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UNDERSTANDING AND ADDRESSING PSYCHOLOGICAL AND SOCIAL PROBLEMS: THE MEDIATING PSYCHOLOGICAL PROCESSES MODEL

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Abstract

Background: Psychological and social problems such as mental disorder, unemployment, substance misuse and crime are personally distressing and absorb huge proportions of Government effort. Addressing these is a multi-agency, multidisciplinary exercise, but there is evidence of a marked policy shift toward the provision of psychological therapies and interventions.

Aim: To offer a distinctively psychological perspective on these key social and mental health problems.

Method: Scholarly review of the relevant literature.

Results: This paper presents a coherent model – the mediating psychological processes model – addressing the complex, interconnected, nature of these problems. The mediating psychological processes model suggests that disruption or dysfunction in psychological processes is a final common pathway in the development of mental disorder and social problems. The model proposes that biological, social and circumstantial factors lead to mental disorder, crime and other social problems through their conjoint effects in influencing or disrupting relevant psychological processes.

Conclusions: The implications for policy, and implementation of policy, are discussed.

Keywords: psychological model, mental disorder, crime, social exclusion

INTRODUCTION

The human and economic costs

About 450 million people worldwide suffer from a mental or behavioural disorder. Depression alone ranks as the third leading contributor to the global burden of diseases (World Health Organisation, 2003a). In the UK, mental health problems represent approximately 10% of total healthcare costs (Department of Health, 2005) and result in an estimated £23 billion of lost employment and productivity (Social Exclusion Unit, 2003). Three of the 10 leading risk factors for physical disease are psychological or behavioural (unsafe sex, tobacco use, alcohol use) and three others are closely related to psychological issues (obesity, high blood pressure and cholesterol) (World Health Organisation, 2003b). Drug misuse is estimated to cost the UK up to £18 billion a year in social and economic costs (Home Office, 2002). There were nearly 11 million crimes in England and Wales in 2005-2006; costing an estimated £60 billion a year (Home Office, 2000).

Clearly these issues overlap, and not only because some crimes are drug related and some offenders have mental health problems. A fundamental theoretical, as well as practical, challenge is to account for this interconnectedness.

A psychological model

In 1977 George Engel published his 'biopsychosocial model' of mental illness. His aim was to challenge biomedical paradigms of understanding human distress, and to offer a framework that would allow psychological and social factors to play a more appropriate role in understanding and caring for people in personal crisis. Engel commented that: "the dominant model of disease today is biomedical, and it leaves no room within its framework for the social, psychological and behavioural dimensions of illness" (Engel, 1977; p130). In contrast, Engel's biopsychosocial model suggests that mental disorder and other medical conditions emerge as products of a whole human system which has physical, biological, elements, but also psychosocial systems including personal, dyadic, familial, community and societal elements

The biopsychosocial model was widely and enthusiastically adopted by psychiatry (or at least English psychiatry) (Falloon & Fadden, 1993), but opposition from some mainstream psychiatrists has led to social and psychological factors often relegated to become mere moderators of the direct causal role of biological processes (Guze, 1989). Similar models have promoted sociological, ecological and psychological approaches (e.g. House, 2002), but are typically imprecise in the causal relationship between the bio- psycho- and social elements.

The mediating psychological processes model (Kinderman, 2005), in contrast, suggests that disruption or dysfunction in psychological processes is a final common pathway in the development of mental disorder. Psychological approaches have always separated events from the interpretation of events. The mediating psychological processes model addresses this issue by separating circumstantial factors from the psychological processes that interpret, buffer, and control responses to those events. These processes include, but are not limited to, cognitive processes. The model proposes that biological and social factors, together with a person's individual experiences, lead to mental disorder through their conjoint effects on those psychological processes.

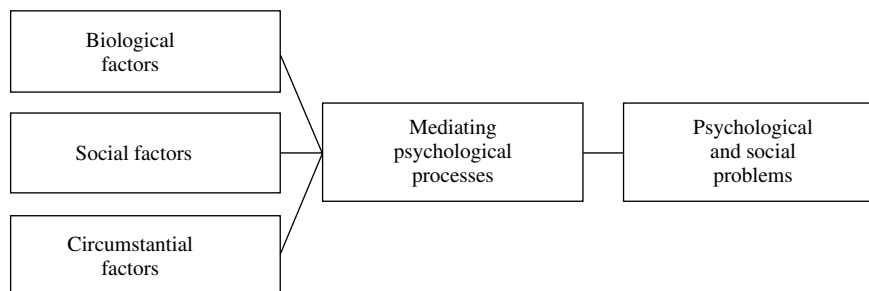


Figure 1. The mediating psychological model of psychological and social problems

In this model, physical, biological, factors are clearly recognised as of causal importance in mental disorder – and in other social issues – but achieve their effects through their effects on the mediating (and not merely moderating) psychological processes. For example, dopaminergic factors believed to be significant in schizophrenia are acknowledged (as are the genetic aspects of these factors) but are seen to have their effects on individuals through their impact on perceptual and cognitive systems (Bentall, 2003). Similarly, serotonergic processes associated with depression are seen to be associated with mental disorder because of their effects on psychological processes associated with self-esteem, beliefs in self-efficacy, motivation and expectations of reward.

The same principles apply to social and circumstantial factors. Living in conditions of social deprivation and poverty can indeed lead to problems such as depression – but through the effects on psychological processes related to the disillusionment, hopelessness, and learned helplessness which constitute a realization that one's actions have no effect or purpose (Evans, Saltzman & Cooperman, 2001). Being abused or traumatized obviously leads to problems, but this association is, again, mediated by the disruption or malformation of psychological processes - the ways in which the children (and later the adults) appraise themselves, the people in their lives, and the ways in which relationships and social intercourse should be governed (Young, 1999).

The central claim of the mediating psychological processes model presented here – that such processes constitute a final common pathway for the emergence of mental disorder and related social problems – should be seen as evolutionary, rather than revolutionary. The five component elements; the experiences themselves – the distress (or ‘symptoms of mental illness’), the biological, social and circumstantial factors and psychological factors, are commonly referred to in psychological approaches (Read, Mosher & Bentall, 2004). And it is not unique for psychoanalysts and psychotherapists to argue that psychological processes are important (see, for example, Allen, Fonagy & Bateman, 2008). The mediating psychological processes model is different not because it incorporates new material, but in the hierarchical relationship it proposes between these factors. Traditional psychiatric or medical approaches to human behaviour and emotional distress places weight on biological, synaptic changes or processes (see Guze, 1989). Traditional social models of mental health and social problems certainly acknowledge the role of social causal factors, but differ from psychological models in the weight or role given to the personal, individual, cognitive, processes. Even the biopsychosocial model differs from the mediating psychological processes model in that, while the former implicitly gives equal weight to the three elements of its name, the latter treats psychological issues differently. The fact that those psychological processes are responsible for determining the human response to the causal factors means that these processes are given a more central role. By suggesting that disruption of psychological mechanisms is a final common pathway in the development of problems, this approach has significant, if subtle, implications for policy.

Implications for mental health services

The clinical implications of this model (Kinderman & Tai, 2006) are that formulations rather than diagnoses should predominate clinical planning, that these formulations should detail the hypothesised disruption to mediating psychological processes or mechanisms, that psychological therapies should receive higher priority, and that medical, social and even psychological interventions are most likely to be clinically effective if they are designed on the basis of their likely beneficial impact on underlying psychological mechanisms. Of course, this does not mean that only psychologists should develop such formulations, Indeed, Kinderman and Tai (2006) acknowledge that many mental health professions use such formulations, and argue that this should continue. Of course, social workers have traditionally had professional responsibility for many of the problems referred to here. It is unlikely (and probably undesirable) that an army of applied psychologists be recruited to take their place. But it does follow that the formulations or care plans drawn up by social workers and other social care providers should address the psychological processes – and not merely the social and environmental circumstances – contributing to the identified problems.

This model implies that mental health services should be planned on the basis of need and functional outcome rather than diagnostic categories. Identification of common mediating psychological process, along with common antecedents and empirically demonstrable interventions for those psychological mechanisms may offer a common language for research and planning. In residential care, a concept of ‘hospital’ should be avoided. The focus of specialist teams should be based on underlying psychological principles. Services should fully embrace the recovery approach (Ralph & Corrigan, 2005) and should facilitate genuine service user involvement. Access should be improved to psychological therapies based on individual case formulations and recovery models, and nurses, occupational therapists and social workers should develop increasing competencies in psychosocial interventions. Psychologists should offer consultation and clinical leadership, while psychiatry should emphasise the application of medical expertise as it assists a multidisciplinary team in the understanding and treatment of mental disorder.

The mediating psychological processes model may have implications for legal process too. In most jurisdictions, it is important to determine whether a person was unable, at the time of an offence, to understand what they were doing or if it was wrong. In the UK, this is judged on the basis of the presence of a ‘disease of the mind’ (Butler Committee, 1975). In a psychological model, the question whether the person knows the difference between right or wrong is entirely sensible, but the material issue is not one of a ‘disease of the mind’, but whether the person’s ability to understand the difference between right and wrong was significantly perturbed by the sources of influence outlined above. The law has always required a very high threshold in this respect – people are presumed ‘to possess a sufficient degree of reason to be responsible’ for their actions (Butler Committee, 1975). From

a psychological perspective, however, courts should consider issues of diminished responsibility by examining the extent to which the person's normal psychological processes (relevant to the crime in question) were disrupted or disturbed. Was the person, at the material time, very significantly impaired in their ability to exercise normal, reasonable, judgement?

Social problems

The mediating psychological processes model of mental disorder is wholly applicable more widely to social problems such as crime, antisocial behaviour, social exclusion, drug use and the like. A transliteration of 'mental disorder' into 'social problem' seems perfectly reasonable if one accepts that mental disorder should no longer be regarded as similar to a disease process (Bentall, 2003).

Although different commentators may disagree about how much variance in criminality or indeed other social problems can be laid at the feet of biological or physical factors (most would suggest much less than at the feet of social difficulties), it is entirely possible that these factors are non-trivial. In the mediating psychological processes model, this is addressed in the same manner as the biological contributors to mental disorder. If such biological factors do impact on crime and other social problems, the mediating psychological processes model suggests that they do so because of the ways in which they disrupt relevant psychological processes.

The same general approach applies, as it did in the case of mental disorder, to social factors and life circumstances. There is no doubt that these two broad classes of causal agents are implicated in the development of social problems (e.g. Canter & Alison, 2000; Cullen, 1984; Robinson, 2004). But clearly not everyone exposed to causal factors such as social deprivation goes on to offend, misuse drugs or otherwise experience social problems. The mediating psychological processes model suggests that these individual differences are explained by the differential ways in which these factors impact on the relevant mediating psychological processes.

It is not surprising, therefore, that issues of disillusionment, lack of personal efficacy or sense of agency and the like are associated with social deprivation and abuse on the one hand and with both social issues such as crime, drug misuse and antisocial behaviour as well as depression and other mental disorders on the other. But this analysis does rather beg the question of what psychological mechanisms are actually associated with the kinds of social problems discussed here. This is not the place to outline these in detail, but it is fair to say that a considerable number of psychological issues – mainly 'hard' issues such as cognition, memory, attention, concentration IQ and problem-solving capacity – have been associated with key social challenges (McGuire, 2000). Social commentators and criminologists discuss issues such as social alienation or anomie, failures in parenting, difficulties in attachment and role models, discipline in the sense of the learning of the consequences for behaviour. Others comment on the possible problems some challenging young people appear to have in terms of deferment of gratification, problem-solving, social cognition and emotion-control. Above, in relation to mental health, the cognitive schemas governing relationships and social intercourse were seen as key mediating psychological mechanisms (Kinderman, 2005). This principle clearly extends wider – to the network of relationships collectively referred to as social capital (Baron, Field & Schuller, 2000). Indeed, it suggests how that social capital is constructed psychologically, and how, and how functioning communities may be developed.

These ideas raise interesting questions of the nature or meaning of responsibility – even of 'free will'. If our actions, even criminal actions, are the consequences of the psychological processes that are themselves affected by social adversity, to what extent can we be said to be responsible for our actions? Current psychological science cannot claim to have answers to all such questions, but it is worth noting two significant points. First, psychologists have long recognised that people distribute responsibility between salient causal influences when making causal attributions (Hewstone, 1989). Second, some jurisdictions (in particular the Netherlands) operate a 'sliding scale' of criminal responsibility, explicitly acknowledging the varying level of external influence on such behaviours (and, in this model, on psychological processes) (van der Leij, Jackson, Malsch & Nijboer, 2002).

Multi-agency solutions to multi-factorial problems

Many complex and difficult issues in mental health and social care are increasingly being addressed using multi-agency approaches. There are in the UK several major initiatives

aimed at developing multidisciplinary approaches to mental health care (Department of Health, 2004). The Care Programme Approach (a multidisciplinary plan for mental health care) is paralleled by multi-agency services such as Child and Adolescent Mental Health Services, 'BEST' Behaviour and Educational Support Teams, and SureStart (a multi-agency attempt to address social exclusion and child developmental difficulties in socially deprived areas). Multi-agency approaches protecting the public from sexual predation and other serious crimes through 'Multi-Agency Public Protection Arrangements', bringing together health, prison, police, probation and social services personnel can also be seen. This is the common currency of the UK Government's Social Exclusion Task Force, and similar approaches exist in most Western countries.

The mediating psychological processes model is clearly consonant with this approach. It is axiomatic that a number of distal causes (from the social, biological and experiential constituencies) achieve their impact through their conjoint effects on a number of psychological processes. It makes sense therefore, to regard reasonable interventions or solutions as inviting a multi-agency response. The model does not, incidentally, imply that social factors are unimportant. Quite the reverse. It suggests that identifying and ameliorating social disadvantage is vital in addressing positive outcome. It may be possible, as an expert psychological therapist, positively to influence psychological mechanisms concerned with self-concept, interpersonal relationships and motivation. But any such interventions are likely to be much less effective than removing or addressing the social disadvantage at source.

Again, this is an evolutionary rather than revolutionary perspective. This approach does not suggest that psychologists hold the keys to the kingdom. Of course, there exist professional psychologists – clinical psychologists, neuropsychologists, forensic, occupational, counselling, health and educational psychologists. These professionals attempt to develop and deliver psychological interventions addressed to the mediating psychological processes themselves. Given the central and mediating role offered to psychological processes in the model presented here, the role of psychological expertise could be substantial. Psychologists should assist in developing and ensuring the implementation of care plans that draw together identified needs of the service user (Kinderman & Tai, 2006). Psychologists should not be secondary to social policy, but should be imbedded in it.

But the point of this model is that social and health initiatives achieve their effects (mirroring the causation of problems) through their positive impacts on the mediating psychological processes. This can inform planning regardless of the activity of professional psychologists. Parenting programmes may be welcome, but should be evaluated on the basis of their impact on the psychological mechanisms theoretically identified as legitimate targets – self-concept, attachment, an appreciation of sanctions for unacceptable behaviour, or models of social problem-solving. Psychosocial crime reduction programmes should be similarly targeted on the psychological issues (for example social problem-solving, impulse-control, etc) believed to mediate the route to criminality. If we wish to address, say, addiction (to nicotine, alcohol or any other substance), the model presented here would suggest that it is essential – whatever the mode of intervention – to ensure that any interventions target effectively those psychological mechanisms that maintain addictive behaviour. This clearly does not necessitate psychological therapy. Rather it means that social policies, health education campaigns and Government action such as taxation or legislation should be planned on the basis of their positive effects on psychological processes. A multiagency response is a logical extension of the mediating psychological processes model.

Conclusions

The mediating psychological processes model presented here offers a coherent conceptualization of the role of psychological mechanisms in the origin of both mental disorders and a range of social problems. The suggestion that disruption or dysfunction in psychological processes is a final common pathway in the development of such social problems can help to understand the causal roles played by biological, social and circumstantial factors, in that these elements lead to problems through their conjoint effects on mediating psychological processes or mechanisms. The implications for research, interventions, and policy could be considerable. The mediating psychological processes model of the development and maintenance of personal and social problems has the potential to facilitate the development of public policy on a wide range of issues.

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