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THEORETICAL ARTICLE

The end of mental illness thinking?

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Abstract Mental health theory and practice are in a state of significant flux. This theoretical article places the position taken by the British Psychological Society Division of Clinical Psychology (DCP) in the context of current practice and seeks to critically examine some of the key factors that are driving these transformations. The impetus for a complete overhaul of existing thinking comes from the manifestly poor performance of mental health services in which those with serious mental health problems have reduced life expectancy. It advocates using the advances in our understanding of the psychological, social and physical mechanisms that underpin psychological wellbeing and mental distress, and rejecting the disease model of mental distress as part of an outdated paradigm. Innovative research in genetics, neuroscience, psychological and social theory provide the platform for changing the way we conceptualise, formulate and respond to psychological distress at both community and individual levels.

PALABRAS CLAVE
Diagnóstico;
Formulación;
DSM-5;
Bienestar;
Estudio teórico

¿El fin de pensar en enfermedad mental?

Resumen La teoría y la práctica de la salud mental se encuentran en un momento de cambios significativos. El objetivo de este artículo teórico es mostrar la posición adoptada por la *British Psychological Society Division of Clinical Psychology* (*DCP*) en el contexto de la práctica actual, tratando de analizar de forma crítica algunos de los factores clave que impulsan estos cambios. La necesidad de una revisión completa de los planteamientos actuales procede del mal funcionamiento de los servicios de salud mental en los que las personas con graves problemas de salud mental han reducido la esperanza de vida. Se aboga por el uso de los avances en los conocimientos de los mecanismos psicológicos, sociales y físicos que sustentan el bienestar psicológico y la angustia mental, rechazando el modelo de enfermedad de la ésta como parte de un paradigma obsoleto. Los avances de la investigación en genética, neurociencia,

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psicología y teoría social proporcionan la plataforma para cambiar la manera en que conceptualizamos, formulamos y respondemos al sufrimiento psicológico, tanto a nivel comunitario como individual.

There is a powerful movement in train, which is seeing old ideas in mental health being replaced as new scientific advances, including in epigenetics (Toyokawa, Uddin, Koenen, & Galea, 2012), neuroscience (for example in child development) (Riem et al., 2013) and psychological understanding of cognitive mechanisms underlying mental distress (Susan & Edward, 2011). Mental health is increasingly understood as a public health issue (World Health Organisation, 2010) and research on income inequality has clearly shown the link with expressions of mental distress (Wilkinson & Pickett, 2010). This paper addresses one aspect of this change, in which we advocate abandoning the outdated 'disease model' of mental distress and the development of new ways in which we can bring together all the elements of a person's experience in order to help them most effectively, and follows the publication by the Division of Clinical Psychology of the British Psychological Society on classification of behaviour (Awenat et al., 2013).

The United Kigdom context

Due to the impact of austerity on communities and services across the whole of the Unted Kingdom, mental health services are under severe stress and increased pressure. The governments programme of 'health service liberation' (Department of Health, 2010) has changed the way that services are funded. Power has shifted to doctors working in community settings and away from centralised decision-making. The people who use services have been put at the heart of policy making and every other part of the system is being told that there is to be ''no decision about me without me''. Budgets for social care have been dramatically reduced and mental health service funding has been curtailed. The traditional near monopoly of the National Health Service is being replaced by a much more mixed economy of providers. Many services are being put out to tender and are starting to be provided by Non-Governmental Organisations (NGO's) and private for profit companies. These changes have been highly problematic but also have resulted in significant challenges to historic patterns of practice and have brought forward new providers and new ways of working. The government agenda of 'Parity of Esteem' which is designed to increase equity of resources between mental and physical health care services has helpfully highlighted the very significant reduction in life expectancy for people very serious mental health difficulties (Royal College of Psychiatry, 2013).

There has been a consistent demand, by those who experience distress, for more psychologically based mental health care (Hicks et al., 2011). In England this has resulted in a new programme of psychologically driven care. More people are now seen in the improving access to psychological therapies programme (IAPT) than are seen in secondary mental health care (IAPT, 2012). This programme has in large part been lead by Clinical Psychology. The programme was initially for people with anxiety and depression in the community but has since developed a range of service redesign arms into the areas of psychosis, long term physical conditions, and mental health services for children and young people.

The service user and recovery movements have been gaining political strength and maturity (Centre for Mental Health, 2003). Peer recovery workers and recovery colleges are becoming commonplace. In the latter you do not need to take on the identity of a patient to receive support and guidance to manage whatever the issue that is causing concern and distress. The whole basis of expert professional practice and power is being questioned in new and challenging ways.

The Diagnostic and Statistical Manual version 5 (DSM-5) debate

The recent DCP contribution to the debate concerning DSM-5 (Awenat et al., 2013) has been to release a statement calling for a very different approach; one that does not deny the importance of biology and physical factors but which calls into question the extent to which disease based models have led us up a conceptual and practice blind alley. The introduction to the statement says. 'The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and the International Classification of Diseases (ICD), in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations, consequently there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system which is no longer based on a 'disease' model'.

The statement needs to be read in the context of the DCP good practice guidance on the use of psychological formulation (DCP, 2011). This guidance states that psychological formulation starts from the assumption that 'at some level it all makes sense'. From this perspective mood swings, hearing voices, having unusual beliefs can all be understood as psychological reactions to current and past life experiences and events. They can be rendered understandable in the context of an individual's particular life history and the personal meaning that they have constructed about it and