

“Mental illness is like any other medical illness”: a critical examination of the statement and its impact on patient care and society

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The nature of mental illness has been the subject of passionate discussion throughout history. In ancient Greece Plato,^{1,2} promoting a mentalist definition of mental illness, was the first to coin the term “mental health,” which was conceived as reason aided by temper and ruling over passion. At around the same time, Hippocrates,³ taking a more physicalist approach, defined different mental conditions as a variety of imbalances between different kinds of “humours.” Griesinger^{4,5} almost 2 centuries ago was the first to state that “mental illness is brain illness,” an expression that has provided a strong impetus to the more recent medical conception of mental illness. The substantial progress accomplished in genomics and brain imaging in the last few decades made biological psychiatry stronger than ever and contributed to the reification of mental disorders as illnesses of the brain. The almost exclusively biogenetic conceptual framework for understanding mental illness has acquired a hegemony that has influenced mental health practitioners while also influencing campaigns designed to improve public attitudes toward the mentally ill. As a result, the statement “mental illness is like any other illness” has become almost axiomatic and, therefore, by definition it embodies an accepted truth not in need of a proof.

This view of mental illness is presented for better acceptance of the mentally ill by the public and of treatment by those experiencing mental illness and is indeed based on accumulated, albeit limited, knowledge in the neurobiology of mental disorders. However, anything that reaches axiomatic proportions needs a serious examination. In this editorial we examine the reasons underlying this perspective, its consequences and the evidence to support or refute its continued justification. We then present a position that we believe best fits the current state of knowledge and is closest to clinical realities and public perceptions of mental illnesses.

What does the statement actually imply?

The statement that “mental illness is like any other medical illness” implies that mental illness has a biological basis just like other medical illnesses and should be treated in the public’s eye in a similar manner. The purpose of this article is not to present a philosophical or ideological argument in favour of or against a biological basis explaining mental illness, but rather to examine the clinical and public utility of presenting a dominant neurobiological model of mental illness to patients, their families and the public at large.

Illness, pathophysiology and the “self”

To understand the justification of equating mental and medical disorders, a comparison often made between type 2 diabetes and mental disorders, especially schizophrenia, other psychoses and depression, is worth examining in some detail. Diabetes, although very complex, is understood as the result of dysfunctional glucose metabolism related to absolute or relative insufficiency of insulin signalling. This dysfunctional metabolism is the consequence of endogenous predispositions, such as hereditary diathesis, and environmental factors, including personal choices, such as poor diet and sedentary life style. Therefore, by improving glucose metabolism, either through medication, insulin replacement or changes in lifestyle, positive health outcomes can be expected. Diabetes is diagnosed by confirming high levels of fasting glucose and other related biochemical markers of glucose metabolism. Further, the cascade of its effects on other systems (e.g., cardiovascular, central nervous system) are, or could be, well explained on the basis of physiologic mechanisms. They can also be prevented/treated by better and early control of diabetes. All through this, however, the patient

Editors’ note: The ideas expressed in this editorial are not necessarily those of the journal. Importantly, *JPN* continues to focus on publishing “papers at the intersection of psychiatry and neuroscience that advance our understanding of the neural mechanisms involved in the etiology and treatment of psychiatric disorders.”

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is aware of the nature of his or her problems, including personal choices, and diabetes generally does not affect his or her day-to-day thinking, behaviour or perception. Except for mental health complications due to neurologic illnesses (e.g., delirium in the context of severe metabolic complications, depression as a consequence of awareness of the life and death implication of the disorder, abnormal perceptions in the case of some neurologic conditions), it can be stated that somatic illnesses, such as diabetes do not usually alter the core self of a person substantially. More importantly, the model of attribution presented to the patient is congruent with the scientific “facts,” thereby making it easier for the person as well as society to accept the condition.

Mental disorders, on the other hand, affect the very core of one’s being through a range of experiences and phenomena of varying severity that alter the individual’s thinking, perception and consciousness about the self, others and the world. This is seen to an extreme degree with more serious mental disorders, such as psychoses and bipolar disorders, but to a lesser albeit significant degree with anxiety, mood, eating and other psychiatric disorders. Emotion, perception, thought and action are the essence of human identity and the concept of “self,” and these are the prime domains altered in mental disorders. The precise definition of what constitutes the self and whether the location of a state of self is a material reality in the brain, its form and the brain-related factors that influence it are deeply philosophical issues,^{6,7} but not the subject of this editorial. Suffice it to say that factors involved in increasing the risk for mental disorders are endogenous (genetics is recognized as a major contributor to most mental disorders) as well as environmental, much like most medical disorders. Psychological deprivation and trauma, social defeat and isolation, poverty and poor family environment are but some of the environmental factors that have been reported to increase the risk for mental disorders. In addition to changes at the physiologic level, common to somatic and mental disorders the latter encompass changes in one’s definition of “self,” and are not situated outside the “self.” It can even be argued that in the absence of any substantiated biological marker for mental disorders (only 1 has been included in the recent DSM-5: orexin change in narcolepsy),⁸ the hallmark defining features of mental disorders, at least for now, remain the changes in how the patients feel, think and act and how these changes affect their relation to themselves and to others.

As a first corollary of this definition, contrary to medical conditions where restoring dysfunctional physiologic mechanisms is the main target of therapeutic interventions, this is only 1 part of the therapeutic interventions for mental disorders. The primary focus of therapeutic interventions in mental disorders is helping the patient to feel better and interact more adaptively with his or her social and physical environments. Although there is little doubt that all medical conditions require psychological attention, mental health interventions focus primarily on achieving a positive change in feeling, self-esteem, mood, perceptions, thoughts and action — all changes in the “self” that are not primarily targeted in the treatment of medical conditions. Different models of psychological and social interventions are the main ingredients for these desired changes in the self.

A second corollary of this definition is the fact that mental health is very laden with values, not because scientific fac-

tors are lacking, but because values become of the utmost importance — more so than for medical disorders — when we deal with the self and its restoration. While somatic illnesses such as diabetes are primarily defined and shaped by biologically discernible facts, values do play a certain role but do not define the disorder. Societal and personal values are important in the treatment of most medical disorders, but acquire paramount importance in the case of mental disorders. Societal and cultural values even define variations in diagnoses over time and across geographic locations. Compulsory treatments, a particularity in the mental health field, are a strong testimony of how mental health can interfere with the self and how the personal values of the patient can clash with the societal values, thus necessitating legal, value-laden mitigation.

Neurobiology and experience of mental illness

Advances in neurosciences have surely given us much better biological mechanistic explanations of many of the uniquely human cognitive, emotional and conative functions, such as memory, thinking, perception, mood and action. This knowledge has informed us that many mental illnesses derive their vulnerability from underlying biological variations. However, we are far from being able to explain in neurobiological terms many of the behaviours and experiences that constitute the core presentations of mental disorders. Even if neurobiology one day were to provide better explanations of the workings of the brain, more elaborately explain the role of genes in increasing the risk for mental illness and the mechanisms behind complex human behaviour, one would still need to understand the experiences of patients with different forms of mental illness in psychological terms, as recently described by Kendler⁹ so eloquently. By equating mental illness with any medical illness and, therefore, situating it in an organ within the human biology and not recognizing its unique nature in the way it affects the “self” cannot be justified on the basis of current state of knowledge nor may it serve our patients and society well, as we explain in the rest of this editorial.

Mental illness and the utility of explanatory models

Indeed, it is envisaged that putting mental illness on the same footing as medical illness, society will understand it better and not react negatively toward those with mental illnesses. It is hoped that as a result those with mental illness may face less social stigma — a major obstacle to people seeking and/or receiving help — and reducing stigma may help individuals regain eventual acceptance by society as productive members. Interestingly, the public’s explanatory models of mental illness do not follow this narrative and, on the contrary, the public have multiple models of explaining mental illness varying across cultures and times.

One needs to ask the pragmatic question of whether the strategy of using a biogenetic model of mental illness and equating it with medical illness has actually helped. There are 2 areas worthy of examination in this regard.

Explanatory models, stigma and society

The first is to examine the effect of the statement, “mental illness is like any other medical illness,” on social stigma toward people with mental illness. As indicated previously, implicit in the axiomatic statement is a primarily biological origin of the behaviour and suffering that characterize mental illness. Let us examine the evidence in this regard. In the last decade or 2, biogenetic attribution of all mental disorders, having acquired a hegemonic status¹⁰ has been used primarily to inform campaigns for reducing stigma and promoting better acceptance of mental illness and the people with mental illnesses by society.^{11,12} Several well-conducted studies have concluded, almost uniformly, that this strategy has not only not worked, but also may have worsened public attitudes and behaviour toward those with mental illnesses. Investigations of stigma have shown that those who consider mental disorders as primarily attributable to biological forces, just like other medical disorders, while absolving the mentally ill person of responsibility for their behaviour and actions, tend to feel less optimistic about their ability to get better and function well, are less accepting of them and feel less positively toward them.^{13–16} In a review of the literature related to the concept of mental illness being like any other illness, Read and colleagues¹⁷ reported that biogenetic causal theories and diagnostic labelling as illness are both positively related to perceptions of dangerousness and unpredictability and to fear of and desire for social distance. The attitudes investigated in these studies are reflected in individuals’ responses to whether they would live next door to, socialize or make friends with or have a close relative get married to a person described as being mentally ill. There is also evidence to suggest that biogenetic explanatory models may have negative consequences for those with mental illness in terms of their implicit self concept and explicit attitudes, such as fear.¹⁸ Further, campaigns to reduce stigma that encourage people to think about mental illness as simply another form of medical illness have produced results that show effects to the contrary. For example, a recent study showed that over a 10-year period of deliberate use of the biogenetic explanatory model for campaigning to reduce stigma has resulted in worsening of most, if not all, aspects of public attitudes toward individuals with mental illnesses.^{19,20} The strength of these perhaps counterintuitive findings comes from the fact that these studies were adequately designed, well powered and, most importantly, replicated in several countries (e.g., United States, Britain, Germany) with very similar results. It is acknowledged that these relatively negative attitudes may be particularly stronger in relation to certain forms of mental illness (e.g., psychosis, manic depressive illness) and addictions.

Explanatory models of mental illness and the mentally ill person

Another domain — perhaps the most important — of examination is the individual with mental illness. In clinical practice, telling patients that their presenting mental illness is like any other medical illness may initially reassure some and assist them in accepting to take medication, especially during the distressing acute phases of a serious mental disorder. They or their families may welcome a simple explanation for encouraging them to ac-

cept treatment, which in many cases includes medication. While this strategy can achieve something very important in acute crisis-like situations, it may become problematic, if persistent over time, in getting individuals to accept other highly effective psychological and social treatments. These latter interventions are highly effective and considerably less noxious than often less effective medications for some forms of mental illness, such as mild to moderate depression, anxiety and eating disorders, and emotional dysregulation associated with several long-standing mental illnesses. Even in the most serious mental disorders, such as psychotic, bipolar and severe major depressive disorders, where medications are invariably an essential part of treatment, psychological and social therapeutic interventions are the essential bridge between pharmacological interventions during the acute crises and the need for their sustained use in the long term while at the same time achieving the essential goals of relief of internal distress, restoration of self and a return to productive social and working lives.

Furthermore, presenting mental illness as any other medical illness often implies a medical treatment (medication in most cases) as the dominant treatment strategy. Patients’ rejection of the treating clinician’s medical illness model is generally described as lack of insight and starts the cycle of nonadherence to medication, which then translates into nonadherence to treatment. In reality, if patients and families are allowed to articulate their attributional models, given credit for their “experiential knowledge” and encouraged to enter into a dialogue with the treating clinician, it is more likely there will be some consensus on acceptance of recommended treatment. This may prevent the cycle of disengagement and decline in the course that follows.

What needs to be done?

In clinical practice, if we are to take seriously the multidimensional goals of providing mental health services, as articulated by those seeking and receiving help for mental illness, clinicians have to work within an attributional model that makes sense to the person receiving service, that can be supported by sound argument and evidence and that provides a framework within which those receiving service and those providing it can share a common language. Such a framework will need to include the biogenetic model of attribution of mental illness as 1 of several parallel and equally authentic social, psychological, environmental and cultural models offered by service providers and researchers (acquired knowledge) as well as those who experience mental illness (experiential knowledge). There is a need to create a common language in order to come to an understanding of the person’s experience and to promote such an understanding among the public at large. Denying the special nature of mental illness is unlikely to achieve these important goals.

Some recent developments, such as the promotion of a recovery model^{21–23} and the early intervention movement,^{24,25} may hold more promise in improving both the quality of care and possibly involvement of and improvement in public attitudes. The former has emerged from experiential knowledge and advocacy from service users, supported later by sound qualitative research, whereas the latter has emerged from a combination of

a shift in philosophy of delivery of care on the part of service providers, parallel generation of evidence of its effectiveness^{26,27} and greater acceptance by service users and their families, who have now joined the movement as advocates. A third emerging movement, the concept of positive mental health,^{28,29} may prove to be effective in combating the negative image of mental illness. This movement promotes and is based on human resilience and positive aspects of the experience of mental illness. There is a burgeoning literature emerging in this field, which may balance the rather deterministic, deficit oriented and largely pessimistic miasma created by using an exclusively biogenetic model to explain mental disorders.

Conclusion and recommendations

Simply seeking an axiom of “mental illness is like any other medical illness” is at best simplifying a complex human problem and at worst doing a major disservice to patients, their families and the mental health field. Our dialogue should incorporate the general complexity of human thinking, behaviour, memories and the idea of self and consciousness, including knowledge emerging from sophisticated biogenetic and social science research while attending to the specific complexities that each of us as human beings carry as part of our life stories. That is true for those receiving and those providing services.

We therefore argue that we should continue to have a social and a professional conversation where we find a proper place for neurobiology, social, cultural and environmental forces, personal histories and the uniqueness of each individual when trying to understand, explain and treat mental disorders while avoiding a simplistic reductionism that may be perceived at best as patronizing but ultimately harmful, even though the intentions may be noble. We propose that future antistigma campaigns should give up the axiom of “mental illness is like any other medical illness” and instead present the complex and multifaceted explanations of mental illness as unique along with the positive aspects as discussed here. These campaigns need to be informed not only by the acquired knowledge of service providers and scientists but equally by the experiential knowledge from service users and their families, taking into consideration new knowledge emerging from fields of recovery, early intervention and positive mental health. For clinicians, it would be equally important to embrace explanatory models of mental illness that are based on evidence in science and to include biogenetic, social and cultural models as well as those told to them by the very people they are trying to serve.

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