Can a biomedical approach to psychiatric practice be justified?

DBDouble

The modern explicit and intentional concern with psychiatric diagnosis contrasts with earlier views de-emphasising diagnosis in favour of understanding the life story of the individual patient. Psychiatric diagnosis became increasingly codified following the original paper by Feighner, et al (1972) and the introduction of the Research Diagnostic Criteria (Spitzer, et al, 1975), through editions of DSM-III, DSM-IIIR and DSM-IV (American Psychiatric Association, 1994). Symptom checklists and formal decision-making rules for diagnoses were produced. This operationalisation of diagnostic criteria was developed specifically to respond to criticisms of the basis of psychiatric classification. These criticisms included contentions that psychiatric diagnosis was unreliable, that diagnosis involved labelling of patients and that diagnosis was associated with the biomedical model of mental illness (Blashfield, 1984).

The attempt to make psychiatric diagnosis more reliable, combined with a return to a biomedical model of mental illness, has been called the "neo-Kraepelinian" approach (Klerman, 1978). This perspective promotes many of the ideas associated with the views of Emil Kraepelin, often considered to be the founder of modern psychiatry. It regards psychiatry as a scientific, medical speciality that clearly demarcates mentally ill patients, who require treatment, from normal people. The focus is on biological aspects of mental illness and an intentional concern with diagnosis and classification. Belittling of the value of psychiatric diagnosis is discouraged. The view that mental illness is a myth is emphatically opposed.

CRITICISMS OF BIOMEDICAL PSYCHIATRY

The views of Thomas Szasz

The most trenchant critic of psychiatry who has argued that mental illness is a myth is Thomas Szasz (www.szasz.com). Szasz makes clear that his regarding mental illness as an illusion does not deny the reality of the behaviours to which the term points. Nor does he forego the possibility that certain behaviours now called "mental illnesses" may at some time in the future qualify as medical diseases if neuropathological correlates are discovered. His argument arises out of his definition of illness as a physical lesion. The proposition that mental disorders are brain diseases therefore is a "big lie". As far as Szasz is concerned, mental dysfunction cannot be regarded as illness. To do so is a logical and semantic error.

Alongside this, Szasz acknowledges that belief in mental illness as a disease of the brain is a negation of the distinction between persons as social beings and bodies as physical objects. Here, he does have authoritative support within psychiatry from Adolf Meyer amongst others. Meyer was the foremost American psychiatrist at the beginning of the 20th century and his practice, which was called Psychobiology, emphasised the importance of understanding the patient as a person (Winters, 1951/2). For Meyer, as much as for Szasz, the supposed biological disease underlying psychologically mediated disturbance is a myth.

Meyer argued for mind-brain integration. He warned against going beyond statements about the person to wishful "neurologising tautology" about the brain. He would have agreed with Szasz's sentiment that there is something positively bizarre about the modern, reductionist denial of persons. At its most extreme, biomedical psychiatry reduces the person to a brain that needs its biology cured.

The justification for psychiatric interventions

Szasz goes on to argue that literalising the metaphor of mental illness by suggesting that it has a physical basis serves as the justification for psychiatric interventions and institutions. The biomedical hypothesis seems to function as an apology for psychiatric practice. It needs to be defended and promoted because it appears to provide the foundation for psychiatric intervention and treatment. To deny that mental illness is a physical disease may therefore be seen as dangerous as it seems to undermine orthodox practice.

Szasz rejects mainstream psychiatric practice because it promotes social control based on unproven claims for physical causes of mental illness. If these assertions cannot be established, then there is no justification for medical intervention. Ironically, biomedical psychiatry agrees with Szasz's position that the definition of mental disease implies physical pathology. Contrary to Szasz, it tends to believe the claims for the somatic hypothesis, even if at times it admits that the evidence is uncertain (Leff, 1991). This is why biomedical psychiatry feels so threatened by Szasz's critique.

This sense of threat may lead to attack as the best form of defence. The biomedical perspective tends to dominate other points of view in psychiatry. In a power struggle, the authority of the biomedical viewpoint needs to be ascendant.

As an illustration, in the Osheroff case, an argument was made for the right to effective treatment for depression with medication (Klerman, 1990). In this example, a patient, Dr Osheroff, sued the Chestnut Lodge for negligence. This renowned private hospital in Maryland specialises in intensive individual psychoanalytically-orientated psychotherapy. Osheroff's claim was based on the failure to administer what was regarded as appropriate antidepressant medication for his condition. The hospital's management policy was seen as being unreasonable in view of the apparent lack of research evidence for the effectiveness of psychotherapy.

The extent to which an attempt to establish a uniform scientific standard in psychiatry is the expression of individual opinion does need to be acknowledged (Stone, 1990). The inadequate scientific basis of psychiatry allows for widely varying interpretations and the inevitable clash of different opinions. The current authoritarian control of practice by biomedical psychiatry based on its alleged firmer foundation may need to be rebuffed.

The Critical Psychiatry Network

The Critical Psychiatry Network (www.criticalpsychiatry.co.uk) was formed in Bradford, UK, in January 1999. It is a small group of psychiatrists that provides a network to develop a critique of the current biomedical dominance of psychiatry. The limits and uncertainties of psychiatric practice are acknowledged (Double, 2002a). A new direction for mental health theory and practice is developed and promoted (Bracken & Thomas, 2001).

One way of viewing the position of the Critical Psychiatry Network is that it takes a neo-Meyerian approach to psychiatry. When Klerman (1978) enunciated the neo-Kraepelinian perspective, he expected a neo-Meyerian response. It seems to have been slow to be constituted. The reformulation of Meyer's ideas takes place in the context of the criticisms of psychiatry over recent years, including those of Szasz, commonly collected together as "anti-psychiatry".

Anti-psychiatry does not represent a set of homogeneous views (Double, 2002b). In particular, the hostility between R.D. Laing and Thomas Szasz is apparent. The essence of anti-psychiatry could be seen as deriving from the sense in which psychiatry itself is regarded as part of the problem by its objectifying of the mentally ill

(Jones, 1998). Anti-psychiatry ranges from the radical libertarian views of Szasz to the politically Marxist critique of David Cooper (1967). Not all "anti-psychiatrists" agree with Szasz that mental illness does not exist. Rather, they tend to take the view that it is a reaction to unbearable life stresses (Roth & Kroll, 1986).

Critical psychiatry wishes to avoid the polarisation of psychiatry and anti-psychiatry. Anti-psychiatry may have failed because some of its main proponents were ultimately more interested in personal and spiritual growth than changing psychiatry.

Reassertion of the biomedical model in the neo-Kraepelinian movement took place not only to replace Meyerian ideas, but also as part of the reaction to what were seen to be the far more threatening criticisms of anti-psychiatry. If Meyerian ideas are now restated they appear tainted with the unorthodoxy of anti-psychiatry. This may be why the synthesis of the neo-Meyerian approach has been slow to be formulated.

IMPLICATIONS FOR CHILD AND FAMILY STUDIES

Child and family studies have not been immune from the developments in biomedical psychiatry over recent years. In particular, where once it was the case that medication had a very limited role in child psychiatry, it now has an increasing role, even if still restricted in the context of family and behavioural therapies.

The data on methylphenidate as treatment for attention-deficit/hyperactivity disorder is now regarded as testimony to its benefits (Lord & Paissley, 2002). Clinical trials have shown the effectiveness of fluoxetine in children in the acute phase of non-psychotic major depressive disorder (Michael & Crowley, 2002) and obsessive-compulsive disorder (Geller, et al., 2001), whereas drug trials on older antidepressants were less convincing.

Neurological and biochemical explanations of childhood problems are widely accepted and popularised (Diller, 2001). The public is informed that many mental illnesses in children have a biological component that makes them susceptible to such disorders. Studies that purport to show that people suffering from depression have imbalances of chemicals, such as serotonin, in their brains are said to apply as much to children as adults. For example, the American Psychiatric Association's public information leaflet on childhood depression encourages the speculation that "An imbalance in serotonin may cause the sleep problems, irritability and anxiety characteristic of depression, while an imbalance of norepinephrine, which regulates alertness and arousal, may contribute to the fatigue and depressed mood of the illness" (American Psychiatric Association, 1998).

The hypothetical nature of these propositions needs to be reinforced. The implications for practice of taking the step of faith in believing the biomedical model needs to be acknowledged. Of course, in practice, many clinicians are aware of the dangers of reductionism and avoid the worst excesses of the biomedical approach.

Historically, child and family studies have tended to take a more holistic approach to personal and social problems. The speciality of child psychiatry has served as a haven and opportunity for those who wanted to escape the reductionism of their colleagues in adult psychiatry. It may be a pity that the discipline has now been so invaded by the biomedical model.

CONCLUSION

Child and family studies, as much as adult psychiatry, should be aware that psychiatric practice does not need to be justified by the somatic hypothesis. If it did, it would be in real trouble, and this of course is Szasz's contention. Meyer was fond of seeing his approach of Psychobiology as an advance over the mechanistic approaches of the 19th century. Maybe the Critical Psychiatry Network can help to promote and establish a

neo-Meyerian perspective in the post anti-psychiatric 21st century. To do this, it does need support from within child and family studies, which have always tended to take a more biopsychological approach in the mental health field.

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