



OPEN LETTER

Why it's time to stop saying "mental illness": A commentary on the revision of the Irish Mental Health Act [version 1; peer review: awaiting peer review]

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Abstract

The Irish Mental Health Act (2001) is undergoing revision. In 2014 an Expert Review Group recommended that the term currently used in the act "mental disorder", should be replaced with the term "mental illness". We argue that the proposed change, while well intentioned, contradicts the internationally adopted terminology of "mental disorder" used by the United Nations, World Health Organisation and European Commission. The term "mental illness" is atavistic, it implies an unsupported cause, it contravenes the United Nations Convention on the Rights of Persons with Disabilities (UNCPRD), and it is associated with concerns regarding stigma and reduced self-efficacy. Furthermore, the term "mental illness" is not used in any internationally accepted diagnostic or classification system in the mental health field. While any term used to describe mental health problems, may be contested, Ireland should not revert to using archaic terminology. In accordance with international best practice, and perhaps in lieu of a willingness to accept more progressive alternatives, Ireland should continue to use cause-neutral terminology, such as "mental disorder", in the revised Mental Health Act.

Keywords

mental illness, mental disorder, psychosocial disability, Mental Health Act, Ireland, UNCPRD

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In their classic work “Models for Mental Disorder”, psychiatrists [Tyrer & Steinberg \(1998\)](#) indicate that among the central tenets of the disease model are that “mental pathology is also accompanied by physical pathology” and that “the causes of physical and mental pathology in psychiatric illness are all explicable in terms of physical illness” (p. 10). They go on to state: “[a]lthough laboratory and other independent tests are not available to confirm the clinical findings...[t]he examination of the mental state is the mental equivalent of the physical examination” (p. 13). This remains the essence of the disease model from which the concept and term “mental illness” arises. In essence, the presence of a distressed mental state or *dis-ease*, is taken as evidence of the presence of a diseased physical state.

Just as in 1998, there are still no “laboratory tests or other biomarkers” to support the idea that mental health problems are disease-like states that express themselves through “illness” ([Bhugra et al., 2017](#); [Kapur et al., 2012](#)). This is not in any way to deny the legitimacy of the distress or the disruption to life that those with mental health problems suffer. It is perhaps surprising that no recognised biological marker of mental health problems exists given the extremes of human experience and behaviour that are apparent in conditions as varied as bipolar disorder, schizophrenia, obsessive compulsive disorder, or anxiety. Yet, repeatedly, and despite the attempts of many brilliant psychiatric researchers (e.g. see [Kendler & Schaffner, 2011](#)), no evidence for a neurobiological cause of mental health problems has yet been found ([Harrington, 2020](#)), and assumptions about psychotropic drugs as disease-specific interventions continue to be contested (e.g. [Götzsche, 2020](#); [Moncrieff, 2020](#)).

The importance of biological research

This is not to say that biological based research on mental health problems is without value, or prospects (e.g. [Mongan et al. 2021](#); [Strawbridge et al., 2017](#)); or that important discoveries are not to be found in such research (e.g. [Brückl et al., 2020](#)). However, until we find evidence to suggest otherwise, it seems reasonable to assume that the usual range of biological functioning is sufficient to produce a great variety of mental and behavioural experiences. We are definitely not suggesting that research should cease looking for biological causes or concomitants of mental health problems; nor that we should necessarily stop using psychotropic drugs, which can effectively suppress unwanted ‘symptoms’, experiences, or behaviours for many people with mental health problems.

Cause-neutral terminology

The language we use should not however imply and/or promise a causality where evidence for such a cause is absent. How language is used, its metaphors and allusions, influence how people understand their own experiences and the world

around them and how they are treated by others ([Bruffee, 1986](#); [Schultz, 2017](#); [White, 2018](#)). In such a contested, nascent field, it is surely judicious, respectful, humble, and honest to use *cause-neutral* terminology; that is, terminology which does not imply a physical cause, a psychological cause, a social cause, or any other cause; language that does not privilege one perspective over another. [Kendler \(2014\)](#), in arguing for the importance of clarifying causal processes in “psychiatric science” suggests that “[t]olerance for diversity and humility come with scientific maturity”. Indeed, the imposition of what [Kendler](#) calls “fervent monism” has been argued to unjustifiably diminish legitimate alternative perspectives ([Deacon, 2013](#)).

Implications of “illness”

At the same time, it is important to recognise that the linking of mental and physical illness is often well-meaning. For instance, such an attribution has the potential to reduce victim blaming/stigma or to increase help-seeking by reducing perceived personal responsibility for ‘symptoms’. Unfortunately, it seems that such an emphasis on illness has in fact been more linked with increased discrimination and reduced perceived personal control over one’s mental health ([Pescosolido et al., 2010](#); [Read et al., 2006](#)). An extensive empirical literature has examined the implications of holding biological illness explanations of mental disorders and the “mental illness is an illness like any other” approach to reducing stereotypes which has been described as an “unequivocal failure” in reducing stigma ([Deacon, 2013](#)). For instance, a review of anti-stigma initiatives in relation to schizophrenia concluded that “diagnostic labelling as ‘illness’, are both positively related to perceptions of dangerousness and unpredictability, and to fear and desire for social distance.” ([Read et al., 2006](#)). Another meta-analysis of 25 studies confirmed these trends ([Kvaale et al., 2013](#)). Experimental studies have found that presenting people with biogenetic illness explanations for mental disorder increased perceptions of dangerousness and decreased their perceived recovery prospects ([Bennett et al., 2008](#); [Walker & Read, 2002](#)). A meta-analysis examining trends in public attitudes towards “mental illness” found that biological models of mental disorders have been increasingly endorsed in recent decades, but that this has not been coupled with a reduction in social acceptance of those individuals with such disorders ([Schomerus et al., 2012](#)). Taken together these findings suggest that diagnostic labelling of mental health problems as “illness” is unlikely to reduce mental health stigma and may in fact result in the opposite.

Review of the Irish mental health act (2001)

[The Irish Mental Health Act \(2001\)](#) is in the process of revision and has received input from a range of stakeholders, including an Expert Review Group (ERG), which reported on its recommendations for revisions to the act in 2014. This group made many useful recommendations. However, the [ERG \(2014\)](#) also recommended that the existing term in use in the Act, “mental disorder”, should be replaced with the term, “mental illness”. Confusingly, the ERG suggests that the term ‘mental disorder’, “reflects a strongly medical model approach to mental illness” (p16). However, in attempting to diverge from the language of

the biomedical model, they have instead reinforced it through the use of ‘mental illness’ terminology; where “mental illness means a complex and changeable condition where the state of mind of a person affects the person’s thinking, perceiving, emotion or judgement and seriously impairs the mental function of the person to the extent that he or she requires treatment”. (p. 17). Compared to the existing [Mental Health Act \(2001\)](#) this definition is actually very similar: with “complex and changeable” added, and with reasons for treatment “in the interest of others” being dropped. Interestingly then, the proposed definition of “mental illness” does not refer to any biological process, which one might imagine is a pre-requisite for the use of “illness” terminology. So, even in its own terms, the proposed definition for the Irish Mental Health Act is not viable.

While the stated intention of the ERG to separate the “definition of mental illness from the criteria for detention” is welcome and appropriate, there is no reason why the same effect cannot be achieved by distinguishing between the definition of “mental disorder” and the criteria for detention. At the most fundamental level, the act is about “Mental Health”. The suggestion that the archaic phrase “mental illness” be used in place of “mental disorder” not only ignores current best practice but is atavistic by referring to a nomenclature that is less and less used, including in psychiatry. This retrograde step would make Ireland an outlier on the international landscape, while instead we should be aligning with best practice in international human rights and international public health. We now outline below just what that is.

United nations statements

In the 2019 recommendations of the *Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* ([United Nations Human Rights Council, 2019 A/HRC/RES/42/16](#)), Dainius Pūras (a Professor of Psychiatry) submitted in accordance with Human Rights Council resolutions 6/29 and 33/9 ([United Nations Human Rights Council, 2007](#); [United Nations Human Rights Council, 2016](#)):

[O]bstacles exist that impair the provision of mental health care and hinder the realization of the right to health ([United Nations Human Rights Council, 2017 A/HRC/35/21](#)). Such obstacles include the overuse of the biomedical model to define emotional distress and a medical hierarchy that can result in coercion that is detrimental and dehumanizing to patients, as well as providers of mental health. Power asymmetries between medical specialties, between doctors and other health-care workers, and between doctors and users of services, create additional barriers to the realization of the right to health (p. 18).

The Special Rapporteur argued that the use of terminology which privileges a medical model, in the absence of any evidence to support it, is inappropriate and that such a stance is contrary to the [UNCRPD \(2006\)](#). Ireland ratified the UNCRPD in 2018 and is now obliged to report to it. As the UNCRPD does not use biologically-orientated terminology, Ireland would be in contravention of the convention should it revert to using

“mental illness” as terminology in the revised Irish Mental Health Act.

The Annual report of the *United Nations High Commissioner for Human Rights*, 2017, specifically addressed the theme of mental health and human rights. The term “mental illness” is not used anywhere in the document; rather the phrases repeatedly used are “[u]sers of mental health services”, “persons with mental health conditions” and “persons with psychosocial disabilities”. For instance, it is stated that:

Mental health is not merely a health or medical concern, it is very much a matter of human rights, dignity and social justice. The overview of the challenges facing persons with mental health conditions and those with psychosocial disabilities indicates that fundamental changes are necessary in current approaches to the protection of their rights and how that protection is implemented in policy ([UNHCHR, 2017](#), p. 11).

The High Commissioner for Human Rights concludes:

Consequently, in meeting their obligation to achieve the full realization of the rights of persons with mental health conditions, users of mental health services and persons with psychosocial disabilities, States should align the policy and legal framework with human rights norms, develop and implement rights-based strategies and plans, and share technical expertise and other resources, such as good practice norms. (p.18).

If Ireland were to return to using “mental illness” within its Mental Health Act, it would be failing to align policy with prevailing human rights norms; such as the UNCRPD, the Statements of the High Commissioner for Human Rights, and the Statements of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ([United Nations Human Rights Council, 2019 A/HRC/RES/42/16](#)).

World health organization (WHO)

The World Health Assembly officially adopted the International Classification of Diseases 11th Revision (ICD-11) in 2019 ([World Health Organization, 2019](#)). This system of classification and diagnosis does not use the term “mental illness”. The “ICD is the foundation for the identification of health trends and statistics globally, and the international standard for reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes. ICD defines the universe of diseases, disorders, injuries and other related health conditions” ([World Health Organization, 2020](#)). The scope of the ICD is therefore very broad conceptually and has been developed to be used internationally, throughout the world. Indeed, from 2022, all countries will be required to report their health statistics using ICD terminology. The terminology used within the revised Mental Health Act should therefore be consistent with the terminology with which we will be required to report our mental health statistics. WHO uses the term ‘mental disorders’ and defines them thus:

Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse ([World Health Organization Mental Disorders, 2019](#)).

While not the same, this definition is very close to the proposed Irish definition of “mental illness”. The WHO definition of mental disorder was carefully crafted by an international expert committee specifically to move away from disease models due to a lack of supporting evidence for this approach. Importantly, the WHO position is not ideological or aligned to any professional discipline, rather it is based on the international evidence and deliberately does not privilege one causal model (e.g., disease) over any other causal model. As with all mental health classification systems, it is descriptive rather than explanatory.

WHO’s Mental Health Action Plan 2013–2020 ([World Health Organisation, 2013](#)) does not use the term “mental illness”. In different places, it variously uses the terms “mental disorder” or “mental health problem” or “psychosocial disability”. In fact, it repeatedly uses the phrase “people with mental disorders and psychosocial disabilities”. Its glossary of terms does not define “mental illness”. The current WHO Europe website on “Key Terms and Definitions in Mental Health” ([Euro WHO, 2021](#)) defines “mental disorders” but does not define “mental illness”. Historically, some have argued that the term “illness” should be retained for more severe problems. Severity and causality are, of course, distinct. WHO does not use the terms “illness” even for more severe conditions. For example, it defines schizophrenia as “[a] severe mental disorder, characterized by profound disruptions in thinking, affecting language, perception, and the sense of self”. It defines depression as “a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness and poor concentration”.

European commission

All European Commission (EC) documentation in this area uses “mental disorder” or “mental health problem” terminology. The Council of Europe in Parliamentary Assembly 2019 refers to “persons with mental health conditions or psychosocial disabilities” ([Council of Europe, 2019](#)). The EU Joint Action on Mental Health and Wellbeing seeks to “champion mental health as a European public health priority and to develop tools to support Member States in improving conditions for the prevention, diagnosis and care of mental disorders in their countries.” ([Caldas de Almeida, 2016](#)). No EC documentation uses “mental illness” terminology.

DSM

Traditionally, the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association had adopted a stronger

disease model orientation than the WHO equivalent (ICD). However, its most recent edition, the DSM-5, does not use the term “mental illness”, it does not define mental illness, and has explicitly been revised to use cause-neutral terminology. Thus, it is not possible to be “diagnosed”, or classified, as having a “mental illness” using either of the classification systems available to mental health professionals around the world.

Conclusion

In being critical of the term “mental illness” and suggesting retention of the term “mental disorder” in the revised Irish Mental Health Act, we are also aware that the latter term may also be contested; and that some experts-by-experience question the legitimacy of implying “disorder” in conditions that are often patterned – ordered – in recognisable ways. Beresford notes that “[t]erminology has become a battleground” ([Beresford, 2019](#); p. 35) on which different ontologies are paraded and contested. We therefore also appreciate that the terminology utilised within international human rights legislation is not necessarily universally accepted and can be argued to be culturally encapsulated ([MacLachlan, 2006](#)). We acknowledge that any linguistic and philosophical framing of human suffering - especially by those who have not experienced it - is likely to be problematic and contested. With that realization our intention is to urge Irish alignment with international progression in this field, rather than reversion to an outlying discourse.

The revised Mental Health Act could also consider using terms such as “mental health problems”, “mental health difficulties”, “mental health conditions” or “psychosocial disabilities” – all used to some extent in the international documents cited above. However, in lieu of a willingness to embrace these - perhaps more progressive terms - we should not be regressive. The term “mental disorder” has at least the benefit of not privileging one ontology over another. As Faulkner and Kalathil argue “[t]he definitions we work with are not just a matter of academic clarity, they are tied up with funding decisions and policy priorities” ([Faulkner & Kalathil, 2012](#); p.27). The revision of the [Mental Health Act \(2001\)](#) should reflect our policy priorities. Ireland should not replace the existing and internationally adopted terminology of “mental disorder” with terminology that: implies an unsupported cause; is atavistic; is associated with concerns regarding stigma and beliefs about personal coping efficacy; is contrary to the UNCRPD; and is not actually viable within any current mental health, psychiatric, or psychological diagnostic or classification system.

Data availability statement

No data are associated with this article

Author contributions

MM wrote the first draft and RM, MD and PH all contributed revisions and to the final draft.

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