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THEORETICAL ARTICLE

# The end of mental illness thinking?

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**Abstract** Mental health theory and practice are in a state of significant flux. This theoretical article places the position taken by the British Psychological Society Division of Clinical Psychology (DCP) in the context of current practice and seeks to critically examine some of the key factors that are driving these transformations. The impetus for a complete overhaul of existing thinking comes from the manifestly poor performance of mental health services in which those with serious mental health problems have reduced life expectancy. It advocates using the advances in our understanding of the psychological, social and physical mechanisms that underpin psychological wellbeing and mental distress, and rejecting the disease model of mental distress as part of an outdated paradigm. Innovative research in genetics, neuroscience, psychological and social theory provide the platform for changing the way we conceptualise, formulate and respond to psychological distress at both community and individual levels.


**PALABRAS CLAVE**
Diagnóstico;
Formulación;
DSM-5;
Bienestar;
Estudio teórico

**¿El fin de pensar en enfermedad mental?**

**Resumen** La teoría y la práctica de la salud mental se encuentran en un momento de cambios significativos. El objetivo de este artículo teórico es mostrar la posición adoptada por la *British Psychological Society Division of Clinical Psychology* (*DCP*) en el contexto de la práctica actual, tratando de analizar de forma crítica algunos de los factores clave que impulsan estos cambios. La necesidad de una revisión completa de los planteamientos actuales procede del mal funcionamiento de los servicios de salud mental en los que las personas con graves problemas de salud mental han reducido la esperanza de vida. Se aboga por el uso de los avances en los conocimientos de los mecanismos psicológicos, sociales y físicos que sustentan el bienestar psicológico y la angustia mental, rechazando el modelo de enfermedad de la ésta como parte de un paradigma obsoleto. Los avances de la investigación en genética, neurociencia,

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psicología y teoría social proporcionan la plataforma para cambiar la manera en que conceptualizamos, formulamos y respondemos al sufrimiento psicológico, tanto a nivel comunitario como individual.


There is a powerful movement in train, which is seeing old ideas in mental health being replaced as new scientific advances, including in epigenetics (Toyokawa, Uddin, Koenen, & Galea, 2012), neuroscience (for example in child development) (Riem et al., 2013) and psychological understanding of cognitive mechanisms underlying mental distress (Susan & Edward, 2011). Mental health is increasingly understood as a public health issue (World Health Organisation, 2010) and research on income inequality has clearly shown the link with expressions of mental distress (Wilkinson & Pickett, 2010). This paper addresses one aspect of this change, in which we advocate abandoning the outdated 'disease model' of mental distress and the development of new ways in which we can bring together all the elements of a person's experience in order to help them most effectively, and follows the publication by the Division of Clinical Psychology of the British Psychological Society on classification of behaviour (Awenat et al., 2013).

## The United Kigdom context

Due to the impact of austerity on communities and services across the whole of the Unted Kingdom, mental health services are under severe stress and increased pressure. The governments programme of 'health service liberation' (Department of Health, 2010) has changed the way that services are funded. Power has shifted to doctors working in community settings and away from centralised decision-making. The people who use services have been put at the heart of policy making and every other part of the system is being told that there is to be ''no decision about me without me''. Budgets for social care have been dramatically reduced and mental health service funding has been curtailed. The traditional near monopoly of the National Health Service is being replaced by a much more mixed economy of providers. Many services are being put out to tender and are starting to be provided by Non-Governmental Organisations (NGO's) and private for profit companies. These changes have been highly problematic but also have resulted in significant challenges to historic patterns of practice and have brought forward new providers and new ways of working. The government agenda of 'Parity of Esteem' which is designed to increase equity of resources between mental and physical health care services has helpfully highlighted the very significant reduction in life expectancy for people very serious mental health difficulties (Royal College of Psychiatry, 2013).

There has been a consistent demand, by those who experience distress, for more psychologically based mental health care (Hicks et al., 2011). In England this has resulted in a new programme of psychologically driven care. More people are now seen in the improving access to psychological therapies programme (IAPT) than are seen in secondary mental health care (IAPT, 2012). This programme has in large part been lead by Clinical Psychology. The programme was initially for people with anxiety and depression in the community but has since developed a range of service redesign arms into the areas of psychosis, long term physical conditions, and mental health services for children and young people.

The service user and recovery movements have been gaining political strength and maturity (Centre for Mental Health, 2003). Peer recovery workers and recovery colleges are becoming commonplace. In the latter you do not need to take on the identity of a patient to receive support and guidance to manage whatever the issue that is causing concern and distress. The whole basis of expert professional practice and power is being questioned in new and challenging ways.

## The Diagnostic and Statistical Manual version 5 (DSM-5) debate

The recent DCP contribution to the debate concerning DSM-5 (Awenat et al., 2013) has been to release a statement calling for a very different approach; one that does not deny the importance of biology and physical factors but which calls into question the extent to which disease based models have led us up a conceptual and practice blind alley. The introduction to the statement says. 'The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and the International Classification of Diseases (ICD), in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations, consequently there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system which is no longer based on a 'disease' model'.

The statement needs to be read in the context of the DCP good practice guidance on the use of psychological formulation (DCP, 2011). This guidance states that psychological formulation starts from the assumption that 'at some level it all makes sense'. From this perspective mood swings, hearing voices, having unusual beliefs can all be understood as psychological reactions to current and past life experiences and events. They can be rendered understandable in the context of an individual's particular life history and the personal meaning that they have constructed about it and

within their cultural context. While this assumption in any individual case may turn out to need review, it provides a healthy starting point.

Illustrating the sea changes in thinking in this field, a recent paper (Forgeard et al., 2011) records the discussions of a distinguished group of American researchers and practitioners (Aaron Beck, Richard Davidson, Fritz Henn, Steven Maier, Helen Mayberg, and Martin Seligman) concerning the current understanding of depression and how people who experience this condition can best be helped. One contributor, Steven Maier's summed up the view: *''We need to get rid of our current categories because they do not inform us about the best way to treat people''*.

They took to some degree as a starting point the US National Institute for Mental Health's current Strategic Plan (Insel, 2008) which has laid down the challenge of bringing together the current scientific understanding of brain and mind with practice, something it regards as sadly lacking at present with the contemporary diagnostic framework. Forgeard et al. (2011) report that *''despite decades of research on the etiology and treatment of depression, a significant proportion of the population is affected by the disorder, fails to respond to treatment and is plagued by relapse''* (p. 1). This fact, together with the relatively poor treatment success of any therapy, is referred to by Seligman (2011) as 'The dirty little secret of drugs and therapy' (p. 45) is part of the recurring theme of the problem of using the current classification system, rather than one which looks at how brains, minds and people (not forgetting people are social) work.

It is useful here to quote the NIMH 2008 strategic plan (Insel, 2008) to be clear what a fundamental change is being articulated:

> *''The urgency of this cause cannot be over-stated. The President's New Freedom Commission on Mental Health, which examined the need for reform of the mental health care system, concluded that the problems of frag- mentation, access, and quality of mental health care were so great that nothing less than transformation would suffice. With several large-scale clinical trials completed by NIMH, we can add that for too many people with mental disorders even the best of current care is not good enough. To fully address these issues, we must continue to (a) discover the fundamental knowledge about brain and behavior and (b) use such discoveries to develop better tools for diagnosis, preemptive interventions, more effective treatments, and improved strategies for delivering services for those who provide direct mental health care. These activities point toward NIMH's ultimate goal, which is not merely to reduce symptoms among persons with mental illness, but also to promote recovery among this population and tangibly improve their quality of life'' (p. iii)''*.

And further on:

> *''Currently, the diagnosis of mental disorders is based on clinical observation—identifying symptoms that tend to cluster together, determining when the symptoms appear, and determining whether the symptoms resolve, recur, or become chronic. However, the way that mental disorders are defined in the present diagnostic system does not incorporate current information from integrative neuroscience research, and thus is not optimal for making scientific gains through neuroscience approaches. It is difficult to deconstruct clusters of complex behaviors and attempt to link these to underlying neurobiological systems. Many mental disorders may be considered as falling along multiple dimensions (e.g., cognition, mood, social interactions), with traits that exist on a continuum ranging from normal to extreme''* (p. 9).

## The need for a paradigm shift

The DCP call for a paradigm shift is not a denial of the embodied nature of human experience or the complex relationship between social, psychological and biological factors but instead calls for a system that acknowledges the growing evidence of psychosocial causal factors in many types of mental distress.

To speak of a paradigm shift could be seen as something of a cliché. However, we have used this term very deliberately as it does sum up the pivotal moment we find ourselves in; but the necessary change is not inevitable, and the form of change may or may not be the one we would envisage. Such is the nature of paradigms. In the very successful book on science Chalmers (2013) gives a very useful account of the debates which surround the ideas of how science progresses and the meaning of scientific facts. The contemporary assumptions concerning mental distress–for example the serotonin deficit theory of depression–are deeply rooted in the minds of mental health professionals. The idea that depression and other diagnoses are real things is similarly strongly believed. This is similar, in our view, to the assumptions that the earth was the centre of the universe in pre-Copernican days. There was much to commend the idea–the sun rose in the morning and set at night and clearly went round the earth. Critiques of these ways of reasoning, together with the vested interests in maintaining the current views of mental disorder (Goldacre, 2009, 2012) have shown how important the required change is. Our account is only one aspect–another example which Goldacre has been advocating is the Alltrials project (www.alltrials.net) aiming to provide at last an honest account of the effectiveness of drug and other therapies.

A DCP project entitled 'Beyond psychiatric diagnosis' aims to outline the first principles of an evidence-based conceptual alternative to psychiatric diagnosis which will provide a more effective basis for reducing complexity by grouping similar types of experience together. While biology plays a mediating role in all human experiences, mental distress is not best understood as disease process, and this particular paradigm has comprehensively failed in the field of psychiatry. Rather than assuming that human thoughts, feelings and behaviours can be theorised in the same way as body parts, the project will draw on the large body of knowledge about psychosocial causal factors in mental distress. It will describe the first steps towards identifying patterns and pathways which can be used to inform the co-construction of individual narratives and formulations based on personal meaning. This will provide a sounder and more productive basis for developing interventions, carrying out research,

planning services and empowering service users to make changes in their lives. It will also have implications for social policy and issues of social justice.

Another approach which may have merit comes from so-called 'transdiagnostic' models (Dudley, Kuyken, & Padesky, 2011). These argue that we can begin to make sense of an individuals distress through an understanding of underlying psychological mechanisms. Rather than starting with a set of symptoms and trying to find a way in which they hang together, it sets out to explore how a particular psychological experience is mediated across many different diagnostic groups. Poletti and Sambataro (2013) for example, have looked at how delusional ideas function from a cognitive and neuropsychological perspective in schizophrenia, bipolar disorder, major depressive disorder and neurological disorders stroke, and neurodegenerative diseases. Here there is a clear account of an experience which can lead to considerable distress and anxiety and an understanding of the underlying mechanisms and possible ways to help alleviate the problem.

Seligman (2014) takes this further, and in a discussion of transdiagnostic models uses the example of smallpox to show that before Jenner discovered that there was an infective agent, it was simply a description of symptoms. Afterwards there was a mechanism–the germ theory. He makes the point that this was a landmark change–and led to a paradigm shift in understanding infectious diseases and their treatment. He goes on to say about mental health diagnostic systems however:

> *''The underlying processes are therein called ''transdiagnostic.'' Transdiagnostic of what? ''Transdiagnostic'' assumes that the disorders have a reality that is illuminated by these processes. But this puts the cart before the horse. In a post-Jenner world, what is real are the underlying processes and what are mere way stations (fictions?) are the ''disorders.'' ''Comorbid'' smacks of just the same anachronism. Two diagnostic categories, mere congeries of symptoms, are ''comorbid'' if they share the same underlying process. But if it is the underlying process that is real, and the ''disorders'' convenient way stations to the process, ''comorbid'' vanishes into thin air''* (p. 2).

## What then is the way forward?

Kinderman (2013) has cogently argued that we need abandon the disease model and adopt a psychosocial model in its place. He argues that we need to stop diagnosing non-existent illness. In the place of diagnosis we need to base planning for individuals and services on a simple list of people's difficulties and to recognize our primary role lies in supporting their wellbeing. Despite its many limitations the positive psychology movement (Seligman, 2011) is correct in its assertion that we have been overly preoccupied with deficits and deficiencies and that we need to approach psychologically distress by building on peoples strengths. We need to significantly reduce our ever-increasing reliance on psychotropic medication and instead offer redesigned psychosocial services than aim for recovery and personal agency.

From yet another perspective the World Health Organisation International Study of Schizophrenia (ISOS) on recovery among people given a diagnosis of schizophrenia is also instructive (Hopper, Harrison, Janca, & Sartorius, 2007; Mason, Harrison, Croudace, Glazebrook, & Medley, 1997; Mason, Harrison, Glazebrook, & Medley, 1996). This research found, contrary to expectations, much better recovery rates in less developed (by which you could perhaps read less prescribing and western psychiatric approaches) than in so called 'advanced' countries. This work has never been satisfactorily absorbed by the mental health system in the United Kigdom but it provides another strong evidence-based challenge to the contemporary approaches.

Whitaker (2010), a science journalist has made a study of the impact of the way we currently provide services, and extensively quotes from the ISOS studies: He provides chapter and verse that in the United States, and probably also in the United Kingdom there is a mental health epidemic–a public health problem largely caused by the system we have in place. He also describes some services that seem to making real progress in putting some innovative and groundbreaking ideas into practice. One of these is based in Western Lapland and is called Open Dialogue and it has recently been introduced in the UK (Open Dialogue, 2014). This approach draws on a number of theoretical models, including systemic family therapy, dialogical theory and social constructionism and has echoes of some very early work on crisis intervention in the United Kingdom (Scott, 1973).

## Conclusions

Mental Health theory and practice is at a crossroads. The language and categories we use to to describe psychological distress are changing and as evidenced by the furore over DSM-5 are being challenged from all sides. The complex interplay between the physical, the psychological, the social and cultural is always likely to be controversial and prone to change. We however have argued that it is time that the current disease-based systems are replaced. We advocate using the advances in our understanding of the psychological, social and physical mechanisms that underpin psychological wellbeing and mental distress to change the way we respond at a community an individual level. These new insights need to be incorporated into practice and research. Central to the way we move forward will be the role and power of people experiencing mental health difficulties. As McKnight (1995) says ''Revolutions begin when people who are defined as problems achieve the power to redefine the problem'' (p. 16). We need to be careful that we don't just replace disease based frameworks with overly restrictive psychological ones. Success will include social inclusion in the local community, friendships within and outside of the mental health system, and purpose in life.

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