we think it. It seems likely that thought disorders are more related to brain chemistry and other biological factors. Brain chemistry and hormonal responses change in relation to thoughts and behaviour just as thoughts and behaviour change in response to chemistry. Anxious thoughts produce adrenalin and adrenalin disrupts the flow of thought.

The stress and vulnerability model's view of psychosis could almost be thought of as the chicken and egg explanation.

We can get a glimpse of thought disorders by thinking about the difficulties we all can have when stressed, intoxicated or tired – all stressors that can create thought disorders if severe enough. We've all had the experience of at least mild paranoia at the end of a particularly stressful week and we've all had trouble collecting our thoughts coherently when we're overtired.

Interestingly in all the years I worked on acute psychiatric wards I can't recall ever admitting a psychotic individual who'd been sleeping well during the previous few nights.

Thought disorders then are extreme versions of the disturbances in thought we all experience when under stress. As the model suggests the greater the stress or individual vulnerability the more problematic the 'symptom'.

Hopefully by now you can see that problems progress step by step along the imaginary road as stress increases. This awareness of the progressive nature of symptoms in relation to stress and vulnerability is vital. It forms the basis of formulation, relapse prevention, early indicators for self management and eventually recovery itself.

Stressed 11: Personality disorder – a diagnostic red herring

Before we begin today's post I need to make a statement that may seem surprising. The title of this post is misleading – or at least it ought to be.

When used properly the diagnostic category of Personality Disorder, far from representing a red-herring, a misleading distraction, is both reasonable and useful. As regular readers of this blog will know I have some very real concerns about the medical model assumptions underlying the theory of Personality Disorder but let's not throw the baby out with the bathwater. The more we know about a person's personality the more focussed our interventions can be.

Remember what we said earlier about the purpose of diagnosis – it must either inform treatment or predict outcome. Ideally it will do both.

When used appropriately the diagnosis of Personality Disorder can achieve both of these aims. The problem, the 'red-herring' if you will, is related to the way that the diagnosis is used in practice. What should be a useful way to understand a person's vulnerabilities and likely reactions to treatment options has become a poorly understood label used to dismiss some of the most vulnerable people in modern society.

I don't generally sing the praises of the American psychiatric system over the Uk's approach. As a rule I think the Americans are much less effective and far too mechanistic by comparison. However in relation to the Personality Disorder classifications I have to make an exception.

The American diagnostic system, represented by the DSM-IV (soon to be DSM-V) includes the 'multi-axial' approach. This puts Personality Disorder in perspective as one of a range of factors (we might say stress and vulnerability factors) that contribute to the person's presenting problems.

The multi-axial diagnostic approach is based upon 5 areas of consideration known as 'axes'. The five interacting axes are….

Axis 1 Psychiatric diagnosis – based upon presenting symptoms. In relation to the stress and vulnerability model this would include anxiety, depression and psychosis. Technically this category would also include dementias such as Alzheimer's disease whereas the stress and vulnerability model might be just as likely to place that in the developmental category.

Axis 2 Developmental diagnosis – this includes personality disorder. It's useful background information that informs us of the person's vulnerabilities and likely reactions (informs treatment and outcome) but is not, in itself, the focus of treatment or interventions.

Axis 3 Physical diseases – In terms of stress and vulnerability this would form part of the 'biological stressors' category. Of course axis 3 is less comprehensive than the stress and vulnerability based biological formulation but at least it's a start.

Axis 4 Psychological stress factors – Another category used in stress and vulnerability formulation although again this is probably less comprehensive than the PSI based psychological assessment.

Axis 5 Global functioning – a way to bring together all the above factors in relation to the actual experience of the individual.

Hopefully it is clear that, if properly understood through this multi-axial approach personality disorder becomes useful information but it is not in itself the focus of therapeutic work. The task remains the same – to treat symptoms of anxiety, depression and psychosis. We are never expected to change a person's personality, disordered or not.

Personality Disorder diagnoses can highlight vulnerabilities to symptom groups or predict a person's probable thinking style (theory of mind) but only to help us to treat the three main symptom groups. There is value but it can mislead too. We treat the problem, we shouldn't get hung up on the personality or value judgements about them.

And that's where the red-herring comes in. In practice, many professionals in UK do not see the diagnosis of Personality Disorder as a way to inform treatment – they see it as a reason to deny treatment. The justification for this untherapeutic abandonment of vulnerable people is the fact that we cannot treat personality. This is true, of course, but then we are never expected to.

If you, the reader became anxious, depressed or psychotic you'd expect to receive help for your problems – you wouldn't expect mental health professionals to try to change who you are. This basic truth is the same for all people regardless of personality type. We should try to understand the personality so far as we are able but we treat problems. This is why the American distinction between axis 1 and axis 2 is so useful. It is also why workers who fail to think through the proper use of Personality Disorder Diagnoses are likely to fail their service-users most spectacularly. It is amazing that many of those professionals who dismiss people diagnosed with personality disorders cannot even name the diagnostic categories of Personality Disorder. Of those who can, most cannot explain whet the criteria are, let alone describe their meaning in practice. This is abusive practice and it is based as much upon ignorance and discrimination as it us upon genuine clinical need.

There is a valid argument that people suffering from various personality disorders will be more appropriate for some services than for others but to refuse access to all services on the grounds of personality disorder is taking it too far. It's also likely to breach the duty of care of many statutory services in the light of department of health guidelines such as the document:

'Personality Disorder: No longer a diagnosis of exclusion' (Department of Health 2003)

Knowledge is power but denial of services altogether is a misuse of that power.

Stressed 11a: Crime, cannibalism and treatability

Stephen Griffiths is in prison following the murder, dismemberment and apparent ingestion of at least three women. Dubbed the 'Crossbow Cannibal', a nickname I'm told he chose for himself, Mr. Griffith's crimes were both appalling and hard to understand.

It's this very incomprehensibility that has given rise to the latest round of superficiality from Westminster.

Philip Davies is the conservative MP for Shipley. He has apparently latched on to the phrase 'personality disorder' (Mr. Griffith's diagnosis) and is calling for a review of the way people with this diagnosis should be dealt with:

"It does seem extraordinary that someone with his profile was considered safe to be allowed in the community. There does seem to be an issue with regard to people with personality disorders. We need to look at how we deal with people with personality disorders, what treatment we give and what we do with them.

"It does seem a perverse situation in that we are waiting for people to commit a crime before we are prepared to do something with them."

This is not the first time that politicians have responded so superficially in the wake of serious crime. Back in 1997 Tony Blair's 'New Labour' stood on the same platform following the Michael Stone murders. Ignoring long-standing libertarian issues such as the presumption of innocence they came up with the failed doctrine of the 'preventative detention of people with severe and dangerous personality disorder'. Such a policy rests upon two equally dangerous propositions:

1. It is reasonable to incarcerate people simply because we think that they might commit crime at some time in the future.

2. Antisocial Personality Disorder is a reasonable predictor of antisocial behaviour rather than a label given to people because we already know that they behave in antisocial ways.

These points are extremely important.

Firstly, here in UK we have a legal system that does not predict potential guilt and sentence people because of crimes they have not yet committed. The courts do not have the gift of clairvoyance and neither have psychiatrists. On the contrary the right to liberty is an important part of our society's basic culture.

Secondly, personality disorder is a psychiatric label but it's not a mental disorder in the way that most people would understand it. Rather the personality disorders (there are several different types) are descriptions of character traits. These traits may have a bearing upon susceptibility to other problems but they're not illnesses and they don't reliably predict murder.

Far from making responsible comments as one might expect from Members of Parliament, Mr. Davies has managed only to fuel superficial stigma and prejudice based upon fear of mental disorder. His comments were irresponsible, ill advised and divisive. They got him a few headlines though and I find myself wondering if that's all that really matters to him.

Stressed 12: Vulnerability factors

Let's look at the areas of vulnerability in a bit more detail. As we said before the aim of this blog is not to make the reader an expert in the stress and vulnerability model so much as to provide a 'flavour' of the subject. Remember that we identified five vulnerability areas:

Biological;
Psychological:
Social & Cultural;
Environmental;
Developmental.

We'll begin with biology….

Biological vulnerabilities can be divided into a number of 'subgroups'. These include:

Genetics;
Physiology;
Anatomical;
Lifestyle.

Genetic vulnerabilities relate to the specific 'hand' that nature has dealt the individual. Just as some people are genetically vulnerable to disease processes such as diabetes or cancer others carry a genetic vulnerability to mental and emotional disorders.

There has been significant research in this field and although the results aren't so clear as perhaps the researcher would have preferred it does seem that specific genes (or combinations of genes) create specific vulnerabilities.

Clearly options for altering a person's genetic make up are limited to say the least but that doesn't mean we ignore the very real possibility of genetic vulnerability. Fortunately though there is more to biology than concerns about the genotype.

Some people are more vulnerable to sleep deprivation than others (although everyone has a limit in that respect). Then there are those vulnerabilities associated with diet and other ways to intake food or substances. From simple sugars to illegal drugs like heroin or cannabinoids the effects of different compounds can be remarkable.

Exercise and activity are important both to physical and mental health. Indeed one of the fastest ways to lower your own mood is to do nothing except spend a few days staring at the walls. We need activity and we need meaningful stimulus to maintain mental health.

The greater our biological vulnerability the more susceptible we will be to biological stressors from sleep deprivation to enforced inactivity or substance misuse (prescribed or otherwise).

Psychological vulnerabilities are related to thinking habits and beliefs. At the most obvious level they are concerned with beliefs. For example the individual

who believes themselves to be 'special' in some way may well come to expect special consideration from those around them. This is just one example of a belief or expectation that does not fit reality.

It is well understood by psychologists that a major source of distressing or unhelpful emotions including anger, resentment and anxiety is the mismatch between expectations and reality. So unreasonable expectations or inaccurate self belief can be a major psychological vulnerability.

Another, more general psychological vulnerability relates to basic 'attitude'. For example an optimist is more at risk than a pessimist because they are less likely to be disappointed when life doesn't meet their expectations. Of course a realistic attitude is probably more healthy than either but that can be elusive.

The concept of 'theory of mind' is significant. Essentially it boils down to the idea that we accept the evidence we see that supports our existing beliefs but ignore or 'disattend to' evidence that doesn't fit. This is the sort of thinking style that allows racists to believe that all black, Asian, Jewish or other people are inferior or that all members of their particular group are superior. The evidence doesn't fit the belief but that's not a problem because they simply don't see the conflict.

This 'selective abstraction', this focus only on the evidence they agree with can be a major problem though if circumstances force the person to re-evaluate their cherished beliefs. Their entire self esteem might depend upon a lie that they can no longer support – a major vulnerability factor. I have personal experience of this re-evaluation when, following almost a decade of increasingly fundamentalist Christianity circumstances forced me to reconsider my beliefs and indeed my place in the world. We are vulnerable to the extent that we ignore the evidence of the world around us.

My old biology teacher used to claim that he always held the best opinion. Actually he was a true scientist in that he was always happy to re-evaluate his beliefs in the light of new evidence. He wasn't emotionally invested in any idea except the idea that he might be wrong. This commitment to reality is rare but much more healthy than selective abstraction. It means that new evidence doesn't shock us because our worldview already includes the expectation that our understanding will need to be updated from time to time.

Consider though the plight of the woman who, as a result of sexual abuse in childhood came to believe that she was dirty and that she deserved what happened to her. How vulnerable would that belief system make her?

Other beliefs and expectations that create problems include:

I must always be in control;
People should behave the way I think they should;
Only the best is good enough;
I must never make mistakes;
Failure is shameful;
Apologising is a sign of weakness;
Big boys don't cry.

The list, of course goes on and on but there is no need to continue with it here. It's enough to create a sense of the psychological vulnerability that needs to be considered in practice.

In the next post in the series we'll consider the remaining three categories of 'social', 'cultural' and 'developmental' vulnerability.

Stressed 13: More vulnerability factors

Continuing the 'Stressed' series of posts it's time to consider the three remaining vulnerability factors that contribute to emotional distress and mental disorders. Previously we identified biological and psychological factors. Today we'll focus on socio-cultural, environmental and developmental factors.

The 'socio-cultural' category of factors is wide and very far reaching. It includes the social relationships of families, friends and associates, of care workers and service-users. The interactions between people are immensely significant in an individual's life. They can provide curative support or cruel discrimination.

The same is true of the wider culture in which that person is fortunate enough, or conversely sufficiently unlucky to live. My own UK culture is certainly significant with the general (false) beliefs about incurability or the idea that psychotic means 'dangerous'. These cultural perceptions lead to real problems in terms of acceptance, discrimination and employment, to name but a few. Arguably UK culture is far from helpful to people diagnosed with mental disorders.

The environment also is important. People living in run down bedsits surrounded by violent gangs of youths are less likely to feel secure than those who live in sleepy villages or well to do suburbs. The phenomenon known as 'social drift' is an interesting (but also depressing) example of the way that culture and environment come together to make recovery more difficult. This is the result of cultural fears that mean people diagnosed with mental disorders are more likely to lose work than they are to gain it. This creates economic hardship and so the person 'drifts' into poorer and poorer environments as their finances change.

Developmental issues relate to biological processes from puberty to dementia and socio-cultural changes such as leaving education, joining the workforce, marriage, parenthood and retirement. Each of these changes carries it's own stresses but also brings it's own strengths and vulnerabilities.

The interaction of all five factors – biological, psychological, socio-cultural, environmental and developmental determines a person's vulnerability and also the degree of stress they face. The trick is to influence as much as we can to decrease vulnerability and decrease stress whilst at the same time helping people learn to manage their own stress levels independently from services.

When that person can keep both vulnerability and stress to within 'normal' limits they have recovered.

Stressed 14: Dealing with problems, not medicating diagnoses

As we have seen there is much more to mental health and disorder than biology alone. The traditional psychiatric approach of diagnosis and prescription can be helpful in controlling symptoms but much less effective in tackling underlying causes. This is not to suggest that medicine has no place in treating mental disorder. There is value in medication but it is not the full story. There are many reasons for this that are reviewed briefly below:

Diagnosis: Literally the term 'diagnosis' means 'through knowledge' and yet, in many psychiatric diagnoses knowledge is replaced with 'correlation'. Psychiatrists note the array of symptoms that they see and compare them with descriptions of disorders to arrive at a diagnosis. This is much like the diagnostic process found in physical health but with one major difference – the 'knowledge' base is much weaker.

Knowledge: It's important to distinguish between 'understanding' and 'naming' problems. For example the diagnosis of schizophrenia is made when a certain number of symptoms are present for a certain time. If the symptoms fit the right pattern the diagnosis is made. It is not necessary to understand why the symptoms exist or how they developed. This is not understanding, it's categorisation.

Assumption: Because psychiatrists are doctors first they work on the assumption that chemical changes are needed. This isn't surprising – it's how they are trained. So they give chemical treatments even though the diagnosis does not involve any attempt to see if there really is a chemical problem. It's the 'biomedical assumption'.

Pessimism: When chemical treatments don't work the assumption is that the disorder is 'treatment resistant'. The idea is not that non medical interventions are indicated. Rather there is an arrogant belief that if medicine can't help then nothing else can either. This is extremely pessimistic.

Maintenance: For many people the result is a degree of tranquilisation that not only fails to get to the real root of the problem, it can also prevent them from thinking through their troubles as cognitive function is impaired. In other words mental disorder itself is maintained as people are effectively prevented from effective use of psychological interventions.

Addiction: Some medications, particularly the minor tranquilisers, are addictive and create an additional problem on top of the anxiety states that they are designed to alleviate.

Stressed 15: The role of medication

Despite all this there is a very real place for psychiatric medications when used appropriately in tandem with other interventions. It is also true that a growing number of psychiatrists are acknowledging the role of other approaches but, in practice many, many people receive medication or nothing. There is still much work to be done. However….

It seems likely that for some people there really is a chemical imbalance that medication can alleviate. This is especially so with some of the mood disorders and, although the evidence is far less robust, some psychotic states may also be caused by abnormal body chemistry.

Additionally many people can benefit from the symptom relief that appropriate use of medication can bring. It would be wholly inappropriate and extremely irresponsible to pretend that medications have no role in mental disorder. The reality is that in many cases both medical and non-medical interventions are necessary.

This little collection of blog posts isn't intended to make anyone an expert in the use of stress and vulnerability based approaches to mental health care. That's not what it's about. But it should give readers the confidence to know that there is more to life than medicine and that whilst psychiatric drugs have their place (and in my opinion they most certainly do) they are far from the end of the story. They may be a beginning though.

I hope you found this information useful. Please feel free to get in touch if you have any comments about this PDF by Email via:

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I look forward to hearing from you.

Stuart Sorensen