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Mental Illness - Chapter 5 of "Counseling and the Demonic"

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CHAPTER FIVE

MENTAL ILLNESS

Defining mental illness is not an easy task. Much controversy swirls around the definition, and even around whether "mental illness" is a helpful concept. The use of the word *illness* implies that some form of disease is the root of the problem. This issue lies at the heart of a major conceptual controversy in the mental health field.

Szasz called mental illness a myth.[1] Others describe mental illness in terms of several "models."[2] These include the spiritual model, the moral model, the medical model, the sociopsychological model, and the systems model.

This chapter will begin with a case example. Then we will briefly examine each of these models, as well as the possibility of

a Christian model. We will conclude with a discussion of some issues that are raised from a Christian perspective. In chapter 6 we will turn to an overview of the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R), the most widely accepted manual for cataloguing the nature and types of mental disorders.[3]

JENNIFER

"My name's not Jennifer; she left. I'm Gina. That dumb slob Jennifer is gone. Good riddance. I can't have any fun when she's around." As I looked at the woman my confusion must have been apparent. I was sure it was Jennifer. Yet her clothes, her expression, her voice, her posture—almost everything about her—seemed different. I almost believed that I was speaking with the wrong woman.

When I'd seen her the day before, Jennifer was severely depressed, suicidal. She had been hospitalized for fear that she would kill herself. Before admission, she had been systematically slashing her arm with a razor; the mutilated skin on her left arm hung in ribbons. Now it was all bandaged, and hidden under the sleeves of her low-cut, seductive blouse. She wanted a pass so that she could "go out and have some fun."

As I came to know Jennifer/Gina better, I discovered that there were other "personalities" as well. They came and went unpredictably. Each had a characteristic pattern of mood and behavior. Yet all shared the same body. Jennifer was prim and proper, always doing the correct thing. Gina was fun-loving and outgoing, but irresponsible. Mae was a clever thief who managed to steal things Gina enjoyed, but which were an embarrassment to Jennifer, who could not understand how the items came into her possession. Polly was a boozing babe who would tumble into any man's bed "just for a lark."

As I pondered my experience with Jennifer, I reflected on the various ways to view her "personalities." Surely she had a mental illness, a multiple-personality disorder, together with depression, I thought. Or could she be acting? In some of her personalities she clearly engaged in various forms of sinful conduct; could it be that she was just a clever but sinful woman who had found out how to get away with doing as she pleased?

Or was she demon possessed? As we work through this and following chapters our goal is to better understand how to resolve such questions.

Models of Mental Disorders

The Spiritual Model

From antiquity until the nineteenth century, mental disorders were viewed largely as a religious and moral issue. Persons with unusual behavior were considered malingerers or possessed by spirits. If the spirits were viewed as good, the person was accorded status and favor, and no efforts were made to remove their influence. By contrast, if the spirits were considered bad, exorcism and torture were used as ways to free the person from their influence. Jennifer probably would have undergone exorcism or torture.

The Moral Model

In the late eighteenth and nineteenth centuries a number of changes took place in the treatment of the mentally ill. At the beginning of this era the mentally ill were housed in large asylums. One such asylum was Bethlehem Hospital of London, from which we get the corruption "bedlam." Late in the eighteenth century, reformers such as Philippe Pinel, William Tuke, and Dorothea Dix led efforts for reform and the provision of more humanitarian care in these asylums.

In the United States this reform movement was most fully developed in the "moral treatment" approach which was most prominent at the beginning of the nineteenth century. This approach included an emphasis on small institutions of less than 250 patients. The superintendent was a father figure to the patients. Curability of mental illness was stressed, and treatment emphasized training in appropriate moral conduct. At the time, this approach was believed by some to be curative, though others disputed this claim.[4] Under the moral model, Jennifer would have received training in moral conduct in a small institution.

The Medical Model

About the same time as the humanitarian reforms and moral treatment were being practiced, Wilhelm Greisinger

and Benedict Morel, among others, were involved in an effort to advance the disease notion of mental disorders. John Gray, editor of the *American Journal of Insanity* from 1855 to 1885, was a strong crusader in support of the disease view. He used his prominent role to advance the notion that physical lesions were responsible for mental illness, and he led in the movement to transform mental asylums into treatment facilities.

The theoretical work of Jean Charcot, Pierre Janet, Hippolyte Marie Bernheim, and Sigmund Freud gave further impetus to the development of the medical model. According to the moral model, persons whose symptoms did not make anatomical sense were thought to be unwilling to face the difficulties of life, and hence morally defective. Because of the work of the medical pioneers, they came to be seen as hysterics who were presumed to have medical rather than moral problems. In this way the medical model was extended to persons outside institutional settings.

A major factor giving further credence to the medical model was the discovery that general paresis, a psychotic disorder, was the result of advanced syphilitic infection. The initial suggestion was made in 1857; positive identification of syphilitic infection as the causative agent was provided in 1913. This significant discovery, together with the growing inclination to view other problems as medical, culminated in a major shift in viewpoints: The disease model replaced the moral-religious explanation of mental disorders.

The medical model, in its various forms, has been the dominant conceptual model from 1915 to the present. Although several alternative models have been proposed, none has received the widespread acceptance which the moral-religious model enjoyed before the nineteenth century, or which the medical model has been given in the twentieth century.

Blaney[5] has suggested four variations of the medical model:

1) mental disorders are in fact diseases which are physiologically based;
2) symptoms of mental disorder are reflections of an underlying condition which may be organic, but need not be so;

3) mental disorders are not under personal control, and the individual has no responsibility for his or her behavior;
4) psychiatric symptoms can be best understood by ordering them into syndromes, or groups of symptoms which normally occur together so that each syndrome or group of symptoms can be viewed as a single disorder.

As we shall see later, none of these definitions seems adequate to encompass all of the disorders listed in the *Diagnostic and Statistical Manual of Mental Diseases.*

The medical model assumes the person with the disorder is a patient who is sick. The sickness is characterized by a number of symptoms which are presumed to be the result of an underlying disease having a specific cause or etiology. Because the underlying problem is often not apparent, diagnosis is important prior to treatment. The illness is presumed to have a predictable developmental history or course, and prognosis or outcome.

Symptoms are presumed to be indicators of the underlying illness. They may change or even disappear without the illness being cured. Thus, identifying the disease and evaluating the effect of treatment requires special training, and becomes a medical specialty. Other concerns include the possibility of relapse or of symptom substitution, which is the development of new symptoms stemming from the same underlying ailment. Since the individual is often unable to provide basic self-care, society provides care for him or her.

The illness model takes away personal responsibility; since the patient cannot do much about the condition, the patient becomes a passive recipient of treatment.

The patient may receive special considerations such as financial support or care provided by the state. Legal rights may be lost since the person is presumed to be unable to make responsible choices. Sometimes the person is not held responsible for legal infractions. These are thought to be the result of the disease process; it is assumed that the patient did not know what he or she was doing, or did not recognize that the actions were wrong. In some respects the problem may be even more complicated; patients are believed to be incapable of evaluating their own conditions, and may not even recognize that they have problems. Alternatively, the patient may recognize the presence

of a problem, but may misidentify it. In some instances, the denial of a problem is taken as evidence that the problem is more severe than if it were recognized. People like Jennifer would likely be committed to large mental hospitals under the medical model, often for extended periods of time.

Under the medical model, research and treatment are medical specialties. A concept of health must be developed against which illness is measured. Research focuses on a search for physical causes such as infections, genetic anomalies, or endocrinological abnormalities. A radical discontinuity is presumed to exist between health and disease, thus research focuses on patients; study of normal individuals is presumed to be irrelevant.

In evaluating the medical model we should recognize that it is the most widely accepted formulation at the present time. The medical model clearly underlies the early versions of the American Psychiatric Association's *Diagnostic and Statistical Manual,*[6] although later editions include some recognition of alternative models.[7]

Many mental disorders clearly fit the medical model. Among these are general paresis, the organic brain syndromes, and some cases of retardation. Clearly disease, trauma, genetic anomaly, and exposure to toxic substances can result in mental disorder. Traditionally, physical disorders such as irritable bowel syndrome, spastic colitis, ulcerative colitis and a variety of related gastrointestinal disorders were listed among the mental disorders because they were thought to be caused by psychological rather than biological factors. However, with the development of new diagnostic techniques, a number of specific biological factors have been found which account for a significant percentage of these disorders.[8] Recent evidence suggests that other mental disorders such as Alzheimer's disease and manic depressive disorders have at least a biological predisposing factor if not an outright biological cause.[9]

Despite recent findings, many mental disorders still have no known underlying disease process; Jennifer's suffering is such a disorder. It remains unclear whether further research will discover biological causes of these disorders.

Considerable difference of opinion exists regarding the contribution of the medical model. Some contend that the medical

model led to the elimination of earlier abusive and inhumane methods of dealing with the mentally ill. But this view has been challenged by those who believe that the moral-treatment approach, which was replaced by the medical model, was actually responsible for more humane treatment of the mentally ill.[10]

Another criticism of the medical model is the role which it has played in the development of the legal principle of finding persons not guilty for criminal behavior because of insanity. Szasz has been a particularly outspoken critic of the model because of this effect. Thus, in some quarters the medical model is viewed as a backward step.

The Sociopsychological Model

The sociopsychological model, closely related to earlier behavioral models, is probably the most widely accepted alternative to the medical view. Where the medical model suggests qualitative distinctions between normal and disturbed functioning, the sociopsychological model contends that disordered behavior follows the same principles as normal behavior. Disordered behavior results from unusual learning experiences rather than from a disease process. Problem behavior develops by the same principles as normal behavior, and thus may be changed through application of the principles of normal learning and behavior control.

The sociopsychological model suggests that diagnosis should focus on identification of the frequencies, topographies (or forms), and social or environmental controlling conditions of problem behaviors. It assumes that the average individual is sufficiently aware of the problem to be motivated to seek change and to become an active participant in the change process. Since the person's behavior is believed to follow the normal laws of behavior, the individual is neither exculpated from social consequences nor given special privileges. Under this model the counselor would seek to discover the patterns of behavior associated with Jennifer's different "personalities" and the circumstances in which they occurred. The counselor would then seek to develop more constructive ways for Jennifer to deal with the events of her life, and to weaken or eliminate all the "personalities" except "Jennifer."

Research under the sociopsychological model focuses on discovering the principles of behavior acquisition, control, and elimination, rather than on identifying disease processes.

The sociopsychological model is based on the accumulated results of over seventy-five years of laboratory research on learning, motivation, perception, social relations, growth, and development. The basic principles of behavior are well established, and there is much evidence that therapy approaches based on this model can be very effective.[11]

Systems Model

Another model that has gained considerable support in the past few years is the systems model. This view holds that mental disorders arise out of disturbances in the family system or social system rather than from a disease or disturbed learning pattern. In this model the focus is on the interactions among members in a social system rather than on an "identified patient." Although the parents may come seeking help for a disturbed child, it is believed that the problem does not lie solely within the child; rather, the problem arises out of the interaction between the parents and the child. The problem may be affected by other individuals as well, such as siblings, extended family, and peers.

Intervention with this model is focused on changing the properties of the system rather than on changing the individual. For example, instead of directing efforts toward eliminating stealing by the second child, treatment might seek to resolve chronic conflict between the parents. According to the family-systems view, the child steals in order to keep the family together; while involved in dealing with him, Mom and Dad do not fight with each other. Thus if Mom and Dad ceased fighting, stealing would no longer be necessary.[12]

For Jennifer, this model suggests examination of her family or living situation, then seeking to alter operation of the overall system, thus changing Jennifer.

The Christian Model

Dissatisfied with the medical model, and concerned with many anti-Christian implications in the other models, some have proposed development of Christian models. During the 1970s,

for example, there were a number of efforts to develop a Christian approach to counseling. Implicit in each of these is a view of mental illness or psychopathology.

Despite these efforts, it seems unlikely that there will be a single Christian approach to counseling, or a universally accepted Christian view of mental illness.[13] This is not too surprising. Just as there are many different Christian theologies and approaches to the understanding of Scripture, it seems likely that there will continue to be many Christian approaches to counseling and mental illness.[14]

Although differences seem inevitable, there are some distinctive emphases which characterize the various efforts to develop a Christian model. Almost all believers share these convictions: first, that persons have a spiritual dimension because we are all made in the image of God, and second, that mankind is fallen as a result of sin. These two factors have profound implications for a Christian approach to mental illness.

The spiritual dimension is believed to provide a resource which can prevent or ameliorate mental disorders. Also, many Christian authors believe that at least some mental disorders come about because the spiritual dimension is neglected, or is distorted through sin.[15] If this view is correct, then a complete and fully effective approach to treating mental disorders must include the use of spiritual resources such as forgiveness, repentance, prayer, and Scripture.

Despite general agreement in some areas, there are other areas of disagreement among Christian authors. For example, consider the different views about the relationship between theological and psychological approaches to knowledge.

At one extreme on this issue are those who agree with Ellens:

> Since Christians acknowledge that all truth is God's truth, no matter who finds it or where it is found, the information derived from both psychology and theology is taken with equal seriousness. God's message in the special revelation of Scripture and God's general revelation in the created world are both sought diligently to ensure the maximum constructive interaction between theology and psychology.[16]

Carter and Narramore, and Cosgrove and Mallory hold similar views, as do many other Christian professionals.[17]

At the other extreme are persons like Hunt and McMahon, who argue in this manner:

> [Psychology] is a pseudo-science riddled with contradiction and confusion. . . . The basic problem with the "all truth is God's truth" approach lies in the fact that psychology pretends to offer answers which, even if it were a science, it could never give. We have no quarrel with chemistry, medicine or physics, but with psychology's pretense to scientifically understand and deal with the heart of man, who is a spiritual being made in the image of God.[18]

A number of others, such as Adams, the Bobgans, and perhaps Kilpatrick, seem to agree with Hunt and McMahon's view.[19] These authors believe that psychology has little or nothing to offer; in fact, they view psychology as distinctly harmful.

A third group of Christians holds an intermediate position, seeing some value in psychology, but contending that biblical and psychological truth do not stand on equal footing. To them psychology must be made subject to Scripture. Advocates of such a view include McQuilkin and Crabb.[20]

In light of the diversity of views among Christians about the relationship between psychology and theology, it is understandable that there is also a diversity of approaches to the problem of mental illness or psychopathology among pastors and Christian professionals. In general, two basic approaches have been taken. The first is one which largely adopts one of the many psychological theories, adapting it in various ways to fit the author's understanding of Scripture. Proponents of the "all truth is God's truth" perspective generally take this approach.

In contrast are those who reject psychology on the grounds that it is anti-Christian. Instead they advocate "Christian Counseling" or "Biblical Counseling." Adherents of this view generally reject the medical, sociopsychological, and systems models of mental illness; in their place they propose a moral or sin model. In Adams's words,

> . . . the Scriptures plainly speak of both organically based problems as well as those problems that stem from sinful attitudes and behavior; but where, in all of God's Word, is there so much as a trace of any third source of problems which might approximate the modern concept of "mental illness."[21]

For Adams all problems come from sin. The solution is nouthetic counseling, an approach which confronts the individual with scriptural teaching about the sinful patterns in his or her life, counsels confession and repentance, and emphasizes change into conformity with God's Word. Adams advocates that all Christians take this approach, but he is especially concerned with those who are involved in pastoral ministry. In his view, this approach should be adequate for all mental-health problems except those rare instances which clearly have an organic (or biological) basis.

Since Jennifer's problems have no identified organic basis, adherents of this view would likely focus on exhorting her to acknowledge her present sinful conduct, repent, and change her ways. In the likely event that she proved unwilling or unable to admit her sin and repent, they would have little more to offer her until she was ready to do so.

Although proponents of the biblical and Christian counseling approaches often vehemently reject psychology, they seem to overlook the fact that in adopting counseling they are embracing techniques which have their intellectual roots in psychology and education. Those who have studied counseling theory readily recognize that familiar psychological models and theories underlie the popular "Christian counseling" and "biblical counseling" approaches.

For example, Jay Adams draws heavily on the writing of psychologist O. Hobart Mowrer; Lawrence Crabb's approach leans heavily on the rational emotive therapy of psychologist Albert Ellis; and William T. Kirwan extensively uses the ideas of the late humanistic psychologist, Carl Rogers.[22]

Advocates of these approaches are a minority. Most efforts to develop a Christian model acknowledge at least some aspects of the medical model. Further, the medical model enjoys

widespread acceptance among respected professionals across the boundaries of a variety of mental-health disciplines, including psychiatry, psychology, and social work.

Any credible effort to deal with the complex issues involved in mental disorders must take into account the diversity of phenomena involved. Mark Cosgrove and James Mallory, in their book *Mental Health: A Christian Approach* provide one example of a successful attempt to deal with this complexity.[23] One of the major reasons for the continued diversity of models of mental disorders stems from this complexity and from the fact that so far no single model seems to adequately address the roles of physical, social, psychological, and spiritual issues involved. This will become clearer as we examine in more detail the scope of disorders included in DSM-III-R.

Summary

Several models have been proposed over the years to account for the phenomenon now known as mental illness, including the spiritual model, the moral model, the medical model, the sociopsychological model, and the systems model. By far the most common model is the medical model. Some Christian theorists reject the medical model, and tend to reject the notion of mental illness entirely except for instances of organically caused difficulties, which are presumed to be rare.

If we are to understand the relationship of demonic influence to mental illness it is important that we understand the medical model, especially as incorporated in the DSM-III-R diagnostic system. It is to this issue that we turn in the next chapter.