Proposal for a Cognitive Model of All Non-Psychotic Mental Health Disorders Based on the Concept of Loss

Abstract

This article proposes a cognitive model of all non-psychotic mental health disorders based on the concept of loss as an attempt to provide a coherent and easy to understand underlying mechanism for distress. The model proposed is not designed to overturn previous cognitive models or treatment protocols rather to supplement them and show how they all may be connected in one coherent framework.

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Full-Text

Proposal for a Cognitive Model of All Non-Psychotic Mental Health Disorders Based on the Concept of Loss

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SUMMARY: This article proposes a cognitive model of all non-psychotic mental health disorders based on the concept of loss as an attempt to provide a coherent and easy to understand underlying mechanism for distress. The model proposed is not designed to overturn previous cognitive models or treatment protocols rather to supplement them and show how they all may be connected in one coherent framework.

KEYWORDS: Cognitive behavioural therapy, case formulation, depression, anxiety

The validity of psychiatric diagnoses has been questioned, critics arguing that diagnoses are essentially symptom clusters without clear underlying mechanisms or necessary inter-connection (Bentall, 2004). Cognitive models of psychiatric illness have been offered to 'explain' psychiatric conditions (Westbrook, Kennerley & Brook, 2007) and in this article a model will be proposed that attempts to describe the mechanism behind all non-psychotic psychiatric disorders as pathological response to loss. This model will attempt to demonstrate how this may link pre-existing CBT models into one conceptual framework that makes non-psychotic disorders easy to understand for clinicians, patients and carers.

The model is based on the following question:

If you had nothing to lose would you ever get anxious or upset?

Loss in this model will be defined in three areas; as physical/material, for example loss of life, health, property, money. Relational, so loss of a relationship via death, separation or conflict. And finally psychological, so loss of esteem, from self or others, loss of meaning, understanding, hopes, roles, purpose etc.

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Loss will also be defined in three temporal areas: the past, so negative events and regrets; the present, where we perceive what we don't have or lack rather than what we do; and in the future, where we worry about what we might lose.

Theoretical foundation for the model

Human beings have been shown to be more sensitive to loss than gain (Kahneman, 2011). Loss is an integral part of the reward system and the threat system in the brain, as shown by negative reinforcers and punishments in operant conditioning (Skinner, 1953), and the flight fight response, which is triggered in response to a threat e.g., loss (Pittman & Karle, 2009). These mechanisms have been proposed as underlying emotional distress (Gilbert, 2010).

The fear of loss appears to be a conditioned response that can be seen as having evolved as a primitive response to predator prey situations (Panksepp, 1998) and as survival and breeding strategies in a social group/species. For example, the distress of an infant when separated from its mother in line with attachment theory (Bowlby, 1958; Harlow & Zimmerman, 1958) and the drive for individuals to mate as otherwise they will lose the opportunity to pass on their genes (Dawkins, 1979; Gray, 2013).

Loss has also been shown to be an essential part of human decision making as shown in the development of game theory (Davis, 1983). Loss can trigger strong emotions, such as anxiety, anger and sadness, (Kubler-Ross, 1969) and emotions can reduce our ability to make rational decisions (Angie et al., 2009; Kahneman, 2011).

Trauma has also been argued by multiple clinicians to be a significant factor in the development of mental disorders and has been used as the basis of models that try to explain mental illness in a transdiagnostic manner (Mueser et al., 2002; Ross, 2000).

Trauma is defined as exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (American Psychiatric Association, 2013). This fits with loss of life or physical or psychological health, as defined by the present model.

Application of the model to specific disorders

The basis of this model is that each of the main categories of non-psychotic disorder is a specific pathological response to loss as detailed:

Phobias: Phobias are an example of where the response to a possible loss, for example of life or physical health, is avoidance in line with the flight aspect of the flight or fight response. So, for example, an individual would respond to the phobic stimuli, such as a crowded place, a dog or a spider, by experiencing intense anxiety and a compulsion to remove themselves from the stimuli to

feel safe again. In a phobia such as social phobia the mechanism is the same but the loss would be psychological rather than physical, for example loss of esteem of self or others if the person were negatively judged. These examples are all in line with standard CBT theory (Leah & Holland, 2000).

Obsessional Disorders: For example, Obsessive Compulsive Disorder and Eating Disorders. The response to loss here is to try and reduce the risk by controlling it, as demonstrated by safety behaviours such as hand washing to reduce contamination or restricting diet to reduce weight, as well as ruminations on how to reduce the risk, for example being hypersensitive to possible contaminants or being aware of the calorie content of any food and how long it would take to burn off. Again this is line with standard CBT theory (Fairburn, 2008; Leah & Holland, 2000).

Post-Traumatic Disorder: Here the loss is in the past but is re-experienced in the present as a traumatic memory, which can cause fears of loss in the present because the memory causes so much distress, for example, the belief that 'I am going mad' and 'the next disaster will strike soon' (Ehlers & Clark, 2000). This can also involve significant feelings of regret, such as self-blame, guilt and shame, leading to loss of self-esteem (Lee et al., 2001).

As this model is an attempt to explain all non-psychotic disorders it would be argued that the memory is seen in the context of an intrusive thought in line with OCD theory. This fits with the treatment protocol outlined by Ehlers & Clark (2000), which advises avoidance of thought suppression.

Depression: In depression the response to a loss is to feel hopeless and give up, which fits with Beck's model of depression (Beck et al., 1979). The loss may be a death, the ending of a relationship, a job, a loss or role, such as a parent when children grow up, or health, after having developed a serious illness or being disabled after an accident.

Personality Disorder: In so called personality disorder the responses to loss would fit with the fight part of the flight fight response and would be seen in the context of aggression in anti-social personality disorders or behaviour designed to avoid abandonment or rejection in borderline personality disorders, for example threats to harm self (American Psychiatric Association, 2013).

Low self-esteem: Low self-esteem has been shown to be an issue for the majority of psychiatric patients and can be partly defined as a feeling of worthlessness (Silverstone & Salsai, 2003). In regards to the model this will be translated into a belief a that an individual is 'not good enough' and this can only make sense

in the context of loss, so a person loses whatever they are not good enough for; love, a job, university etc.

Comorbidity has been shown to be a common feature of psychiatric labelling and a criticism of the validity of mental health diagnoses, as individuals will present with a variety of symptoms that do not fit with one disorder (Bentall, 2004; Ross, 2000). This model would try to address this issue by stating that an individual could have multiple responses to loss that would cause different presentations. For example an individual may have OCD but also depression, as they would be trying to control loss but feel hopeless that their attempts were not successful.

Loss of knowing

A key feature of this model is that a person can experience a loss when they do not know. A semantic proof of this would be that when a person does not know something they can feel 'lost' and there can be a pathological need to know, as demonstrated by the concept of intolerance of uncertainty in Generalised Anxiety Disorder (Dugas & Roubichaud, 2007).

Cognitive heuristics have been shown to be mental short-cuts to understanding situations, which occur automatically and unconsciously. They can be activated by strong emotions, such as anxiety and anger, but can lead to inaccurate understandings, such as stereotyping (Angie et al., 2009; Kahneman, 2011). This is because they can create the illusion of certainty, which reduces anxiety by increasing the sense of control an individual has (Kahneman, 2011). This would also fit with the tendency towards black and white thinking, as this provides a greater feeling of certainty.

Based on these ideas the model would predict that if loss triggered strong emotions an individual may develop inaccurate beliefs as a preference to feeling 'lost'. For example, 'everything is my fault', 'you can't trust anyone', 'going outside is dangerous' or a myriad of other generalised beliefs that would maintain mental health difficulties.

Implications for treatment

The implications for treatment from this model would not be significant as they would fit with standard CBT treatment for non-psychotic disorders. These would be cognitive restructuring and behavioural experiments to develop more accurate and healthy beliefs about loss, such as its risk, developing behaviours that reduce the chances of loss rather than increase it and developing ways of reducing the impact of emotions on developing inaccurate beliefs.

Where the model may have specific contributions is with regard to misconceptions of failure, which can be seen as another form of loss when

translated from the terms of 'success' and 'failure' into 'winning' and 'losing' (loss). The model would then predict that individuals would be more susceptible to failure than success and therefore developing inaccurate beliefs about it. A focus of treatment would therefore be helping an individual develop constructive beliefs around failure rather than pathological beliefs that would help maintain mental health difficulties.

This has particular relevance to self-esteem issues where a person can perceive themselves as a failure (Rosenberg & Owens, 2001) and with regard to perfectionism, which can be seen to be an intolerance of failure (Goldspon, 2008).

The model can demonstrate that when an individual is so over focused on loss in the three temporal areas, past, present and future, there is a loss of enjoyment of the now; it has been argued that the 'now' is the *only* place happiness can be genuinely experienced (Tolle, 2004).*

Relevance to other areas of research and CBT treatments

The model is an attempt to take some of the implications of loss-aversion theory, as developed by Kahneman and Tversky (1979).

It also fits with the Kubler-Ross 5 stages of grief model (1969), where loss is responded to via denial, anger, bargaining, depression and acceptance. Loss in the context of this model would be much broader than death and would fit with the stages as follows; the denial stage could be seen as avoidance of loss and would fit with phobias, the anger stage would fit with personality disorders as the fight part of the flight fight response, the bargaining stage would be seen as an attempt to limit loss in line with obsessional illnesses, and the depression stage with depressive illness.

The acceptance stage would therefore be the healthiest and most adaptive response and achieving it would be a focus of treatment based on these principles.

As Kubler-Ross states an individual goes through the stages in a variety of ways, which would fit with the comorbidity problems outlined before. For example, an individual may be having difficulties with agoraphobia and anger, which could be translated as trying to avoid or deny loss, such as physical health, by not going out but then being angry as they have lost opportunities to enjoy their life because they are unable to go out.

The focus on acceptance would fit with one of the key concepts in Acceptance & Commitment Therapy (Hayes et al., 2004). Its focus on enjoying the 'now' would fit with mindfulness, as utilised in Mindfulness-Based CBT (Crane, 2009), Dialectical Behavioural Therapy (Dimeff & Linehan, 2001) and Compassionate

* Though the Editor notes that St. Augustine famously remarked that 'now' cannot exist.

Mind Therapy (Gilbert, 2010). Its focus on reducing the emotional reaction to loss would also fit with elements of these 3rd wave therapies.

The model may have a philosophical application as according to existential philosophy proposed by thinkers such as Kiergaard and Satre (Wartenburg, 2008), life is about the search for meaning and therefore life without meaning would be experienced as a loss. This would fit with the author's own profession, occupational therapy, and its focus on meaningful occupation (American Occupational Therapy Association, 2011).

An additional philosophical application may be in the concept of emptiness, which can be triggered by grief (Kuehn, 2001). Emptiness in mental health is viewed as a negative state, as described in DSM V (American Psychiatric Association, 2013) which defines borderline personality disorder as experiencing chronic feelings of emptiness. In Eastern religion this is not the case - rather emptiness is seen as state of inner peace (Goode & Sander, 2013).

Conclusion and further reading

This article outlines a theoretical model for non-psychotic disorders. It is only a proposal and therefore will stand or fall by whether it fits with experience of clinicians and patients and if it proves itself to be a useful therapeutic model.

As detailed the model proposes that all non-psychotic disorders are due to responses to loss and that this fits with the pre-existing CBT models and third wave treatments.

Further reading that would be recommended in relation to this model outside of the CBT material referenced would be *Thinking Fast and Slow* (Kahneman, 2011) and *On Death & Dying* (Kubler-Ross, 1969).

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