Module:
Mental Health in the Commnunity

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

Topic 1
Conceptualisations of mental disorder

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Lecture transcript

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Right, well I'm now going to talk about mental disorder and, more specifically, different ways we have of conceptualising a mental disorder. Conceptualisation's a rather clumsy word, so I've looked up some synonyms. There's lots of them, like: approach, conception, image, perception, brainchild, conceit, conceptualisation, consideration, thought, view, apprehension, impression, intellection, and even brain wave. Highlights are perhaps: notion, hypothesis, big idea, theory, abstraction. Perhaps less positively: slant, supposition, wrinkle, fool notion. Perhaps I should just have said 'ways of looking at things', There's lots of ways of looking at mental disorder, and we'll explore some of them.

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Now historians use the word 'madness'. I think they use it deliberately provocatively. It's been, in fact, out of date since at least Freud. Why do they use it? Ask them. What are the alternatives? Are any of the alternatives better? There are other people, by the way, who use the word 'madness'. So some elements of the user movement, or survivor movement, use it with a slogan-- 'we're not mad, we're angry!'

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So naming the phenomenon of interest-- are we interested in mental disorder, mental illness, mental health problem, mental distress, mental health, or something else? Each of these conjures up a network of different ideas. So mental illness: we think of things like depression, sadness, psychology, help, brain, mind, problem.

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Now words are inevitably value laden. So when I think of mental disorder, I think of it as a legal and administrative construct. When I think of mental illness, I and many people think of it as a medical construct; seen by some as a bad thing, seen by others-- like me, as a doctor-- not a bad thing. When I think of mental health problem or mental distress, I think of acceptable alternatives, perhaps euphemisms. And when I think of mental health, I think of popular conceptions, and WHO, and perhaps slightly airy fairy notions.

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So mental disorder is a legal construct. Section 1.2 of the 1983 Mental Health Act, which applies to England and Wales, as amended in 2007, defines mental disorder within the meaning of the act as 'any disorder or disability of the mind.' And the Mental Health Act sets out the criteria for detaining and treating someone with a mental disorder against their will.

The Crown Prosecution Service in the UK uses the term 'mentally disordered offender' to describe a person who has a disability or disorder of the mind and has committed, or is suspected of committing, a criminal offence. This term covers a range of offences, disabilities, and disorders, and the CPS tell us that a mental disorder may be relevant to the decision to prosecute or divert from prosecution, fitness to plead, and sentencing and disposal of the case.

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Now Code of Practice of Mental Health Act gives a list of clinically-recognized conditions which could fall within the Act's definition of mental disorder. That includes, for example: affective disorders, such as depression and bipolar disorder; schizophrenia and delusional disorders; neurotic disorders; organic mental disorders, such as dementia and delirium; personality and behavioural changes caused by brain injury; importantly from a legal perspective, personality disorders; mental and behavioural disorders caused by psychoactive substance use; eating disorders; learning disabilities; autistic spectrum disorders; and behavioural and emotional disorders of children and young people. So that's a very long list. Incidentally, dependence on drugs and alcohol is not a mental disorder under the meaning of the Act although, of course, it is a mental disorder otherwise.

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In England and Wales, if three professionals agree that a mental disorder is present and other criteria are met, then someone can be detained in hospital and treated against their will. So who decides whether a mental disorder is or is not present? Well I'll give you a clue. It's me and another doctor and an approved mental health professional, who gives a social perspective.

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Mental disorder can be seen as an administrative construct. So, it can be used to identify mental disorder, it can be used to count mental disorder, calculate the burden of mental disorder, and as a label to access specific services and benefits. So some people want to have a label of mental disorder. There are some things you won't get unless you have a label of mental disorder of, for example, autistic spectrum disorder as a child or a young person. And we can answer questions. So we can look at the Diagnostical and Statistical Manual of Mental Disorders, DSM 5, like a cookbook and answer the question, 'do I have a mental disorder?'

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DSM 5 is the current authoritative book on this subject. It's much criticised, and I'm going to discuss it some detail in later talks. There are those critics who reject the 'mental illness' language that's implicit in DSM 5 outright, and then there are others-- very much within the biomedical world-- who feel that the DSM approach is an intellectual blind alley. Again, more on this later.

Slide 13 – an uncontroversial disorder

Let's look at disorders, perhaps an uncontroversial disorder like depression. You all agree that depression exists. Many of us have experienced depression.

Slide 14 – a 'fashionable' disorder

There are even disorders that are fashionable. Famously Stephen Fry has come out as having bipolar

disorder, as have many other public figures. He says, "I want to speak out to fight the public stigma and to give a clearer picture of mental illness most people know little about".

Slide 15 – a contested disorder

And then there are contested disorders, such as schizophrenia, again, a lot more on this later.

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Then, there are ways of misusing mental disorder. So, mental disorders are not adjectives. You can't say, 'you look so anorexic.' 'Oh, dear, my OCD's coming on again.' There are bad labels in headlines-- like psycho, schizo, paedo-- which are both inaccurate and also demeaning and raise stigma.

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What about other approaches? Well, we've got mental health problem. What is a mental health problem? Well Mental Health Foundation helpfully tells us, 'mental health problems range from worries we all experience as part of everyday life to serious long-term conditions.'

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Now what information does the term 'mental health problem' actually convey? Well it certainly tells the listener that the speaker's careful about their language, perhaps by using a normalising term. It acknowledges that there's a spectrum of difficulties from the every day to the extremely severe and long term, and it certainly avoids 'illness' language.

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Then there's the construct of mental health. The World Health Organisation have a lovely definition: 'Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community,' which all sounds really nice.

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So WHO has a very inclusive definition of mental health, although in reality, WHO policy focuses on how to increase services for people with mental illness, mental health disorder, mental health problems-- and by that I mean severe mental health problems.

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And then there's the construct of positive mental health. So the UK NHS provides us with a toolkit-- 'Five steps to mental wellbeing.' If you're interested, these are: 'connect'-- connect with the people around you; your family, friends, colleagues, and neighbours, spend time developing these relationships; 'be active'-- you don't have to go to the gym, which I'm pleased about-- take a walk, go cycling, or play a game of football, find an activity that you will enjoy and make it part of your life; 'keep learning'-- learning new skills can give you a sense of achievement and new confidence, so why not sign up for that cooking course, start learning to play a musical instrument, or figure out how to fix your bike?; 'give to others'-- even the smallest act can count-- whether it's a smile, a thank you, or a kind word-- and large events, such as volunteering at your local centre, can improve your mental wellbeing and help you build new social networks; finally, 'be mindful'-- be more aware of the present moment, including your thoughts and feelings, your body, and the world around you. Some people call this awareness 'mindfulness'. It can positively change the way you feel about life and how you approach challenges. So there you have it, five steps, and that's for all of us.

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Let's look at ways, again, of understanding mental disorder. You remember those three explanations for madness in the ancient world: madness as a disorder of the brain, as a reaction to circumstances or moral weakness or failing, and madness as spiritual or demonic possession. Again, one's tempted to say, 'what's new?' Well I suppose one thing that's new is that we less often take interest in the spiritual domain.

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Now if we look at psychological constructs, associationism-- that was based on Locke and informed 18th and 19th century approaches to treatment. Psychodynamics was extremely influential in the 20th century, particularly in the US. Nowadays, we have cognitive behavioural approaches, which has become the dominant paradigm. It's a whole industry, much flourishing at the Institute of Psychiatry, Psychology, and Neuroscience, I have to say.

Going back to associationism, John Locke wrote, 'Madmen do not appear to have lost the faculty of reasoning; but having joined together some ideas very wrongly, they mistake them for truths and they err, as men do that argue right from wrong principles.' That was written in 1659. Psychodynamics remains of great cultural importance and certainly still informs psychological treatments for personality disorder.

And then cognitive behavioural approaches-- so I'm quoting here from a paper by Daniel Freeman and colleagues, which is actually about avatar therapy and the rationale for it, and he tells us, 'individuals with persecutory delusions erroneously believe that others are trying to cause them physical, psychological, or social harm. Our psychological conceptualisation is that at the heart of persecutory delusions are unfounded threat beliefs.' Spot the similarities.

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So what's missing from the psychological approaches I've mentioned? Well, there are a few things: psychometric testing for example, the assessment of cognitive function, the development of structured risk assessments. Those are all very important features of some elements of mental health practice, particularly when you're dealing with very complex phenomena.

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Now the next way of understanding mental disorder is mental disorders of brain disease. Degeneration theories dominated thinking in the late 19th century, and dominated in a rather malignant way, one has to say; their subsequent life led to sterilisation for people with learning disability and euthanasia as public policies, which were even adopted in so-called 'advanced' countries. We have the example of 'general paralysis of the insane' (GPI), which was understood as caused by an infective agent; Alzheimer's disease, which was shown as having clear neuropathology. I've already mentioned the psychopharmacological revolution of the 1950s, which remains immensely important to contemporary psychiatric services.

There are new disciplines that are important; so genetics and epigenetics, which is currently a focus for an enormous amount of research with potentially important therapeutic implications, and similarly imaging and functional imaging, which are largely still research tools, except for the investigation of dementias, but again, may move into routine clinical practice.

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One of the powerful things about imaging, for example, is it does what it says on the tin. It gives us pretty pictures that even if we can't understand the physics and mathematics behind the images are highly persuasive.

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Now there is something new, actually, from the late 19th century onwards, and that's sociological approaches. That's to say, mental disorder and society. So Emile Durkheim wrote about suicide and linked it to the sociological construct of 'anomie'. Goffman writes about 'the total institution' and its effect on individuals-- total institution being an asylum, but also prison or monastery or nunnery. Scheff writes about labelling theory. Goffman and Scheff have had continuing influence on the ways we look at mental health and mental health services. Put rather crudely, institutions are a bad thing and deviant behaviours, in this world view, are societally determined. And implicitly, that world view denies reality to disability, which is seen as a social phenomenon.

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Now there are very good quality empirical studies using sociological paradigms. There's a nice book by Craig Morgan and colleagues, Society and Psychosis, that summarised those in relation to psychosis. So we have very good evidence that psychosocial stressors act as precipitants of illness, all forms of mental disorder. Childhood adversity and abuse is important in the onset of many mental disorders, as is the immigration experience, as is the family environment, although not quite in the way that it was though of in the 1950s.

We learned an awful lot about stigma and its effect on the outcome of mental disorder. And we've learnt, and are learning more and more, about gene environment interactions, and those interactions aren't all one way, as epigenetics tells us.

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There are many ways of trying to understand mental disorder. There are many different models of mental disorder. Peter Tyrer has over 25 years and five editions, published a book on models for mental disorder (fifth edition came out in 2013), and he gives us four broad models-- a disease model, a psychodynamic model, a cognitive-behavioral model, and a social model-- and he suggests that we try and synthesise these models in practice. And in fact, mental health professionals, as one of the joys of the job, are shifting between different models all the time in their day-to-day practice.

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So if I try and make sense of mental disorder, my own personal view is that we're dealing with very complex phenomena. Simplistic explanations about causation are likely to be wrong in almost all cases. Diagnosis and formulation-- bringing into the formulation a wide range of different concepts-- are helpful in making sense of a person's problems and, importantly, planning interventions to alleviate them. There is no single model that's satisfactory, and in practice, we need to adopt an eclectic approach, which to my mind, at least, implies a biopsychosocial approach to psychiatry and mental health practise.