The Limits of Biomedical Models of Distress

Lucy Johnstone

Psychiatric theory and practice is based upon a biomedical model – that is, an assumption that mental distress is best understood as a *medical illness*; a disease process which involves an alteration of biological structure and functioning. This fact is so obvious that it may seem as if it does not need stating. However, it is exactly this taken-for-granted status that makes it so important to draw out and examine the assumptions behind the model, which will otherwise remain implicit but will nevertheless shape every aspect of our approaches to those in distress.

This can be illustrated, at the most basic level, by our use of language. Language shapes the way we think, and hence the way we act. The vocabulary of psychiatry is ‘illness, patient, prognosis, remission, treatment’. Having conceptualised the problem in these terms, it seems to follow naturally that interventions should consist of ‘diagnosis, admission, medication, ECT’ in the context of ‘hospitals, clinics, wards’ and administered by ‘doctors, nurses’. With a different starting point – say, the assumption that we are dealing with ‘problems of living’ not ‘illnesses’ – all of the above would suddenly seem questionable rather than inevitable.

This, of course, is why critics of psychiatric practice, both professionals and service users, have developed an alternative vocabulary (Wallcraft, 2003). However, policy makers, the media, popular advice columns and many campaigning organisations are still using biomedical terms and concepts. The National Service Framework for Mental Health (Department of Health, 1998b) uses phrases such as ‘One adult in six suffers from one or other form of mental illness ... one person in 250 will have a psychotic illness such as schizophrenia or bipolar affective disorder ... many of these patients have not been getting the treatment and
care that they need ... assessment and diagnosis, treatment, rehabilitation' and so on. A drug company-sponsored information sheet says: 'Schizophrenia is a brain disorder with characteristic signs and symptoms probably due to physical and biochemical abnormalities in the brain' (Orion Pharma, 1995). The current move to evidence-based practice is based on an uncritical acceptance of terms such as 'schizophrenia' as a valid basis for conducting treatment trials. And there is no shortage of celebrities eager to talk about the 'biochemical imbalances' that have led to their depression, alcoholism, compulsive rituals and so on.

Of course, this is all perfectly valid if, in fact, the biomedical model of mental distress does seem to fit. But is it true? Or, to ask the same question in its currently fashionable form, is it evidence-based?

I would like to examine this question under three main headings; (1) psychiatric diagnosis, and claims about both the (2) biochemical and the (3) genetic factors in mental distress. First, though, I want to be clear what I am doing in this critique. I am not simply disputing certain facts or findings, although that is a part of it. Rather, I am challenging the whole paradigm on which the biomedical model is based. This paradigm can be characterised as positivist, reductionist and deterministic. These characteristics make biomedical psychiatry not only inappropriate for the study of human beings, but even in its own terms, bad science.

A shorthand summary of the positivist approach in science is treating people as if they were objects; the particular way of thinking that underpins traditional scientific enquiry in the natural sciences, in which theories, based on objective facts and observations, are tested in order to come to an ever more complete knowledge about the laws of nature. While this has been fruitful in many areas, its usefulness as applied to human emotional distress is much more debatable. (The classic essay by Ingleby, 1980b has a detailed discussion of the issues.) It is ironic that while much modern scientific thinking has moved well beyond this rather simplistic model (see, for example, Zohar, 1991; Capra, 1997), a particularly primitive version still holds sway in the field it is least suited to, psychiatry.

The positivist approach does not have to be reductionist, but nevertheless, biomedical psychiatry abounds with examples of what could be called the nothing but approach; the view that people are no more than the sum total of their biochemical or other physiological reactions. Complex phenomena are thus reduced to simple or simplistic terms. Professor Steven Rose, the eminent neuroscientist, has repeatedly challenged the idea that social and psychological phenomena can be reduced to such terms, and that this kind of explanation is somehow 'truer' than others (Rose 1998). We can look at any human experience,