Module:
Mental Health in the Commnunity

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

Topic 2
Mental illness and its critics

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Lecture transcript

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I'm now going to talk about the construct of mental illness and also criticisms of the construct. I'm a psychiatrist so not unnaturally, I'm quite comfortable with 'illness' language, because it's a language that doctors use. Though I have to say, not everybody in contact with mental health services is experiencing a problem that fits in easily with the 'illness' label.

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And now a couple of quotes. '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.' That was written by a psychiatrist called Eliot Slater in 1954. Sargent and Slater's textbook is the dominant textbook of the immediate post-war years.

Another quote-- '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.' Now that quote's from Peter Tyrer in the 1998 version of his book on Models of Mental Disorder, and it certainly fits the experience of some people I meet and that of their carers-- that is to say, there's something fundamentally different, something wrong.

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Now going back to the idea of psychiatric diagnosis, the DSM is what you might call a recipe book where you need to know what the ingredients mean. Now I'm using an example of the diagnostic process for the disorder alcohol intoxication, which I suppose most of us would say is not really an illness as such anyway, but it's useful illustratively. So it's structured thus: A) recent ingestion of alcohol; 'have I had a drink?', B) clinically significant problematic behaviour or psychological changes-- for example, inappropriate sexual or aggressive behaviour, motor ability, impaired judgement that develop during or shortly after alcohol ingestion-- 'has the drinking led to a problem?' in other words, C) one or more of the following signs or symptoms developing during or shortly after alcohol use-- 'have I experienced a specified number of symptoms?' In this case, just one is required:

(i) slurred speech, (ii) incoordination, (iii) unsteady gait, (iv) nystagmus-- that's medical jargon, but you'd certainly know it if you had it, (v) impairment of intentional memory, (vi) stupor or coma;

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and then D) the signs or symptoms are not attributable to another medical condition and are not better explained by any other mental disorder, including intoxication and other substances-- so is there an exclusion, 'was I merely "tired" and "emotional?"'

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DSM-5 code for administrative purposes for uncomplicated intoxication, is F10.929, and that maps onto the International Classification for Diseases code. It's not the same as a legal definition for drink driving, for example, which is based on blood levels, and as I've said, alcohol intoxication-- not really a medical diagnosis at all. You don't need a medical degree to tell when somebody is drunk, except that there are important medical differentials-- for example, hyperglycemia.

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The mental illness construct has been repeatedly criticised-- so by sociologists such as Goffman and Scheff, from the perspective of the user (The Alleged Lunatic's Friend Society onwards), from the perspective of the antipsychiatrists, critical psychiatrists, now postpsychiatrists, by opponents of 'Big Pharma', by proponents of psychological approaches to mental distress, and by the recovery movement.

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Let's look at a couple of these perspectives. So critical psychiatry, which originated in the 1970s, is, broadly speaking, from a left-wing, Marxist perspective. There is a libertarian/existentialist trend in antipsychiatry. So Szasz, author of The Myth of Mental Illness, is certainly not a Marxist, but very much a libertarian.

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So I mentioned Szasz. His book, 1961 textbook, was very influential for a whole cohort of psychiatrists, mental health professionals. And he published a manifesto in 1998. In that manifesto, under 'myth of mental illness,' he says, '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 a 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 of state-sponsored social control as medical treatment.'

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Now another very prominent anti-psychiatrist was R.D. Laing who's a Scotsman-- works in Britain. In The Politics of Experience, which he published in 1967, he had this statement to make: '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.' Now Laing has been extremely influential on a whole generation of psychiatrists, and he might actually be better characterised as an existential psychiatrist, as much as an antipsychiatrist.

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Now critical psychiatry perhaps brings science and Laing together. It's a well-organised movement, has a website. On the website there's a sort of manifesto. It says, 'participants in the critical psychiatry network 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 among psychiatric diagnoses and scepticism about the efficacy of antidepressants, mood stabilisers, and antipsychotic agents.

According to them, these concerns have ramifications in the area of the use of psychiatric diagnoses 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 a pursuit of better understanding and improved treatment.

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Beyond critical psychiatry, we have postpsychiatry. There's a textbook I own on postpsychiatry by Bracken and Thomas subtitled Mental Health in a Postmodern World, published by Oxford University Press in 2005. OUP, by the way, is the world's leading philosophy textbook publisher. So postpsychiatry is philosophically informed. It emphasises hermeneutics and tells us, 'human reality is something open, full of potential, and unyielding to formulae or models. Meaning cannot be fixed. Central to hermeneutics is context.' Now this is a intellectually intriguing perspective, not obviously conducive to care-planning on a wet Thursday in Croydon.

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Other criticisms of the medical model come from a perceived linkage between psychiatry and pharma. And there's a nice cartoon to that effect with Siamese twins, psychiatry and Big Pharma linked with a doctor looking on, saying, 'We could attempt a surgical separation but it's doubtful either of you would survive alone.' In a book published in 2014 by Kinderman, A Prescription for Psychiatry, we have these views quite well rehearsed.

So to think about Big Pharma and the Medical Model, the criticism is that the medical model of mental disorder is dependent on the pharmaceutical industry. Now in general, the pharmaceutical industry's business model is to develop new treatments for common and long-term conditions. That's the holy grail.

Pharma has been criticised in many perspectives but particularly in recent years in the context of mental illness or mental disorder, systematically suppressing negative studies-- for example, to the efficacy of antidepressants-- and encouraging new disorders and over diagnosis; so that in America, for example, you have an explosion of diagnosis of paediatric bipolar disorder, which results in young people being treated with potentially large quantities of potentially toxic medication, and attention deficit hyperactivity disorder: an ideal disorder-- chronic, long-term and does indeed respond to pharmacological interventions.

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So Kinderman's prescription for psychiatry, which in parentheses is a psychological prescription for psychiatry-- and no surprise, that Kinderman is president of the British Psychological Society at the moment-- he rejects psychiatric diagnostic classificatory systems. And his book, he tells, 'is a manifesto for an entirely new approach to psychiatric care; one that offers care rather than coercion, therapy rather than medication, and a return to the common sense appreciation that distress is usually an understandable reactions to life's challenges.' And I've put 'common sense' in italics.

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So Kinderman's views are very attractive. Who could be against care versus coercion? Who would not prefer therapy as opposed to medication? Well actually, there's quite a lot of empirical evidence that lots of people would prefer medication as opposed to therapy, but there you go. And who could possibly be against common sense? There is, though, a slight sense that perhaps Kinderman's setting up false antithesis. Kinderman also rejects diagnoses in favour of formulation,

although in reality, the formulation-based psychological therapies that he advocates have been developed on the basis of diagnostics-equivalent constructs, such as anxiety, psychosis, delusions-- 'diagnosis light,' if you like.

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Now I want to make an argument, briefly, for reclaiming mental illness. Firstly, illness language seems highly appropriate to some forms of mental disorder. So if you see somebody in the throws of an acute psychotic episode, acutely manic, somebody with very severe obsessive compulsive disorder, it really looks like illness. The differences between mental and physical illnesses have been exaggerated. In fact, they're grossly exaggerated, I think, by Szasz. There's also positive value in diagnosis as an agenda for action. And then diagnosis has a specific meaning-- now this should not be over-interpreted, It's not a complete description of the person, merely a statement that their presentation or problems meet certain criteria.

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In understanding mental disorder, I have a personal toolkit. The first comes from psychiatric nosology. Remember, nosology is the study of disease. And DSM-5 is the latest-- admittedly flawed-- attempt to delineate mental disorders. The second is phenomenology, which can be defined as the philosophical study of the structure of experience and consciousness, and in practice allows me to look, in a structured way, at the experiences and behaviours of a person. That is defined in textbooks, like that of Sims' Symptoms of the Mind, of descriptive psychopathology, which describes and categorises the abnormal experience as recounted by the patient and observed.

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For really good quality practice, we may need to resort to psychometric testing, for example, for exploring constructs such as personality disorder, learning (intellectual) disability, and cognitive impairment. There's a whole range of structured assessments in relation to specific diagnoses-- for example, the diagnosis of autism. There are many assessment tools for that. It's not something that should be just plucked clinically out of the air.

And also for cognitive impairment-- so the Addenbrooke's cognitive examination, for example, is a useful tool for investigating suspected dimentia. Neuroimaging is a tool, although of diagnostic use in the mainstream, only in the context of neuropsychiatric disorders. And finally, forensic practice is quite significantly reliant on structured risk assessments, which aren't in fact so much diagnostic tools as tools for understanding problematic behaviours and care planning.

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So back to making sense of mental disorder and my own personal view, and I apologise if I've said this before. When we're looking at mental disorder, we're dealing with complex phenomena. Simplistic explanations about causation are very likely to be wrong in almost all cases. Diagnoses and formulation are helpful in making sense of a person's problems and planning interventions to alleviate them, so Kinderman doesn't have a monopoly on interest in formulation. No single model is entirely satisfactory in every circumstance. So in practice, we will tend to need to adopt an eclectic approach. In want of better terminology, I would describe that as a biopsychosocial approach to psychiatric practice and mental health care.