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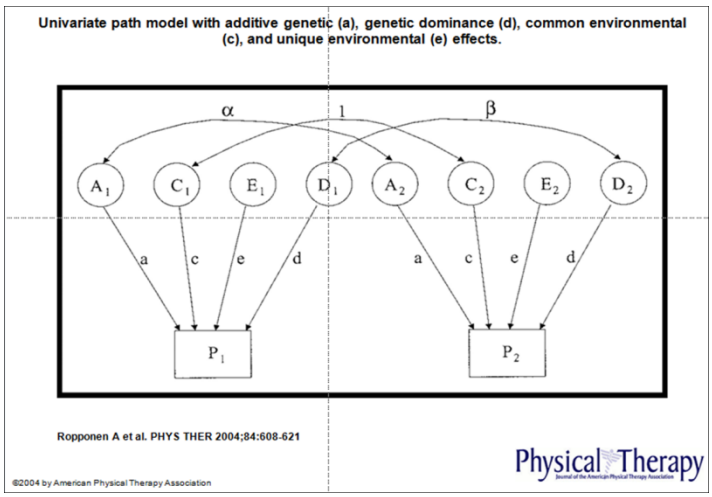
METHODS OF MODELING MENTAL ILLNESS

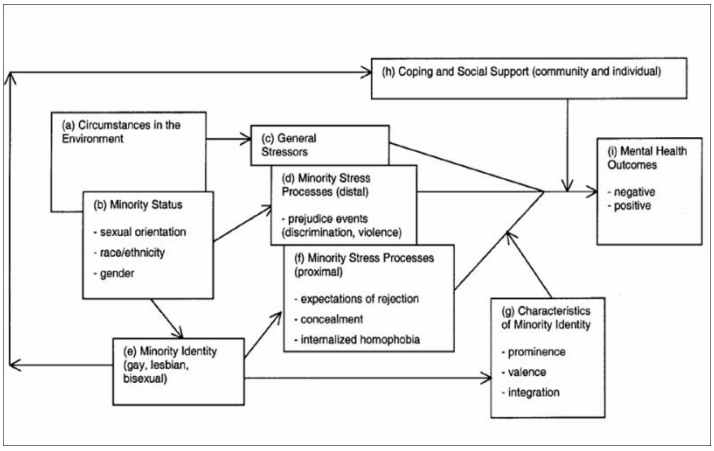
Medical-Biological Model

- seek to understand irregular behavior or reported symptoms through reference to the underlying biological processes occurring in the body of the individual displaying the malady
- point of treatment: fix the "abnormality"—the physical cause of the symptoms/condition



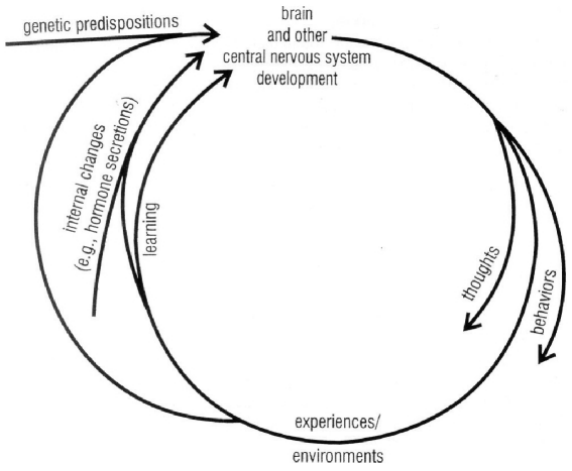
Social Construction Model

- seek to explain the behaviors associated with certain kinds of maladies by mapping the relationships between the social standards of normalcy and the reaction to oppressive enforcement of social norms in particular populations
- point of treatment: empower patients to reject unfair ideals, norms, or labels



Interactive Kind Model

- captures the dynamic interaction between internal (biological) and external (social) variables
- preferable because our environments, including societies and cultures, help shape our cognitive processes, which indirectly inform when and how our chemical and hormonal processes react to situations



WHAT IS PREMENSTRUAL DYSPHORIC DISORDER?

The American Psychiatric Association publishes the *Diagnostic and Statistical Manual of Mental Disorders*, which is an authoritative classification of mental disorders for those in the mental health profession and any doctor who can prescribe psychiatric medications. Premenstrual Dysphoric Disorder currently lies in the appendix "Criteria Sets and Axes Provided for Further Study"; it is also mentioned in the main text under Depressive Disorder Not Otherwise Specified, code 311.

According to the *DSM-IV-TR*, a woman has Premenstrual Dysphoric Disorder if, during the week prior to her period, she experiences at least five of the following symptoms, one of which must be (1), (2), (3), or (4):

1. marked anxiety, tension, feelings of being "keyed up," or "on edge"
2. markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts
3. marked affective lability (e.g., feelings suddenly sad or tearful or increased sensitivity to rejection)
4. persistent and marked anger or irritability or increased interpersonal conflicts
5. decreased interest in usual activities (e.g., work, school, friends, hobbies)
6. subjective sense of difficulty in concentrating
7. lethargy, easy fatigability, or marked lack of energy
8. marked change in appetite, overeating, or specific food cravings
9. hypersomnia or insomnia
10. a subjective sense of being overwhelmed or out of control
11. other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of "bloating," weight gain

The manual specifies that the symptoms must "interfere with work or school or with usual social activities and relationships with others" (*DSM-IV-TR* 774). The diagnostician must also make sure that the symptoms are not merely exacerbations of Major Depressive Disorder, Panic Disorder, Dysthymic Disorder, or a Personality Disorder; the clinician should determine whether the patient has a family history of any of these disorders. The manual claims that only 3-5% of women have PMDD.

SOCIAL POSITIONING IMPACT STATEMENT

Relevance: By thinking about categories of mental illness which target historically disadvantaged populations as interactive kinds, and how these interactive kinds give rise to compounded vulnerabilities, mental health professionals have a conceptual tool that can better evaluate how labels are not only reflective of the biological determinants, but also how the social determinants inform how to interpret biological factors. Compounded vulnerabilities arise when systemic or institutional conditions intersect in a manner that creates additional barriers to the agent's ability to develop or achieve wellness of being. Historically disadvantaged populations are particularly susceptible to being kept in disadvantaged positions when an institutional standard or condition plays into, reinforces, and perpetuates the stigma of the population stereotype. Understanding the function of labels and their corresponding categories as interactive kinds opens up the possibility of understanding how different kinds of vulnerabilities intersect.

Expected Results: From this shift in perspective, the mental health community, including the American Psychiatric Association (APA), general practitioners, and pharmaceutical companies, should consider the following as ways to **address and mitigate compounded vulnerabilities associated with categories of this kind**:

- Modify the presentation of mental disorders to ensure the population they pertain to are aware of the seriousness of receiving the label of a mental disorder. This includes modifying the perception of the treatment as a serious condition that can affect the individual in a variety of ways, including, potentially, one's legal standing in child custody and criminal cases (Solomon; E. Caplan), one's ability to make medical decisions for oneself (Ussher 268; Rodin 55), one's ability to have other medical conditions paid due attention (Thachuk 155), one's job and career opportunities (E. Caplan 51; Rodin 55), and one's standing in the social community (Jimenez 12). This last point—that one's standing in the social community could be compromised—relates to the concern that these categories compound vulnerabilities that the individual might already experience, given that he/she is a member of a group that is historically marginalized.

- Incorporate diagnostic tools, such as narrative-focused structured interviews, whose aim is to provide contextually rich details when patients present symptoms or seek treatment. Doing so will help to ensure proper diagnosis and identify intersecting social factors, such as abusive relationships, stressful working conditions, or past history of abuse. There are significant advantages to an open-ended format, since it encourages patients/subjects to a) provide fuller and nuanced details of their experiences, b) explain what the symptoms mean to them as individuals, c) make distinctions that are significant for understanding their condition, and d) communicate comfortably about the circumstances of their lives (Cumming et al.). Knowledge gained from these interactions will provide alternative or supplementary explanations for the cluster of symptoms, thus better ensuring long-term positive outcomes in treatment.

- Oversight and transparency standards should be implemented into the APA to attempt to better ensure proper and consistent diagnosis of categories pertaining to historically disadvantaged groups. These standards should entail higher standards of scrutiny. These categories require *greater evidentiary support* for their recognition as an official mental disorder. If the answer to the question "Is this category a distinct clinical entity?" is ambiguous or contentious among members of the APA or the general public, the default should be to either a) defer placement of the category in the *Diagnostic and Statistical Manual of Mental Disorders* until more scientifically robust evidence warrants its reconsideration by *DSM* committees *or* b) place the category in an appendix marked for further research and study. *If option (b) is chosen*, no diagnostic code should be given for the condition. When the *DSM* provides a diagnostic code to a category intended for further research, the category ends up being in a "limbo state" in which it can be diagnosed and treated just like any other category. This "limbo state" has potential for significant harm, however, when the category targets historically marginalized groups and reinforces stigmas levied against them. Moreover, additional diagnostic measures and supplemental patient information about the diagnosis and ways to mitigate susceptibility to harm from the diagnosis are important steps for taking seriously the possibility of compounded vulnerability.

- Consider category modification, which could include re-framing the category in such a way that it does not target historically marginalized groups *or* the full removal of the category from the *Diagnostic and Statistical Manual of Mental Disorders*. Modification should be considered for categories that meet any of the following criteria:*

    - either directly or indirectly target historically disadvantaged populations
    - the disorder itself plays into the historical stereotypes and prejudices against these groups, resulting in an additional layer of vulnerability and harm to the patient or population
    - when the label will clearly present barriers to a patient's or population's ability to develop or achieve well-being (e.g., unsupported challenges to one's legal competency, potential discrimination in employment opportunities, or present barriers to access to goods and services from other social institutions)
    - cannot clearly demonstrate biological indicators as the **only** trigger of disorder-related symptoms

*When more than one of these criteria is present, mental health professional have stacking reasons to consider category modification or removal.

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See our website on this topic: http://engage.bioethics.georgetown.edu/mentalillness