Paradigm Shift in Psychiatry

D B Double

A recent statement from the American Psychiatric Association (APA) (2003) on the diagnosis and treatment of mental disorders maintained that schizophrenia and other mental disorders are serious neurobiological disorders. This unequivocal stance was made in response to a hunger strike by six survivors of the psychiatric system (Mind Freedom, 2004). The challenge of the hunger strikers was that the APA should provide evidence to show that major mental illnesses are "proven biological diseases of the brain" and that emotional distress results from "chemical imbalances" in the brain.

The APA supported its contention of the neurobiological nature of mental illness by claiming that (a) research has shown reproducible abnormalities of brain structure and function, (b) evidence for a strong genetic component of mental disorders is compelling, and (c) the mechanisms of action of effective medications have been elucidated. Each of these claims is controversial and the evidence for them can be questioned (Double, 2004).

Why does the position of the APA on mental disorders instigate an extreme reaction such as a hunger strike? This is what I want to look at in this chapter. My thesis is that mainstream psychiatry, represented by the APA, has become contingent on the biomedical model of mental illness. This approach is now so dominant that it seems that any challenge needs to be made by extravagant action.

Although the somatic model of mental illness may have always dominated psychiatric practice, there have been times when psychiatry has been more open to other possibilities. Previously the biological hypothesis would have been recognised as a hypothesis; now it tends to be regarded as fact. Such a consequence may be justified, as in the APA statement, by apparent scientific advances over recent years in the understanding of the neurobiological basis of mental illness. This progress is said to have occurred at the level of neurochemistry by demonstrating the basis of action of psychotropic medications, and at the level of structural and functional abnormalities by the development of brain scanning technology. But is this really the case? Has psychiatry advanced to such a state that the biomedical model is now impregnable?

I don't think so. Instead I want to argue that the controversy is about the most appropriate paradigm for psychiatry. To simplify I want to concentrate on what it might mean to shift from the current, dominant biomedical model to a biopsychological model. Simplification may be necessary when talking about change at the level of paradigm. Inevitably we are trying to distil patterns about the way we view psychiatry. In the real world, people do not always stick very closely to the described model, and there may be variations within one perspective without being totally clear about what constitutes the essence of the approach. Still, I think there is enough agreement about the nature of the biomedical and biopsychological models of mental illness for our discourse to be meaningful. I will use definitions that have clearly stated propositions.

The biopsychological model is not new. For example, it was promoted on the basis of systems theory when such thinking was favoured (Engel, 1977). In many ways, the best representative of the perspective was the Psychobiology of Adolf Meyer (1866-1950) (Winters, 1951/2). Meyer, an immigrant to the United States from Switzerland, had an important role in American psychiatry. He vies to be the foremost American psychiatrist of the first half of the 20th century. Although he lived in the United States for many years, Meyer had a rather convoluted style of communication in english. His ideas never really took hold as a systematic theory of psychiatry (O'Neill, 1980), and maybe for this reason they are now little known.

What I am suggesting is that Meyer's ideas should be better known. Of course, the biopsychological

approach has a set of assumptions, concepts, values and practices, as does the biomedical model. I want to look at these assumptions. I also want to look at the natural tendency to favour a biomedical perspective. I want to emphasise that the way we view the reality of mental illness does have ethical consequences.

My discussion will be set in the context of so-called "anti-psychiatry", a term used for a diverse set of critiques in the 1960s and 70s of the theoretical basis and practice of psychiatry (Tantam, 1991). In particular, I relate a previous shift of paradigm from a biopsychological to a biomedical perspective that occurred about 1970, perhaps particularly in the USA, to the reaction of orthodox psychiatry to the critique of anti-psychiatry. As I said previously, biomedical psychiatry has not always been quite so dominant. There was a retraction of the generally accepted view of psychiatry towards a biomedical bias following the critique of anti-psychiatry. If we can understand what led to this paradigm shift, we may be able to appreciate what needs to happen to reverse it and create a new synthesis.

The neo-Kraepelinian approach

I want to take what has been called the "neo-Kraepelinian" approach as the modern expression of the biomedical perspective. Klerman (1977) first enunciated the principles underlying this approach. There are nine propositions, not all entirely discrete from each other. I will briefly look at them each in turn:-

(i) *Psychiatry is a branch of medicine*

This is a clear statement about the relationship between psychiatry and the rest of medicine. In many ways, it arises because psychiatry wants to gain the respect of the rest of medicine, rather than be seen as a vague discipline with less authority. It also has implications for non-medical practitioners who are viewed as subsidiary to the appropriate psychiatric professional, ie. the medical doctor.

(ii) *Psychiatry should use modern scientific methods and base its practice on scientific knowledge*

Science is not defined in this statement. What is implied is natural science, in the sense of causal laws that have been enormously successful in producing technological advances. Placing an emphasis on this objectivity and progress is therefore understandable. Empirical, verifiable, reproducible knowledge is valued for its predictive abilities. The consequence is that "soft" sciences such as psychoanalysis are viewed as unscientific and unverifiable, although Freud himself regarding psychoanalysis as a deterministic science.

(iii) *Psychiatry treats people who are sick and need treatment for mental illness*

The claim here is that mental illness is like physical illness and people who suffer with mental illness need medical management. The implications for the role of people identified as sick are that they are exempted from responsibility and care needs to be taken of them (Parsons, 1952).

(iv) *A boundary exists between normal and sick people*

An absolute distinction between normality and mental illness is proposed. The implication is that mental illness is foreign to normal experience and therefore attempts to understand its psychogenic origins are discouraged or at least not given priority.

(v) *Mental illness is not a myth; there are many mental illnesses. It is the task of scientific psychiatry to investigate the causes, diagnosis, and treatment of these mental illnesses*

Mental illness is not regarded as a unitary concept in this statement. Discrete mental illnesses are said to be diagnosable with implications for how they are treated. The specific reference to mental illness not being a

myth is to counteract the polemic of Thomas Szasz (1972). Szasz regards the concept of mental illness as a category error, because, in his view, the word 'illness' can only be applied to physical disorder and the physical aetiology of so-called 'mental illness' has not been proven. In contrast, neo-Kraepelinianism accepts the somatic hypothesis and advocates more research to elucidate its basis.

(vi) *The focus of psychiatric physicians should be particularly on the biological aspects of mental illness*

We started the chapter with the APA claim that mental illnesses are neurobiological disorders. This claim follows directly from this neo-Kraepelinian proposition. The danger is that focusing too much on the brain as an organ overlooks the experience of the patient as a person.

(vii) *There should be an explicit and intentional concern with diagnosis and classification*

Modern psychiatry concentrates on classification systems such as the International Classification of Disease now in its 10th edition (ICD-10) (World Health Organisation, 1992) and the Diagnostic and Statistical Manual of the American Psychiatric Association (1994), now in its fourth edition (DSM-IV). From this perspective, the aim of clinical assessment is to identify "the" diagnosis. The problem is that a false impression of knowledge may be created by a single word diagnosis that reifies the complexity of people's problems.

(viii) *Diagnostic criteria should be codified, and a legitimate and valued area of research should be to validate such criteria by various techniques. Psychiatry departments in medical schools should teach these criteria and not belittle them, as has been the case for many years*.

Operational criteria of psychiatric disorders were introduced following the original paper by Feighner et al (1972). Symptom checklists and formal decision-making rules for diagnoses were produced. This trend was followed with the introduction of DSM-III. The aim was to improve the reliability of psychiatric criteria, so that they could be applied more consistently (Spitzer & Fleiss, 1974). The reference to belittling of criteria refers to the Meyerian approach to diagnosis, which saw the understanding of the person as more important than the convenience of a nomenclature.

(ix) *Statistical techniques should be used in research efforts directed at improving the reliability and validity of diagnosis and classification*

Inter-rater reliability can be measured and empirical support for proposed criteria can be obtained in field trials. The concordance of different diagnostic criteria and their coverage can be calculated (Blashfield, 1994). Careful analysis of the evidence presented in reliability studies may not be as much in favour of operational criteria as is commonly assumed (Kutchins & Kirk, 1997). Moreover, low reliability does not necessarily imply poor validity in all contexts, as overprecise definitions can be less valid (Carey & Gottesman 1978).

These nine propositions clearly define the neo-Kraepelinian position. It can be seen as the modern representative of biomedical psychiatry, set in the context of the development of DSM-III and IV. By way of contrast, I want to move on to define the biopsychological perspective.

Biopsychological approach

As previously mentioned, Adolf Meyer could be seen as the best representative of the biopsychological approach. The essence of his approach was his emphasis on the assessment of the person. Although mind is contingent on the brain, the central therapeutic concern should be the life story of the individual patient interacting with others in the context of society and culture. Although Meyer introduced Americans to

Kraepelin's classificatory system of specific disease entities, he later developed a unitary nosology in which he considered the various classical syndromes to be reaction types (the "ergasias", from the Greek *ergon*, meaning energy). He stressed the dynamic nature of psychiatric illness, and was opposed to the idea that a hypothetical underlying lesion should be postulated just because mental disorders may seem unintelligible.

The assumptions of the biopsychological model are listed by Wilson (1993). Again, I want to look briefly in turn at each of these propositions:-

(i) *The boundary between mentally well and mentally ill people is fluid because normal people can become ill if exposed to sufficiently severe trauma*

This proposition is in contrast to the neo-Kraepelinian position that there is an absolute differentiation between normality and mental illness. Instead the relative nature of the continuum between mental illness and normality is emphasised.

(ii) *Mental illness is conceived along a continuum of severity from neurosis through borderline conditions to psychosis*

Again, rather than viewing mental illnesses as discrete entities, as in the neo-Kraepelinian perspective, the emphasis is on the overlap between the various presentations of mental disorder.

(iii) *An untoward mixture of noxious environment and psychic conflict causes mental illness*

Psychosocial factors predominate in the understanding of the aetiology of functional mental illness. For example, Meyer (1906) explained schizophrenia (dementia praecox) as a maladaptation that could be understood in terms of the patient's life experiences. Although psychotic phenomena may seem "un-understandable" (Jaspers, 1963), efforts need to be made to make sense of such experiences. It is not necessary to postulate a brain abnormality merely because of the difficulty in elucidating the psychosocial context of mental illness.

(iv) *The mechanisms by which mental illness emerges in an individual are psychologically mediated*

The emphasis is on the understanding of human action rather than a reductive analysis of physical causes. A single-word diagnosis may not help much to explain the mechanism of mental illness.

Again, these propositions provide a clear definition of the biopsychological perspective. Having stated our definitions, I want to move on to a comparison of the foundations of the two approaches. I want to analyse why there tends to be a bias in favour of the biomedical rather than biopsychological model.

Comparison of the idea of mental illness from biopsychological and biomedical perspectives

The conceptual foundations of Meyer's Psychobiology are different from those of neo-Kraepelinianism. Essentially, the differences could be said to relate to how the two approaches attempt to answer two main philosophical issues (a) the mind-body problem and (b) the application of scientific method to the study of human nature. In looking at these two problems, which are not totally unrelated, I also want to look at some reasons why biomedical solutions may be favoured over the biopsychological.

(a) *The mind-body problem.*

The paradox of the mind-body split is exposed in the dichotomy between the subjectivity of mind and the causal laws of matter and motion. By contrast, Meyer argued for mind-brain integration, bringing the mind

and body together in his concept of Psychobiology. He wanted to avoid a dualistic solution, such as Cartesianism. In particular he wanted to move on from the 'doctrine of psychophysical parallelism', which views mental and physical events as occurring in parallel.

The biomedical model comes to a different solution and instead focuses on the brain as the cause of mental illness. Mind then tends to be seen as secondary or an epiphenomenon of physiological and other physical processes. The speculation is that abnormalities at a biological level will be demonstrated to explain mental illness. Although the hypothetical nature of the disease basis of mental illness may be acknowledged, there are clearly strong factors encouraging the step of faith in the hypothesis. The physical world is seen as objective and more substantial compared to the subjectivity and insubstantiality of mind. The factors favouring objectivity must be powerful as it could be said to leave us without knowledge of what really matters, which is meaningful existence in the world.

How does avoiding the personal dimension then help? Let us look at an example of the potential advantage. This element is related to the notion of responsibility and blame for mental disorder. A biomedical perspective, because it looks for the explanation in the brain, could be seen as avoiding such niceties. For instance, Anthony Clare (1997) has condemned the cultural critique of psychiatry by R.D. Laing. In Clare's words:-

> Many parents of sufferers from schizophrenia cannot forgive [Laing] … for adding the guilt of having 'caused' the illness in the first place to their strains and stresses of having to be the main providers of support.

This seems to be an overarching reason why Laing should be dismissed. It is actually a misunderstanding of his views. One only has to read *The Politics of Experience*, commonly regarded as the most 'radical' of Laing's books to find a clear quote that counters this perception:-

> [It is not] a matter of laying blame at anyone's door. The untenable position, the 'can't win' double-bind, the situation of checkmate, is by definition *not obvious* to the protagonists' (Laing 1967 p. 95) [his emphasis].

Laing is not talking about conscious motivation to cause harm. He took an interest in Sartre's concept of dialectical rationality and translated Sartre's work with David Cooper in the book *Reason and Violence* (Laing & Cooper, 1964). He would not have been so naive as to suggest that what he was proposing was a causal one-to-one connection between schizophrenia and the family. The unfortunate fact is that this misinterpretation of Laing has discouraged further study of the family context of mental illness. Nonetheless the myth is perpetuated that a biopsychological critique, such as Laing's, leads to unnecessary and unfair criticism of the influence of the family in the causation of schizophrenia. Focusing on the brain rather than family context seems to avoid this dilemma.

A more recent example of the same phenomenon, demonstrating the motivating factor of avoiding blame can be seen in the debate about the validity of attention-deficit/hyperactivity disorder (ADHD) in children. An international consensus statement (Barkley, 2002), essentially arguing that ADHD is not primarily the result of environmental factors, ends with the following sentence:-

> ADHD should be depicted … as a valid disorder having varied and substantial adverse impact on those who may suffer from it through no fault of their own or their parents and teachers.

In other words, the advantage of a neurobiological hypothesis of ADHD is that it creates a neutral physical disorder, taking us out of the realm of personal and social fault and blame for the disorder. I can understand

why people may want to avoid these difficult issues. Parents may do dreadful things to their children, not always consciously. Developmental factors are crucial in the behaviour of children. But can we really avoid looking at these reasons for human action?

As in the case of Laing, it is a mistake to suggest that cultural critics of the biomedical model of ADHD are primarily motivated by the wish to attribute blame. The biopsychological perspective is merely suggesting that consideration of personal, family and social factors is important. This analysis needs to be undertaken before moving on to think about blame and responsibility.

(b) *The importance of the scientific method*

The other aspect of the conceptual foundations of understanding mental illness that I want to consider is concerned with the role of science. Scientific abstractions about physical processes have been enormously successful. How mind becomes an object for scientific study is more open for debate. Biopsychological and biomedical perspectives take different views on this issue.

Meyer, as the representative of the biopsychological model, had a broad notion of science that included the study of the person. He took over the Huxleyan notion of science as being 'organised commonsense'. As far as he was concerned, science not only has a physical basis but also can be applied to mental life.

By contrast, biomedical psychiatry is positivist in the sense that the purpose of science is regarded as objective observation. Empirical sciences are the only source of true knowledge. Since the origins of modern psychiatric practice, the contention has been that all that is needed is more research to uncover the physical basis of mental illness.

What is it about the biomedical approach that gives it an advantage in this debate? After all, it is not clear how to decide *a priori* between the legitimacy of the biomedical and biopsychological models of mental illness. To obtain an answer to this question, we can look at criticisms of Meyer by biomedical psychiatrists. For example, Slater and Roth (1969) regarded the Meyerian approach as "almost entirely sterile". What they meant by this was that Meyer seemed to foreclose discussion at too vague a level. Meyer realised that attempting to understand mental disorder at the personal level did not necessarily provide dependable and effective data and that it could be "scoffed at" for this reason. Biomedical science seems to hold out the possibility of certainty and this factor does sway heavily in the debate.

For example, we can look at the views of John Haslam (1764-1844), apothecary at Bedlam during 1792-1815 (Scull et al, 1996). Using him as our example shows that the psychological pressures to believe in the biological hypothesis of mental illness are not new. For example, in his book *Considerations on the moral management of insane persons* (1817) he concluded that insanity is "a corporeal disease". The professional implications for him were clear, because it then made mental illness "the peculiar and exclusive province of the *medical* practitioner" (his emphasis). His motivation to reach this conclusion is disclosed another book *Observations on insanity* (1798):-

> [T]he various and discordant opinions, which have prevailed in this department of knowledge, have led me to disentangle myself as quickly as possible from the perplexity of metaphysical mazes.

In other words, he was taking a positivist perspective of mental illness. Metaphysical aspects of mind related to meaning are just too complex. Notwithstanding intuitive understanding of mental illness as a disorder of the mind, it is simpler to concentrate on its bodily substrate. Ironically, as he himself said, "[F]rom the limited nature of my powers, I have never been able to conceive . . . *a disease of the mind*." (again his emphasis). A

disease of the brain provides a firmer foundation than the woolly notion of psychological abnormality.

I can understand the craving for logical unity and simplicity. However, the reality is that human action is complex and ultimately unpredictable for individuals. Application of the scientific method to human behaviour may hold out the possibility of absolute conditions, but we may nonetheless continue to have to struggle with the relative nature and ethical dimension of our practice in psychiatry.

The social dimension of mental illness

The advantage of the biopsychological model is that it encourages an emphasis on context and therefore brings a social dimension to the understanding of mental illness. Before moving on to discuss the nature of the paradigm shift between biomedical and biopsychological perspectives, I want to make some comments about this social dimension.

Laing's views about the family, which we have already mentioned, clearly provide this perspective. *The politics of the family* (Laing, 1971) reinforced the importance of understanding people in social situations. Laing saw himself as a psychiatrist commonly being called into a social crisis defined as a medical emergency.

Laing gives examples of how situations need to be uncovered. Rather than constructing situations in terms of psychiatric "myths", an effort needs to be made to make sense of people's stories. For Laing, few psychiatrists are experts in sorting out these stories.

The implication for service users and their families is that the biopsychological approach avoids making too much of a single word biomedical diagnosis (Double, 2002). Their complex problems are not reified into an hypothesised biological abnormality. If no physical lesion is postulated, there is less emphasis on physical treatments, such as medication.

The social dimension is crucial, but it is important not to seek a total explanation in social terms for mental illness, which is essentially psychological rather than social dysfunction. As an example, I want to consider the notion of mental illness as social deviance. This is just one of a number of aspects of the social dimension of mental health and illness. Others include social structural issues, such as social class, poverty, oppression, social exclusion and injustice, which may be implicated in the sequences of events leading to mental health problems. Other research looks for explanatory associations with various psychosocial dimensions and life events. For example, the study by Brown and Harris (1978) into depression in women implicated vulnerability factors such having three children under the age of 14 years, not working outside the home, having no one to confide in and loss of one's mother by death or separation before the age of 11 years.

Labelling theory is a particularly influential social theory of mental illness. This theory is perhaps most closely associated with the name of Thomas Scheff. His classic 1966 textbook has been reissued and there have been significant mollifying differences in the argument from the first edition (Scheff, 1999).

The mentally ill person does not fit into society and can therefore be seen as deviant. The essential point of Scheff's theory is that the person perceived as mentally ill is the deviant for which society does *not* provide an explicit label. Of all the categories of norm violations, such as crime, perversion, drunkenness and bad manners, labelling someone as mentally ill is identified as *residual* rule-breaking.

Scheff's theory proposes that stereotyped imagery of mental disorder is learnt in early childhood and is continually reaffirmed, inadvertently, in ordinary social interaction and in the mass media. Labelled deviants may be rewarded by doctors and others for conforming to the idea of how a patient ought to behave when ill. They may be systematically blocked from returning to the non-deviant role once the label has been applied. Labelling is seen as an important cause of ongoing residual deviance. Labelling theory describes the process

of social control - it does not imply intentionality.

Scheff's theory is compatible with wider aspects of "anti-psychiatry", such as the study of families of schizophrenics by Laing & Esterson (1964). This research describes the disturbed and disturbing patterns of communication that lead to the labelled family member being elected to the role of "schizophrenic". For Laing as much as Scheff, the label is a social event and the social event a political act.

Anti-psychiatry, therefore, came to regard psychiatric practice as repressive in that it was seen as identifying and suppressing social dissent. For example, Laing (1967) was explicit that civilisation represses transcendence and so-called 'normality' is too often an abdication of our true potentialities.

Despite the implications of anti-psychiatry, social deviance cannot be the total definition of mental illness (Lewis, 1955). Other forms of deviance, such as criminality, exist in society. It is not always sufficiently appreciated that Scheff's theory could be seen as accommodating this point by proposing that mental illness is residual deviance ie. his theory acknowledges other forms of deviance.

The problem with labelling theory is that it could be seen as ignoring the individual dimension and, in this sense, overstating the social basis of the theory. Thomas Scheff came to realise that the approach of his original edition was too one dimensional, and did not sufficiently acknowledge the integration of individual and social factors. The theory also tends to avoid social structural issues, such as social class.

Mental illness is primarily a psychological concept, in that it points to abnormalities in psychological functioning (Farrell, 1979). Social deviance itself cannot be used as evidence, let alone sufficient evidence for diagnosing mental illness.

Even if a thoroughgoing sociological explanation of mental illness, in a Durkheimian sense, is unsuccessful, the social nature of psychiatric practice cannot be denied. Labelling theory does need to be taken seriously, as mental health practice is inevitably a form of social control. To be identified as mentally ill implies social maladjustment. Biological psychiatrists may play down any close tie between mental illness and social deviance because they wish to emphasise individual somatic abnormality. However, psychiatric intervention occurs in social context. The environment and milieu cannot be disregarded.

Psychiatry does have a cultural role and is directly related to social control through the Mental Health Act. Historically the practice of psychiatry arose in the asylum. Mental health practice needs to accept this social perspective and, therefore, explicitly place itself in its ethical context. It needs to define its role and responsibilities in relation to human rights, freedom and coercion. How we understand mental illness does make a difference.

Paradigm shift between biomedical and biopsychological perspectives

Let us summarise where we have got to in our account of paradigmatic understanding of mental illness. To simplify, we have concentrated on biomedical and biopsychological perspectives. We have looked at definitions of these two positions and the various propositions underlying them. We then discussed the conceptual foundations of the two approaches, not in an exhaustive way, but so that we can appreciate illustrations of how and why the biomedical perspective becomes favoured. We acknowledged that the social dimension cannot be ignored.

I now want to move on to look at the paradigmatic shift that occurred in mainstream psychiatry following the critique of anti-psychiatry. Finally, I want to put this change into the current context of psychiatric practice. We need to understand the barriers to any shift back to a biopsychological paradigm. Any hope of a shift in this direction may be unrealistic.

(a) *From biopsychological to biomedical*

In retrospect, the view that mental illnesses have primarily psychological causes could be regarded as a brief interlude in the history of psychiatry, covering no more than the period 1900-1970 (Roth & Kroll, 1986). Psychoanalysis was influential, as well as Meyerian psychobiology, particularly in the USA during this period. These forces became less prevalent as the biological model of mental illness reasserted its dominance following the development of modern psychopharmacology with the introduction of chlorpromazine, the first neuroleptic medication for schizophrenia. In the early years of psychopharmacology, much less than in current practice, there was controversy about whether psychoactive drugs were an advance in treatment.

Under Meyer's influence, American psychiatry came to have a distinctively pragmatic, instrumental and pluralistic approach. In the immediate post-war years, Karl Menninger's (1963) *The Vital Balance* represented a broadly conceived psychosocial theory of psychopathology. Menninger regarded Meyer's efforts, together with those of William Alanson White, as influential forces in producing a unitary concept of mental illness.

This apparent unanimity was broken by the late 1960s. Psychiatry came under intense attack on a number of different fronts. The anti-psychiatry movement, made up of an ideologically and politically diverse group of critics, ranging from the radical libertarian views of Thomas Szasz to the revolutionary critique of self and society by David Cooper, viewed psychiatry as an agent of social control. What these critiques have in common is the sense that psychiatry itself is part of the problem by its objectification of those diagnosed as mentally ill (Jones, 1998). Many became sceptical that psychiatry could diagnose and treat patients. The anti-authoritarian, popular, even romantic, appeal of anti-psychiatry produced an array of criticism of the use of psychiatric diagnosis, psychotropic medication, ECT treatment and involuntary hospitalisation.

The response from mainstream psychiatry was to attempt to make psychiatric diagnoses more reliable. From the 1950s there was increasing concern about the reliability of psychiatric diagnoses. Empirical studies of inter-clinician agreement reached disquieting conclusions about the consistency of psychiatric diagnosis. The inherent vagueness in category definitions due to the Meyerian approach was blamed. Although careful analysis of the evidence presented in these reliability studies may not be as negative as this conclusion may suggest, the commitment to increase diagnostic reliability became a goal in itself

This explicit and intentional concern with psychiatric diagnosis was developed following the original paper by Feighner, et al (1972). Diagnostic criteria were operationalised by constructing symptom checklists and formal decision-making rules. This trend was followed in the evolution of the Research Diagnostic Criteria (Spitzer, et al, 1975) and in work which started in 1974 on the revision of DSM-II, through editions of DSM-III, DSM-IIIR and DSM-IV (American Psychiatric Association, 1994).

Although DSM-III itself may not have been covertly committed to a biological perspective, the increasing evidence base for pharmacological treatment, as well as developments in genetics and brain scanning, led to the biomedical model being regarded as the only valid method of psychiatry (Guze, 1989). There had been a shift from a biopsychological to a biomedical perspective. This emphasis remains today, and can be seen, for example, in the statement from the American Psychiatric Association (2003) with which we started the chapter.

(b) *From biomedical to biopsychological?*

Is it possible to shift back from the hegemony of the biomedical model? A problem is that criticism of the biomedical model tends to be viewed as denial of the reality of mental illness. This may be a way of marginalising the impact of the criticism. Debate tends to become polarised. If there is to be a paradigmatic

shift back to a biopsychological model, somehow the message must be promulgated that questioning the biological basis of mental disorder does not necessarily amount to denial of the reality of mental illness or invalidation of the practice of psychiatry. We also need to move on from dismissing all criticism of the biomedical model as "anti-psychiatry".

In summary, the problem with the claim that mental disorders are biological diseases is that it creates the reductionist tendency to treat people as brains that need their lesions cured. Psychosocial factors in aetiology tend to be avoided. If biological and genetic factors determine psychopathology, the implication may be that personal and social efforts to improve one's state of mind may be pointless. Treating the biological abnormality and not the person, therefore, has ethical implications. To repeat, this critique is not meant to imply that bodily factors can or should be ignored.

Too much is invested in the biomedical model to expect this argument to produce much change. As we have discussed, the biomedical model tends to avoid the personal dimension. An advantage of this strategy is that it protects those trying to provide care from the pain experienced by those needing support. The temptation to retreat into objectification of those identified as mentally ill may be overwhelming.

Furthermore, the biomedical model tends to avoid the uncertainty of human action. Clear prescriptions for treatment may appear to simplify the response to mental suffering. Complexity and uncertainty may make mental health practice too difficult.

I have tended to concentrate on the psychological barriers to acceptance of the biopsychological paradigm. I don't really see these being overcome very easily. However, I would like to see more acceptance of a pluralistic approach to psychiatry. Biomedicine is not the only paradigm. An interpretative, biopsychological approach has as much consensus as the dominant biomedical model. This argument is conceptual. My main aim in this chapter has been to stimulate a professional debate about the ideological basis of psychiatry.

The point of the chapter has been to highlight biomedical bias in psychiatry, rather than provide a full critique. A more systematic analysis would have to cover more areas. For example, materialistic factors maintaining the biomedical perspective, such as the need to support academic research and defend pharmaceutical company profits, would require more space than this chapter allows me.

Nonetheless, however broadbrush my argument may have been, I hope I have highlighted the value and strength of a biopsychological perspective in psychiatry. Shift in the currently dominant, biomedical paradigm is necessary, however strong the barriers to change may be.

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