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THE MEDICAL MODEL IN PSYCHOPATHOLOGY

Psychotherapy and psychiatry have long been regarded as proper to the domain of medicine, both by their practitioners and by society at large. According to a statement issued by the American Psychiatric Association in 1958, "Psychotherapy is a form of medical treatment and does not form the basis of a separate profession." Noyes and Kolb define psychiatry as "*that branch of medicine* which deals with the genesis, dynamics, manifestations and treatment of such disordered and undesirable functionings of the personality as disturb either the subjective life of the individual or his relations with other persons or with society."[1] Implicit in such definitions is the belief that the approach used by physicians in treating and investigating physical illnesses can be used by psychologists and psychiatrists in treating and investigating mental disturbances. Like many other psychiatrists and psychologists,[2] we find this approach open to question.

[1] A. P. Noyes and L. C. Kolb, *Modern Clinical Psychiatry* (Philadelphia, 1958), p. 1.

[2] E.g. Thomas Szasz, *The Myth of Mental Illness* (New York, 1961), and J. B. Rotter, *Social Learning and Clinical Psychology* (Englewood Cliffs, 1954).

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I. SOME DIFFERENCES BETWEEN MEDICINE AND PSYCHOPATHOLOGY.

According to the most commonly accepted concept of disease, an illness can be differentiated into a series of discrete entities which are objectively distinguishable from the person in whom they are found. Each of these entities is said to possess specific etiological, prognostic, and therapeutic significance. A mental disorder is similarly regarded by many as a disease which can be differentiated into a series of discrete entities. The understanding of mental disturbances, however, requires thinking based on dynamic concepts which is not inherent in these "Aristotelian" formulations.[3] When a person suffering from coughing spells is said to have tuberculosis, we know at least that he is suffering from a certain disease caused by a given bacteria. We know further that he is suffering from a disease with a determinable etiology, prognosis, and therapy. On the other hand, when we say that a person who is afraid of closed spaces is suffering from claustrophobia, we are communicating nothing about the nature of the cure of his ailment; we have only given the malady a name. It is not surprising, then, to learn that many studies have shown the labels used as psychiatric categories to have little value in determining the etiology, prognosis, or therapy of a putative mental illness. Numerous studies have found that the diagnostic categories used by psychiatrists not only have a very low reliability but also have little relationship to the way in which the patient is treated.[4]

Although there have been many attempts to establish objective criteria for mental health and illness,[5] the tendency to label

[3] K. Lewin, *A Dynamic Theory of Personality* (New York, 1935), pp. 1-42.

[4] P. Ash, "The Reliability of Psychiatric Diagnosis," *J. Abnorm. Soc. Psychol., 44* (1949), 272-277; B. Mehlman, "The Reliability of Psychiatric Diagnosis," *J. Abnorm. Soc. Psychol., 47* (1952), 577-578; M. Schmidt and C. Fonda, "The Reliability of Psychiatric Diagnosis: A New Look," *J. Abnorm. Soc. Psychol., 52* (1956), 262-267; E. Zigler and L. Phillips, "Psychiatric Diagnosis and Symptomatology," *J. Abnorm. Soc. Psychol., 63* (1961), 69-75.

[5] J. W. Eaton, "The Assessment of Mental Health," *Amer. J. Psychiat., 108* (Aug. 1951), 81-89; B. Wootton, *Social Science and Social Pathology* (London, 1959); M. Jahoda, *Current Concepts of Mental Health* (New York, 1958).

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deviant, disagreeable, or seemingly unmotivated behavior as "sick" persists everywhere. "The evaluation of behavior as sick, or normal, or extraordinary in a positive sense," as Jahoda asserts, "depends largely on social convention."[6] In New York State, to take an extreme example, a man was kept in the Hospital for the Criminally Insane for four years because he insisted that his wife's love had been won by another man who had drawn blood from the husband's arm and had drunk it in beer to prove his vigor. Over the years, eleven psychiatrists testified to the man's insanity; the story seemed too fantastic to be true. Only the perseverance of the man's lawyer in gathering evidence to verify his client's claim led to the man's release years later.[7]

Moreover, labeling behavior as sick or healthy is largely "political," in the sense that it expresses the special interest of one particular faction or person.[8] In Russia, for example, Crankshaw reports that "rebel" authors are commonly disposed of by commitment to insane asylums.[9] In Israel, the prosecution repeatedly referred to Eichmann as a "perverted sadist," while in the United States, liberals not infrequently refer to the extreme right wing as "the lunatic fringe."

Designating behaviors or attitudes that are very different from our own as "sick" or "crazy" relieves us of the necessity of trying to understand that behavior. In applying the label "sick" we separate ourselves from the affected person as though he were no longer a member of the human race. We assume, mistakenly, that we could never behave similarly. As Hannah Arendt points out, however, "the trouble with Eichmann was precisely that there were so many like him and that many were neither perverted nor sadistic but were, and still are, terrifyingly

[6] M. Jahoda, "Toward a Social Psychology of Mental Health," *Mental Health and Mental Disorder*, ed. A. M. Rose (New York, 1955), p. 559.

[7] M. Phillips, "4-Year Inmate Proves Tale, Is Freed from Asylum," *New York Times*, Sept. 28, 1962, p. 18.

[8] E. Goffman, *Asylums* (Garden City, 1960), p. 363.

[9] E. Crankshaw, "Another Russian 'Rebel' Author Put in Asylum," *Observer*, Feb. 17, 1963, p. 9.

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normal."[10] The extent to which such psychiatric labels are limited in their usefulness is shown further in a study of collaborators among the American prisoners of war in Korea.[11] According to these findings, there were many psychopathic personalities among the group that resisted collaboration best. The conclusions of both Arendt and Schein suggest that what is deemed an undesirable or "sick" personality type in one situation can be deemed a commendable or "normal" personality type in another. We are led to conclude, then, that in psychopathology there are no objective or non-cultural standards for judging behavior, but that the designated pathological behavior is always a joint function of an individual and specific environment in which he lives.

As much as the very nature of a mental ailment differs from that of a physical illness, so does the mode of diagnosis of the one differ from that of the other. In the diagnosis of a physical disease, the symptom of source of discomfort can generally be observed by empirical means independent of the behavior of the patient. Treatment of the disease can proceed on the basis of these observations. In the diagnosis of a mental disturbance, on the other hand, the only symptom is "abnormal" behavior. There is no objective or empirical evidence that can be invoked. The basis for the diagnosis is strictly the appropriateness or inappropriateness of the behavior according to an evaluation of the actor's motives, and the prevailing norms of the society in which he lives.

In treatment, the active participation of the patient is far more crucial in psychotherapy than in medical treatment. Where psychotherapy is unsuccessful, the competence of the therapist or the accuracy of his diagnosis is rarely questioned. The failure is attributed rather to the patient's "resistance" to therapy.

The role of the psychiatrist in psychotherapy is also very different from that of the physician in medical therapy. In a case of organic illness, such as tuberculosis, a patient could expect

10 H. Arendt, "Judgment in Jerusalem," *New Yorker*, March 16, 1963, p. 132.

11 E. H. Schein, W. F. Hill, H. L. Williams and A. Lublin, "Distinguishing Characteristics of Collaborators and Resisters in American Prisoners of War," *J. Abnorm. Soc. Psychol.*, 55 (1957).

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similar diagnosis, treatment and therapeutic goals from all physicians of equal competence, regardless of their differences in personality, values, or attitudes. In psychiatric treatment, however, the values and attitudes of the therapist together with the expectations of the patient are of primary importance, since it is often the therapist who designates a given action as "sick" or "healthy," prescribes the type of treatment, and determines the goals of therapy. One study found a positive relationship between the therapist's socio-economic background and his evaluation of certain hypothetical actions as indicative of mental health or mental illness.[12] Another study found a significant correlation between the therapist's attitude toward the patient and the form, frequency, and length of treatment.[13] Still another study has shown that some Rorschach responses of patients changed in the direction of the response of the therapist during the course of treatment.[14]

Even the social definition of the role of the psychiatrist differs from that of the physician. In medical treatment, the physician always acts as an agent of the patient; i.e., he always acts in accordance with the wishes of the patient even if he had strong moral or professional reservations about the patient's decisions. In commencing psychiatric treatment, on the other hand, the patient is asked to give over to the therapist part, if not all, of the responsibility for making decisions. The psychiatrist then is likely to act independently of the wishes of the patient and often contrary to them. This is especially true of psychiatrists treating inmates of prisons and mental hospitals. Here, in performing a custodial function, the psychiatrists are, therefore, working as agents of society and not of the patients themselves.

An added difficulty in psychotherapy is that there are no definite standards of cure as there are in medicine. In traditional

[12] M. Spohn, "The Influence of Social Values on the Clinical Judgments of Psychotherapists," *Festschrift for Gardner Murphy*, eds. J. G. Peatman and E. L. Hartley (New York, 1960).

[13] H. H. Strupp, "The Psychotherapist's Contribution to the Treatment Process," *Behav. Sci.*, *3* (1958), 34-67.

[14] S. R. Graham, "The Influence of the Therapist's Character Structure upon Rorschach Changes in the Course of Psychotherapy," *Amer. Psychologist*, *15* (1960), 415.

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medicine, the cure is usually defined as the disappearance or the arrest of symptoms. The stated goals of psychotherapy, on the other hand, range from a vague "capacity to work" to an even more vague "capacity to enjoy life."[15] Psychologists sometimes stress the existence of a common element in all forms of treatment: "They all aim at increased individual effectiveness and the good life."[16] Definitions of "the good life" are widely varied, however, and "increased effectiveness" can be spoken of only in terms of a specific social context. Behavior which is considered "effective" in one environment can conceivably be considered detrimental in another. For example, a Jew in Nazi Germany of 1933 who was generally distrustful of Gentiles and who took steps to protect himself against them would then be considered prudent. A Jew in the United States today who was similarly distrustful of all Gentiles would be considered "paranoid" for acting on his suspicions.

In pointing out that the therapeutic process is overlaid with value judgments, we do not mean to belittle the worth of psychotherapy. We mean, rather, to indicate—to therapists as well as to the public—that the values upon which psychotherapy is based are more disputable and more and more subjective than the values upon which the practice of medicine is based.

II. SOME EFFECTS OF IDENTIFYING PSYCHOTHERAPY WITH MEDICINE

The medical approach to psychopathology has not been entirely without value. Most important of its benefits has been the humanizing influence it has brought to bear on the treatment of social deviants. In earlier times the mentally afflicted were persecuted and mistreated. People would visit insane asylums for entertainment, much as we today visit zoos. Even in the "enlightened" eighteenth century, the mentally afflicted were not distinguished from the criminal. No differentiation was made

[15] V. Frankl, *From Death Camp to Existentialism* (Boston 1959), p. 105.

[16] G. Allport, "Personality: Normal and Abnormal," *The Sociological Rev.*, 6 (1958), 178.

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between prisons and mental hospitals. As the medical profession gradually assumed responsibility for the treatment of the insane, their treatment came to be tempered with kindness and understanding.

Psychopathology has benefited, too, from the high prestige of the medical profession. Much needed funds for research and large numbers of practitioners have been attracted to psychopathology on the basis of its connection with the medical profession. There is some speculation, moreover, that the high prestige of the practice of medicine has a positive effect on the therapeutic process itself. That is to say, since psychotherapy is basically considered an influence process wherein the expectations of the afflicted are of crucial importance, it is supposed that the process is aided by the connection of the psychiatrist with the highly regarded medical profession. There have, however, been no studies to indicate that psychiatrists are more effective practitioners than other therapists with comparable therapeutic training and experience.

The handicaps to the study of psychopathology which have resulted from the medical approach are greater in number and importance than the benefits. Research into the nature of mental afflictions has suffered unduly. In trying to adhere to the basic assumptions of traditional medicine, researchers in psychopathology have been trying to discover the nature of the specific physiological factors that appear to be related to "abnormal" behavioral symptoms. Despite the recent advances in psychosocial explanations of mental disorders, many researchers hold fast to organic interpretations of mental disturbances. Although this approach may be valid for traditional medical research, it is not valid for psychopathological research. We agree with Maher that it would be more fruitful to ask *whether* a given behavior is organic in origin, instead of *what* are the organic origins of a given behavior.[17]

Research in psychopathology has also been hindered by its ambiguous structural relationship both to the social sciences and to medicine. Neither social scientists nor physicians fully accept the work of psychiatrists. In the literature on psychotherapy,

[17] B. Maher, *Research Methods in Psychopathology*, in press.

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consequently, there is little attempt to integrate psychopathological theory and concepts with those of other areas of psychology, especially experimental and social psychology. At the same time, most of the literature on traditional medical practice has little relevance to the work of psychiatrists. The result is that psychiatric research is often lacking in the kind of empirical scrutiny and formal integration of ideas that is so crucial to scientific progress.

The use of the disease concept in psychopathology has, moreover, had adverse effects on the patients. An individual who commences psychotherapy can not have the same expectations of psychotherapy that he has of medical treatment. Patients, especially those of lower-class background who have had little education, often think that the psychotherapist will be able to diagnose and cure their emotional difficulties with the same precision and speed that the physician would display in treating an infected toe. In order for the treatment of these patients to be successful, their expectations of psychotherapy must be changed. Much time is spent in their psychotherapy in teaching them the procedural differences between psychotherapy and medical therapy. Were emotional disturbances not looked upon as "diseases," this wasteful situation would not arise.

Furthermore, the use of the disease concept in psychopathology has been a serious handicap to the emotionally disturbed individual in his role as a patient. The sick role in our society, as it is generally accepted for the physically ill, is said by Parsons to be comprised of four aspects: (1) the patient's inability to perform his normal obligations, (2) the patient's inability to alter his condition by an act of will; (3) the patient's need for trained assistance, and (4) the patient's desire to get well and to abandon the sick role as soon as it is possible for him to do so.[18] In accepting the socially defined sick role, as K.T. Erikson aptly observes, the emotionally disturbed person is caught between divergent sets of expectations. On the one hand, to fulfill the expectations of the sick role, he must stress his inability to function, which in cases of mental afflictions is defined as the inability to make meaningful contact with other people; on the

[18] T. Parsons, *The Social System* (Glencoe, 1951), pp. 428-479.

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other hand, to fulfill the expectation that he cooperate in the treatment process, he must act in a completely contradictory way by making contact at least with his therapist. The result is that every time the patient takes a positive affiliative step in his treatment, he has to counter it with an action which indicates his continued inability to function, thereby perpetuating his affliction. The sick role for the emotionally disturbed patient is not so clearly a transitory role as it is for the physically ill patient. Unlike most physical illnesses, mental afflictions are generally considered incurable. Moreover, the goal of psychotherapy, unlike that of medical treatment, is not the restoration of the pre-morbid state of the patient but the total reorganization of his personality. Finally, the effort of the mentally afflicted patient to establish himself in the sick role may well be his first successful attempt to establish for himself a clear-cut sense of identity; he will therefore be reluctant to give it up and may even submerge himself in it permanently. As Erikson concludes:

> When the patient has to seek definitions as acutely sick and helpless in order to achieve a measure of public validation for his illness, and simultaneously has to use all his remaining strength to struggle against that illness, a dilemma is posed which he may resolve by simply giving up the struggle altogether and submerging himself in the sick role permanently.[19]

Psychiatrists as well as their patients suffer from the affiliation of psychopathology with medicine. One study reports that psychiatrists are often regarded by their physician colleagues as being "not really doctors" since, as we have noted, the diagnostic procedures and therapeutic activities of psychiatrists are entirely unrelated to those of physicians.[20] The result is that many psychiatrists are more conservative in their thinking and

[19] K. T. Erikson, "Patient, Role and Social Uncertainty," *Psychiat.*, 20 (1957), 271.

[20] M. R. Sharaf and D. J. Levinson, "Patterns of Ideology, Role Definition among Psychiatric Residents," *The Patient and the Mental Hospital*, eds. M. Greenblatt, D. J. Levinson, and R. M. Williams (Glencoe, 1957).

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experimenting than they would otherwise be if they were not trying to gain acceptance by the medical profession.

Primarily because the disease concept is at present inseparable from psychopathology, psychotherapists who want to practice with maximum freedom, efficiency, prestige, and monetary rewards must be trained as physicians before they are trained as psychotherapists. The skills required to make a good physician are not so closely related to those required to make an effective psychotherapist that training for one should be prerequisite to training for the other. In view of the current shortage of psychotherapists, the usefulness of medical training to practicing psychiatrists should be examined more carefully.

It can even be argued that, in some instances, medical training misleads the psychiatric practitioner. An example is the notion that Goffman calls the "danger mandate."[21] In medical practice, an inappropriate action on the part of the physician can seriously endanger the well-being or even the life of the patient. In psychiatric treatment of hospitalized patients, it is often assumed, similarly, that an inappropriate word or action on the part of the psychiatrist could seriously endanger the progress of the therapy. There is, however, no evidence to indicate that a single inappropriate word or action can have this effect. Even if the assumption were warranted, since the patient sees the psychiatrist for at most an hour a day, it is likely that he is subject to other influences, potentially as harmful as the psychiatrist's miscalculation, during the other twenty-three hours of the day.

Furthermore, it can be argued that medical training is often a barrier to the understanding of certain issues involved in psychotherapy. In his medical training, the physician is taught to conceptualize problems in intrapersonal terms. The problems that a psychiatrist treats, on the other hand, are interpersonal in nature. Medical training, in this respect, often gives the physician a trained incapacity to treat problems of a social nature adequately. For example, a physician faced with the problem of inculcating respect in the hospital staff for mental patients is likely to use moral exhortations or even group or individual psychotherapy

[21] E. Goffman, *op. cit.*, p. 377.

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in order to effect the desired attitude change. What he fails to realize, however, is that no amount of moral exhortation or psychiatric orientation will have much effect on the staff until the very structure of the hospital is changed in such a way as to allow the patients more control over their own dispositions.[22]

The physician's tendency to consider psychiatric disturbances in intrapersonal terms has also led to neglect of the underlying social and ethical questions. On the whole, our knowledge of social ethics, class structure, and cultural values has had little effect on psychotherapeutic theory. In order for us to practice preventive psychiatry successfully, we must fully examine our social and cultural patterns, e.g., acquisition drive, open-class society, achievement orientation, Protestant ethic.[23]

There has been an increased tendency in the Western world to extend the area of medical responsibility to all forms of social deviance. Criminal behavior, juvenile delinquency, and homosexuality are all considered proper subjects for psychiatric consideration. A murderer in our society is indeed as H. L. Mencken described him, "one who is presumed innocent till he is proven insane." Psychiatrists are called upon to pronounce value judgments concerning abortions, divorces, drug addiction, homosexual behavior, the nature of the good life, and many other controversial issues. Psychotherapists can, in fact, indirectly modify the very structure of our society. In treating lower-class patients and enabling them to increase their demands on society, psychotherapists serve in a radical way to promote change in the existing social order. In administering vocationl guidance tests, on the other hand, psychotherapists serve a conservative function, ensuring that future employees, executives, or professionals will be very much like the present ones.[24] The social ramifications of these issues require the critical examination of knowledgeable persons outside the medical profession. In any case, psychiatrists

[22] M. Schwartz et al., *Social Perspectives on Mental Patient Care*, in press.

[23] R. Davis, "Mental Hygiene and the Class Structure," *Mental Health and Mental Disorder*, ed. A. M. Rose (New York, 1955).

[24] E.g. the Strong Vocational Interest Test.

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are no more qualified by virtue of their medical training to make such decisions than are accountants or street-cleaners.

All of these considerations make us question seriously the applicability of the disease concept and the medical model to the study and treatment of psychopathology. In some respects, there can be little doubt that the use of the disease concept in psychopathology has had deleterious consequences. Reformulation of the present psychiatric framework is necessary, with particular emphasis on the ethical and social elements in material disturbance and on revision of the present diagnostic categories. Such radical reformulation is possible. It occurred in the past, when the devil notion of mental disturbance was replaced by the disease concept. That change brought great advances, and now it is time once again to revise our thinking.

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