
MENTAL HEALTH AND WELL-BEING
Alternatives to the Medical Model
NEIL THOMPSON
ROUTLEDGE

Mental Health and Well-Being

Mental Health and Well-Being provides a sound foundation for understanding alternatives to the medical model of mental health. Students and professionals alike will find an easy-to-understand overview of critiques of the dominant medical model of mental health and well-being, both long-standing and more recent, and will come away from the book with a more theoretically sound, holistic conception of mental health and well-being. Written by an experienced mental health expert and replete with practical anecdotes, exercises, and examples to help readers apply the book's material, this book offers an essential foundation for developing more humane mental health practices.

Neil Thompson PhD, DLitt, is an independent writer, educator and adviser with extensive experience in the human services. Formerly a university professor, he now helps individuals and organizations to maximize their learning.

Mental Health and Well-being

Alternatives to the Medical Model

Neil Thompson

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For Paul and Monique

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Preface

The overall aim of the book is to provide a sound foundation of understanding of alternatives to a medical model of mental health and well-being. This will enable students and practitioners from a range of disciplines and professions to approach the subject matter from an informed basis.

Criticisms of narrow, medicalized conceptions of mental health problems date back to at least the 1960s. However, in recent years there has been a growth in literature that draws attention to the major shortcomings of a biomedical approach. But these books provide little discussion of the *practical* implications of such a critique. Also, the various criticisms have come from a range of separate theoretical perspectives, each staking its own claim, but with limited consideration of other bodies of critical thought. The book draws on a sociologically informed existentialist philosophy to provide a unified and more holistic theoretical approach to making sense of mental health and well-being.

My specific objectives are:

i To provide an overview of critiques of the dominant medical model of mental health and well-being, both long-standing and more recent;
ii To develop a more theoretically sound understanding of mental health and well-being; and
iii To clarify the implications for professional practice of moving away from a narrow medical model towards a more holistic model of mental well-being.

In writing this book I have deliberately adopted an accessible style suitable for newcomers to academic study and more experienced readers alike in order to make sure that the important messages about mental health are not lost in jargon or unnecessarily obscure academic writing. The book should therefore be of value to a wide range of students from basic introductory studies to Master's level.

This book will be of value primarily to students and practitioners from a wide range of disciplines: social work and social care; nursing, especially mental health nursing; counseling and psychotherapy; probation and prison studies; pastoral care; police work; and youth and community

work, and so on. It should also be of interest to those medical practitioners who are prepared to reconsider the basis of their work and policymakers who appreciate the need to revisit the medicalized assumptions on which current policy is largely based. There will also be some value in it for people who have been "through the mill" (as patients or caregivers) of the mental health system and want to develop a fuller understanding of their experiences.

What has motivated me to write this book is many years' experience as a social work practitioner, manager and educator working alongside people who are deemed to be "mentally ill" and recognizing that the dominant medical model of mental health problems:

i seemed very ill suited to the highly complex situations that "patients" found themselves in – it did not do justice to the wide range of factors that were clearly playing a part in shaping the circumstances; and
ii in many cases seemed to be making the situation worse, rather than better, by presenting a distorted, oversimplified picture of what was happening that had the effect of disempowering and misleading the people it was designed to help.

I was being told that the people I had been asked to help were "ill," which strongly suggested a biological framework of reference. But, what I was actually encountering was people wrestling with a range of psychological, social and spiritual challenges (which may have had some sort of biological *effect*, but it made no sense to me to see these situations as having simply a biological *cause*).

As will become clear in the pages that follow, there is much that is highly problematic with the current mental health system and much that can be done to offer a better, more humane and more effective approach to helping and supporting people who face mental health challenges if we radically rethink what mental health and well-being are all about. This book is intended to make a contribution to that radical rethink. It does not have all the answers, but it does pose a number of key questions that should be able to help us move forward in our thinking and, it is to be hoped, our practice.

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First and foremost I want to thank all those people I have worked with in the mental health system, people I learned so much from. I am also grateful to Anna Moore and her colleagues at the publishers for their unstinting support.

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But, most of all, my sincere thanks must go to Dr Sue Thompson. She makes such a positive difference in so many ways.

About the Author

Neil Thompson PhD, DLitt is an independent writer, consultant and tutor. He has held full or honorary professorships at four UK universities. He has over 40 years' experience in the helping professions as a practitioner, manager, educator and adviser, during which time he has established himself as a trusted and highly respected expert in human relations and well-being.

He has 40 books to his name. These include:

Power and Empowerment (Russell House Publishing, 2007)
People Management (Palgrave Macmillan, 2013)
People Skills (Palgrave, 4th Edn., 2015)
Understanding Social Work (Palgrave, 4th Edn., 2015)
The Authentic Leader (Palgrave, 2016)
The Palgrave Social Work Companion (with Sue Thompson, 2nd Edn., 2016)
Anti-discriminatory Practice (Palgrave, 6th Edn., 2016)
Social Problems and Social Justice (Palgrave, 2017)
Theorizing Practice (Palgrave, 2nd Edn., 2017)
Effective Communication (Palgrave, 3rd Edn., 2018)
The Critically Reflective Practitioner (with Sue Thompson, Palgrave, 2nd Edn., 2018)
Applied Sociology (Routledge, 2018)
Social Work Theory and Methods: The Essentials (edited with Paul Stepney, Routledge, 2018)
The Social Worker's Practice Manual (Avenue Media Solutions, 2018)

He has also produced a range of e-books, e-learning courses and DVDs. In addition, he runs an online learning community, based on principles of self-directed learning and geared towards critically reflective practice: The Avenue Professional Development Programme (www.apdp.org.uk).

He is a Fellow of the Chartered Institute of Personnel and Development and the Higher Education Academy and a Life Fellow of the Royal Society of Arts and the Institute of Welsh Affairs. He is a long-standing member of the International Work Group on Death, Dying and Bereavement and a former Board member.

Neil is a sought-after conference speaker who has presented in the UK, Ireland, Italy, Spain, Greece, Norway, the Netherlands, the Czech Republic, Turkey, India, Hong Kong, Canada, the United States and Australia. In 2011 he was presented with a Lifetime Achievement Award by BASW Cymru (the Wales branch of the British Association of Social Workers). In 2014 he was presented with the Dr Robert Fulton Award for Excellence in the field of Death, Dying and Bereavement from the Center for Death Education and Bioethics at the University of Wisconsin-La Crosse.

He has qualifications in social work, training and development, mediation and alternative dispute resolution and management (MBA), as well as a first-class honors degree, a doctorate (PhD) and a higher doctorate (DLitt).

He is passionate about helping people to learn in order to support them in making a positive difference to their own lives and the lives of others. He does this by exploring complex ideas and presenting them clearly and accessibly without oversimplifying them. His website and blog are at www.NeilThompson.info.

Introduction

Mental health is a topic that has attracted huge interest and investment over decades. While there are many dissenting voices, by far the most dominant approach is to regard any problems people experience in relation to their mental health and well-being as manifestations of an underlying illness, a medical condition rooted in our biological functioning.

This book seeks to challenge that dominant thinking by highlighting fundamental flaws in the logic on which it is based and the vested interests that serve to maintain that dominance despite those flaws. This will be achieved by reviewing some of the arguments put forward by those dissenting voices and exploring the practice implications for mental health professionals, broadly defined, of alternative approaches to mental health and well-being that reject the simplistic notion that mental health problems are illnesses parallel with physical illnesses.

I shall be drawing on existentialist philosophy, partly because it is well suited to exploring mental health in terms of existential challenges and crises, and partly because it has the potential to draw on ideas from a diverse range of theoretical perspectives and use them as part of a holistic approach. Such a holistic approach is a welcome counterbalance to the narrowness of the dominant medical model.

Before we get too far into these wide-ranging discussions it is important to focus down and be clear about what we exactly mean by mental health and the associated term of mental well-being.

Mental Health and Well-Being

We are very familiar with the notion of physical health and the associated problems of diseases, illnesses and injuries relating to the human body. Biology is therefore understandably to the fore when it comes to addressing health concerns. To be healthy means to be free of such problems or at least managing them effectively in ways that enable us to get on with our lives.

By analogy, mental health is generally understood to relate to the mind, with problems like schizophrenia, anxiety and depression being seen as the equivalent of physical illnesses or diseases. To be mentally healthy is

therefore widely understood as the absence of such problems or at least the ability to manage them without their disrupting our life (or other people's lives) too much. The parallel with physical health is a strong one according to this dominant view, with medical terminology (symptoms, diagnosis, treatment, prognosis and so on) being the norm. The focus is on brain pathology and presumed chemical imbalances. However, to reduce problems of the "mind" to the malfunctioning of the brain is the equivalent of reducing the human person to just a body. It fails to recognize that to be human is not just to be or have a body. Being human involves a complex range of psychological factors (cognitive, emotional and behavioral); a complex web of social factors (biographical, cultural and structural); and a host of spiritual considerations (meaning, purpose, direction and connectedness) that interact with not only our biological base, but also each other. This complexity of what it means to be human (and thus to face human or existential challenges) is a major part of what we shall be exploring throughout the book (and a key part of the rationale for adopting an existentialist approach to underpin our discussions).

A basic premise of this book is that this analogy is not only invalid, but highly problematic, misguided and oppressive, creating major problems for large numbers of people and blocking the way to more effective and less problematic ways of helping and supporting people through their difficulties. Pickering, an experienced psychiatrist, acknowledges that this analogy is a metaphor, but sees no problem with this (Pickering, 2006). He appears to fail to see that responding to a complex multi-level human problem as if it were an illness of the mind is to engage in a significant distortion and to justify the use of "treatments" that, as we shall see in the ensuing chapters, have at best a mixed record of effectiveness and an extensive record of exacerbating existing problems or creating new ones (see, for example, Hari, 2018). To recognize that conceptualizing what have come to be known as "mental health problems" as illnesses or disease states is an exercise in metaphor is, as I see it, a positive step forward. However, to fail to recognize the implications of this is not so positive. A metaphor is a *representation* of reality, not the reality itself.

What complicates matters further is that, in recent times, the notion of "mental well-being" has come to be used more and more. This is a mixed blessing. It is positive that mental health is increasingly being seen as a matter of quality of life (for that is what well-being refers to) and not simply a medical matter – thus an emphasis on well-being plays the important role of widening our focus beyond the narrowness of the medical model. However, the negative side of this development is that a large well-being industry has grown up that has the effect of trivializing and oversimplifying mental health problems. While massage, meditation, aromatherapy and such like may well have a role to play, the idea that this is enough to address the major challenges of a floridly psychotic episode in which someone appears to have lost all grip on reality is clearly misplaced.

We have to be careful, then, not to allow a focus on mental well-being to emphasize the "lighter" end of the mental health spectrum and lose sight of the "heavy" end with its huge challenges.

The use of the term "mental well-being" can also play a part in reaffirming the medical model – for example, when, as commonly occurs, people distinguish between mental well-being as part of the everyday struggle for happiness and contentment and mental illness as the more serious problems a minority of people encounter. We need to be clear, then, that it is not in this consumerist sense of well-being (the "fluffy" approach, as some people call it) that I am using the term. Rather, I am using it to affirm that what we traditionally call mental health can be better understood more holistically as a matter of well-being, of quality of life, ranging from everyday happiness and related spiritual concerns right through to major life-disrupting conditions. Indeed, one of the points I will be emphasizing later is that it can be helpful to understand even the most severe of mental health problems as an extension and intensification of everyday concerns and problems, rather than qualitatively different as illnesses or diseases.

Mental "Illness"

In Part I of the book we shall see how the contemporary use of the notion of "mental illness" has arisen historically as one conception evolved into another. For Lieberman (2015) this has been a journey from one set of myths to the current "truth" arrived at through the application of the scientific rationality adopted by the medical profession. However, as we shall see, an alternative view of this is that the medical model is just as flawed as its predecessors and in need of critical scrutiny. The concept of "mental health" remains a contested one, and the use of the term "mental illness" closes the debate to a large extent by buying into a medical understanding of the issues involved. This book does not offer an alternative "truth" or "the right answer". Rather, it seeks to re-open the debate by: (i) showing how the medical model is not a helpful way of understanding or addressing mental health concerns; and (ii) presenting a range of alternative understandings based on the work a number of scholars and commentators – the "dissenting voices."

Traditionally mental health problems have been divided into two main categories, psychosis and neurosis. Psychosis refers to what, in everyday terms, is generally referred to as "madness." It describes conditions in which people seem to have lost touch with reality, are behaving in highly irrational ways and are defying social conventions in major and often disturbing ways. This includes such presumed conditions as schizophrenia and bipolar disorder. Neurosis refers to what are generally seen as "nervous disorders," primarily anxiety-related concerns and depression.

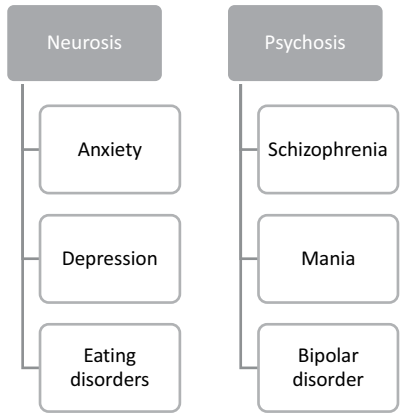

Figure 0.1 Psychosis and neurosis as traditionally formulated

These two sets of issues are presented within conventional psychiatry as two related aspects of "mental illness," but they can be seen to be very different phenomena, with different contributory factors, different mechanisms and different outcomes. This reflects a phenomenon we shall discuss later, namely the empire-building activities of psychiatry, driven and supported by the pharmaceutical industry, to incorporate more and more conditions into the realm of psychiatric oversight.

We shall revisit these issues below, but for now my main aim is to clarify these two different components of the current mental health system.

It is important for me to stress that, in questioning the validity of mental illness as conceptualized within the medical model, I am in no way underestimating the seriousness of the challenges that people diagnosed as mentally ill have to contend with.

The rejection of the medical model is often interpreted to mean that "mental illness" does not exist. However, this is a dangerous oversimplification, as it implies that what we understand to be mental health problems (whether psychotic or neurotic) do not exist.

The fact that these challenges are not "illnesses" does not mean that they are not major problems for a significant number of people. Critiques of the medical model are often dismissed because they are perceived not to recognize the intense pain and suffering associated with mental health problems, but this is a misrepresentation of such critiques. What they are saying is not that such problems do not exist, but that it is unhelpful and counterproductive to refer to them as illnesses and to tackle them as if they are primarily examples of biological misfirings, rather than complex, multi-level phenomena that need to be understood holistically by recognizing the role of psychological, social and spiritual factors and their various interactions.

Consider this hypothetical parallel. Imagine that hunger were defined as a medical condition (it does have a biological basis, after all). Think of a hunger pang as a symptom of your "disorder," a café or restaurant as your medical center, grocery stores as your pharmacy, a meal as your medication and eating as your treatment. To question the validity and wisdom of conceptualizing hunger as an illness is not to deny that hunger exists or to argue that it should not be taken seriously and fully addressed.

As I mentioned in the Preface, I have many years' experience of working in the mental health system. I have seen first hand how mental health problems can ruin people's lives, break up families, generate incredible levels of stress, bring about intense and prolonged suffering and prove to be terrifying for not only the person concerned, but also for their family and others around them. To deny that such concerns are medical matters is not to deny that they are problems of immense significance and impact. Rather, it is to say that there are better ways of addressing these problems and the range of factors that give rise to them.

The HEART Framework

From time to time I will refer to the "HEART framework" or one or more elements of it. I have adopted this framework in order to emphasize what I see as five key elements of what needs to be done to make the mental health system a more humane and effective one. The five elements reflect my view that our approach to the subject needs to be:

- *Holistic* The current dominant model focuses heavily if not exclusively on the biological dimension of human experience. I shall be arguing that this is too narrow and thereby neglects other important aspects, thereby producing a distorted and unhelpful picture. Drawing on the holistic approach to loss, grief and trauma I utilized in my *Grief and its challenges* book (Thompson, 2012a), I will be urging us to think in terms of psychological, social and spiritual factors in addition to the biological ones. The four elements interact in complex ways, and so to focus primarily on one of the elements to the exclusion of the others (and their significant interactions) is to leave out a significant amount of important information from the picture. That is dangerous, and so we need to make sure that our approach is holistic.
- *Emotion focused* The emphasis on brain pathology and chemical imbalances has served to prioritize the cognitive aspects of human psychology, while the focus on risk and public protection has tended to prioritize behavior, particularly potentially dangerous behavior. The emotional dimension has therefore tended to be marginalized, pushed into a peripheral role. The idea that what are often perceived to be "symptoms" of an "illness" are actually emotional responses is one that we will revisit from time to time.

- *Alienation aware* Alienation is a hugely important concept that has considerable explanatory power in relation to mental health problems. Despite this, it rarely features in discussions of the contributory factors to mental health problems. The significance of alienation will therefore be highlighted and emphasized.
- *Reconsidering our assumptions* The biomedical model is so dominant that its premises have come to be seen as "common sense," largely accepted without critical scrutiny. As we shall see, the assumptions underpinning this model are not only highly questionable, but also potentially quite harmful and oppressive. There is therefore a pressing need to revisit, reconsider and re-assess those dominant assumptions and explore alternative understandings that will serve us better.
- *Trauma and loss informed* There is a growing literature base emerging now that draws important links between experiences of trauma, especially childhood trauma, and mental health problems (Bentall, 2010; Bracken 2002; Thompson, Cox and Stevenson, 2017). Trauma can be understood as a particularly significant form of loss. One of the key issues we will be examining together is the significance of loss and grief, especially traumatic loss, as a major contributory factor in the development of mental health problems.

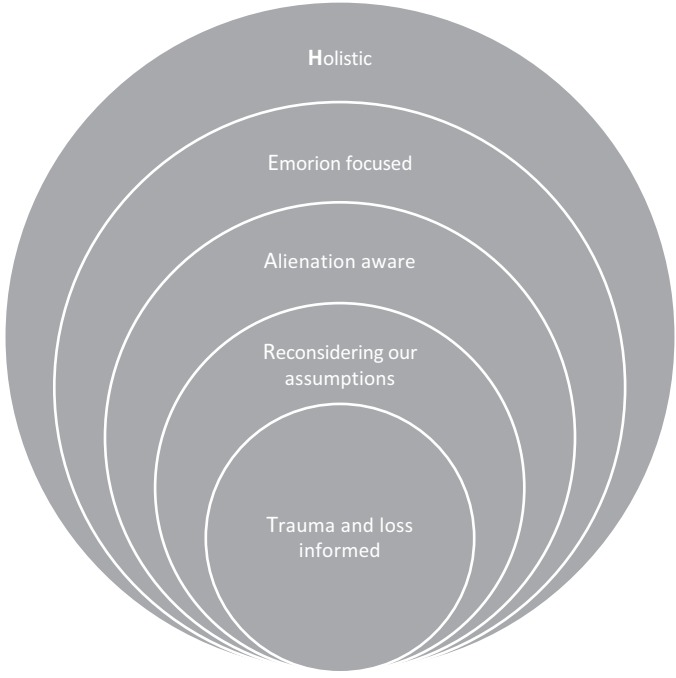

Figure 0.2 The HEART framework

Occasional reference will be made to this framework throughout the book, and its significance should become clearer each time this happens.

The Structure of the Book

The book is divided into four parts. The first one is entitled "Constructing mental illness," and its four chapters each tell part of the story of how ideas about madness and associated ideas have evolved over time, leading to the present-day medical model. The second part is entitled "Deconstructing mental illness," and the chapters in here cover four particular approaches that have called the medical model into question: interactionism, anti-psychiatry, post-structuralism and the flawed science critique. Each one has important points to make, but, while there is some degree of overlap and interconnection, they remain largely disparate approaches, with no unified basis.

Part III, "Theorizing mental health and well-being," also contains four chapters. The emphasis here is on combining, extending and building on the critical insights covered in Part II. Key issues relating to meaning, selfhood, roles and responsibility, and spirituality provide the main topics of interest. In Part IV the emphasis is on "Promoting mental health and well-being." This involves looking at individual, group, community and societal responses. The aim is to demonstrate and illustrate the breadth of focus that is needed to make a positive difference, by contrast with the narrow focus of the medical model approach.

Each chapter has a small number of "practice focus" illustrations and "voice of experience" quotes. The former are either direct examples (derived from my own practice experience and comments made by participants on training courses I have run) or composite examples combining typical elements from across many cases. But, either way, they are examples firmly based in real life experience. As for the voice of experience examples, these too are drawn from either my own practice experience or from my involvement in training courses and/or consultancy projects. The names have, of course, been changed for confidentiality reasons.

The field of mental health and well-being is a complex and multifaceted one. This book does not offer easy answers, and nor do I believe that easy answers are possible. My intention is not to deliver any kind of definitive solution, but, rather, to highlight the need to look more holistically at this important subject matter. We still have so much learn, so much we still do not understand. The medical model exaggerates and distorts our level of understanding and therefore stands in the way of theory development and practice effectiveness.

Part I

Constructing Mental Illness

Introduction

Despite the current dominance of a medicalized approach to mental health problems, it was not the original way of conceptualizing what we would today call mental health problems. In this first of four parts we concern ourselves with the historical development of social perspectives on the subject.

This is not a history book, and so I will not be presenting a detailed historical analysis or drawing on primary sources. Rather, my aim is more modest than that, namely to provide a basic overview of some of the key ideas that helped to shape current thinking and thereby pave the way for the discussions that follow in Parts II to IV.

Through these first four chapters certain themes will emerge that will prove to be significant in later chapters, and so some of the points made in Part I will be revisited and further developed in the context of the subject matter of later chapters. In this way, the complex nature of mental health problems will be exemplified and clarified. This will lay the foundations for Part IV where the emphasis is on practical responses to the challenges mental health problems give rise to.

1 From Demons to Drugs

Introduction

This chapter presents a historical overview of conceptions of madness, from demons and witchcraft to "illnesses" that need (drug) "treatments." My aim is to show how "mental illness" is socially constructed (that is, shaped by social forces) and has been understood differently at different times in history. Gender is used as an example of the need to develop a broader, more sociologically informed approach to mental health problems.

In addition, the chapter briefly explores how alcohol-related problems have also come to be construed in narrow medical terms.

Madness Then and Now

Porter argues that the notion of mental illness dates back to at least the days of the Ancient Greeks:

> Ever since the Ancient Greeks, insanity has been deemed a disease and claimed by medicine. But it has remained shrouded in mystery. Whereas complaints such as measles involve clearly delineated physical symptoms, the manifestations of madness, by contrast, though often flamboyant and bizarre, can be fleeting and fantastically labile – cries and gestures, moods and movements that commonly produce no lasting perceptible physical change, nothing discernible even in a post-mortem.
>
> (1991, p. 34)

This is an important passage for two reasons. First, it shows that a medicalized understanding of mental health problems is not by any means a recent development. Second, it highlights that, even in such early times, there was a problem in reconciling such a view with any firm evidence to back it up.

Practice focus 1.1

Karen was looking forward to her time on the psychiatric ward as part of her nurse training, as she was keen to broaden her understanding of

> nursing in all its forms. However, she found her time on the psychiatric ward confusing and unsettling. She struggled to see what positive difference she could make to the patients. For the most part they were heavily sedated by their medication and no one seemed too interested in finding out what had led to their problems. She had read about innovative approaches to mental health, but she could see no sign of any such work being done here. The major focus seemed to be managing the medication regime, but she could not see any sign of anyone improving under that regime. She was very disappointed, as this was so different from what she had encountered on other wards dealing with physical illness issues.

Although such a view has a long-standing basis, it is only at a much later date that this becomes the predominant way of thinking. Over the millennia there have been other conceptions of madness and related matters that have vied with the medical model. It is an overview of some of these key ideas that we shall be focusing on here.

I find it helpful to think of the history of madness in terms of three different frames of reference. These are not being presented as objective or definitive epochs, but, rather, simply as a helpful way of mapping some key issues in the historical development of current ways of thinking.

Pre-Enlightenment Thinking

"The Enlightenment" is a term used to refer to a period of over 200 years, beginning towards the end of the seventeenth century. It describes the shift in thinking away from the largely superstitious and irrational thinking that was the norm towards a more rational, scientific outlook on the world and what goes on within it. It represented a move from what was regarded as primitive thinking to a more modern approach, hence the use of the term "modernity" to refer to the period that followed the Enlightenment and "modernism" to refer to the type of thinking it reflected.

As far as madness and related matters were concerned, pre-Enlightenment thinking was characterized by very simplistic beliefs. Given how disturbing, frightening and unsettling encounters with mental health problems could be and how, for the most part, such encounters would be out of the ordinary and far removed from people's sense of what is "normal" behavior, it is understandable that they would want to try to make sense of the phenomena they were witnessing. Given that the idea of "possession by evil spirits" (or demons) was part of the common belief system at that time, it is not surprising that this came to be a way of conceptualizing madness – someone who was displaying the bizarre and unfathomable behavior that today would be called psychotic would be labelled

as "possessed," a label that would fit, to a certain extent, what onlookers were seeing in the context of the dominant beliefs at that time.

This was linked to the idea of the role of the Devil as the master of evil and how he could take over people's souls in certain circumstances. Madness was therefore conceived of not as an illness of the body or mind, but as a malady of the soul.

This in turn was linked to witchcraft, in the sense that this was a means of trying to explain what were perceived as phenomena that were not only "unnatural," but also threatening or unsettling in some way. Being a witch, like being mad, was explained as the operation of evil forces acting on human souls.

Although the medical model subsequently involved a very different perspective by relocating the problem in the body – specifically the brain and nervous system – rather than the soul and replaced evil with medical pathology, there were also continuities. For one thing, the emerging medical model was equally monocausal, rather than holistic – that is, it was offering a simplistic level of explanation that focused on there being "something wrong" in how the body functioned without reference to wider or deeper factors. Another continuity was the gender bias involved in both approaches. It was witches, not wizards, who were perceived as unnatural and threatening. And, within, the medical model the gender bias remains to this day. For example, as Ussher explains:

> As the outspoken, difficult woman of the sixteenth century was castigated as a witch and the same woman in the nineteenth century a hysteric, in the late twentieth and twenty-first century she is described within patriarchal psychiatric discourse as "borderline," or having PMDD. All are potentially stigmatising labels. All are irrevocably tied to what it means to be a "woman" at a particular point in history.
>
> (2018, p. 76)

Voice of experience 1.1

I had expected switching from a men's prison to a women's prison to be different in a number of ways, but I hadn't appreciated just how profoundly different the two set ups were. In particular, the approach to mental health was nothing like I had experienced before. It was as if there were two mental health systems, one for men and one for women.

Sandy, a prison officer

It is beyond the scope of this book to look in detail at the relationship between mental health and the prison system – see Thompson (2010) for an interesting perspective on this.