Is mental illness real?
You asked Google – here's the answer

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When people ask whether mental illness is real or not, my suspicion is that they really mean: does mental illness have a physical, material cause, in the same way as cancer or a broken leg? Can it be tested for, diagnosed and treated with the same certainty as a physical disease? Whatever the answer to that question, it should cast no doubts or aspersions on the very real suffering of people with mental health problems.

When we think of mental illness, we tend to think of categories such as schizophrenia, bipolar affective disorder, depression and anxiety. These categories cannot be verified with objective tests, in the way as, say, cancer or diabetes can. Neither do they tend to stand up to scientific scrutiny as distinct constructs. For people with a diagnosis of schizophrenia, there is no specific treatment or predictable outcome. To take another example, most people with a diagnosis of depression have symptoms of anxiety, and vice versa.

Framing problems as being part of distinct disorders is a powerful thing to do, and loads of the categories that reach our diagnostic bibles appear relatively new, historically. Many can be traced back to the pharmaceutical industry, which has a direct interest in shaping behaviours and emotions into various symptoms, to be sold back to consumers as disorders requiring medication. This has led people to argue that these categories do not represent real illnesses.

Such arguments can come across as diminishing the lived experience of mental anguish, its embodiment, and the potential role of medication. Some mental health problems are less contested than others, and medication does save lives. It would be cruel to suggest a grieving widow unable to cope could not benefit sometimes from anti-anxiety medication, or to deny an option of antipsychotics to quell the intrusive, menacing, persecutory experiences that can accompany an acute psychosis.

The problem, though, is that the efficacy of such treatments, and the mechanisms by which they work, tend to be oversold and presented as long-term solutions. We are right to be cautious about the overprescription of antidepressants, to take one example. These tend to be prescribed along with a scientifically dodgy idea that the pills are rejigging an imbalance in serotonin, a chemical messenger in the brain. Similarly, emerging evidence suggests that the long-term prescription of antipsychotics may actually hinder recovery for many.

Psychological and social factors are at least as significant and, for many, the main cause of suffering. Poverty, relative inequality, being subject to racism, sexism, displacement and a competitive culture all increase the likelihood of mental suffering –

as the survivor-led collective Recovery in the Bin brilliantly illuminates. Add into the mix individual experiences such as childhood sexual abuse, early separation, emotional neglect, chronic invalidation and bullying, and we get a clearer picture of why some people suffer more than others.

Crucially, all of these experiences affect our psychological and physiological makeup. For example, the Adverse Childhood Experiences studies show that childhood trauma, neglect and structural oppressions manifest later not just in mental distress but in chronically inflamed bodies stuck on hyper-alert (this we can pick up through blood tests).

Governments and pharmaceutical companies are not as interested in these results, throwing funding at studies looking at genetics and physical biomarkersas opposed to the environmental causes of distress. Sociologists argue that this is because citizens who consider themselves ill are easier to manage than people who consider themselves maddened by toxic families and injustice.

Mental health practitioners often try to sidestep this whole debate by claiming that most sensible professionals subscribe to a biopsychosocial model of mental distress. But unfortunately such a model nearly always ends up privileging the biological, despite the best intentions of many psychiatrists. As a society, we have a somewhat fetishistic relationship to bodies and brains, a moth-to-light-like attraction to shiny brain-imaging scans or a hint at a breakthrough in genetic research. Correlations between experiences and genetic phenotypes are conflated with evidence for molecular pathways that prove the existence of distinct disorders. Studies with only a few participants generate multiple headlines, and remain entrenched in the public imagination. At the same time, treatments that we know work fail to get funding due to the unconscious bias towards biological explanations.

Consider family interventions. Professionals have known for decades that reducing hostility, criticism and emotional over-involvement in families improves how well people recover from a number of serious mental health problems, regardless of how severe patients' symptoms are. Yet despite the robust evidence base – up there with medication and individual therapy – family work is rarely available through the NHS.

Similarly, there is little political will to combine increasing mental distress with structural inequalities, though the association is robust and many professionals think this would be the best way to tackle the current mental health epidemic. The idea that mental suffering is a "real" illness residing in individuals, and especially in their genes, can therefore be damaging.

It is also not necessarily what the public wants, despite the current emphasis on the "just like any other illness" narrative. When researchers ask people how they understand mental illness, they tend to prefer psychosocial explanations to medical ones. Simplistic biological explanations tend to increase stigma, not least because they

cement a division between ill and well people. Many people have felt silenced and traumatised by such accounts, feeling that the illness model shuts down their truth.

There is an implicit suggestion here that mental health problems have to be viewed as being equivalent to physical illnesses if they are to warrant society's care and funding. This may inadvertently cement prejudice, given the contested nature of mental illness. Mental health problems are no less real, no less disabling, for occupying a peculiar space between inner and outer, meaning-making and meltdown, the inner world and the environments that shape us.

Rather than clumsily trying to squeeze people's distress into different boxes, and attempting to convince the public that these reflect illness processes, as with flu or cancer, we must shift our focus to one that validates the lived experience of people who are suffering, however they choose to understand their pain.

Some will choose to conceptualise their distress as an illness, others as a result of trauma, others yet as an embodied response to the mixed messages that are rife in society about who and how we are supposed to be. Our guiding principle should not be whether such forms of accounting are true or false, but whether they are useful for any given individual at any given moment. Acceptance, after all – is the great friend of good mental health just as writing over one another's truth is the great enemy.

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