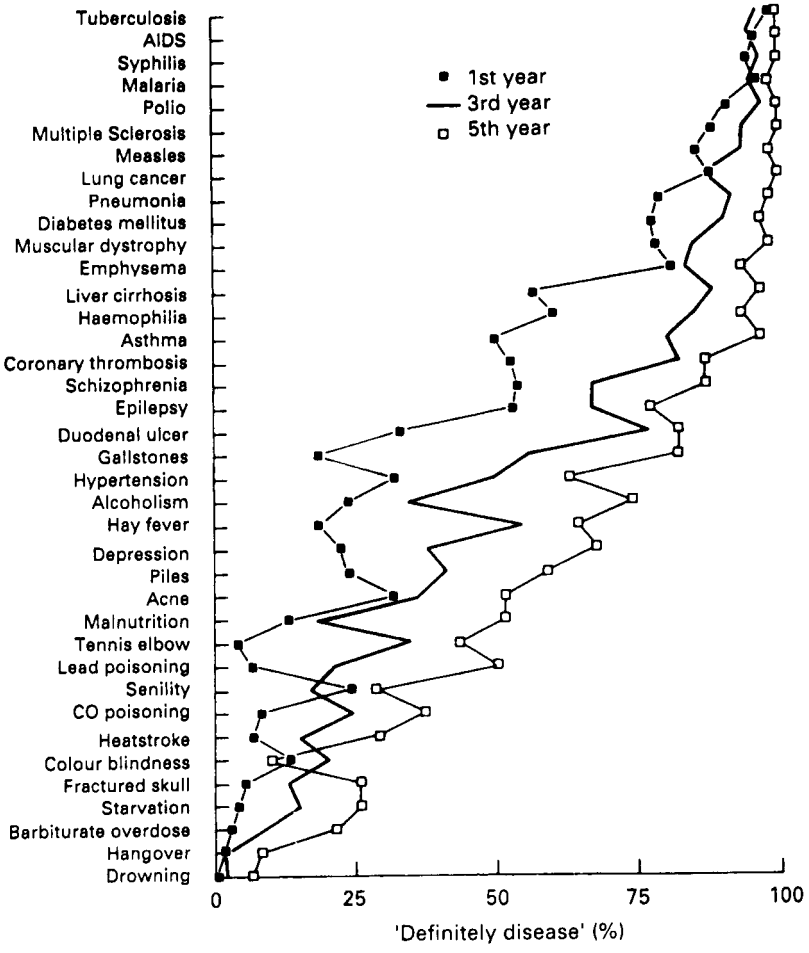
Models of mental illness

- The definition of ABNORMALITY, both in psychology and medicine, is fraught with difficulties and cannot be based solely on statistical criteria, biological maladaptivity, or personal awareness by the patient.
- As they pass through medical school, students change their perceptions of whether particular conditions are 'diseases', becoming less ESSENTIALIST and more NOMINALIST.
- The MEDICAL MODEL and the BEHAVIOURAL MODEL of psychiatric illness differ in most of their implicit assumptions about the nature of psychiatric illness and its appropriate treatment. Many practising psychiatrists are ECLECTIC, utilizing features from both in the BIO-PSYCHO-SOCIAL MODEL.
- Psychological models, such as LEARNING THEORY, PERSONAL CONSTRUCT THEORY, and PSYCHOANALYTIC THEORY, differ to a large extent in

classifies behaviours such as suicide as abnormal (although lemmings may provide a problem), but also has to say that chastity is 'abnormal'. More problematic is that many homozygous genes, such as sickle-cell anaemia, are disadvantageous for individuals but nevertheless selected for due to their beneficial effects in heterozygotes: should therefore biological maladaptation be considered for the individual or the population? An alternative defines abnormality as being antisocial, and although including the arsonist's fire-raising, the definition also includes minor offences like parking on a yellow line or over

consumption of garlic. Yet another approach defines abnormality as a person seeing themself as abnormal, so that symptoms are defined by the patient's decision to attend a doctor. Unfortunately a defining characteristic of psychoses is an absence of insight (see Chapter 28)

Abnormal behaviour alone does not indicate mental illness, any more than one cough indicates physical disease. As a concept, DISEASE is broader and more difficult to define, despite it being obvious that, say,


Tuberculosis
AIDS
Syphilis
Malaria
Polio
Multiple Sclerosis
Measles
Lung cancer
Pneumonia
Diabetes mellitus
Muscular dystrophy
Emphysema
Liver cirrhosis
Haemophilia
Asthma
Coronary thrombosis
Schizophrenia
Epilepsy
Duodenal ulcer
Gallstones
Hypertension
Alcoholism
Hay fever
Depression
Piles
Acne
Malnutrition
Tennis elbow
Lead poisoning
Senility
CO poisoning
Heatstroke
Colour blindness
Fractured skull
Starvation
Barbiturate overdose
Hangover
Drowning
1st year
3rd year
5th year
0
25
50
75
100
'Definitely disease' (%)

other assumptions in what is now described as the MEDICAL MODEL OF DISEASE, which is contrasted with other models such as the psychoanalytical and moral models. With psychiatric abnormalities the medical model emphasizes the central role of a clear, specific and accurate DIAGNOSIS, from which comes a precise treatment and prognosis. The AETIOLOGY (cause) of a disease may not actually be known but in principle is always knowable. SYMPTOMS are regarded as an inexact reflection of the disease process, which may be better assessed by special tests. TREATMENT is by medical and surgical procedures, such as drugs which are specific and depend upon the diagnosis. The

PROGNOSIS is also specific, but may always be transformed by a therapeutic breakthrough. Attempted SUICIDE is an especial problem with psychiatric illness, and must be predicted if possible and prevented by treatment. The FUNCTION OF THE HOSPITAL is to care, treat and cure

Other models of mental illness often contribute components; for instance the MORAL MODEL is concerned entirely with behaviour which

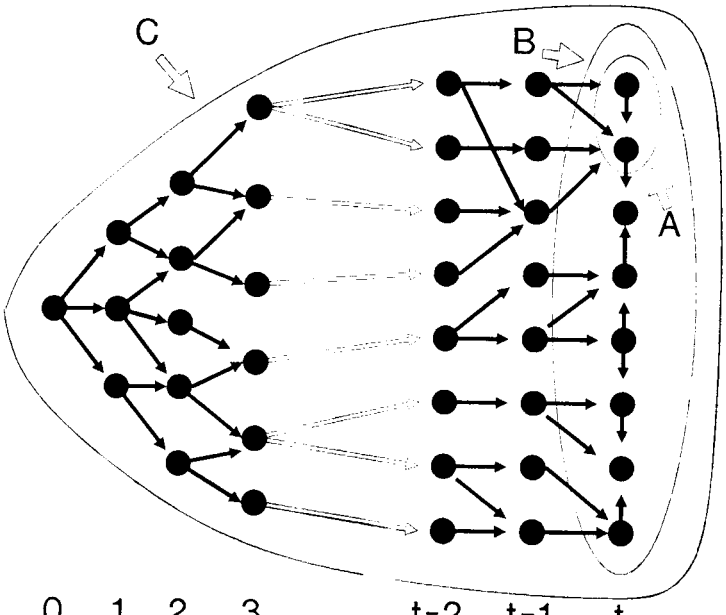


Fig. 27.3 A diagrammatic representation of the levels of explanation of

their problem. Since however this book's purpose is principally to describe psychology, treatment will not be considered in depth, except in so far as it illuminates *psychological* processes; therapy is primarily the province of psychiatry and of clinical psychology, and you must go elsewhere for a detailed discussion of those matters.