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# Operational and Theoretical Issues in Mental Health. Time for Challenges?

**Gian Piero Turchi, Filippo Maria Sposini,  
Guido Pasquale and Michele Romanelli**

**SUMMARY:** This paper summarizes major critical issues in mental health disciplines with the aim to develop possible research directions within the scientific community.

**KEY WORDS:** Mental health, diagnosis and classification, models/theory of psychiatry, psychopharmacology, *DSM-5*.

Historically, mental health disciplines have been engaged in a precise project. The research goal was to build a coherent framework of knowledge assuming organic medicine as model (Bracken et al, 2012). This mission has led current mental health care to emulate the medical outlook considering certain human problems as pathologic. Although initially fruitful for research, in previous decades this approach has faced significant concerns. Recent literature clearly shows a number of critical cores that undermine the entire project. Current issues can be divided into two major groups. One can be referred as 'operational' concerns including diagnostic flaws, doubts on treatments' benefit and lack of significant research progress in previous decades. The other group covers much more profound theoretical issues such as the absence of a clear definition of mental disorder, difficulty to effectively differentiate between normality and pathology, and radical epistemological concerns.

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### Operational issues in mental health

*Diagnostic flaws.* The actual diagnosis in mental health follows the track of the revolution made by the *DSM-III* in the psychiatric field. This system proposed a temporary descriptive nosography based on symptomatological criteria waiting for the discovery of presumed organic causes underlying each disorder (McHugh & Slavney, 2012). The introduction of the *DSM-5* in 2013, three decades later, has spotlighted the limitations of the current approach. Despite the technological advancement in neurosciences, this knowledge could not be translated in clinical practice, leaving classification with no organic validity (Alda & Hajek, 2012). Just like thirty years ago, today's diagnosis relies on a descriptive and non-etiological approach where clinicians can only collect behaviours, call them symptoms and label them as illnesses (Linden, 2013). From *DSM-III* to the current edition, the number of mental disorders listed by the manuals has steadily increased. The tremendous effect of this diagnostic expansion is revealed by the NIMH report suggesting that 26 per cent of the US population meets the criteria for at least one disorder presented in the *DSM-5*. This result translates into an astonishing 57 million people that could be diagnosed (Batstra & Frances, 2012). It is very difficult to explain this abrupt increase of illnesses if not referring to a confusing and dubious reconsideration of criteria (Angell, 2011). In the absence of clear biological evidence, disorders can be grouped and regrouped continuously in a way that would be impossible and unthinkable in other areas of medicine. The uncertain framework makes everyday practice extremely fragile where the risk of misdiagnosis and overdiagnosis is always present and around the corner (Braithwaite, 2014). Furthermore, the DSM system aims to ensure at least some degree of reliability but it lacks validity. The fact that many clinicians agree in recognizing a group of symptoms, does not mean that there is an actual pathology occurring. In mental health diagnosis there is no gold standard to evaluate validity (Ghaemi, 2016). Not forgetting that a clinical judgement can have massive consequences in people's lives. Stigma associated to mental disorders is well documented in literature indicating how diagnostic labels have the potential to cause more harm than good (The Lancet, 2016). It is not surprising that there is an ongoing credibility crisis in psychiatry where its contribution remains in dispute (Katschnig, 2010; Rose, 2015).

*Benefit of treatments.* A clinical evaluation of mental disorder is usually followed by pharmacotherapy. The importance of this kind of treatment in other areas of medicine is doubtless. In mental health though, there is a consistent literature questioning the effectiveness of psychotropic drugs, adverse-effects and addiction-related problems. For example, in 2010 87 per cent of children diagnosed with ADHD in the US received pharmacological treatment. From 2000 to 2011 the

prescription of ADHD medication has steadily increased in UK, Australia and US but there is no conclusive evidence about the benefit to children (Thomas, Mitchell & Batstra, 2013). Animal studies strongly suggest that these drugs can produce brain damage which is probably the case of all psychotropic drugs (Gøtzsche, Young & Crace 2015). Regarding antipsychotics, there is no doubt about their dramatic effects like shaking, infertility, obesity, frail bones, increased risk of heart attack, diabetes, and stroke (Yawar, 2009). In this kind of scenario a responsible physician would have to consider alternatives but in the mental health environment, antipsychotic treatment still constitutes the main therapeutic strategy (The Lancet, 2011). The situation is even more complicated regarding antidepressants. These drugs are by far the most prescribed in mental health care but their actual effectiveness is questionable. In a meta-analysis of 100,000 patients half of whom were diagnosed with major depression, only 10 per cent of the patients might have benefited from the treatment (Overview for December 13 Meeting of Psychopharmacologic Drugs Advisory Committee, 2006). Furthermore, antidepressants are strongly associated with addiction, trapping people into what becomes a lifelong treatment (Leo & Lacasse, 2010; Gøtzsche, 2016). There is also a publication bias that amplifies the selective appearance of positive results trials altering the effect size of the drugs (Turner Matthews, Linardatos, Tell & Rosenthal, 2008). Given the modest or low benefit of ADHD drugs, antipsychotics and antidepressants, several psychiatrists are considering a decrease in prescribing almost all psychotropic drugs (Castelnuovo, Faccio, Turchi, Salvini & Molinari, 2008).

*Research idling.* It can be questioned if the last 30 years of research have brought any consistent advancement for patients and clinicians in mental health (Priebe, Burns & Craig 2013). Although technological resources like neuroimaging have become increasingly precise, mental health practitioners have not benefited from these methods (Linden, 2013). The leading research field of biological psychiatry has not yet produced any clinically viable biomarkers for major psychiatric syndromes. Investigation of underlying mental disorders frequently ends up with barely significant findings and the validity of results is often challenged (Alda & Hajek, 2012). The past three decades have produced no biomarker or etiology for diagnosis, no clear knowledge of mechanisms underlying biological treatments, no new antipsychotics, antidepressants or moods stabilizers (Priebe et al, 2013). This is a glaring sign of a problem. Why has the enormous volume of well-funded and high-quality psychiatric research produced so little? Maybe psychiatric diseases are very complex and hard to study or maybe, the chosen methods of investigation are inadequate (Saraga & Stiefel, 2011).

### Theoretical issues in mental health

*Definition of mental disorder.* A remarkable thing in mental health research is that the primary object of study remains undefined (Summerfield, 2013). The *DSM-5*, like its predecessors, does provide a definition but it is far from unequivocal. It describes disorder as a 'clinically significant disturbance' without specifying any available measure that should be used to evaluate significance (Kecmanovic, 2013). This definition presents practitioners with the task of determining when a clinical picture has to be considered relevant and how it can be precisely assessed. At the moment, the ascertainment of an indisputable clinically significant condition is difficult or even impossible (Maj, 2007).

*Normality and pathology.* Setting the boundaries to separate normal from disturbed conditions, appears an extremely confused operation in mental health (Batstra & Frances, 2012). We might ask: is there any conclusive evidence that indicates the normal length of sufferance, sadness, fear, anxiety or any other dimensions used in diagnostic criteria? At the moment, there is no clear idea of how to fix the threshold for the diagnosis of mental disorders (Maj, 2007). This is not only a statistical issue, it is firstly a theoretical one. Indeed, it is not clear to which terms a pathologic condition has to be ascribed. These problems increase when new editions of the nosography pretend to add new syndromes expanding mental health influence in ordinary life (Kleinman, 2012).

*Epistemological concerns.* Mental health practitioners have always been faced with a central question: can mental disorders be assessed in the same way as medical diseases? Today with the introduction of the RDoC project by the NIMH it seems that a reductionist answer will lead scientific research for the next decades (Cuthbert, 2014). In this position, mental disorders are ultimately to be considered as brain diseases. This basic assumption is far from uncritically accepted. Experts from the neuroscientific field have explicitly criticized this stand arguing that the straightforward axiom 'mental illness is like any other medical illness' represents at best a *naïve* conception, at worst a major disservice to patients and professionals (Malla, Joober & Garcia, 2015). If from the medical side, it is unquestionable to conceive the body according to anatomy, physiology and genetics, in mental health we still lack a profitable and univocal theoretical frame (Kendler, 2016).

### Conclusions

The points described give an idea of the state of art in mental health research. The operational issues encountered cannot be solved without consideration of the theoretical points suggested above. In mental health there is no definitive

agreement on how the mental domain is to be conceived. In this state of confusion there is no clarity about the foundation of diagnosis, organic treatments remain controversial and the entire research project shows fragmentation and uncertainty. By not addressing the inextricable epistemological problem the entire body of 'knowledge' rests on an unstable platform. It is of paramount importance to recognize and address this situation which compromises the quality of services and damages the entire scientific reputation with the only result that patients are not supported in the best way they deserve. There is an undeniable need for change that requires consideration of today's critical issues. Once informed by past errors, the future becomes clearer. Mental health disciplines are facing disputes, concerns and a major question: what future can we expect for the field?

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