

# Understandings of mental illness – mired in the past?

Are psychological conceptions stuck in the 20th century? John Cromby thinks so: Vaughan Bell disagrees.



Dr John Cromby is at Loughborough University

All knowledge is shaped by its past: psychological understandings are no exception. But ‘mired’ suggests a negative shaping, a constraining or unhelpful trajectory. I would argue that the tendency to still conceive of psychological distress as mental illness, as diseases with primarily biological causes, is indeed constraining and unhelpful.

The prominence of this tendency in psychology is illustrated by

the available textbooks in this field. The majority have the term ‘abnormal’ in the title, and their chapters are structured around the diagnostic categories of the DSM or ICD. This is in part because the psychiatric idea of distress as diseases with primary biological causes also dominates the research. Calton et al. (2009) found that of 10,000 papers at major international conferences on schizophrenia 75 per cent were predominantly biological in their orientation, whereas less than 5 per cent took a predominantly psychosocial stance and less than 2 per cent included any overt consideration of actual experiences of distress.

All this would be understandable if there were good evidence that the illness model is correct, but in respect of the functional psychiatric diagnoses – those that comprise the vast majority, schizophrenia, depression, anxiety disorder, eating disorders, personality disorders, and so on – this is simply not the case. There is, of course, good evidence for biological causation in relation to the organic diagnoses – the dementias, intellectual impairment, Huntington’s disease, Korsakoff’s syndrome, syphilis, and so on; however, in relation to the functional diagnoses this evidence is lacking.

More than a century of extremely well-funded research using increasingly sophisticated technologies has failed to consistently demonstrate that any biological disease or impairment is the cause of any one of these presumed illnesses.

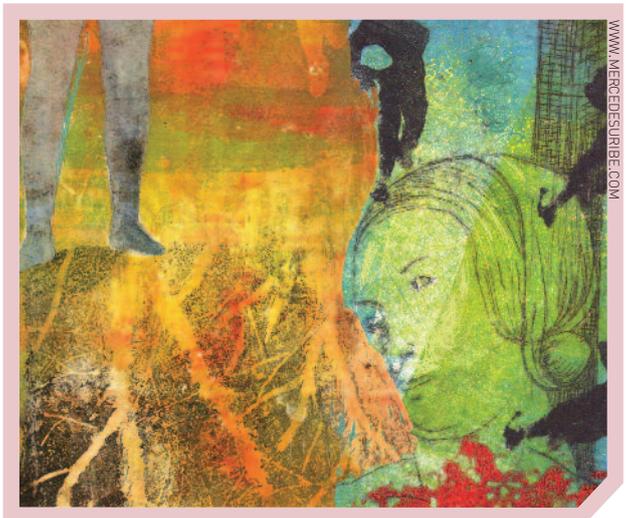
In other words this research has failed to establish that these experiences are illnesses – rather than acquired, and frequently meaningful, responses to circumstances and life events. And this, of course, is why diagnosis is still dependent upon interviews, observations and history taking. There are no objective tests such as we see in physical medicine, simply because no biological impairment has ever been consistently identified in relation to any of these diagnoses. Despite this, some psychologists cling to illness models of the experiences associated with these diagnoses, even though doing so impedes the development of consistently psychological explanations and plays down other relevant bodies of evidence. In this sense, understandings are mired in the past.



Dr Vaughan Bell is at University College London

John, I admire your compassion, but I’m struck by the distinction you make between people who have difficulties associated with clear biological differences that are detectable through medical tests (what you call an ‘illness’ – although this is not a definition of illness I recognise)

and people with ‘acquired, and frequently meaningful, responses to circumstances and life events’. This strikes me, I have to say, as an unhelpful false dichotomy. Let’s take a patient with epilepsy who develops seizures after being attacked and brain-injured in the street and now hears music from his childhood whenever a generalised seizure is about to occur. The patient



We are at once personal, social and biological beings

**references**

Calton, T., Cheetham, A., D’Silva, K. & Glazebrook, C. (2009). International schizophrenia research and the concept of patient-centredness – an analysis over two decades. *International Journal of Social Psychiatry*, 55(2), 157–169.

Cromby, J., Harper, D. & Reavey, P. (2013). *Psychology, mental health and distress*. London: Palgrave.

Department of Health (2003). *Mainstreaming gender and women’s mental health: Implementation guidance*. Retrieved 11 August 2011, from [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAndGuidance/DH\\_4072067](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAndGuidance/DH_4072067)

Gazzaniga, M.S. (2000). *The mind’s past*. Berkeley, CA: University of California Press.

Harré, R. (2002). *Cognitive science: A philosophical introduction*. London: Sage.

King, M., Coker, E., Leavey, A. et al. (1994). Incidence of psychotic illness in London: Comparison of ethnic groups. *British Medical Journal*, 309, 1115–1119.

Lee, S. (2001). Fat phobia in anorexia: Whose obsession is it? In M. Nasser, M.A. Katzman & R.A. Gordon (Eds.) *Eating disorders and cultures in transition*. London: Routledge.

Melzer, D., Fryers, T. & Jenkins, R. (2004). *Social inequalities and the distribution of the common mental disorders*. Hove: Psychology Press.

Newton, T. (2007). *Nature and sociology*. London: Routledge.

Read, J., Fosse, R., Moskowitz, A. & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry*, 4(1), 65–79.

arrives in the clinic anxious, depressed and having difficulty adapting to their new circumstances. Which part of this don't you find meaningful? Every response to the attack, from the development of seizures, to the hearing of childhood music, to the worries about the future, is perfectly meaningful when we consider the person as a whole and not just a disembodied mind.

In fact, there are biological causes in everything we do and experience. The fact that we can't adequately explain them does not make biology suddenly irrelevant. Your exact same argument applies to social factors, of course, but I don't see you arguing that we should ignore the role of society because we don't have a perfect theory of human interaction. If

you're arguing that social factors are important because we have solid evidence that they play a role, then I'm afraid biology cannot be excluded either. We are at once personal, social and biological beings. All are important, whether you call someone's problems distress, illness or a problem of living. These concepts are tools and none is the final answer. If we're stuck in the 20th century it is because people persist in seeing different levels of explanation as mutually exclusive. Death to the ideology of explanations! All are tools, to be forged by evidence, and used in the service of a common humanity.



Vaughan, there are various assumptions embedded in your response. It may help to make some of them explicit. Your response assumes I would deny meaning to a person experiencing epilepsy: this is wrong. Both theory and evidence suggest it is part of our species-nature to be meaning creators who use cultural resources to narrate our experiences. According to the neuroscientist

Gazzaniga (2000), we even have a left hemisphere system specialised for this. Likewise, your response assumes that I am saying that biology is irrelevant to distress: this is also wrong. Biology continuously enables all experiences, including experiences of distress.

So of course the person with epilepsy whom you describe will find meaning in their experiences. And of course these meanings will be enabled by their biology, shaped by their culture, and reflective of their individual trajectory of social relations. More specifically, in this neurological example EEG or MRI examinations could identify neural features or patterns associated with the person's seizures. However, the lack of consistent biological evidence means that this kind of objective testing is not possible for any of the functional psychiatric diagnoses. Your response makes the further assumption that by highlighting this I am naively separating biological and social factors, but that is not correct either.

For me, the best part of your response is your proclamation of 'death to the ideology of explanations'. Nevertheless, we must tread cautiously when making such assertions. All psychological research necessarily presumes some notion of persons and their worlds. It is therefore always entangled with values, ethics, morals and – ultimately – ideology. We must also be mindful that the conceptual and methodological development needed to produce research of the kind you call for has, for the most part, simply not been conducted (Rose 1997; Newton, 2007).

With these caveats always in mind then, yes, let's challenge the taken-for-granted distinctions – the dualisms – between biology and culture, individual and social, and so on. But let us also distinguish the truism that biology enables psychological distress from the

unsubstantiated belief that biological impairments *cause* it. Let us recognise that we do not have to accept psychiatric concepts of mental illness in order to include biology in our understandings. And let us recognise the robust evidence that the primary causes of psychological distress are, in fact, not simply biological at all.



Many thanks for a thoughtful reply, John, but I can't help being struck by your seeming to have quite a narrow view of causality. If we accept that we are biological, we must accept that biology is causal. If we are

psychological beings, we must accept that psychology is causal. Both of these are true at the same time. There is no one causality that necessarily trumps the others, just theories about causes, at different levels of explanation, some of which are better supported by evidence than others.

You rightly note that different theories of causality are culturally entangled with values and ideology, but it seems to me that by suggesting that biology plays no causal role, rejecting the laws of physics in the process I note, you are as much a slave to those values and ideology as the person who argues only biology 'matters'. As to your distinction between biology 'causing' and 'enabling' distress, I'm afraid I'm lost as to how this makes sense either philosophically or scientifically.

But here's where I do agree with you. When you say 'we do not have to accept psychiatric concepts of mental illness in order to include biology in our understandings' I wholeheartedly agree. Let's sidestep the argument over what might be considered 'psychiatric' (dear old Foucault, of course, would have us psychologists well within the psychiatric power structure) and just say that one does not have to work within a medical framework to successfully work with people to overcome their distress or impairment.

These frameworks are tools, however, and to suggest that certain approaches are necessarily more compassionate than others entirely misses the point. Just as some people object to their psychological distress being medicalised, others object to their problems being 'psychologicalised'. Is it our job to persuade people of our own prejudices? Or to inform them of how each can be a tool for progress? If our responsibility lies anywhere, it is to highlight how social and psychological approaches are under-emphasised while simultaneously

"the primary causes of distress are, in fact, not simply biological at all"

Read, J., van Os, J., Morrison, A.P. & Ross, C.A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, 112, 330–350.

Rose, S. (1997). *Lifelines: Life beyond the gene*. Oxford: Oxford University Press.

Tienari, P. (1991). Interaction between genetic vulnerability and family environment: The Finnish adoptive family study of schizophrenia. *Acta Psychiatrica Scandinavica*, 84(5), 460–465.

## head to head

encouraging an integrated view of human existence. A 21st-century psychology should drop the incoherent battles over the false dichotomies of the mind when the issue is one of understanding people in all their rich complexity.



So it seems we agree that the idea of mental illnesses with primary biological causes is unhelpful. We also agree that more attention should be paid to social and psychological influences. But we disagree, somehow, about causality.

The distinction between enabling and causing comes from Harré (2002). Simply put, we all have dreams, desires, wishes and hopes. We all experience pains and frustrations when these are challenged or blocked. All of these experiences – all the dreams and desires, all the pains and frustrations – are made possible or enabled by biology. But this does not mean that they are simply caused by biology. Their causes are vastly more complex, and in many respects not simply biological at all. Nothing here breaches the laws of physics.

In our recent textbook on distress (Cromby et al., 2013) my co-authors and I used Harré's distinction between enabling and causing. In the chapter on causal influences we characterised causality in distress as multiple, complex, over-determined, neither necessary nor sufficient, probabilistic, contingent and (sometimes) synergistic.

This notion of causality is necessary because, although biology remains influential, there is no consistent evidence for causal biological impairments, diseases or diatheses (as in the diathesis-stress model). It is necessary because there is good evidence that social inequality causes distress (Melzer et al., 2004) – albeit that most people in poverty do not experience distress. There is good evidence that trauma, abuse and neglect cause distress (Read et al., 2005) – although most people abused as children do not receive diagnoses. There is good evidence that distress is more common amongst women (Department of Health, 2003) – although most women do not receive diagnoses. There is good evidence that black people in the UK are more likely than white people to be given a diagnosis of schizophrenia (King et al., 1994) – even though most will never be given this diagnosis. And likewise, there



Biological features are only associated with distress when their bearers occupy toxic environments

is good evidence for various other causal influences – but they all seem to operate probabilistically and contingently, in complex and sometimes synergistic interactions.

Such an account of causality is needed precisely because distress is not illness. It is, instead, a set of variable, fluctuating and heterogeneous psychological experiences. These experiences are biologically enabled and culturally shaped (e.g. Lee, 2001). They are simultaneously thoroughly bound up with social and material circumstances, power relations (Foucault was right!), personal biographies, relationships, and life events.



I'm afraid, John, you've lost me. I entirely agree with what you say about the under-appreciated social factors that can promote, enhance and cause distress, but the fact you think these

are in competition with biological accounts seems to be an ideological position rather than coherent argument. To say biology has no causal role in distress is like saying humans have no causal role in unemployment. Just because you're trying to explain a higher-level concept you don't get to ignore the components of the system if you want to understand how it works. You won't find distress inside a neuron,

just like you won't find unemployment inside a person, but claiming they are not part of the causal chain defies reason and leads us into dualism.

I sense that a great deal of your misplaced objection relates to diagnosing 'mental illnesses' which you seem to arbitrarily distinguish from 'biological illnesses' – based, entirely it seems, on what methods we use to diagnose them. But this argument is not an attempt to address human nature – it's just pointing at whatever we cannot diagnose biomedically and saying, somewhat bombastically, 'See! No biology there!' The goalposts shift, of course, every time science makes a new discovery; but more than that, I find it a naive approach to understanding ourselves that misdirects us from genuinely important debates about the validity of diagnoses as tools for directing treatment and the role of medically sanctioned classification as an agent of social power – both of which have important implications for the humane care of people who are experiencing distress.

When you talk about how poverty, marginalisation, abuse and neglect are under-emphasised in debates about mental health, I'll be shoulder-to-shoulder with you. But when you try and justify this by reality-stretching accounts of causality and critiques based on straw-man definitions of illness, I can only think you're undermining these laudable

aims. So here's what I propose for the 21st century: a tools-based approach to mental health resting on sound philosophy and nuanced empiricism with compassion and respect as its highest ideals. Join me on the barricades, John, we need good people.



The evidence suggests that biological illnesses are not the primary causes of distress. I have acknowledged that biology nevertheless remains influential. So we need sophisticated accounts of

biological influence that go beyond commonsense assumptions. Consider (1) general traits (2) general biological capacities and (3) concepts of biological difference.

First, general traits: in the adoption study by Tienari (1991), children born to parents given diagnoses of schizophrenia were only themselves at increased risk of diagnosis if the adoptive home was dysfunctional. Tienari hypothesised that what these children inherited was not a genetic predisposition for schizophrenia, but a general tendency to be more sensitive and reactive to others. This trait – which might make its bearers better lovers, parents or colleagues – had adverse consequences only when those carrying it were placed in toxic environments, because the effects of those environments were then felt more keenly.

Second, general biological capacities – for example, Gazzaniga's (2000) putative left-hemisphere system – can get adversely socialised (by social inequality, abuse, racial prejudice, etc.) to produce the intrusive voice-hearing associated with psychotic-spectrum diagnoses. Research has begun detailing the specificities of these interacting social, material and relational forces and capacities.

Third, Read and colleagues (2014) traumagenic neurodevelopmental model compares the neural consequences of child abuse with the brain features sometimes observed amongst people given psychotic spectrum diagnoses. It reconceptualises the biological differences seen in some people with these diagnoses as injuries, not illnesses.

A simplistic account of these examples might erroneously posit biological causes. A sophisticated, ethically sensitive account recognises that these biological features are only associated with distress when their bearers occupy toxic environments. This account identifies those environments as the causes of distress, and the biological

features as enabling, mediating, or even (as in the third example) being produced by them.

Despite more than a century of research, the illness model of distress is unproven. Despite the ideological bias toward biological causes, good evidence for social and psychological causation has emerged. Some biological influences have been identified (the above are not the only examples) and clinical psychological techniques that do not presume biological illness have been developed. Biology does not simply cause distress – it enables it. Time, now, to leave the mire.



What you describe in your first example, is called a gene-environment interaction, and it is the mainstay of modern genetics. In this case, you think you're arguing against the orthodoxy, but you're actually arguing for it. This is a good thing, because it's a well-supported foundation for understanding human nature. Your second example sounds like the ghost of Julian Jaynes (who sounds like he owes an apology to Michael Gazzaniga), and the third example like a reasonable attempt to highlight the under-appreciated effects of trauma while incorrectly suggesting that this fully explains any biological differences found between people with psychosis and people without. Psychosis is sometimes compared to fever (not a medical illness, you might be interested to know) because it seems to be a common result of what happens when lots of things start working unpredictably through various pressures on their functioning. In the case of

psychosis, these pressures can be trauma, a history of child abuse, drugs, brain injury, neural instability (like epilepsy) and our susceptibility to these differs, in part, due to genetics and prenatal development. Call it what you will – psychological distress, illness, disorder, revelation – but let's not blinker ourselves to inconvenient evidence.

I think, however, you reveal both your humanity, and the source of your misunderstanding, when you say you are arguing for an 'ethically sensitive account' of human nature. If I might say, John, one thing I have been impressed by during our exchange is how you have consistently championed a compassionate approach to human suffering. But ethics relates to how we apply knowledge, not the knowledge itself. To say that some sorts of knowledge are 'ethical' is a category error and there is no 'ethically correct' theory of human nature, only those that are better supported by evidence than others. Ethics enters the picture when we attempt to translate our understanding into action.

Compassion lies not in our tools, but in our actions and objectives. Theories, evidence, science, humanities, fMRI, grounded theory, blood tests, twin studies, art, matrix algebra, clinical experience, neuropsychological tests, statistics, lived and shared experience, are all tools – ways for us to understand ourselves – for which humanity should be our common aim. This is the 21st century in which I want to live, and in which I hope we can work together to alleviate distress and disability.

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## Let the debate continue

To share your views on this topic, e-mail your letters to [psychologist@bps.org.uk](mailto:psychologist@bps.org.uk) or go to our new website – <http://thepsychologist.bps.org.uk> – to comment at the bottom of this debate.

Each month, on the inside front cover of this publication, we state that *The Psychologist* 'provides a forum for communication, discussion and controversy among all members of the Society'. But does it?

Yes, we have our 'Letters' pages each month, and the occasional 'Opinion' piece (all collected on our new website at <http://thepsychologist.bps.org.uk/debates>). But the 'head to head' debate you have just read is our first for more than 12 years. And it's not for want of trying... during that time I have repeatedly invited psychologists and non-psychologists, members and non-members, to take each other on in print. People don't seem to like doing it, so credit to John and Vaughan for agreeing to this one.

However, readers have often asked me for more debate in the publication, arguing that the discipline moves on through the airing of genuine controversy in such a prestigious and prominent forum. So get in touch, or engage on Twitter @psychmag – let's have your suggestions for topics and participants.

Dr Jon Sutton (Managing Editor)