In the West, the dominant discourse for understanding mental distress is a psychiatric one and a key element in this discourse is diagnosis. Systemic practitioners encounter diagnoses every day because they are enshrined in their institutional contexts. In the USA, for example, practitioners are required by insurers to give clients a diagnosis from the American Psychiatric Association’s (2000) *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. In other countries, diagnoses from the World Health Organisation’s *International Classification of Diseases (ICD)* might be required for a range of administrative reasons. In addition, in the UK, the National Institute for Health and Clinical Excellence (NICE) has published a range of clinical guidelines based on diagnostic categories. Systemic therapists might have a range of responses to diagnosis. For example, in their study, Strong, Gaete, Sametband, French, and Eeson (2012) noted “counsellors shared a diverse range of views on the DSM: everything from an enthusiastic embrace to dismissal or even subversion” (p. 97).

Before I moved to my current post in clinical psychology training twelve years ago, I practised as a clinical psychologist in the NHS for nearly a decade. Part of my clinical work involved working in a
psychological therapies’ service where, rather than diagnose, we formulated the problems presented by those who had been referred. However, I have also worked in a number of community mental health teams where diagnostic categories were regularly used. Although it is often claimed that use of diagnosis aids communication between professionals, in my experience such terms always needed supplementing with further information, since two people with the same diagnosis could be experiencing quite different forms of distress. For example, one person with a diagnosis of schizophrenia might have problems in getting out of bed and in motivating themselves (quite often as a result of the side-effects of neuroleptic medication), whereas another might predominantly hear voices. Thus, a diagnosis was only the beginning of a conversation: I always had to ask for a fuller description of the person’s experiences and concerns.

I was influenced by systemic and narrative approaches and ideas from critical psychology, discourse analysis, and social constructionism (e.g., Harper, 1994; Parker et al., 1995) and developed a deconstructive reading of the diagnosis of paranoia (Harper, 1996). More recently, I have been part of a collaboration seeking to move beyond diagnosis, and to view experiences of distress in their proper context (see, for example, Cromby, Harper, & Reavey, 2013). As a result, I have developed an ongoing interest in both why, sixty years after critiques of diagnosis first emerged, it is still with us, and in the need to develop alternatives.

In this chapter, I attempt to address the question of how systemic practitioners might both conceptualise and engage with psychiatric diagnosis. At the end of the chapter, I discuss a number of strategies ranging from those aimed at enabling us to live alongside diagnosis to those aimed at rejecting it and moving beyond it. However, before we get to that, I think it is important to contextualise diagnosis, to understand its history and social functions. Diagnostic discourse affects both how we come to view ourselves and the interventions that we develop. Understanding its historical and social contexts helps us to realise not only that this particular way of viewing distress is merely one among many, but also that its dominance serves a number of social functions and, if we are to move away from it, we need to consider how we address those functions. I also explore critiques of both medicalisation and psychiatric diagnosis and investigate some potential alternatives.
A brief history of diagnosis

By the middle of the nineteenth century in Britain, medicine had become professionalised (e.g., in the 1858 Medical Act) and had generally won the battle to administer the new mental asylums. From then onwards, a particular form of diagnostic mentality began to take shape. One of the legacies of this mentality within contemporary psychiatry is the distinction between form and content; thus, it is regarded as more diagnostically relevant that a person hears a voice that others do not than what the voices say. However, it is easy to forget that the history of diagnosis has been a heavily contested one with a number of classificatory schemes competing with one another throughout the history of psychiatry. Only with the arrival of the DSM and ICD in the middle of the twentieth century was there a systematic attempt to impose order and these systems are really compromises between different factions within psychiatry (e.g., psychoanalytical vs. biological psychiatrists), hence the need for committees of experts to discuss and even vote on diagnostic categories. Despite these attempts to reach consensus, critique and debate have not been quelled.

At the time of writing, the fifth edition of the DSM is soon to be published, after which the ICD revision process will get under way. Blashfield and Fuller (1996) note how this has become a regular occurrence, with the number of categories of disorder gradually increasing from 128 in DSM-I (1952) to 357 in DSM-IV (1994). In the space of twenty-six years, the number of psychiatric diagnoses has doubled. This explosion of “vocabularies of deficit” (Gergen, 1990) has been accompanied by a rapid growth in the mental health professions. For example, my own discipline, clinical psychology, has more than quadrupled in size in the UK in the past twenty years. One could argue that there has been a symbiotic relationship between the creation of new forms of knowledge (e.g., diagnostic discourse) and the proliferation of disciplines to develop this knowledge.

Alongside the growth in the number of diagnoses, their reach has also increased, and we have begun to see an increasing medicalisation of everyday life (Illich, 1976) which has since been exported to other countries (e.g., Watters, 2010). Now, increasing numbers of behaviours previously seen as part of ordinary life are seen as indications of mental pathology (Furedi, 2004; Rapley, Dillon, & Moncrieff,
Allied to this increasing medicalisation has been an increasing pharmaceuticalisation of society (Healy, 1997; Moncrieff, 2008). This seems to be a result both of the desires of Western populations for a technical fix to complex human problems and the result of active marketing by multi-national pharmaceutical companies who spend more on marketing than research (Rose, 2006). Indeed, there is evidence that activity by pharmaceutical companies has led to the creation of new psychiatric categories such as “panic disorder” (Moncrieff, 2008), for which pharmaceutical companies have compounds available. Over time, this has led to more drugs being prescribed. Figure 1.1 shows the increasing amount of public money spent on antidepressant and antipsychotic medication in the community in the UK between 1991–2002. Ilyas and Moncrieff (2012) examined the number of prescriptions of different classes of drugs in England, finding that prescriptions of antidepressants rose dramatically between 1998–2010, while prescriptions of antipsychotic medication also rose, but at a less dramatic rate. Rose, who, in the 1980s and 1990s, traced the emergence of the notion of a psychological self, has recently observed that we are increasingly starting to think of ourselves in biological and neuro-chemical terms (Rose, 2006).

Mental health is a much-contested field and criticism of psychiatric diagnosis is not new. Indeed, one of the earliest examples of a mental

![Figure 1.1. Net ingredient cost of prescription items dispensed in the community (from Social Exclusion Unit, 2004).](image)
health survivor movement is the mid-nineteenth century Alleged Lunatics Friend Society in England (Campbell, 1996), the word “alleged” introducing an element of doubt into the diagnosis of lunacy. However, probably the most sustained intellectual critiques of diagnosis and, indeed, of the project of psychiatry itself, began in the middle of the twentieth century with the publication in 1961 of books such as Szasz’s *Myth of Mental Illness* and Laing’s *Divided Self*. These conceptual and ethical critiques were followed by empirical demonstrations of the problems of diagnosis, such as Rosenhan’s (1973) study where he sent to hospitals several “pseudo-patients” (i.e., people without diagnoses and not mentally distressed). When seen by a doctor, they were to report that they heard words such as “thud” but, once admitted to hospital, they were to act normally. What Rosenhan found was that, following diagnosis, every action performed and every statement made by the pseudopatients was interpreted through the lens of the diagnosis. He memorably referred to the “stickiness” of diagnostic labels and, as a result, it became difficult for the pseudopatients to be discharged from hospital.

It is often claimed that problems of reliability and validity like these were resolved with the development of *DSM-IIIR*, but, in fact, despite continued revision, psychiatric diagnostic manuals still suffer from the same problems and, moreover, the past two decades have seen a new generation of critique (Bentall, 2004; Boyle, 2002; Kinderman, Read, Moncrieff, & Bentall, 2013; Kirk & Kutchins, 1992; Kutchins & Kirk, 1999). Many of these criticisms will not come as a surprise to systemic practitioners who are familiar with the way in which diagnostic frameworks individualise relational problems (Gergen, Hoffman, & Anderson, 1996; Strong, 2012a,b, in press; Strong, Gaete, Sametband, French, & Eeson, 2012; Tomm, 1991; White & Epston, 1990). From a systemic viewpoint, one of the crucial difficulties with diagnosis is that it decontextualises distress, seeing it as lying within a pathological individual rather than within the context of a problem-saturated system, as Rosenhan demonstrated. Language plays a key role here, both in effecting this decontextualisation (e.g., through an emphasis on monological rather than dialogical interaction) and in the development of alternative conceptualisations (Anderson & Goolishian, 1988; White & Epston, 1990).
Diagnosis and decontextualisation

Textbook approaches to diagnosis assume that it is simply an objective process of identifying symptoms, comparing them with the symptom checklists found in diagnostic manuals and, thus, reaching a diagnosis. However, in interviews, professionals identify factors indicating that diagnosis is a complex interactional process. In one study, my interviewees described a number of influences on the diagnostic process, for example, the personalities of colleagues (Harper, 1994). As Speed (2004) notes, there are many understandable reasons why psychiatrists diagnose: an attempt to manage complexity, a response to the pressure to “do something”, a way of hiding inexperience or uncertainty, or simply because they have little time to explore fully the meaning of the person’s experiences.

Of course, these processes begin at an early stage. Labelling theory (e.g., Scheff, 1999), though somewhat out of fashion now, can help us understand how a person can position themselves and be positioned by others as distressed. Drawing on the work of Coulter (1973), Rogers and Pilgrim (2005) note how often professionals are simply confirming judgements already made by the those around the person (or the person themselves), because their conduct appears to be unwarranted or hard to understand—what Sarbin and Mancuso (1980) referred to as “unwanted conduct”. Such people are said to “lack insight” into their conduct if they are unable to persuade others of the intelligibility of their actions. Those around the person might mark out certain behaviour as unwarranted through the deployment of subtle rhetorical devices (Smith, 1978) and they might start to act differently around the person, sometimes unintentionally confirming a person’s fears that others are conspiring against them (Lemert, 1962).

One of the dangers here is that problems of living become reified and objectified as an illness separate from the personal family and social context within which they occur. Psychiatrist Fernando (1997) notes that

in the process of making a diagnosis, judgements are hypothesized as symptoms and illnesses – as “things” that exist in some way separately from the people who make the judgements and from the people (“patients”) who are said to “have” them. (p. 16)
Thus, an important aspect of systemic work is to see meaning in distress by placing it in its social context.

Despite the decontextualising effects of diagnosis, some service users are very aware of its social context and functions. Although academic interest in labelling theory has declined over the years, many service users see their diagnoses as negative labels given in a context where their power is limited. One service user with a diagnosis of personality disorder stated that this diagnosis was “a label they put on people when they can’t treat you or figure out what’s wrong with you” (Castillo, 2003, p. 69). Another service user with a similar diagnosis noted:

It is no wonder that those of us with a Personality Disorder diagnosis feel like second-, or more like third-class citizens (life’s rejects). You only have to look at the definitions given in ICD 10 and DSM IV and read comments such as ‘limited capacity to express feelings – disregard for social obligations – callous unconcern for others – deviant social behaviour – inconsiderate of others – incompetence – threatening or untrustworthy’. The list is endless, but one thing that these comments have in common is that they are not helpful in any way. (Castillo, 2003, p. 128)

However, labelling is not the only context within which power operates: its effects can also be seen in the links between diagnosis and social inequality. Social inequality exerts its influence in a number of ways in relation to distress (Harper, 2011a). First, the very experience of distress is shaped by one’s social location. Second, the way a person’s distress is seen by others is also shaped by their social location. Third, access to the resources (personal, social, financial, etc.) necessary to move on from distress is influenced by inequality. These processes feed into diagnosis: thus, for example, people in certain social locations might be more likely to experience certain distressing life events (e.g., abuse, victimisation, unemployment, poverty, etc.). Black people, for instance, are more likely to experience racial abuse. Moreover, the kinds of coping strategies people use could be more socially sanctioned for some social groups than others. Thus, men are much more likely to be given diagnoses of alcohol or drug abuse and are much more likely to engage in violence. This is, perhaps, why certain social groups are over-represented in certain diagnostic categories. However, at the same time, those making diagnoses might be
affected by certain expectations or stereotypes about certain social groups.

The way in which distress is individualised and pathologised in the West means that the social inequalities that cause distress may be ignored and that individual, rather than family, social, or collective, therapeutic solutions (from medication to therapy) are sought (Harper & Speed, 2012). Thus, recontextualising distress can be an important strategy. For example, the GRRAACCEESS approach (Burnham, Palma, & Whitehouse, 2008; Divac & Heaphy, 2005) can help to clarify the multiple dimensions of distress. Moreover, approaches such as Just Therapy (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003) and those focused on liberation (Afuape, 2012) and collective responses (e.g., Denborough, 2008; Freedman & Combs, 2009) point to alternative ways of framing the therapeutic endeavour.

However, if we can learn anything from the fact that diagnosis and individualistic and pathologising ways of viewing distress are still with us, it is that they serve important functions and we need to understand these if we are to consider how to move beyond diagnosis (Harper, 2013).

The consequences of diagnosis

In their service user-led research study, Pitt, Kilbride, Welford, Nothard, and Morrison (2009) conducted interviews with mental health service users using service user researchers. They found that, once diagnosed, their interviewees experienced contradictory consequences. They concluded that “some people will experience diagnosis more positively or negatively than others but for all there were both elements present to a greater or lesser degree in their experience” (p. 421). So, they found that, for all participants, diagnosis provided a means of accessing services, though this was not welcomed by all. Moreover, many participants saw their diagnosis as a cause of disempowerment because of an over-reliance on medication, a lack of information, and because they felt they had been given a “prognosis of doom” (p. 421). Similarly, some found in diagnosis a way of naming their problem, helping them feel that their distress had legitimacy as it was caused by a recognised illness. This could also help them feel they were not personally to blame for the problem. How-
ever, particularly where participants lacked information, they experienced diagnosis as primarily a negative labelling of their experience which then fed into how they saw themselves. Pitt and colleagues (2009) noted that their participants alternated between referring to their diagnosis as something they have, ‘I’ve got bipolar’, and something that they are, ‘I’m bipolar’. This suggests that the ability of diagnosis to serve the function of externalising people’s problems as an illness and protecting their concept of ‘self’ is never fully realised. (p. 421)

Even those seeing diagnosis as largely positive also saw it as a cause of social exclusion, with many people losing friends following their diagnosis. However, despite this, many went on to forge new relationships, drawing most strength from peer support networks.

Of course, diagnosis does not just have direct effects on the lives of those who use services and those around them. There are also wider social effects—diagnostic discourse opens up certain ways of looking at distress and closes down others (Harper, 2001):

- diagnostic categories promote pathologisation through an imperative to focus on abnormality;
- normality is defined by socially sanctioned experts;
- diagnostic categories can act as “thin descriptions” and pseudo-explanations;
- though claiming to be non-blaming, diagnostic discourse often involves implicit moral judgements;
- diagnostic discourse individualises pathology, which can serve as a form of social control (e.g., through risk discourse) and can also lead to a neglect both of structural causal factors and of collective responses to distress.

There have been attempts to counter some of these effects—for example, by normalising experiences of distress (e.g., Romme, Escher, Dillon, Corstens, & Morris, 2009) or deconstructing diagnoses (Parker, 1999). Narrative and systemic practitioners have developed innovative approaches: using language in an anti-pathologising manner (Parker, 1999; White & Epston, 1990); engaging with issues of inequality (e.g., Afuape, 2012; Waldegrave, Tamasese, Tuhaka, & Campbell, 2003); working with communities rather than individuals or families.
(Denborough, 2008; Freedman & Combs, 2009). However, there are problems with trying to redress a problematic tendency simply by switching to its binary opposite (Harper, 1996). Moreover, the danger is that, by adopting different therapeutic strategies, we leave the edifice of diagnosis untouched. Recent debates triggered by the DSM-5 revision process have led to a more explicit discussion of psychiatric diagnosis and it is possible to see a continuum in the strategies adopted by systemic practitioners towards diagnosis from being more accommodating to being more challenging and potentially transformative.

**Strategies for accommodating to, and living alongside, psychiatric diagnosis**

In a number of publications, drawing on a survey of therapists together with some interviews with respondents, Strong and his colleagues have identified a number of strategies to engage with diagnosis (2012a,b; in press; Strong, Gaete, Sametband, French, & Eeson, 2012). One set of responses involves therapists complying with administrative requirements to give diagnoses to clients, though some do this by simply giving all clients a DSM diagnosis of 309.9—“adjustment disorder: unspecified” (Strong, Gaete, Sametband, French, & Eeson, 2012). Another set of responses involves counsellors using DSM diagnoses to interact with psychiatrically orientated colleagues but either challenging the diagnoses or supplementing them by introducing some of the client’s preferred ways of understanding their difficulties (Strong, 2012b) or by the therapists giving a different account of the client in other contexts (Strong, Gaete, Sametband, French, & Eeson, 2012).

Some therapists attempted to make the diagnostic process more collaborative (Strong, Gaete, Sametband, French, & Eeson, 2012). This could involve them in negotiating with the person seeking help “the potential utility and stigma associated with a DSM diagnosis” (Strong, 2012a, p. 58). One survey participant stated,

I explain to the client the good reasons why the DSM exists (research studies etc); explain how managed care is a misuse of it; explore the potential consequences of “labelling”; then I give the client an oppor-
tunity to read and study possible diagnoses to pick from. (Strong, 2012b)

Strong (in press) suggests that, in family work, where family members might be invested in particular diagnoses, therapists explore the “meanings and adequacy associated with the diagnosis as it relates to the member and others in the relationship or family” (p. 13).

Strong, Gaete, Sametband, French, and Eeson (2012, p. 93) also identified a position they termed as “having multiple faces”. Strong (2012a) noted that some therapists ensured that clients met the diagnostic criteria for a service, for example, by categorising their clinical activity as “working with a ‘depressed’ client and his partner – instead of calling their work couples therapy” (p. 58). Strong (2012b) quoted an interview participant describing how they maintained “two sets of books”, practising as I consider ethically necessary, and doing the paperwork necessary to report short-term evidence-based treatment.

Other therapists tried to move beyond the thin descriptions afforded by a diagnostic label, elaborating instead on the meaning of a person’s experiences. For example, given the wide cultural availability of diagnostic discourse in the media, many clients might express their concerns in diagnostic language. Strong (2012a) notes that therapists could respond to this by saying, “Well, that is how psychiatrists might talk about your concern, but what is left out of such an account of your concern?” (p. 58). Where clients express their concerns in diagnostic language and see medication as the primary active treatment, Strong (in press) suggests that the client’s agency can be increased by developing Griffith and Griffith’s (1994) notion of discussing with clients ways in which they partner with their medication so as to bring about change. By interviewing clients in this way, they could begin to reconceptualise positive changes, seeing them as a “combined effort of their initiative and the added support of their medication”, p. 17) rather than being attributable to medication alone.

Strong (2012b) reports a survey participant identifying the need to bring clients’ voices in more fully, for example, by using therapeutic letters to “remind clients of their “and directing clients to a ‘wall of wisdom’ in the therapist’s office containing written ideas from clients emphasising ‘personal agency, strengths, and what they want to happen to the problem”.

Q3

Q3

Q5
Of course, these strategies vary in how much they involve accommodating to diagnosis and, as a practitioner whose income does not rely on giving clients a diagnosis, I am aware that it is easy to be critical but, while at the level of the client these are helpful, they also mean that the validity of the psychiatric diagnostic system remains unchallenged. Systemic practitioners are wary of monological accounts and prefer dialogical ones. However, although diagnosis should not necessarily close down therapeutic conversations, in practice it often does (Speed, 2004). Indeed, the biomedical psychiatric account is so powerful that approaches which claim to be multi-explanatory, like the so-called bio-psychosocial model, are, in practice, “bio-bio-bio” models (Read, 2005). Is it possible to adopt a both/and approach in this context? Anderson, Gergen, and Hoffman (1996) appeared to agree that diagnostic accounts were inherently limiting. As a result, some have considered strategies for rejecting diagnosis and moving beyond it.

Strategies for challenging and moving beyond diagnosis

The fact that, despite over fifty years of well-evidenced and conceptually sophisticated intellectual critique, diagnosis is still with us suggests that there are powerful social and even emotional influences at work and, elsewhere (Harper, 2013), I have argued for the need to adopt a political analysis of psychiatric diagnosis, identifying ways of weakening its institutional pillars of support (e.g., in the academy, health bureaucracies, the media, the pharmaceutical industry, lobby groups, etc.). To give an example from the academy, it is important to weaken the support given to diagnosis through programme curricula and textbooks. For example, undergraduate psychology programmes include courses on “abnormal psychology”, “clinical psychology”, or “psychopathology” and the recommended textbooks are overwhelmingly structured by the DSM. However, alternatives that include critiques of diagnosis and cogent alternatives are beginning to appear (Cromby, Harper, & Reavey, 2013).

Although the clinical guidelines published by the UK’s National Institute for Health and Clinical Excellence appear to reinforce the use of diagnostic categories (because they are structured by “conditions” which mirror diagnostic categories), their introductory sections often raise problems with the validity and reliability of such diagnostic cate-
gories (Midlands Psychology Group, 2010) and this is something which could be publicised more and used more effectively in campaigning activities. The recent DSM-V revision process ignited much more debate than previously across the wider media as well as within the professional literature. The British Psychological Society’s response to the revision proposals argued for the need to abandon categorical diagnostic systems such as the DSM (www.bps.org.uk/news/society-statement-dsm-5) and organisations representing systemic practitioners can join with such calls. Critical psychiatrist Dr Sami Timimi has founded the Campaign to Abolish Psychiatric Diagnostic Systems such as ICD and DSM (CAPSID) (www.criticalpsychiatry.net/?p=527).

If we did away with diagnosis, how else might we conceptualise distress? There seem to be at least two candidates.

One option—which refuses to cede the ground of science to diagnosis by arguing that psychiatric diagnostic categories are unscientific—is to draw on a perspective informed by a critical realist (e.g., Pilgrim, in press) or “social materialist” (West Midlands Psychology Group, 2012) perspective. Here, the call would be to go back to basics and attempt to develop a more sophisticated, experience-based framework. Cluster analysis of symptoms indicates that they do not map on to neat diagnostic categories (Mirowsky, 1990). However, these studies use pre-defined categories from diagnostic interview schedules and what is needed is some basic qualitative research into the myriad ways in which people experience and talk about their own and others’ distress, developing what Wallcraft and Michaelson (2001) refer to as a “survivor discourse”. However, tricky issues to negotiate here include the need to focus on the social and relational (not simply individual) contexts of distress and to consider their meaning. Moreover, there is a danger that we assume there are ways of describing experience that are unsullied by psychiatric terminology when, in fact, Western culture is now suffused with such terminology. However, there is still a very wide range of lay terms in use.

Another path, drawing on a more relativist social constructionist approach (e.g., Anderson & Goolishian, 1988), is to abandon the naïve realism at the heart of the classificatory project and instead to be open to collaborative definition and multiple interpretations of concerns. Here, for example, one might focus on the level of fit between a person’s experiences and their everyday life and relationships with
others. Thus, in relation to psychotic forms of experience, we might be more interested in how someone manages to resist dominant discourses and prescriptions for living (e.g., Afuape, 2012), or how they manage to live in the everyday world while believing things others might find unusual, given the evidence that many people in the general population currently do this (e.g., Harper, 2011).

If we reconceptualise distress, then this has implications for those offering therapeutic interventions. Formulation has been proposed as an alternative to diagnosis. Whereas a diagnosis is often little more than a label, a formulation is more like a story or narrative. Within the discipline of psychology, it has been defined as involving the development of hypotheses about experience based on psychological theory (Division of Clinical Psychology, 2011; Johnstone & Dallos, 2013). Indeed, although within mainstream British clinical psychology formulation is seen from a more critical realist perspective, when framed as a narrative it is possible to think of formulations more consistent with a social constructionist epistemology (e.g., Harper & Spellman, 2013).

Formulation is familiar to many systemic practitioners and is similar to the practice of progressive hypothesising. However, given the dominance of individual therapy approaches within adult mental health settings (especially CBT), the typical formulation is a causal formulation of a problem seen as lying within the individual. As a result, formulation practice might need to be stretched somewhat to accommodate traditions such as narrative therapy and solution-focused practice (Harper & Spellman, 2013), although there is no reason why the formulation could not be of a problem which is “externalised”, as is common in narrative practice. Indeed, Carr (2006) has noted how formulations could also be about exceptions to the problems, as is common in solution-focused practice. The public appear generally to prefer formulations in psychosocial terms, where distress is located in a person’s biography and social context, whereas distress explained in biomedical terms tends to be associated with stigma (Read, Haslam, Sayce, & Davies, 2006). Systemic practitioners are in an ideal position to develop rich, contextualised, and non-pathologising formulations of distress, but we also need to remain vigilant of the societal pressures to individualise and pathologise distress. We also need to ensure that we do not simply replace one professionally self-serving monological account with another, as is a danger with the
increasing prominence of cognitive–behavioural accounts of distress. One thing that might help with this is for systemic practitioners to engage in public debate about the societal causes of distress and their resolution.

However, although debates about diagnosis are important, equally important is the way in which we engage in therapeutic work with those who seek our help. How might we go about this work in a way that counters the pathologisation common in many mental health services? The other chapters in this volume show the exciting range of innovative forms of intervention that are now being practised in a range of contexts. I hope these accounts will provide inspiration to those wishing to offer more helpful interventions to the people who seek their help.

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