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Models of Mental Illness

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Mental Illness, Models of. Although the concept of mental illness is central to the field of mental health and the practice of counseling, there is continuing disagreement about its definition. Several views are widely held. Each has important implications for understanding mental illness, determining which conditions are disorders and who has them, and choosing appropriate approaches to treatment. This controversy involves several important issues.

In a recent review, Wakefield (1992) presents a summary of the different approaches to defining mental illness. They include the views that mental disorder is a myth, purely a value concept, whatever professionals treat, statistical deviance, disadvantage, unexpectable distress or disability, or harmful dysfunction. Wakefield prefers the harmful dysfunction approach, which he believes is essentially identical with common conceptions of physical illness. Several of Wakefield's major points are summarized.

Psychiatrist Thomas Szasz contends that mental illness is a myth. Central to the illness model is the notion that biological lesions and disorders go together. However, physical lesions are possible without constituting a disorder (e.g., albinism, webbed toes), and disorders may occur without a known lesion (e.g., trigeminal neuralgia, senile pruritus). Szasz believes a few mental disorders are based on biological causes. The rest, he contends, are merely evaluative labels that legitimize social sanctions and change efforts directed at persons who do not behave in socially approved ways. Examples include labeling homosexuals, runaway slaves (drapetomania), and social dissidents mentally disordered. Demonstrating abuses, however, does not establish that mental disorder is a myth. Evidence that schizophrenia occurs widely across cultures strains the claim that mental disorder is purely a value concept.

Limiting mental disorder to that which professionals treat also has problems. It implies that without treatment one does not have a disorder. Conversely, seeking treatment only to discover that one is normal becomes impossible under this criterion.

Statistical deviance likewise fails. One can be deviant in both positive and negative ways, yet the statistical approach treats these as equally disordered. Also, some disorders, such as high blood pressure, are statistically common. Statistical rareness is thus inadequate. Defining disorder as negative deviation helps—but it introduces values. Further, crimes, discourtesy, and moral transgressions, while undesirable, are not considered disorders.

Biological disadvantage, an evolutionary concept, labels as disorders those conditions that impair fertility or speed mortality, thus threatening species survival. However, many disorders appear to have neither of these consequences.

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994), or *DSM-IV,* is based on the notion of unexpectable distress or disability. Although harmful dysfunction provides the conceptual foundation, the criteria for specific disorders are based on distress or disability and statistical infrequency. The problem is twofold, Wakefield points out. First, normal reactions that are statistically rare are defined by *DSM-IV* as disordered. Second, such unexpected conditions as extreme misfortune and ignorance can cause distress and disability yet are excluded as mental disorders; *DSM-IV* describes some of these conditions under the V codes.

Wakefield (1992) concludes that harmful dysfunction is the best definition of mental disorder. Harmful dysfunction is a hybrid definition: "disorder must include a factual component . . . (and) disorder requires harm, which involves values" (p. 381). For Wakefield the factual-scientific component of disorder is based on evolutionary biology; that is, disorder involves a failure of a human biological system to perform its intended function in preserving the organism. Wakefield infers intended function from the effects of the system; it need not imply active agency such as that of a creator God. He concludes "an evolutionary approach . . . is central to an understanding of psychopathology. Dysfunction is thus a purely factual scientific concept" (p. 383). In addition, "only dysfunctions that are socially disvalued are disorders" (p. 384). A key factor is that "it is the nature of the cause of the symptoms, and not the nature of the symptoms themselves, that determines whether a disorder is mental" (p. 384).

Central to the concept of mental illness is the notion that behavioral disturbances are in some sense diseases. Although it is clearly no longer the sole model, the disease model, or harmful dysfunction, remains the most widely accepted view. The difficulty one faces in attempting to refer to these phenomena without using terms connoting illness reflects the pervasiveness of the disease/mental illness model.

Historical Perspective. From antiquity until the late nineteenth century persons with deviant behavior were considered to be malingerers, a moral concern, or to be possessed by spirits, a religious concern. Exorcism and torture were used in an effort to remove the influence of evil spirits. Special favor was given to benevolent spirits.

Treatment of the mentally ill changed markedly during the period from the late eighteenth century through the time of Sigmund Freud. The humanitarian reforms under Phillipe Pinel, Tuke, and Dorothea Lynde Dix resulted in modification of asylums. Greisinger and Morel advanced the disease hypothesis. John Gray, editor of the *American Journal of Insanity* from 1855 to 1885, insisted that physical lesions produced insanity and led in the transformation of mental asylums into treatment facilities. The work of Jean-Martin Charcot, Pierre Janet, Bernheim, and Freud led to a conceptual shift; persons who had previously been considered malingerers were subsequently diagnosed as hysterics. Thus the disease model was extended to persons outside the institutional care setting.

Further credence was given to the disease model by the dramatic discovery that advanced syphilitic infection causes general paresis, a psychotic disorder. This hypothesis was first suggested in 1857; positive identification of syphilitic infection as the causative agent was provided in 1913. Together these movements culminated in a major paradigm shift in which the disease notion replaced moral-religious explanations.

The view that mental disorders are diseases has been widely accepted in the twentieth century. However, there is considerable conceptual ambiguity regarding the nature of the disease or medical model. Blaney (1975) suggests four versions: mental disorders are physiologically based diseases; evidences of disorder are manifestations of an underlying condition (not necessarily organic); the individual has no responsibility for his or her behavior; psychiatric symptoms can be best understood by ordering them into syndromes.

Alternative Models. A number of alternative models have been advanced to replace the medical model. Most widely accepted are the various sociopsychological or behavioral models. Sociopsychological models postulate that there is no radical discontinuity between normal and disturbed behavior. The underlying mechanisms of behavior are the processes of learning and behavior control. Diagnosis is focused on identifying the frequencies, topographies, and social or environmental conditions controlling problem behaviors (Kazdin, 1989).

The systems model locates the problem within family and social systems rather than in the individual. For example, many contemporary family therapists view parent-child problems as problems of the system. Neither the parent nor the child is identified as a patient who has the problem. Rather, the problem arises from the interaction between parent and child and may be significantly affected by interactions with other family members or circumstances as well.

Culture and Mental Disorder. *DSM-IV* contains an appendix that examines culture-related syndromes. Anorexia nervosa and chronic fatigue syndrome, disorders that are largely found in the United States and Europe, remain in the main body of the *DSM,* while *ataques de nervois,* a Latin American disorder similar to hysteria, and *tajin kyofusho,* a Japanese disorder similar to social phobia, are relegated to the appendix on culture-related disorders. A study of Hopi culture reveals five conditions that overlap with the *DSM-IV* criteria for depression, although none fully fit: two conditions are translated worry sickness, others include unhappiness, heartbrokenness, and drunkenlike craziness with or without alcohol.

Two conclusions may be drawn. First, mental disorders occur across cultural boundaries. Second, the precise form of disorders varies across cultures, with some disorders being very different and others fairly similar in varied cultures. Stix concludes "although some diseases, such as schizophrenia, do appear in all cultures, a number of others do not. Moreover, the variants of an illness—and the course they take—in different cultural settings may diverge so dramatically that a physician may as well be treating separate diseases" (Stix, 1996, p. 16).

In a recent discussion of culture and mental disorders, Dana noted that there is a tendency to treat cultural differences as pathology. He proposed that cultural information is essential to reduce egregious misclassification. Dana went on to say, "DSM is a very dangerous instrument, and it really is used for social control. . . . It lumps together disease (medical model) and cultural model etiologies" (Dana, 1996).

Christian Perspective. Since a Christian approach is particularly concerned with ethical and moral issues, the differences between a medical and a sociopsychological conceptualization of mental illness have profound implications for a Christian perspective. In a medical conceptualization the alcoholic, the depressive, the psychopathic, the retarded, and other disordered individuals are seen primarily as victims of processes outside their control. If the problem is viewed as a behavioral disorder, the individual's personal responsibility for his or her present condition becomes a prominent issue with clear moral implications. In reality the issues may be even more complex, since contemporary research increasingly shows that personal-social lifestyle is a major contributing factor in contracting various physical diseases.

For many Christians, Wakefield's (1992) appeal to evolutionary biology in explaining dysfunction is objectionable. However, failure to perform a God-intended function is a plausible alternative. The claim that dysfunction is purely factual fails, since science is not possible without making prescientific assumptions, and any interpretation of scientific data inevitably mingles observations and assumptions. In the words of Bevan and Kessel (1994), "most often implicit, ideologies are complex, not easily broken into elements . . . they are like sand at a picnic: they get into everything . . . to talk of scholarship and science as separate from the life

experience, the intentions, the values, the worldview, and social life of the people who create it is to deny its fundamental character as a human activity" (p. 506).

While articulate presentations that are sensitive to complex issues remain rare, the ramifications of these models have not escaped Christian writers. At one extreme Adams (1970) emphatically proclaims that all problems reflect either organic disorder or sin. Other writers recognize that sin and organic disorders are only two of many potential causes of psychological problems. Some causes include response to existential issues, maladaptive use of defense mechanisms, demonic influence, and learning (Cosgrove & Mallory, 1977).

All mental disorders—indeed, all problems in our world—may ultimately be traced to the entry of sin into the world and the subsequent disruption of the created order (cf. Rom. 8:19–22). Thus at one level it is accurate to say that the cause of psychological problems is sin. However, viewing the problem solely as personal sin is too simplistic. The effects of sin are manifested in mental disorders on at least three different levels: the effects of personal sin leading to guilt or anxiety; the effects of sin in the world, resulting in various biological disorders such as genetic disorders, endocrinological malfunctions, disease, and traumas; the effects of the sin of others, such as retardation due to neglect or abuse by a parent and anxiety or depression following an assault. In addition, we see interactions among these factors, such as when a person's abuse of alcohol or drugs results in brain damage.

Ethical and moral issues have often been viewed as largely irrelevant within the medical model of mental illness. However, it is becoming increasingly clear that moral issues are significant. The medical model suggests that individuals should not be held responsible for their diseases. But increasing evidence that personal habits are a major factor in illness underscores the role of personal responsibility for disease. Such habits as use of alcohol, tobacco, and drugs; diet; exercise; sleep patterns; and sexual promiscuity contribute significantly to risk of disease. In addition, compliance with treatment has become an increasing source of professional concern and research. All of this suggests that the distinctions between medical and psychosocial viewpoints may not be as clear-cut as the foregoing discussion might imply.

Analogies can be drawn between the various effects of sin in psychopathology and models of psychopathology. The presence of sin in the world is most clearly reflected in the disease model, which focuses on the physical basis for disorders. The effects of personal sin and to some extent the sins of others seem consistent with the sociopsychological model. Finally, the systems model emphasizes phenomena most consistent with problems stemming from the sinfulness of others.

Conclusions. The medical model has been helpful in some respects and has created problems in others. However, the complexity and diversity of phenomena included in *DSM-IV* require acknowledgment of multiple causal factors in mental disorders, and therefore the medical model alone is inadequate. A comprehensive model of mental functioning must include the following components: biological factors, including genetic, anatomical, and biochemical causes and infectious diseases; psychological factors, including personal, developmental, and family history, and relationships to others; social factors such as societal and cultural norms and standards; spiritual factors, including personal sin, ethical and moral responsibilities, relationship to God, and spiritual growth and development. It is doubtful that any existing model is able to fully encompass this diversity.

Medical considerations are essential to a full understanding of mental disorders, and further advances will likely be made through the medical approach. However, the medical model does not encompass all of the phenomena included under mental illness, and hence other models are required as well. Perhaps an integrative model that brings together elements from several of the present models will emerge. Alternatively, a comprehensive new system may eventually develop. Such a model should reflect the biopsychosocial and spiritual complexity of human functioning.

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