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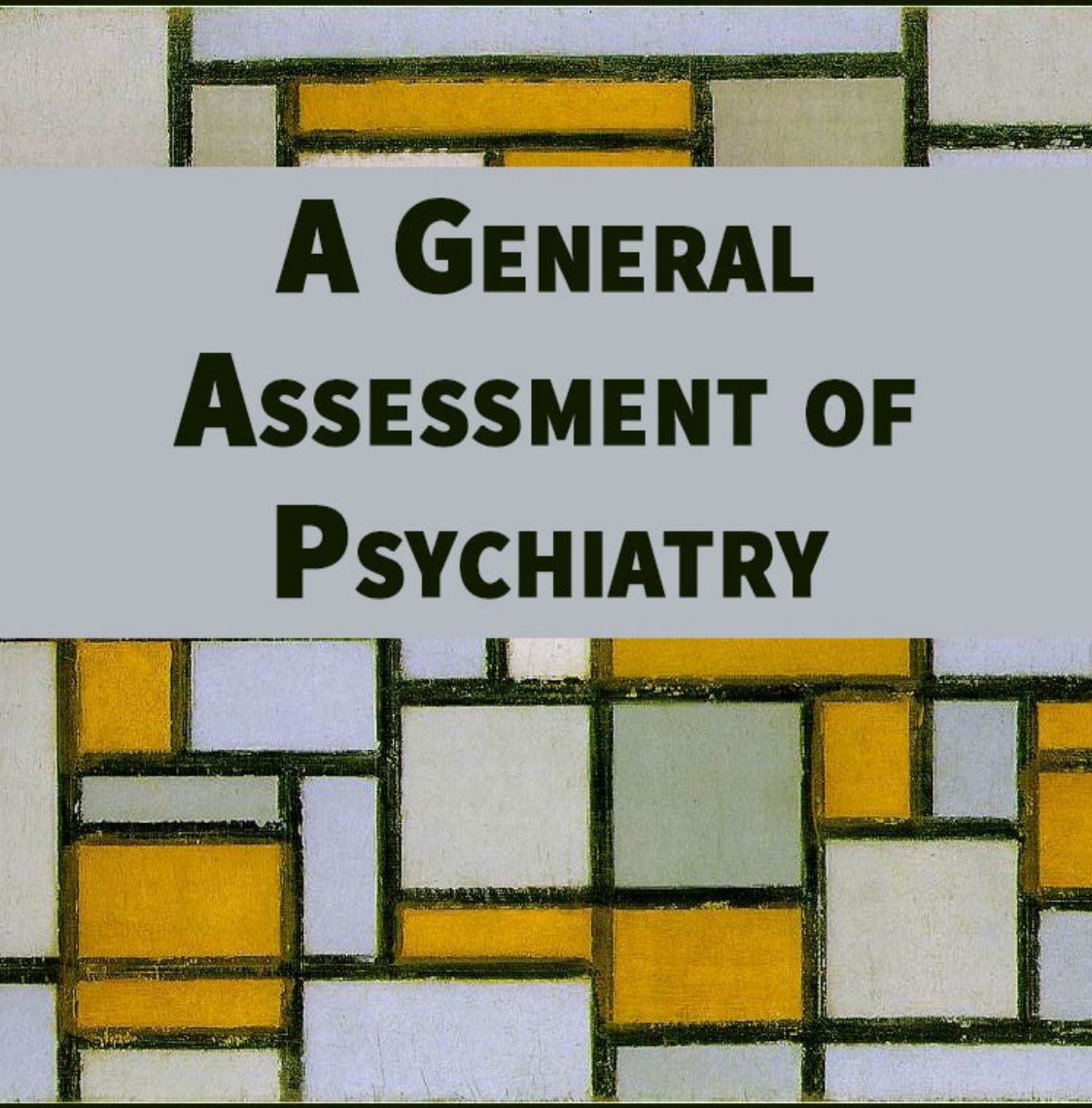

A General Assessment of Psychiatry

American Handbook of Psychiatry

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A GENERAL ASSESSMENT OF PSYCHIATRY

To assess is to determine the amount or worth of, to appraise, to evaluate, to take the measure of. We do not ordinarily consider assessing fields like cardiology, ophthalmology, or pediatrics in the sense of determining their worth, although we may inquire into the efficacy of a particular procedure or a medication. Yet it seems appropriate to seek a general assessment of psychiatry. Why? The question reflects a certain uneasiness, a need to clarify the scope of psychiatry, to fix the proper limits of its concern, to determine the nature of the problems to which it should address itself, and to study the conceptual and technical tools fashioned for the solution of problems. What is to be measured and evaluated? Shall it be the diagnostic scheme and the criteria for health or illness, the "cure" rate achieved by different treatments, the incidence and prevalence of specified disorders, or the various theories and schools of thought? These questions do not have merely academic or theoretical interest; they are of direct and immediate concern in determining many matters of public policy; in assigning investigative priorities; in allocating resources, funds, and personnel; and in establishing programs of education and training for the mental health professions.

A proper assessment of psychiatry requires that the subject be viewed in historical perspective. The physical sciences, dealing with relatively discrete phenomena amenable to direct observation or experimentation, and

aided by the powerful tools of mathematics, were the first to emerge from speculative philosophy. Medicine as a whole was slower to emerge, but its scientific foundations were laid in the sixteenth and seventeenth centuries by anatomical investigations, the discovery of basic physiological functions, and the gradual delineation of clinical pictures. Psychiatry lagged behind as the understanding of human behavior long remained the province of metaphysics and theology. In general, "schools" of medicine faded as cellular pathology and bacteriology established a firm basis for understanding disease processes and their treatment. Today there are hardly any remnants of the great controversies that raged around bloodletting and purgation, or homeopathy versus allopathy. But it was not until 1824- 1825 that J. F. Herbart, a philosopher and educator, published his *Psychology as Science, Newly Based on Experience, Metaphysics, and Mathematics.*'' The steps forward as well as the burdens of the past are evident in this title. It was several decades later before Gustav Fechner demonstrated that psychological functions are amenable to experimental measurement, and only in 1879 did Wilhelm Wundt establish the first psychological laboratory. Mechanism and vitalism are no longer urgent issues, but psychogenesis, the modern descendant of the ancient body-mind dilemma, remains a subject of lively contention in psychiatry. Deeply rooted schisms abound that are not differences in emphasis or variations in technique but fundamental divergences in conceptualization.

Practical limitations require that an assessment of psychiatry must be selective rather than exhaustive. Ideally it should deal with trends and lines of development insofar as these can be discerned, rather than with specific syndromes or procedures. The most significant and most difficult task is to identify central themes and problems, and the strategies devised to explore them.

Schools of Thought

The first matter that calls for attention and appraisal is the prominence of schools of thought. There are many lines of cleavage that take on the qualities of slogans: organic versus psychogenic, heredity and constitution versus life experiences, instinct versus culture, psychotherapy versus chemotherapy or psychosurgery, depth analysis versus "behavioristic" symptom elimination, the medical model versus game theory and social learning. Such profound differences in approach have few, if any, parallels in other branches of medicine. It is often said that theories flourish where ascertainable facts are few. In principle a theory is not provable in any absolute sense; it merely becomes more plausible and perhaps more useful as observations consistent with it accumulate. Furthermore, a theory must be of such form and content that it may be refuted by some crucial observation. The problem for psychiatry is that these conditions are difficult to fulfill. On the contrary, observations may often be marshaled in support of several competing theories, while none is conclusively refuted. These strictures apply to most psychiatric theorizing, but are most often raised against psychodynamic, especially psychoanalytic, theories. Shall we then accept Jaspers' view that ". . . in psychopathology there are no proper theories as in the natural sciences"?

Concerned as it is with disorders of human behavior, psychiatry must

take into account a truly overwhelming diversity of factors and variables. To deal with the vast array, to apply the available modes of reasoning and investigation, this complexity must be simplified and ordered. This is the basic function of schools of thought. Each school of thought offers a body of theory that provides a framework upon which to arrange the data of experience, observation, and experiment. Theory directs attention to certain phenomena in preference to others, determines what will be considered important or relevant and what will be disregarded or dismissed. Theory is also limiting. Applying Sapir's viewpoint we may posit that each school of thought establishes its own language, which classifies, organizes, and to a significant degree predetermines experience for its users. Theory projects meaning into experience and imposes certain modes of observation and interpretation.

It is hardly possible to make a full inventory of the various theories of human behavior, but some useful categories may be delineated. Every individual is part of many interlocking and interacting systems or levels of integration. Within himself he is a delicately balanced set of chemical, physiological, and psychological subsystems. Each individual is also part of several systems of social interaction, extending from those with whom he is in closest contact to the widening circles comprised of groups of differing size, composition, and complexity to which he has some relationship. Psychiatry encompasses at one and the same time the scientific study of man on the

biological level, the psychological study of the individual, and the sociological and anthropological study of human groups on a small and large scale. Not only is psychiatry concerned with these various levels of integration, but also it is a composite of all the levels. Collectively designated the behavioral sciences, these traditional disciplinary subdivisions reflect the course of historical development in the study of human behavior. They bring portions of the subject matter within manageable bounds, but at the same time fragment our understanding.

Recognition of this fragmentation has had several significant consequences in psychiatry. In recent years there have been increasing efforts to make critical comparisons among different viewpoints as well as to develop "unified" theories. The rapid accumulation of information that characterizes the current era makes it less and less possible for any one individual to attain competence in several diverse fields, or even the subdivisions of any one discipline. As a result research efforts, journal articles, and books are more often group undertakings. On the other hand, professional training, institutional affiliation, and the scientific literature are still largely disciplinary.

The educational and organizational issues posed by this state of affairs will be discussed below in connection with some speculations about the future of psychiatry. The more immediate need is to find ways to amalgamate

information from the parochial fields of knowledge in usable fashion, given the present structure of the behavioral sciences. Several steps may be envisaged. The first and most obvious is exemplified by the multidisciplinary conferences and projects already mentioned. What can be expected of these? At the very least the results should include mutual enrichment of information, clarification of definitions and problems, and a deeper understanding of other viewpoints. The disciplines may be using different terminology for the same phenomena, but they may also be applying the same terminology to fundamentally different phenomena.

Beyond this it may be possible to identify related events at several levels of integration. Simple examples would take the form of parallelism or concomitance of chemical events and psychological states, or correlation between social class status and symptom patterns. Such studies usually fall within the newly delineated fields of psychosomatic medicine and social psychiatry.

Psychosomatic medicine is confronted with "the mysterious leap from mind to body" and the reverse. Two major theoretical formulations have emerged: (1) certain bodily disorders are the consequence of physiological concomitants of psychological (mainly emotional) states; (2) certain bodily disorders are the symbolic expression of psychological states (mainly conflict or the need to communicate). Placing the "psycho" first seems to have meant

for most users of the term that the psychological state is primary or causal. Recent findings and more detailed analysis indicate that the interrelationship is more complex. Thus Knapp formulates the issue as a series of feedback interactions that include social as well as psychological and physiological factors. Weiner, relying on other experimental data, sees concomitance that does not necessarily imply causality in either direction.

For social psychiatry the problem of interrelationships is likewise complex. Human survival requires that societal forms be consistent with basic biological needs. The well-documented variation encountered in different societies makes it clear that there is no simple translation of biological needs into cultural institutions. There are evidently many ways in which these needs can be met. The most direct formulations focus on ways in which society facilitates or hinders the expression or satisfaction of needs, with emphasis usually on the repressive aspects of the social system. These formulations are oversimplifications. Societies also create needs apparently as imperative as those ordinarily considered basic and biological. Furthermore, the impact of society on individual needs is not merely to hinder or facilitate. Bell, surveying the literature, lists some of the interrelationships postulated between individual and social variables: one step direct, one step indirect, two step direct, and two step indirect. Even this description is too schematic. Examination of various studies suggests there are many interweaving processes and variables that operate to a greater or

lesser degree simultaneously, such as frustration, disorganization, social change versus stability, definition versus ambiguity of role, and others. The problem in each instance is to specify the variables and the mode of interactions.

Many comprehensive formulations have been made. Knapp presents evidence for a "transactional model" in the etiology of bronchial asthma. Another sophisticated example is the investigation of genetic factors in schizophrenia originating in the National Institute of Mental Health. From a very carefully designed and executed series of studies summarized by Pollin, it appears that genetic factors are significant in this disorder and may consist of predispositions to abnormal metabolism of catecholamines and indolamines due to peculiarities in the inducibility of certain enzymes. Affected individuals therefore suffer a hypothesized hyperarousal state of the nervous system that renders them specially vulnerable to stress. What is stressful, however, depends largely on the life history and experiences of the individual within his familial and sociocultural milieu.

> Thus, we have pictured a sequence which involves an external event, the potential stressor— its resultant psychological meaning and signal, which is based on previous experience, role within the family and within the social structure—the resultant biochemical and physiologic response on the organ and cellular level, its extent determined in part by genetically controlled enzyme activity, and in part by changes in enzyme levels induced by previous experience.
>
> In summary, experiential factors are seen as operating in four

> distinct ways. (1) They form the dictionary with which an individual translates the meaning and significance of any given current experience; and the yardstick by which he automatically measures the amount of threat, ie, stress, it constitutes for him. (2) Their residue determines the quantity and style of defenses and coping abilities with which the individual will attempt to deal with a stressful current life-situation. The determinants include such varied processes as the clarity of intrafamilial communication, the nature and extent of intrafamilial alliances and identifications, and the pattern of perceptions and coping mechanisms associated with one's location in the social class matrix. (3) Prior experience determines, in part, the extent of biochemical response to stress by influencing the level of enzymes available, through enzyme induction. (4) It seems likely that certain events, possibly concentrated in the intrauterine period, are relevant because of a direct slight effect on CNS structure, ie, neonatal anoxia causing minimal brain changes that later appear as subtle decrease in the capacity to maintain focal attention. (Pollin, pp. 35-36)

This formulation is comprehensive and flexible enough to accommodate new findings at any level, including, for example, detailed investigations of formal thought disturbances, family constellations, or social class position. For the purposes of this general assessment it is not necessary to review the evidence for or against the various aspects of Pollin's thesis. Admittedly some portions are speculative. The significant advance is that investigations at different levels are not posed against one another as competing etiologies but are woven into a coherent whole. The concept of stress provides the framework for relating the diverse disciplinary approaches. It also permits relatively simple organization and statistical analysis of data, mainly by treating stress as an intervening variable and relying on twins to equate

genetic factors. Such simplifications are essential.

The underlying logic of most investigations depends on one or more of J. S. Mill's classical canons for discovery of causal relationships in which possibly relevant factors are made to vary one at a time. Twin studies are an elegant application of Mill's canons; the genetic factor is taken as constant so that the effects of other variables can be studied.

Even in the case of identical twins it is difficult fully to satisfy Mill's canons and keep factors truly constant. Differences of personality in identical twin pairs have been noted repeatedly along with many similarities. Pollin cites a twin pair only one of whom was schizophrenic. From an early age there were marked differences in personality. In a further investigation of differences between identical twins, Pollin and his co-workers point out that intrauterine and birth experiences may differ, leading to constitutional but not necessarily genetic differences. Such differences may be reflected in marked differences in personality and behavior at all ages, which, in turn, may evoke different treatment from the parents. Throughout life there is a complex interplay among heredity, constitution, the interpersonal twin relationship, subsequent life events, and extrafamilial relationships.

In general, human behavior must be taken as the resultant of complex systems of factors that vary and interact in many different ways. Any

assertion of cause and effect depends on a condition that is usually unstated: "other things being equal." Since other things cannot ordinarily be taken as equal, demonstration of cause and effect requires procedures like matching and randomization, supplemented by statistical tests to cancel out factors other than those under investigation within some limit of allowable error. In real life situations there are rarely single causes, but rather a multiplicity of factors better conceived of as causal chains or networks. Changes in any portion of the network are associated with changes in other portions, and these, in turn, may affect other variables by feedback. Under such circumstances the classical definitions and demonstrations of cause and effect no longer suffice. Mathematical techniques for dealing with chains and networks are less advanced and more time-consuming. Mathematics aside, it is difficult to think in terms of networks without using simplifications that possibly vitiate the line of reasoning. An interesting example of ways in which such problems may be approached comes from the field of economics. In this area, because numerical measures are available for many variables, complex interactions can be represented by systems of simultaneous equations. It then is possible to identify a hierarchical ordering of variables, which is the basis for defining cause and effect. The procedures are formidable, but in principle it is possible by these methods to derive important conclusions about the behavior of the real economic system even though the available information may be incomplete or approximate. Furthermore, subsystems of variables

exhibit predictable degrees of stability and change within stated limits of probability.

These theoretical considerations have a bearing on the matter of schools of thought. In a multifactorial process, modification of any subsystem will produce measurable change in the system. In practice this will mean that a variety of approaches will find some support in terms of demonstrable effects. Competing theories may each find an acceptable degree of confirmation simultaneously because each affects some portion of the causal network. By directing attention to different subsystems, several investigations may be able to demonstrate what appear to be different valid cause-and-effect relationships. In the schizophrenia studies cited above the conceptual framework makes clear that there is no contradiction between biochemical or genetic etiologies and the competing family structure and social class etiologies. Knapp proposes a similar framework for the etiology of bronchial asthma. Leighton developed a comprehensive "Outline for a Frame of Reference" of similar scope to serve as the basis for testable hypotheses in the well-known Stirling County Study. Competing schools of thought will no doubt persist until sufficient investigation establishes unified conceptual frameworks. As matters now stand, multidisciplinary studies appear to offer the best prospect toward this goal.

Models—Medical and Otherwise

Psychiatry is said by some to be in the throes of an identity crisis epitomized as a challenge to "the medical model." The challenge comes from many quarters and ranges from mild criticism to outright rejection. The sharpest attack comes from Szasz, who denies there is any mental illness, suggesting, instead, that there are only "problems of living," which are moral and ethical, not medical. Similar criticisms of the medical model are voiced by Adams, Albee, Becker, Laing, Leifer, Sarbin, Scheflen. Somewhat less stringent criticism is offered by Cowen, Ellis, Mowrer, Reiff. Virtues and drawbacks are attributed to the medical model by Ausubel, Cohen, Crowley, Halleck, Sarason and Ganzer. Related criticisms from a sociological viewpoint are made by Goffman, Scheff, Spitzer and Denzin. Rejoinders to Szasz and the criticisms of the medical model are offered in a sequence of papers and discussions by Davidson, Slovenko, Rome, Donnelly, Weihofen, and by Begelman, Brown and Long, Brown and Ochberg, Glaser, Grinker, Kaufman, Reiss, Thorne.

Models are devices to make thinking about complex subjects easier. In a formal sense a model is an abstract logical system whose elements correspond to a set of events or things in the real world. If this model is well chosen it may be possible to perform "thought experiments" with the model and draw conclusions that might not be feasible with the real system in the external world. There are also dangers. The usefulness of a model depends on

the degree of correspondence between its elements and the “real” system in the external world. Valid conclusions can be drawn only to the extent of such correspondence. In other respects the model may not behave like the “real” system at all. In the discussion of schools of thought in the preceding section of this chapter the economic system was “modeled” by systems of simultaneous equations. It must be determined empirically how well the model corresponds to the real economic system, and transpositions from model to reality must remain within these limits. Several steps may be involved in using models. Light may first be compared with (modeled by) waves in a real medium (water or air), or the atom is modeled by electrons revolving around a nucleus after the fashion of the solar system. Then a mathematical model is devised to represent the properties of waves or rotating bodies.

It is clear that the medical model being criticized is not of this formal variety. The term is used to describe the explanation, mechanism, or process involved. The challenge is to the medical model. Is there such a model, one model that can properly be labeled the medical model?

Concern with illness is evidently as old as mankind. Explanations and theories about causes and what the process consists of have reflected the state of knowledge in each historical period. Primitive peoples could conceive only of processes that they themselves experienced directly. A man could

inflict pain, so pain of unknown origin was attributed to spirits or demons. The medical model consisted of anthropomorphized creatures of the primitive imagination. The Greeks attributed illness to excesses or deficiencies of the four humors, or to excess blood. Galen left a theory of natural spirits, vital spirits, and animal spirits that survived through the Renaissance, gradually giving way before the advancing knowledge of anatomy, physiology, and chemistry following the Renaissance. During the seventeenth and eighteenth centuries there were several medical models: (1) iatrophysics—the body conceived as a machine operating in accordance with the principles of physics and mechanics then being elucidated; (2) iatrochemistry— based on investigations of acids, alkalis, and fermentation; (3) vitalism—the living body is governed by special laws of its own, not those of the chemistry and physics of inanimate objects. Bloodletting was widely employed by all, along with numerous herbal folk remedies. Cellular pathology and the role of microorganisms became the medical model of the latter half of the nineteenth century. Subsequently other facets were added: toxins and antitoxins, immune and hypersensitivity reactions, allergies, autoimmune reactions, nutritional deficiencies, and more recently, enzyme defects. Many general principles have been formulated: patterned reflex reaction, host resistance and defense, homeostasis, generalized stressors (Selye) to name a few. As infectious diseases have receded in frequency, the emphasis has been shifting to neoplasia, to “wear and tear”—the processes of

aging and degeneration, and to the external circumstances of life and psychological stress. If from this overview a medical model can be discerned, it would seem to be merely that the processes and mechanisms of illness are to be investigated, using previous information as fully as possible but advancing to whatever new views are justified by the facts discovered.

The major criticisms of the medical model are directed against specific features attributed to that model and may be summarized as follows:

1. The medical model assumes the existence of a disorder of the mind that is like disorders of the body. Brain pathology produces specific neurological disorders, but psychiatry deals with functional disorders in which no structural or chemical alteration has been demonstrated. It is usually asserted that mind is not an organ and in principle cannot be reduced to chemical, electrical, or other physiological processes.

2. The locus of the disorder is within the affected person, and the disorder is to be corrected or removed by the physician as is the case with known diseases of the body. This is misleading because the real locus of the disorder may be, and usually is, outside of the individual, in the social system or his interaction with the social system.

3. The medical model fosters a superior, authoritarian attitude in the physician and a dependent, subservient attitude in the patient. Both are antithetical to successful treatment, which requires that the patient achieve a greater degree of

independence or autonomy.

4. Not only are there no demonstrable structural or physiological changes, but also there are no objective criteria for disturbed behavior. Mental illness can only be inferred from behavior that the illness is then supposed to explain, an obvious circularity in reasoning. Furthermore, judgment of behavior is subjective, tied to the value systems of the culture and open to various kinds of bias.

5. Because it depends on deviation from some norm, the medical model fosters conformity and stifles originality and creativity.

Some corollary criticisms may be added. The medical model focuses on pathology that is to be removed rather than on growth, development, and maturation. Many aspects of disordered behavior are not deviations from a norm, but rather normal responses to external conditions. Pathology should be ascribed to these external conditions, not to the individual reaction. The medical model requires vast numbers of highly trained personnel to deal with existing problems. Adequate care for all who need it cannot be attained within any foreseeable time; the model must therefore be replaced.

Leifer and Szasz carry the argument further. In their view a psychiatric diagnosis is intended to derogate and destroy anyone who deviates from accepted societal norms. Once labeled, the patient is stigmatized and

victimized while the power and prestige of the psychiatrist are enhanced.

Szasz's objections to the medical model begin with the definition of mental illness. His experience is that at best mental illness is a metaphor that likens personal unhappiness and socially deviant behavior to symptoms and signs of bodily ailments. Signs and symptoms are caused by specifiable disorders of bodily organs, which can be stated with some precision in anatomical or physiological terms. Disorders of the brain cause neurological defects. But the term "disorders of the mind" refers to a false substantive, mind, which cannot be a cause. Personal unhappiness is subjective and cannot be stated in precise terms. These definitional and philosophical issues are significant but not crucial. Psychiatry may be quite adequately defined without reference to mind, and many textbooks do not use the term, or if they do, specify that it is a collective designation for certain functional activities of the organism rather than a metaphysical entity. Although Szasz states that he rejects the ancient body-mind dualism in favor of a hierarchical scheme of levels of integration, his argument treats mental illness as a metaphysical entity and thus appears to resurrect the philosophical dilemma.

A related aspect of the metaphysical problem is the contention that one cannot "have" a mental disease in the sense that one can "have" diabetes. (The quotation marks indicating special meaning are terms of the critics.) The argument is that diabetes refers to an entity that is "real," while mental

disease does not. What is at issue is the meaning of terms like “have, entity,” and “real.” “Entity” is a metaphysical abstraction usually used to designate a hypothetical property separate and apart from the tangible and experiential aspects of an object. It is an abstraction that has meaning only as a part of a philosophical system that postulates the existence of such properties. Diabetes is not an entity in this sense. Diabetes designates a class defined by certain characteristics. A class name is neither real nor unreal; it may be more or less useful. Whether a class corresponds to anything in the “real” external world is an epistemological problem. A person does not “have” diabetes in the sense of possessing a material object. Saying a person has diabetes merely places him in the class of individuals who show certain defining biochemical characteristics. The class falls within the larger class of diseases, which are defined as states of discomfort and/or impairment of function. There is no logical necessity to restrict the range of discomforts or impairments to be included, although the nature and basis of the discomfort or impairment are legitimate subjects for investigation. In common usage the class of discomfort or impairment is extended beyond the individual. Thus the dictionary definition of disease includes “a derangement or disorder of the mind, moral character and habits, *institutions,* the *state,* etc.” Physiological alterations or the mechanisms of the signs and symptoms are characteristics added to the definition of specific diseases as knowledge about them expands. Diabetes was recognized as a disease and named 011 the basis of one of its

conspicuous and easily observable features long before there was any information about its pathological physiology. In other instances older descriptions had to be revised and new classifications added to accommodate newly acquired knowledge. Some behavioral aberrations that are today called mental diseases were recognized and described as far back as the period of classical Greek antiquity. Szasz proposes that these aberrations be renamed "problems in living" because of restrictions that he believes should be imposed on the category "disease."

The crucial criticism of the medical model focuses on deviancy. The outline of the argument is deceptively simple. Deviancy is a departure from a norm. Norms are either evaluative or statistical. If evaluative, they are arbitrary, culture-bound, and probably biased to reflect a predominant ideology. If statistical, then the distribution of any trait will have extremes, and it is illogical to label the extremes as abnormal. Careful review of the extensive writings of Szasz and the other critics of the medical model reveals several additional elements implicit in the argument. The most important one is that nothing other than a departure from a norm is involved. Mere deviancy, without further qualification or limitation as to its nature, is said to call forth a social reaction of rejection that is institutionalized under the pseudoscientific label of mental illness. It is difficult to accept this very general thesis. Only certain aberrations are labeled in any particular culture. In Szasz's view the problem of mental illness is the right to be different in the

face of societal demands for conformity. This view involves at least two further assumptions: (1) social roles and behavior are imposed against an inherent resistance; (2) conformity or nonconformity is the only relevant dimension and nonconformity is more desirable. Similar views are expressed by Leifer, Parsons, and Scheff, Laing regards psychoses as a superior and creative nonconformity in response to pressures of living in a world he considers irrational.

This line of argument has great appeal. It is addressed to the established tradition of individuality and freedom of expression. It takes advantage of the difficulty of arriving at a satisfactory definition of mental illness, which has vexed even those who accept the concept. It invokes images of arbitrary and capricious restrictions by malevolent control agents, the institutional psychiatrists.

This line of argument is open to question on many grounds. It represents a very incomplete statement of the problem of normality and abnormality in the medical model. Mere deviation from norms does not constitute disease; rather it calls for attention and further investigation into the significance of the deviation. The precision associated with bodily disease has to do only with measurements of certain indicators of physical processes. Norms for judgment are not different in principle from those applied in many psychological processes. To take the example of diabetes again, the

measurement of blood sugar is precise and objective. The dividing line between normal and diabetic is arbitrary. It is based on the relative probabilities that particular levels of blood sugar will be associated with the other alterations characteristic of diabetes. If the blood sugar is near the arbitrary borderline, judgment may be difficult and additional information may be required. In behavioral deviation the case is not different. Certain gross aberrations have been regarded as abnormal, while lesser aberrations may fall into the area of uncertainty. The final judgment is made on the basis of additional information—for example, whether behavioral deviation is associated with changes in mood or thinking processes or whether it is functionally disabling. Deviations are judged in the context of such other indicators and with due regard for background factors such as culture.

The medical model does not take all hallucinations as indicators of schizophrenia any more than it would take all elevations of blood sugar as indicators of diabetes. In a culture where hallucinations are accepted and even approved, the occurrence of hallucinations will not necessarily indicate psychosis. Yet it is possible in such a culture to make a judgment about pathology even though in specific instances the case may be borderline. The most stringent critics of the medical model seem on the whole to be describing individuals who exhibit minor deviations and give little evidence of subjective distress. An adequate model, however, must include those who are severely depressed, markedly agitated, or paralyzed by irrational fears.

Another major objection to the medical model is that it is based on conditions in which there are demonstrable anatomical or physiological alterations. On the other hand, psychiatry is for the most part concerned with the so-called functional disorders in which no consistent physiological changes have as yet been found despite many investigations. Invoking the concept of levels of integration, the critics contend that psychological processes by their very nature can never be "reduced" to a physiological level. Yet, unless one accepts the possibility of a nonmaterial spirit, psyche, or mind, psychological processes must in some way be connected with, and not separate from, the physiological level. The nonreductionist position can only be accepted as an assertion of belief subject to revision in the light of further investigation. Consider an individual who arrives at the incorrect conclusion that two plus two equals five. The error may be due to ignorance or mental defect. Suppose these causes are excluded and the error persists for reasons that are not known but are presumed to be "psychological." The nonreductionist position would hold that these psychological reasons comprise the full description of the error within the appropriate level of integration. Recent investigations by John indicate that there are demonstrable differences in the electrical activity of the brain when correct and incorrect choices are made. It is possible also to demonstrate electrical patterns associated with "psychological" processes like stimulus generalization and abstraction. If such studies can be extended, it may be

possible to resolve the reductionist objection and arrive at physiological measures for normality and abnormality in psychological functions.

Many critics of the medical model assert that it fosters superior, authoritarian attitudes in physicians and dependent, subservient attitudes in patients. No doubt there are physicians and patients about whom these assertions are correct. As a generalization, however, more tangible evidence would be required than is now offered by the critics. As the matter stands, the argument is an appeal to prejudice. Patients arc given "orders" by their physicians, and they "depend" on his technical knowledge and skills. But "orders" and "depend" in this context do not have the pejorative meaning ascribed by the critics. Authoritarianism or dependency are individual qualities in no way inherent in the medical model and not necessarily characteristic of patients or physicians. Szasz holds that the medical model obscures moral and ethical problems that must be confronted. There is no reason to believe that his position is any less likely than the medical model to foster attitudes of superiority.

A major objection to the medical model is that it requires facilities and personnel far beyond what could conceivably be made available in the foreseeable future. A new model must therefore be developed. What alternatives are offered?

Mowrer suggests that the concept of sin has been too hastily excluded. Better sin than sickness in his view. If the responsibility for sin is acknowledged there is at least the prospect of redemption. Szasz does not propose any specific alternatives. He insists that all involuntary treatment and hospitalization be abolished, but is silent about what is to be done with those now under care. Presumably he anticipates that they can all be returned to the community; therefore, he does not attempt to devise any other program. For a select few he offers an austere and forbidding version of psychoanalysis he names autonomous psychotherapy. Most of the other critics refer in general terms to nonmedical psychotherapy, group therapy, day and night hospitals, behavioral and conditioning therapies, and a variety of environmental services. Albee, among the staunchest critics of the medical model, acknowledges the magnitude of the problem of providing such personnel in sufficient numbers. His proposal is a social learning theory of mental disorder.

> Once it is finally recognized and accepted that most functional disorders are learned patterns of deviant behavior, then the institutional arrangement which society evolves to deal with these problems probably will be *educational* in nature. ... It is quite possible that they will be combinations of present day-care centers recast as small tax-supported state schools with a heavy emphasis on occupational therapy, reeducation and rehabilitation. ... It will take several generations, perhaps a century, to replace the illness model . . . (pp. 71-72.)

Albee's new institutions are strongly reminiscent of ideal hospitals

envisaged by psychiatrists save only that he omits all mention of medication or other treatments. Elsewhere in his writings he has already dismissed all biochemical, neurophysiological, and genetic factors as irrelevant. Surely this is too one-sided and premature a view to serve as the basis for professional or public policy in the mental health field. In any event the personnel and financing required would hardly be less than under the medical model.

The most general alternative to the medical model is the social model, which attributes the major portion of mental illness to the impact of social and economic factors. This viewpoint is more concerned with prevention than with caring for those now afflicted, although there is reasonable ground to expect that improvements in social and economic circumstances might assist current patients by reducing the rate of recurrences and rehospitalizations.

What conclusions can be drawn from this overview of the challenge to *the* medical model? What is *the* medical model? On the whole it appears that the medical model is whatever critics attribute to it. The model used by most psychiatrists accepts the notion that the disability of the mental patient is real and represents a dysfunction, but is not specific about the nature of the dysfunction. The concept of cause in the mental realm requires redefinition and will probably turn out to be a complex network of factors. The medical model does not require that treatment be directed internally even if the

dysfunction is within the individual. Treatment can be directed at alteration of external circumstances or can consist of combinations of modalities. These are matters for investigation. Given the present state of knowledge, most of the alternative models offered represent hypotheses subject to investigation in experimental or pilot programs. The most urgent need is for a truly comprehensive model. The closest approach at this time is the kind of formulation for schizophrenia offered by the researchers at the National Institute of Mental Health.

The Future of Psychiatry

If assessment of the present status of psychiatry is subjective, time-bound, and difficult, what can be said of the future? Probably the surest prophecy is that today's speculations will soon prove to be an acute embarrassment, for history seldom moves as predicted. On the other hand, plans for the future are necessary, and some risk must therefore be undertaken. Prediction is so much a matter of personal evaluation that I will in this section depart from the customary style of handbooks and use the pronoun "I." I will attempt to anticipate the future in three time spans—near, intermediate, and long range—and three aspects —theory, education, and delivery.

For the immediate future I believe psychiatry will have to be primarily oriented to the sudden expansion of demand engendered by the extension of health care to all segments of the population under some form of insurance. At this time there is some official hesitation about providing psychiatric services because of the anticipated high costs. Ways will have to be devised to supply the needs, and individual psychiatrists and professional organizations will have to take on roles of active advocacy. It has already been demonstrated that short-term (not brief) ambulatory treatment is insurable. Further explorations are under way. An essential feature of any system of care will be provision of a full range of services and employment of all forms

and modalities of treatment. Psychiatrists must resist efforts to limit services to the least expensive treatments. The aim must be to provide a basis for evaluating the relative efficacy as well as the range of applicability and limitations of different treatments. Heretofore the distribution of treatment has followed economic lines. Only when the various modalities are available to all regardless of economic status will it be possible to determine the indications for each modality. Evaluation of formal treatments will also have to be correlated with the effects of environmental measures, such as improved housing, education, recreation, and social services generally, to help determine their relative influence.

Theory must play a dual role. On the one hand, theory must supply clues for new approaches. These, in turn, will modify and enrich theory. The outcome should be in the form of "unified" theories, drawing upon all levels of integration, as illustrated by the work of the NIMH group previously cited. The most active development should be on the biochemical-neurophysiological level and on the social psychiatry level.

Psychiatric education will have to undergo the most drastic change. I foresee several interrelated pressures. The first is the already discussed challenge to the medical model. The overall impact of this trend has been to move psychiatry away from the rest of medicine. The outcome will depend on the competition between psychotherapies, behavioral therapies, and

environmental modification, on the one hand, and chemotherapies, on the other. The results of this competition will not emerge early, carrying the issue into the intermediate time span. In the meantime there will be mounting pressure from the various subprofessions to achieve independent status. An example of this trend is the move toward autonomous schools of psychotherapy, which will no doubt be accompanied by corresponding professional organizations. The new categories of mental health workers, the indigenous paraprofessionals, will undergo increasing professionalization with gradually increasing educational requirements. At the same time some psychiatrists and associated workers in the basic sciences will be pursuing their investigations.

I see in these various anticipated lines of development a trend to fragment rather than to unify the mental health field. Specialization, I believe, is inevitable, yet the need is for integration. A possible solution is to move in the direction of institutes of behavioral science rather than toward autonomous schools of psychotherapy, social work, or psychiatry. These institutes would be the base for both clinical and research activities and should be located within a university that has a medical school. The core of such institutes would be departments of psychiatry, psychology, and social work, that is, the disciplines most closely involved in treatment. Each institute should also be a major center for research and should include departments of biochemistry, neurophysiology, and experimental psychology, as well as

psychoanalysis and the behavioral and conditioning therapies. In addition to the foregoing, the behavioral science institute should have strong representation from anthropology, sociology, political science, economics, and social psychology.

In an institute organized along these lines the major subdivisions would probably be around treatment and research, but the unified framework would help minimize the current coolness between clinicians and researchers so often encountered. The department of psychiatry would still be concerned with the overall integration of activity and information aimed at treatment, and would centralize and coordinate the delivery of services and evaluation of efficacy.

The relationship of the department of psychiatry to the medical school requires separate attention. If both the medical school and the behavioral sciences institute are based in a university, the pressure to separate psychiatry from the rest of medicine will be minimized. But I also foresee changes in medical education, which is also beset by the trend to specialization and the need for integration. Several medical schools have already introduced a system of "tracks." This arrangement groups the preclinical sciences and basic general clinical training in the first two to two-and one-half years. The student can then choose a track leading toward specialization or continue his general medical training. Psychiatry is one such

track. If this track could be located in the institute of the behavioral sciences, interested medical students would have early access to all the disciplines relevant to psychiatry, such as psychology, anthropology, and sociology, and could at the same time maintain their connection with the rest of medicine. Other students in the behavioral sciences institute might find their primary base in one of the related disciplines and take clinical work in the psychiatry track. The content of the M.D. degree may also change. Ph.D.'s arc now granted in a specific discipline. The trend toward earlier and more intensive specialization may lead to an M.D. in a specialty—M.D. in surgery or gynecology and obstetrics—or perhaps the M.D. will be the basic medical degree, to be followed by a Ph.D. or Doctor of Medical Science in a specialty if desired. A major advantage of a behavioral institute is that it would promote adequate comparative studies and facilitate mutual enrichment of information.

These changes in medical education will certainly not be completed in the immediate future, but will extend into the intermediate time span.

The intermediate term should see the resolution of many current uncertainties. The delivery systems should be functioning with relative efficiency and the roles of the various professionals should have been clarified. Indications for different treatments should be well established and etiological factors should be more accurately defined.

Predictions for the long term are, I am afraid, mainly affirmations of faith. I therefore affirm my belief in the ultimate perfectibility of mankind, at least to the point that men will be able to live harmoniously with other men. I see no basic antithesis between instinct and civilization, so I do not believe that either analyses or psychiatry are interminable. We do not yet know whether some individuals may be so predisposed, say to schizophrenia or manic-depressive disease, that no amelioration of societal pressures will spare them from their disease. If in the intermediate term this should prove to be the ease, I do not doubt that ways will be found to improve the genetic stock of the race. When all this has been done, then perhaps psychiatrists will no longer be concerned with mental diseases but only with problems of living.

Bibliography

Adams, H., "Mental Illness or Interpersonal Behavior," *Am. Psychol., 1*9.191-197, 1964.

Albee, G., "Emerging Concepts of Mental Illness and Models of Treatment: The Psychological Point of View," *Am. J. Psychiat.,* 125.870-876, 1969.

_____, "The Relation of Conceptual Models to Manpower Needs," in Cowen, E., Gardner, E., and Zax, M. (Eds.), *Emergent Approaches to Mental Health Problems,* Appleton-Century-Crofts, New York, 1967.

Ando, A., Fisher, F., and Simon, H., *Essays on the Structure of Social Science Models,* MIT Press, Cambridge, 1963.

Ausubel, D., "Personality Disorder *Is* Disease," *Am. Psychol., 16:*69-74, 1961.

_____, "Relationships between Psychology and Psychiatry: The Hidden Issues," *Am. Psychol,* 11:99-105, 1956.

Avnet, H., *Psychiatric Insurance,* Group Health Insurance, Inc., New York, 1962.

Becker, E., *The Revolution in Psychiatry,* Free Press, Glencoe, 1964.

Begelman, D., "Misnaming, Metaphors, the Medical Model and Some Muddles," *Psychiatry, 34:*38-58, 1971.

Bell, N., "Models and Methods in Social Psychiatry," in Zubin, J., and Freyhan, F. (Eds.), *Social Psychiatry,* Grune & Stratton, New York, 1968.

Braithwaite, R., *Scientific Explanation,* Cambridge University Press, Cambridge, 1955.

Brown, B., and Long, E., "Psychology and Community Mental Health: The Medical Muddle," Am. *Psychol.,* 23:335-341, 1968.

_____, and Ochberg, F., "The Medical Muddle," *Int. J. Psychiat.,* 9:22-25, 1970-1971.

Cohen, L., "Health and Disease: Observations on Strategies for Community Psychology," in Rosenblum, G. (Ed.), *Issues in Community Psychology and Preventive Mental Health,* Behavioral Publications, New York, 1971.

Cowen, E., "Emergent Approaches to Mental Health Problems," in Cowen, E., Gardner, E., and Zax, M. (Eds.), *Emergent Approaches to Mental Health Problems,* PP- 389-455, Appleton-Century-Crofts, New York, 1967.

Crowley, R., "The Medical Model in Psychoanalysis," in Masserman, J. (Ed.), *Science and Psychoanalysis,* Vol. 12, pp. 1-11, Grune & Stratton, New York, 1968.

Davidson, H., "The New War on Psychiatry," *Am. J. Psychiat.,* 121:528-548, 1964.

Davis, K., "The Application of Science to Personal Situations: A Critique of the Family Clinic Idea," *Am. Sociol. Rev., 1:*238-247, 1936.

Deutsch, F., *On the Mysterious Leap from the Mind to the Body,* International Universities Press, New York, 1959.

Ellis, A., "Should Some People Be Labeled Mentally Ill?" *J. Consult. Psychol., 31:* 435-446, 1967.

Glaser, F., "The Dichotomy Game: A Further Consideration of the Writings of Dr. Thomas Szasz," *Am. J. Psychiat., 121:* 1069-1074, 1965.

Goffman, E., *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates,* Doubleday, New York, 1961.

Grinker, R. R., Sr., "Emerging Concepts of Mental Illness and Models of Rx: The Medical Point of View," *Am. J. Psychiat., 125:*865-869, 1969.

Halleck, S. L., *The Politics of Therapy,* Science House, New York, 1971.

Herbart, J. F., Cited in Boring, E., A *History of Experimental Psychology,* Appleton-Century-Crofts, New York, 1950.

Holt, R. R. (Ed.), *New Horizon for Psychotherapy: Autonomy as a Profession,* International

Universities Press, New York, 1971.

Jahoda, M., *Current Concepts of Positive Mental Health,* Basic Books, New York, 1959.

Jaspers, K., *General Psychopathology,* University of Chicago Press, Chicago, 1963.

John, E. R., "Where is Fancy Bred?" in M. Hammer, *et al.* (Eds.), *Psychopathology,* John Wiley, New York, 1972.

Kaufman, M. R., "Psychiatry: Why 'Medical' or 'Social' Model," *Arch. Gen. Psychiat., 17:*347-361, 1967.

Knapp, P., "Revolution, Relevance and Psychosomatic Medicine: Where the Light Is Not," *Psychosom. Med.,* 33:363-374, 1971.

Laing, R. D., *The Politics of Experience,* Penguin, Hanmondsworth, 1967.

Leifer, R., "The Medical Model as Ideology," *Int. J. Psychiat.,* 9:13-21, 31-35, 1970-1971.

Leighton, A., "Psychiatric Disorder and Social Environment," in Bergen, B. J., and Thomas, C. (Eds.), *Problems in Social Psychiatry,* Charles C Thomas, Springfield, Ill 1966.

Lidz, T., and Edelson, M., *Training Tomorrow's Psychiatrist,* Yale University Press, New Haven, 1970.

Mowrer, O. H., " 'Sin' the Lesser of Two Evils," *Am. Psychol.,* 15:301-304, i960.

Nagel, E., *The Structure of Science,* Harcourt, Brace & World, New York, 1961.

Offer, D., and Sabshin, M., *Normality,* Basic Books, New York, 1966.

Parsons, T., "Definitions of Health and Illness in the Light of American Values and Social Structure," in Jaco, E. G. (Ed.), *Patients, Physicians and Illness,* Free Press, Glencoe, 1958.

Philips, D. L., "Identification of Mental Illness: Its Consequences for Rejection," *Com. Ment. Health*

J., 3:262-266, 1967.

_____, "Rejection: A Possible Consequence of Seeking Help for Mental Disorders," *Am. Sociol. Rev., 28:*963-972, 1963.

Pollin, W., "The Pathogenesis of Schizophrenia," *Arch. Gen. Psychiat., 27:*29-37, 1972.

_____, and Stabenau, J. R., "Biological, Psychological and Historical Differences in a Series of Monozygotic Twins Discordant for Schizophrenia," *J. Psychiat. Res., 6* (Suppl. 1):317—332, 1968.

Reiff, R., "Mental Health Manpower & Institutional Change," in Cowen, E., Gardner, E., and Zax, M. (Eds.), *Emergent Approaches to Mental Health Problems,* pp. 74-78, Appleton-Century-Crofts, New York, 1967.

Reiss, S., "A Critique of Szasz's 'Myth of Mental Illness,' " *Am. J. Psychiat., 128:* 1081-1086, 1972.

Sander, F., "Some Thoughts on Thomas Szasz," *Am. J. Psychiat., 12*5:1429-1431, 1969.

Sarason, I., and Ganzer, V. J., "Concerning the Medical Model," *Am. Psychol.,* 23:507-510, 1968.

Sarbin, T. R., "On the Futility of the Proposition That Some People Be Labeled 'Mentally Ill,' " *J. Consult. Psychol.,* 5:447- 453, 1967-

_____, and Juhasz, J., "The Historical Background of the Concept of Hallucination," *J. Hist. Behav. Sci.,* 3: 339-357, 1965.

Scheff, T. J., "Role of the Mentally Ill and the Dynamics of Mental Disorder: A Research Framework," *Sociometry,* 26:436- 453, 1963-

Scheflen, A. E., "An Analysis of a Thought Model Which Persists in Psychiatry," in Bergen, B. J., and Thomas, C. (Eds.), *Issues and Problems in Social Psychiatry*, Charles C Thomas, Springfield, Ill., 1966.

Spitzer, S., and Denzin, N., *The Mental Patient—Studies in Social Deviance,* McGraw-Hill, New York, 1968.

Szasz, T. S., *The Ethics of Psychoanalysis,* Basic Books, New York, 1965.

_____, *Ideology and Insanity,* Doubleday-Anchor, New York, 1970.

_____,*The Manufacture of Madness,* Dell, New York, 1970.

_____,*The Myth of Mental Illness: Foundations of a Theory of Personal Conduct,* Hoeber-Harper, New York, 1961.

Thorne, F. L., "An Analysis of Szasz's 'Myth of Mental Illness,' " *Am. J. Psychiat.,* 123: 652-656, 1966.

Turner,R. J., and Cumming, J., "Theoretical Malaise and Community Mental Health," in Cowen, E., Gardner, E., and Zax, M. (Eds.), *Emergent Approaches to Mental Health Problems,* Appleton-Century-Crofts, New York, 1967.

Weiner, H., "Some Comments on the Transduction of Experience by the Brain: Implications for Our Understanding of the Relationship of Mind to Body," *Psychosom. Med., 34:3*55-380, 1972.