

**Module:**  
**Mental Health in the Community**

Week 1:  
A history of 'madness': Deinstitutionalisation to community care

**Dr Frank Holloway****Topic 2:**  
**Mental illness and its critics****Topic list**

This week, we will be looking at the following topics:

- Topic 1: Conceptualisation of mental disorder
- ***Topic 2: Mental illness and its critics***
- Topic 3: Diagnosis in psychiatry

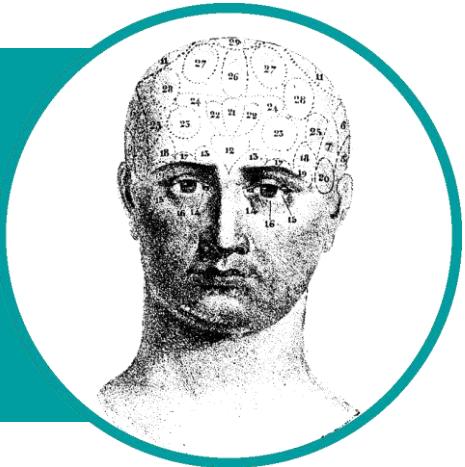
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## Mental illness and its critics

The construct of mental illness: mental disorder as physical illness

I am comfortable with the language of 'illness'...  
It's a language doctors use

Not everyone who comes into contact with  
mental health services fits the illness label well



## Defining mental illness

*"The main claim of the physical approach, that is the assumption that mental disorders are dependent on physiological changes, is that it is a useful working hypothesis. It has made great advances and looks like making more"*

**Eliot Slater, 1954**

Sargent and Slater's textbook was the dominant book of the postwar years

*"The name 'mental illness' implies disease. An illness suggests something wrong that is fundamentally different from normal function and is not just a variation in degree..."*

**Peter Tyrer, 1998**

Tyrer's definition fits the experience of some of the people I meet and that of their carers. Some mentally ill people are fundamentally different.

## Making a psychiatric diagnosis (1)

*The DSM is like a recipe book where you need to know what the ingredients mean*

Example: alcohol intoxication

[A]

Recent ingestion of alcohol

*Have I had a drink?*

[B]

Problematic behaviour or psychological changes (e.g. impaired judgement)

*Has the drinking led to a problem?*

[C]

Symptoms: slurred speech, incoordination, unsteady gait, nystagmus, impairment of attention or memory, stupor or coma

*Have I experienced a specified number of symptoms? – in this case just one is required*

[D]

Symptoms are not attributable to another medical condition

*Is there an exclusion? – was I merely ‘tired and emotional’?*

American Psychiatric Association (2013)

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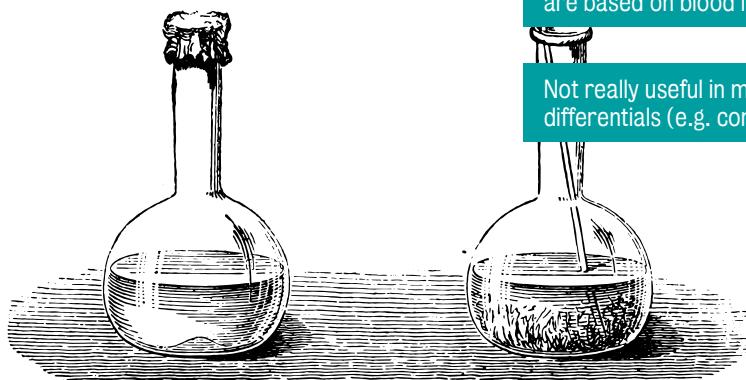
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## Making a psychiatric diagnosis (2)

DSM 5 Code for administrative purposes for uncomplicated intoxication F10.929 (maps onto the ICD code)

Not the same as legal definitions for ‘drink driving’, which are based on blood levels

Not really useful in medical diagnosis, except in diagnostic differentials (e.g. comparing with hypoglycaemia)



American Psychiatric Association (2013)

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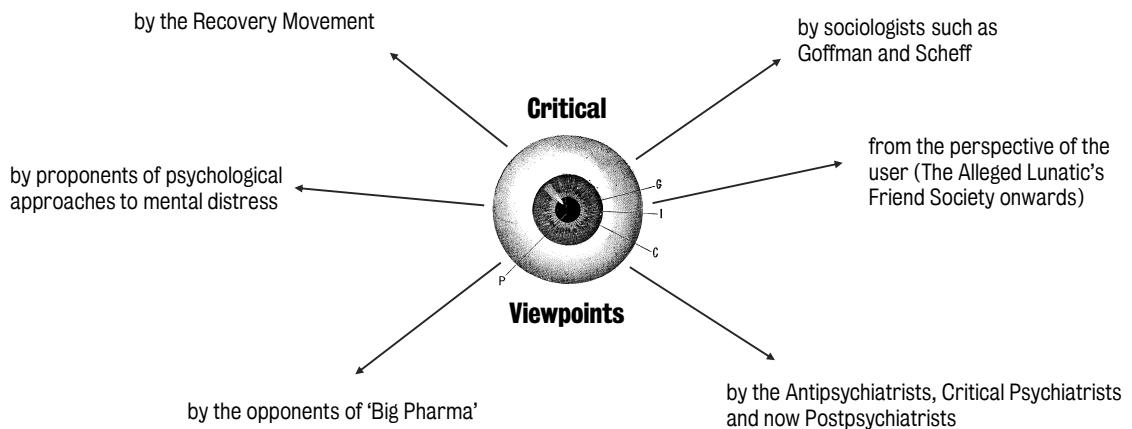
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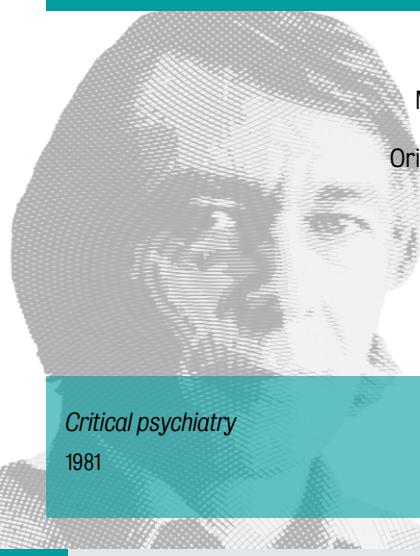
## Criticisms of the mental illness construct

The mental illness construct has been criticised from several view points:



## The antipsychiatrists

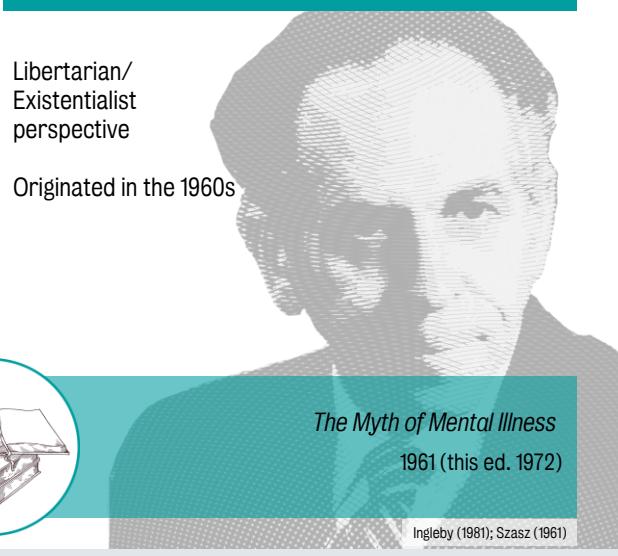
### Critical psychiatry



*Critical psychiatry*

1981

### Antipsychiatry



*The Myth of Mental Illness*

1961 (this ed. 1972)

Ingleby (1981); Szasz (1961)

## Thomas Szasz manifesto (1998)

“

*Mental illness is a metaphor (metaphorical disease). The word "disease" denotes a demonstrable biological process that affects the bodies of living organisms (plants, animals, and humans). The term "mental illness" refers to the undesirable thoughts, feelings, and behaviors of persons. Classifying thoughts, feelings, and behaviors as diseases is a logical and semantic error, like classifying the whale as a fish. As the whale is not a fish, mental illness is not a disease. Individuals with brain diseases (bad brains) or kidney diseases (bad kidneys) are literally sick. Individuals with mental diseases (bad behaviors), like societies with economic diseases (bad fiscal policies), are metaphorically sick. The classification of (mis)behavior as illness provides an ideological justification for state-sponsored social control as medical treatment.*

”

**'Myth of Mental Illness.'**  
Thomas Szasz, 1998

Szasz (n.d.)

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## R. D. Laing



“

*Madness need not be all breakdown. It may also be break-through. It is potential liberation and renewal as well as enslavement and existential death.*

”

- extremely influential on a generation of psychiatrists
- possibly better characterised as an “Existential Psychiatrist”

*'The Politics of Experience'*  
R. D. Laing, 1967

Laing (1967)

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## Critical psychiatry



### Critical Psychiatry Network (CPN):

*Building on the ideas of the so-called antipsychiatrists*



#### Concerns:

- psychiatry that is heavily dependent on diagnostic classification and psychopharmacology
- recognition of poor construct validity of diagnoses
- skepticism about the efficacy of psychiatric drugs
- about the use of psychiatric diagnosis to justify civil detention
- about promoting the study of interpersonal phenomena

Critical Psychiatry Network (n.d.)

## Critical Psychiatry Network manifesto

“

*Participants in the Critical Psychiatry Network (CPN) share concerns about psychiatric practice where and when it is heavily dependent upon diagnostic classification and the use of psychopharmacology. These concerns reflect their recognition of poor construct validity amongst psychiatric diagnoses and scepticism about the efficacy of anti-depressants, mood stabilisers and anti-psychotic agents. According to them, these concerns have ramifications in the area of the use of psychiatric diagnosis to justify civil detention and the role of scientific knowledge in psychiatry, and an interest in promoting the study of interpersonal phenomena such as relationship, meaning and narrative in pursuit of better understanding and improved treatment.*

”

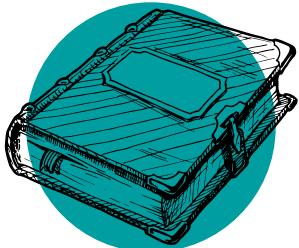


### Critical Psychiatry Network (CPN) ‘Manifesto’

Click **Next** to continue

Critical Psychiatry Network (n.d.)

## Postpsychiatry



*Postpsychiatry:  
mental health in a postmodern world*  
Patrick Bracken, Philip Thomas

### Beyond critical psychiatry: Postpsychiatry

Informed by philosophies (e.g. postmodernism)

Emphasises hermeneutics:

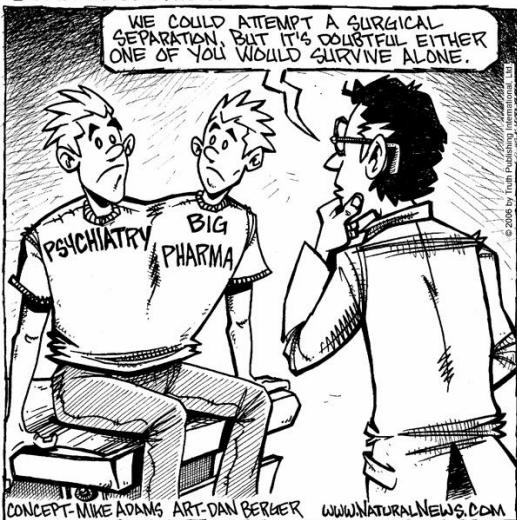
*"Human reality is something open, full of potential and unyielding to formulae or models. Meaning cannot be fixed. Central to hermeneutics is context"*

*Postpsychiatry, 2005*

Intellectually stimulating but not obviously conducive to care planning

## "Big Pharma"

### COUNTERTHINK



### "Big Pharma" and the Medical Model:

- the medical model is criticised for being dependent on the pharmaceutical industry
- 'Big Pharma' business model: innovative treatments for common and long-term conditions

### Criticisms

- suppression of negative studies
- encouragement of new disorders and over-diagnosis (e.g. paediatric bipolar disorder and ADHD)

## Peter Kinderman (1)



“

*This is a manifesto for an entirely new approach to psychiatric care; one that truly offers care rather than coercion, therapy rather than medication, and a return to the common sense appreciation that distress is usually an understandable reaction to life's challenges.*

”

# INDERMAN

*'A Prescription for Psychiatry'*  
Peter Kinderman, 2014

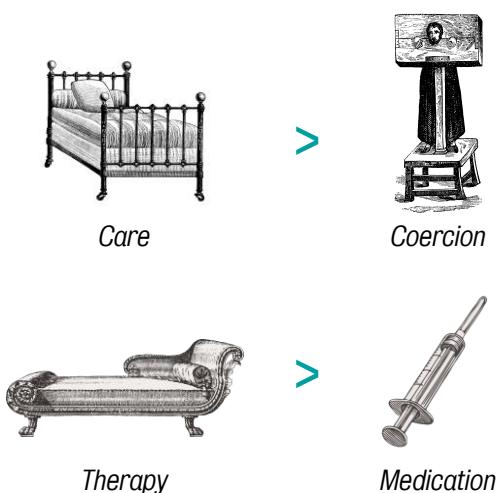
Kinderman (2014)

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## Peter Kinderman (2)

**Kinderman's views are very attractive:**



But: is Kinderman setting up false antitheses?

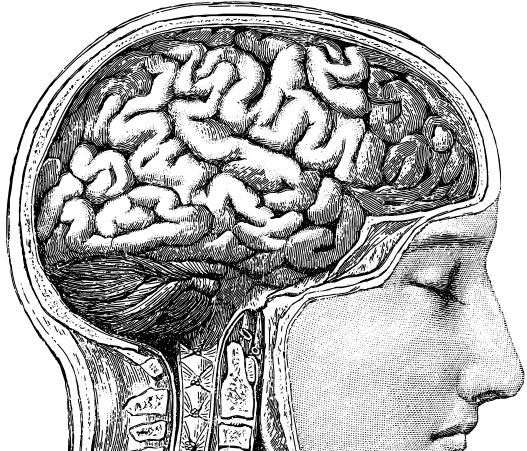
Kinderman also rejects diagnosis in favour of 'formulation'

- although in reality 'formulation-based' psychological therapies are based on diagnosis-equivalent constructs (e.g. 'psychosis', 'anxiety', 'delusions')

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## Reclaiming mental illness



Illness language seems highly appropriate to some forms of mental disorder

Differences between mental and physical illnesses have been exaggerated

There is positive value in diagnosis as 'an agenda for action'

Diagnosis has a specific meaning – which should not be over-interpreted

## My personal toolkit for understanding mental disorder

**Nosology** – the study of disease. DSM 5 is the latest attempt to delineate mental disorders

**Phenomenology** – is 'the philosophical study of the structures of experience and consciousness'.

**Descriptive psychopathology** – "it describes and categorizes the abnormal experience as recounted by the patient and observed"  
Sims, 2003

## Improving the toolkit



**Psychometric testing** - for personality disorders, learning (intellectual) disabilities and cognitive impairment



**Neuroimaging** - only mainstream for neuropsychiatric disorders



**Structured assessments** - in relation to specific diagnoses (e.g. autism); cognitive impairment (e.g. ACE)



Structured risk assessments in **forensic practice**

## Summary

- remember - we are dealing with very complex phenomena
- simplistic explanations about causation are likely to be wrong in almost all cases...
- diagnosis and formulation are helpful in making sense of a person's problems and planning interventions to alleviate them
- no single 'model' is satisfactory – in practice we need to adopt an eclectic approach
- this implies a biopsychosocial approach to psychiatry

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# End of topic