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Why We Need to Abandon the Disease-Model of Mental Health Care

By *Peter Kinderman* November 17, 2014

The idea that our more distressing emotions such as grief and anger can best be understood as symptoms of physical illnesses is pervasive and seductive. But in my view it is also a myth, and a harmful one. Our present approach to helping vulnerable people in acute emotional distress is severely hampered by old-fashioned, inhumane and fundamentally unscientific ideas about the nature and origins of mental health problems. We need wholesale and radical change, not only in how we understand mental health problems, but also in how we design and commission mental health services.

Clarity without diagnosis

Even mainstream medical authorities have begun to question the creeping medicalization of normal life and criticize the poor reliability, validity, utility and humanity of conventional psychiatric diagnosis. It is important that we are able to define, identify and measure the phenomena we are attempting to study and the problems for which people seek help. But we obfuscate rather than help when we use the language of medical disease to describe the understandable, human and indeed normal response of people to traumatic or distressing circumstances. So there are ethical and humanitarian reasons to be skeptical of traditional psychiatric diagnosis. But there are scientific reasons too. It's odd but hugely significant that the reliability statistics for the American Psychiatric Association's influential DSM franchise have been falling steadily over time. It is difficult reliably to distinguish different “disorders”, but also difficult to identify specific biological etiological risk factors. Indeed, Thomas Insel, director of the National Institute of Mental Health, recently suggested that traditional psychiatric diagnoses had outlived their usefulness.

Understanding rather than etiology

It's all too easy to assume that mental health problems — especially the more severe ones that attract diagnoses like bipolar disorder or schizophrenia — must be mystery biological illnesses, random and essentially unconnected to a person's life. But when we start asking questions about this traditional disease-model way of thinking, those assumptions start to crumble.

Some neuroscientists have asserted that all emotional distress can ultimately be explained in terms of the functioning of our neural synapses and their neurotransmitter signalers. But this logic applies to all human behavior and every human emotion and it doesn't differentiate between distress — explained as a product of chemical “imbalances” — and “normal” emotions. Moreover, while it is clear that medication (like many other substances, including drugs and alcohol) has an effect on our neurotransmitters, and therefore on our emotions and behavior, this is a long way from supporting the idea that distressing experiences are caused by imbalances in those neurotransmitters.

Many people continue to assume that serious problems such as hallucinations and delusional beliefs are quintessentially biological in origin, but we now have considerable evidence that traumatic childhood experiences (poverty, abuse, etc.) are associated with later psychotic experiences. There is an almost knee-jerk assumption that suicide, for instance, is a consequence of an underlying illness, explicable only in biological terms. But this contrasts with the observation that the recent economic recession has had a direct impact on suicide rates, a rather dramatic (and sad) example of how social factors impact on our mental health.

Neural activity and chemical processes in the brain lie behind all human experiences, and it's undoubtedly helpful to understand more about how the human brain works. However, this is very different from assuming that some of those experiences (psychosis, low mood, anxiety, etc) should be classified as illnesses. The human brain is not only a complex biological structure; it is also a fantastically elegant learning engine. We learn as a result of the events that happen to us, and there is increasing evidence that even severe mental health problems are not merely the result simply of faulty genes or brain chemicals. They are also a result of experience — a natural and normal response to the terrible things that can happen to us and that shape our view of the world.

Stigma & empathy

Traditionally, the idea that mental health problems are illnesses like any other and that therefore people should not be blamed or held responsible for their difficulties has been seen as a powerful tool to reduce stigma and discrimination.

Unfortunately, the emphasis on biological explanations for mental health problems may not help matters because it presents problems as a fundamental, heritable and immutable part of the individual. In contrast, a more genuinely empathic approach would be to understand how we all respond emotionally to life's challenges.

But things are changing. Over the past 20 years or so, we've seen a very positive and welcome growth of the user and survivor movements, where people who have experienced psychiatric care actively campaign for reform, and signs of more responsible media coverage. We are just starting to see the beginnings of transparency and democracy in mental health care. This has led to calls for radical alternatives to traditional models of care, but I would argue that we do not need to develop new alternatives.We already have robust and effective alternatives. We just need to use them.

Therapy

Clinicians have raised concerns about the relative benefits of psychiatric medication and there is increasing evidence for the effectiveness of psychological therapies such as cognitive behavioral therapy. Indeed, even for people with very serious mental health problems, such as those leading to a diagnosis of schizophrenia, and even for those choosing not to take medication, such therapies have great promise.

We need to place people and human psychology central in our thinking. Psychological science offers robust scientific models of mental health and well-being, which integrate biological findings with the substantial evidence of the social determinants of health and well-being, mediated by psychological processes.

We must move away from the disease model, which assumes that emotional distress is merely symptomatic of biological illness, and instead embrace a model of mental health and well-being that recognizes our essential and shared humanity. Our mental health is largely dependent on our understanding of the world and our thoughts about ourselves, other people, the future and the world. Biological factors, social factors and circumstantial factors — our human experience — affect the key psychological processes that help us build up our sense of who we are and the way the world works.

A new approach

In my new book *A Prescription for Psychiatry* I offer a manifesto for mental health and well-being. I argue that services should be based on the premise that the origins of distress are largely social. The guiding idea underpinning mental health services needs to change; from an assumption that our role is to treat disease to an appreciation that our role is to help and support people who are distressed as a result of their life circumstances.

This also means we should replace traditional diagnoses with straightforward descriptions of problems. We must stop regarding people's very real emotional distress as merely the symptom of diagnosable "illnesses". A simple list of people's problems (properly defined) would have greater scientific validity and would be more than sufficient as a basis for individual care planning and for the design and planning of services. This does not mean rejecting rigor or the scientific method — quite the opposite. While psychiatric diagnoses lack reliability, validity and utility, there is no barrier to the operational definition of specific psychological phenomena, and it is equally possible to develop coherent treatment plans from such a basis.

All this means that we should turn from the diagnosis of illness and the pursuit of etiology and instead identify and understand the causal mechanisms of operationally defined psychological phenomena. Our health services should sharply reduce our reliance on medication to address emotional distress. We should not look to medication to "cure" or even "manage" non-existent underlying "illnesses".

We must offer services that help people to help themselves and each other rather than disempowering them —

services that facilitate “personal agency” in psychological jargon. That means involving a wide range of community workers and psychologists in multidisciplinary teams, and promoting psychosocial rather than medical solutions. Where individual therapy is needed, effective, formulation-based (and therefore individually tailored) psychological therapies should be available to all. When people are in acute crisis, residential care may be needed, but this should not be seen as a medical issue. Since a disease model is inappropriate, it is also inappropriate to care for people in hospital wards. A different model of care is needed.

Adopting this approach would result in a fundamental shift from a medical to a psychosocial focus. It would mean a move from hospital to residential social care and a substantial reduction in the prescription of medication. And because experiences of neglect, rejection and abuse are hugely important in the genesis of many problems, we need to redouble our efforts to address the underlying issues of abuse, discrimination and social inequity.

This is an unequivocal call for a revolution in the way we conceptualize mental health and in how we provide services for people in distress, but I believe it’s a revolution that’s already underway.

About the Author

Peter Kinderman is professor of Clinical Psychology at the University of Liverpool, and is a Chartered Clinical Psychologist. He is Head of the Institute of Psychology, Health and Society at the University of Liverpool. His research interests are in psychological processes underpinning well-being and mental health, and in particular psychotic phenomena such as delusions and hallucinations. In 2000, he received the British Psychological Society's Division of Clinical Psychology 'May Davidson Award', an annual award for outstanding contributions to the field of clinical psychology, in the first ten years after qualifying. He was twice elected Chair of the British Psychological Society Division of Clinical Psychology; from 2004 to 2005, and again from 2010-2011. In that role, he worked with the UK Department of Health, the BBC, the Health Professions Council, the European Union Fundamental Rights Agency and the UK Office for National Statistics, amongst others. He has recently launched a free, online, open-access course exploring our understanding of mental health and well-being. Follow on Twitter @peterkinderman.