Journal of Psychiatry and Psychiatric Disorders

Volume 1, Issue 2 Research Article

Evaluating Some of the Approaches: Biomedical Versus Alternative Perspectives in Understanding Mental Health

Jonathan Beckett

Institute of Public Health, Social Work and Care, University of Wolverhampton, UK

***Corresponding Author:** Jonathan Beckett, Institute of Public Health, Social Work and Care, University of Wolverhampton, UK, E-mail: j.p.beckett@wlv.ac.uk

Received: 19 April 2017; **Accepted:** 2 May 2017; **Published:** 8 May 2017

Abstract

This paper evaluates the biomedical paradigm and approach towards understanding and 'treating' mental illness. In so doing it works towards evaluating the understanding posed by medical views and contrasts this to a psycho-social understanding of 'mental illness'; appreciating the individual within societal context and the range of factors impacting upon their lives.

Keywords: Mental illness; Psychopathology; Mental health; Social relationships.

1. Introduction

This question necessitates a critical analysis of the different approaches to mental health. In so doing this article reflects upon some of the tenets of understanding and practice in mental health and developmental psychopathology and argues for a holistic analysis of mental health and wellbeing – a psycho-social view of ‘mental ill health’.

Some individuals postulate that mental health problems are a medical phenomenon, and so the disease model can explain mental health problems [1]. Whereas, others dispute this, arguing that mental health problems are not caused by disease [2, 3]; instead arising from psychological problems. These two perspectives I shall critically synthesise.

The biomedical model proposes that just as disease causes physical illness, disease is thought to underlie mental health problems. This is based on an assumption that illnesses are caused by a specific disease [4]. There are a range of known biomedical explanations for the causation of mental health issues, including genetics; neurological problems, (for example damage to the brain or faults with neurotransmitters); or substance misuse [5]. Just as physical illness has signs and symptoms, so do mental health problems. For example, a person with depression may be affected by lowered mood and experience change in eating habits (eating more or less), alteration in sleep patterns (sleeping more or less) and so forth.

Because it is assumed that the cause of mental health problems is biomedical, treatments are based around medication, such as antidepressants such as Prozac [6]; and / or psychosurgery; a leucotomy [7]. Drug treatments for mental health problems have come to be seen as a universal remedy for many problems [8].

The biomedical model has aided the development of psychiatry [8]. However, it has been criticised on several fronts. One common complaint is that it results in the medicalisation of commonly experienced anomalous sensations [4]. For example, [8] gave, the example Rob highlighted in the final session - of social anxiety disorder, where the patient complains of marked and persistent fear of social or performance situations where they may experience embarrassment, is actually the ‘medicalising’ of shyness.

The alternative standpoint is that mental health problems are not caused by disease, but rather by psychological or environmental factors [3]; which takes in a vast range of possible causes, including personality Westen et al. [9] and stress [10]. A common critique of this approach has been its difficult to reach agreement on the definition of mental

disorder (or mental health problem), see for example, Szasz et al. [2] and Philips et al. [11]. Because of this failure, it then casts doubt on the reliability and validity of diagnosing a mental disorder [11]. For example, the 'test' to 'diagnose' depression is subjective, non-scientific, based upon the patient answering the doctor's questions of how often they have experienced a range of feelings, and to what severity, in the last fortnight PHQ [12]. This is likely to produce skewed results, as one aspect of depression, I saw whilst in a mental health crisis house, is that individuals are unable to effectively evaluate a situation, especially in relation to the subjectivity of feelings when suffering with severely low mood. Therefore, when a GP / the crisis referral team ask a patient to evaluate their mood, the results have a tendency to be flawed).

Moreover, the authors of the Diagnostic and Statistical Manual (DSM) for identifying mental health and the treatments thereof, are writing from loaded, subjective positions based upon humanistic ideas. For example, homosexuality was removed as an illness relatively recently (1985), the introduction of a range of strands of 'personality' disorders is an innovative entry. It would seem irregular to class homosexuality as an illness in today's society. However, until the 1980s this was how it was officially viewed by practitioners using the DSM as a guide to mental ill health. Equally, being told you have a 'disorder' of your 'personality', in whatever variant / domain has negative connotations.

When viewing conditions we ought to consider these matters within a framework of critical analysis. Copeland et al. [13] writing about the high prevalence of school exclusions, explains that the 'normalisation' of society has determined the aetiology of many innovative 'conditions' arising, such as operational defiant disorder, attention deficit (hyperactivity) disorder and so forth. Copeland's sentiments offer an insight into the potential for why we may have a range of conditions and treatments, which should be critically evaluated, as perhaps they are reactionary responses to the 'normalisation' of society?

By evaluating the psychological causes of mental health problems, this can enable a better understanding of the person's mental health problems in the context of his /her life circumstances; as well as a more holistic approach in the treatment of the person. For example, Laing et al. gave the example of a girl, diagnosed with schizophrenia, who complained she was a tennis ball. However, this apparent bizarre statement was more understandable when

analysing why she felt this - as a result of an experience of being abused in her childhood connected to gulleys and tennis balls. These sentiments are reiterated by recent research from a work conducted at Canterbury [14] in which voices appear to offer insight into the reason for the occurrence of the voice.

Therefore; it is important to understand the alternate perspectives in mental health for diagnosing and treating the mental health problems. Having a clear and correct understanding of the cause of the mental health problem enables the Social Worker to distinguish between whether there is a biomedical aetiology, which would necessitate psychiatric input; and whether the cause of the person's distress is due to an environmental factor, which might be malleable to Social Worker input.

Rather than being officious about the causes of mental health problems, some might argue that it is more important to treat people's distress. This practical approach might have initial benefit. However, this has the potential to miss an important point in the process of care. Depending on which is considered the cause of someone's mental health problems; this will determine how the mental health problem is diagnosed and then treated. As Wade and Halligan [4] have argued; how mental health problems are explained will impact on their organisation of care. Therefore I do not think it is needless to pontificate on the possible cause of a mental health problem. It is vital to consider and seek to rule out each possible type of cause to then diagnose and understand and where appropriate, 'treat' the whole person.

References

1. Engel GL. The need for a new medical model: a challenge for biomedicine. Science 196 (1977): 129-136.
2. Szasz T. The Myth of Mental Illness: Foundations of a Theory of Personal Conduct. New York: Harper and Row (1974).
3. Laing RD. The Divided Self: An Existential Study in Sanity and Madness. London (2010) Penguin Books.
4. Wade DT, Halligan PW. Do biomedical models of illness make for good healthcare systems? British Medical Journal 329 (2004): 1398.
5. Mrazek PJ, Haggerty RJ. Risk and protective factors for the onset of mental disorders. Washington (DC): (1994) National Academies Press.

6. Haby MM, Tonge B, Littlefield L, et al. Cost-effectiveness of cognitive behavioural therapy and selective serotonin reuptake inhibitors for major depression in children and adolescents. Australian and New Zealand Journal of Psychiatry 38 (2004): 579-591.
7. Heeramun-Aubeeluck A, Lu Z. Neurosurgery for mental disorders: a review: review. African Journal of Psychiatry 16 (2013): 177-181.
8. Double D. The limits of psychiatry. British Medical Journal 324 (2002): 900-904.
9. Westen D, Shedler J, Durrett C. Personality diagnoses in adolescence: DSM-IV axis II diagnoses and an empirically derived alternative. American Journal of Psychiatry 160 (2014): 952-966.
10. Cooper CL, Baglioni AJ. A structural model approach toward the development of a theory of the link between stress and mental health. In Cooper CL (2013). From Stress to Wellbeing Volume 1: The Theory and Research on Occupational Stress and Wellbeing, Palgrave Macmillan (2013).
11. Phillips J, Frances A, Cerullo M. The six most essential questions in psychiatric diagnosis: a pluralogue part 1: conceptual and definitional issues in psychiatric diagnosis. Philosophy Ethics Humanities Medicine 7 (2012): 1-29.
12. Patient Health Questionnaire (PHQ). Patient Trusted Medical Information and Support.
13. Copeland IC. The backward pupil over a cycle of a century, Leicestershire, Upfront (2002).
14. Payne TA. An investigation into the experience of hearing voices network groups. Thesis (2015): D.Clin.Psy, Canterbury Christ Church University.

This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC-BY) license 4.0