

## Mental Disorder, Diagnosis, Treatment and Ethics

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This short contribution questions the ethics of basing the way we think and act in relation to mental disorder on beliefs and assumptions that are in the view of the author at best, unhelpful and at worst, simply incorrect.

How is it possible to classify mental “disorder” when we have not yet classified mental “order”? It is generally recognised that there is no one “official” definition of “mental health” let alone a “classification”. Cultural differences, subjective assessments and competing professional theories all affect how “mental health” is defined. The World Health Organisation (WHO) defines mental health as “a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” (<http://www.who.int/mediacentre/factsheets/fs220/en/>).

Each human experience is unique, and whilst there are common elements between people’s experiences, each one of us manages our experiences differently. People who hear voices, whose experience may be classified as “psychotic”, do not all experience voices in the same way and many voice hearers are very able to manage their voices outside of the psychiatric system using a wide range of personal strategies (Bock, 1999). This highlights the fact that the experience of psychosis in the community is significantly greater than identified by people coming into contact with the psychiatric system (Van Os, 2000). Of course there are common elements and themes in the way people experience and/or respond to distress especially those from the same cultural, familial and genetic background. But that does not mean that each person’s experience can be treated in the same way. Each person needs to be treated as a unique being and within our cultural, familial and linguistic worlds.

In July 1990, George Bush Sr. signed the proclamation on the “Decade of the Brain” and significant expectations were raised that biological and genetic causes of “mental disorder” would be identified and solutions achieved. Completion of the human genome led to further expectations that genetic causes of these distressing and damaging disorders would lead to biological solutions. However, despite a decade and a half of investment and expectation, no biological or genetic solutions for mental disorder have materialised although potential advances have been made in relation to identified neurological disorders.

The above beliefs have led to an increasingly singular focus on biological forms of treatment in psychiatry and the development of a plethora of medications over the last 30 years. In the main, these are targeted and marketed by the pharmaceutical industry at specific diagnoses. If you look in any psychiatric journal, the majority of advertising is based around diagnosis. Some adverts even suggest that diagnosis is the key to selecting the most appropriate treatment, that is, of course, medication. Medication becomes equated with treatment. Yet there are arguments that the evidence for the effectiveness of some medications is not as strong as suggested by the industry. Healy (2002) judges that the evidence that the selective serotonin reuptake inhibitors (the SSRIs) and the “atypical” anti-psychotics are superior to older drugs is weak.

This author considers that a singular focus on medication, as the only treatment, is unethical. This is not an argument against the importance of diagnosis or medication, but simply the use of diagnosis to “select the most appropriate treatment (medication)” as a response to people’s distressing mental experiences. It is clear that people who are distressed and challenged by their mental experiences, more often than not, have had the most horrendous life experiences to which their “mental disorder” is a response (Read, 2005). In other words, what we call mental disorder is often the result of people’s inability to cope with “abnormal” life stressors, and if we accept the WHO definition of mental health, then these responses to distressing experiences could even be defined as mentally healthy.

It is considered that if we continue in this singular direction we will journey on around the same old pathologically classified plateau rather than seeing the beauty of the recovery and wellness focused hills and valleys. We should instead be trying to understand the lived experiences of people who can be diagnosed as “mentally ill” and learn about the experiences of people who have overcome their adversities (Journal of Social Issues, Summer 1998). In addition, the connections between mental disorders and artists, poets and other creative people is strong (Jamison, 1994) and it could be argued therefore that the differences provided by the experiences we call mental disorder actually contribute to the richness of our societies. So our thinking needs to change to a focus on people’s narratives and learning how the experience of “mental disorder” can contribute to our lives, our communities and society as is happening with the growing interest in recovery and Wellness Recovery Action Planning (WRAP). This is not just for how it can be used in personally managing mental disorder but many other aspects of people’s lives.

The RISK of not focussing on the richness of recovery and wellness is that we will condemn those diagnosed as mentally ill to a life of chronic illness when “The cause of chronicity, which has long been sought within the individual (biological or psychological characteristics) is not inherent in the illness itself, a part of the natural order, but rather is clearly connected with the person’s life in society” (Topor, 2001).

As John Read states:

“Surveys of public opinion all over the world find that most people believe that emotional problems, including those deemed severe, such as hearing voices, are primarily caused by bad things happening to us rather than by faulty brains or genes. The public also favours psycho-social approaches, such as talking to someone and getting advice, or help finding friends or a job, rather than drugs, electro-shocks or admission to psychiatric hospital.

Some experts, however, dismiss these views as “mental health illiteracy”. They continue to insist that mental illness is an illness like any other, despite many studies showing that the more we adopt this medical model, the more prejudiced and frightened we become.” (<http://www.project-syndicate.org/commentary/read1>)

So let us “add values” (Fulford, 2002) to our thinking in relation to diagnosis. Let us recover diagnostic classification so that it is used correctly/ethically as a common professional language that enables research and professional understanding of a wide range of human psychological experiences. Let us recover the pharmaceutical industry so that they recognise the uniqueness of each person and promote the control of medication being in the power of the recipient rather than promoting treatments based on diagnostic classification.

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