SCOMM

#6:26

"Mental Illness" and "Disease":

Outmoded Concepts in Alcohol and Drug Rehabilitation

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ABSTRACT: *Are the addict and alcoholic mentally ill? By traditional standards, yes. The validity of the "mental illness" concept and its associated psychiatric labeling process, however, is challenged. A synthesis of the human ecological systems and third-force frames of reference is presented as a viable alternative to the medical "disease" model of alcoholism and drug dependency. According to the proposed dis-ease model, "alcoholism," "addiction," and "mental illness" are considered to be modes of coping with pain and anger associated with a person's participating in social systems that frustrate self-actualization and diminish self-esteem. Combined treatment of "alcoholics," "addicts," and "nonaddicted psychiatric patients" is supported with qualifications.*

Are the addict and alcoholic mentally ill? If we attempt to answer this question based on the current psychiatric nosological system for "mental disorders," the answer is yes. According to the Committee on Nomenclature and Statistics (1968) of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, both alcoholism and drug dependence are classified as subdivisions under the heading of "personality disorders and certain other nonpsychotic mental disorders." Of course, the validity of the affirmative answer based on this criterion is only as firm as the validity of the classification system on which it is based. Suffice it to say that this nosological system is not without its critics.

If we attempt to answer the question from a psychometric perspective, based on published studies, the answer again is yes (MacAndrew, 1965; Gilbert & Lombardi, 1967; Sheppard, Florentino, Collins, & Merlis, 1969; Uecker, Kish, & Bell, 1969; Goldstein & Linden, 1969; Goss & Morosko, 1970; Sutker, 1971; Whitelock, Patrick, & Overall, 1971; Rozynko & Stein, 1972; Fitts, 1972; Fitts, Arney, & Patton, 1973; Kammeier, 1973; Kline, Rozynko, Flint, & Roberts, 1973; Overall, 1973; Robinson, 1973). All of the above studies reported extremely deviant scores for alcoholics and addicts on instruments purporting to measure "emotional illness." For the most part the instruments used were the Minnesota Multiphasic Personality Inventory (MMPI) and the Tennessee Self-Concept Scale (TSCS).

Carroll and Klein (1974), however, have demonstrated that when personality characteristics of alcohol and drug addicted men are evaluated with an

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instrument oriented toward normal functioning (for example, the Personality Research Form), they appear to be normal. Could it be that investigators expecting to find pathology, as indicated by their choice of tests (for example, the MMPI), have unwittingly biased their results?

Several of these studies (Goldstein & Linden, 1969; Whitelock, Patrick, & Overall, 1971; Rozynko & Stein, 1972) also indicated that the gross labels "alcoholic" and "drug addict" tend to obscure a significant degree of heterogeneity within each category.

If we attempt to answer the question on the basis of "clinical experience," the response once more is in the affirmative (Rossi, Stach, & Bradley, 1963; Doyle & Nyswander, 1965; Dichter, Driscoll, Ottenberg, & Rosen, 1971; Driscoll, 1971; Driscoll & Barr, 1972; Halikas, Goodwin, & Guze, 1972; Moore, 1972; Poze, 1972; Marsh, 1973; Crowley, Chesluk, Dilts, & Hart, 1974).

My own clinical experience leads me to conclude that once detoxification is completed and some degree of abstinence has been established, alcoholics and addicts are much more similar than dissimilar to nonaddicted mental patients. The "etiology," "dynamics," "defenses," and "treatment" overlap to a considerable degree. I might add that I have worked with both hospitalized mental patients and with alcoholics and addicts residing in a therapeutic community. Clinical experience, however, is a criterion that is particularly subject to various biases, especially that of "seeing" what you have been led to believe you should see.

INTERIM SUMMARY

The question of whether or not the addict and alcoholic are "mentally ill" was examined according to three traditional mental health criteria: the current APA nosology, psychometric studies, and clinical experience. All three criteria suggest that alcoholics and addicts are "mentally ill." It would seem logical that given this conclusion, we ought next to examine critically the concept of "mental illness."

Critical Review of "Mental Illness" Concept

The concept of "mental illness," which is based on a medical model, is the current and dominant theoretical explanation for our understanding of unusual or deviant behavior. Its antecedents (Coleman, 1972) include prehistoric and early civilization's emphasis on naturalistic, evil, spiritual forces as causes. Trephining or opening the skull to enable the invading evil spirit to escape was an acceptable though often fatal "professional" intervention.

Beginning with Biblical times through the Middle Ages, sin, Satan, and witchcraft were advanced as causes. Prayers, exorcism, torture, and death were accepted as "cures," and religious officials reigned supreme as the dominant mental health practitioners.

In the eighteenth century more humane treatment for the deviant person began to come into vogue. With this development the medical model, with its emphasis on "disease" and "mental illness," began to emerge as the preeminent explanation of unusual or deviant behavior. Medical practitioners began

to fill the vacuum created by the departure of shamans and priests of another era. The introduction and widespread use of psychotropic drugs in the 1950s merely strengthened the status quo.

Unfortunately the overwhelming majority of "mental illnesses," including alcoholism and drug dependence, do not neatly conform to the "disease" concept. Despite this imperfect fit, the chemically addicted man and woman did begin to receive somewhat better treatment as a result of their being perceived as sick rather than immoral, sinful, or criminal. They are now, for example, more likely to be referred or sent to treatment centers than to jails. The extent to which this development can be viewed as a gain, of course, depends on the relevance, effectiveness, and quality of treatment and rehabilitative services available at such centers.

Thus in adhering to the medical model's emphasis on "disease" we have apparently reached a plateau in our evolutionary understanding of "mental illness." The language, thinking, staffing, policies, and procedures of the "mental health" professions, of course, reflect this arrested development. The fact that many individuals within the mental health professions recognize that the language, concepts, and related practices are anachronistic, inaccurate, and misleading is no guarantee, however, that any significant breakthrough will be made from within the field itself.

This is not to imply that nothing is stirring within the field or that the "mental illness" blockage in the evolutionary process is impervious or insurmountable. A growing number of innovative thinkers within the mental health field are beginning to score some telling blows against the "mental illness" obstruction.

Philosophical and Professional Concerns

Szasz (1961, 1970) was one of the first to call our attention to the shortcomings and dangers of the "mental illness" concept. In addition to branding "mental illness" as a myth, he argued that psychiatric activity is often used as a form of social control, and that mental health concepts and professionals are often used to de-ethicize and depoliticize important and controversial ethical and political issues.

Laing (1967) has expressed similar concerns that the mental health professions tend to preserve the status quo by discrediting persons who fail to conform to social expectations and conventions.

Halleck (1971) has contended that helping individuals "get their heads together" may actually serve to eliminate their desire to change an oppressive and unhealthy social system. He also expressed the belief that traditional psychodynamic interpretations, with their emphasis on individual motivation, tend to neutralize potential political energy for change and reform.

Beit-Hallahmi (1974), too, has challenged psychology to break free of its preoccupation with intrapsychic concerns, for example, internal conflicts, and to begin seriously to recognize and deal with external causative factors such as social oppression, racism, and poverty. He argues persuasively that most psychologists are called on to "rationalize inequalities . . . or . . . the differential allocation of rewards in society" through such explanations as "low IQ," "weak superego," and "low frustration tolerance." He further describes

psychology as the "new opium of the people" and decries psychologists for blindly and mechanically accepting the role of the "resocializers of the nonconformists."

Caplan and Nelson (1973), Braginsky, Braginsky, and Ring (1969), and Braginsky and Braginsky (1973) have expressed similar concerns. That the American Psychological Association considers these matters to be pressing concerns can be appreciated by referring to two lead articles in the April, 1974, *APA Monitor:* "Committing dissidents—Is it a problem in U.S.?" and "Behavior modification under fire." Both articles cautioned against psychologists allowing themselves to become instruments of political oppression.

Lest we consider these claims to be exaggerated, Lesse (1972), although purporting to recognize the importance of psychosocial causes of addiction (for example, prejudice, poverty, and ignorance), recommended "sterilization" and "permanent institutionalization" for narcotic addicts who repeatedly fail in treatment programs or who are convicted of a felony while on heroin, provided the addict has a history of felonious criminal behavior.

A West German brain surgeon, Dr. Fritz Roeder (Muller, Roeder, & Orthner, 1973), announced the use of an operation called a "hypothalotomy" for the treatment of drug addicts. The operation consists of boring two tiny holes in the patient's skull and then inserting two needle-sized electrodes in the brain's hypothalamus. Appropriate cells in this area are then burned by high-frequency electrical impulses. The moral and ethical implications of this approach are staggering.

Research Evidence Regarding "Mental Illness–Health" Practices

Temerlin (1968) demonstrated the biasing and distorting effects of prestigious suggestion on judgments of "mental health–illness." Using psychiatrists, clinical psychologists, and graduate students as experimental Ss, Temerlin had them listen to an audiotape of an inverview that was introduced by a "prestigious confederate" who described the interviewee as "psychotic." The experimental Ss who had been given this suggestion rated the interviewee as much more emotionally disturbed than did a matched, control group of Ss who had received no such suggestion. The latter group actually perceived the interviewee in relatively healthy terms.

Goldman and Mendelsohn (1969) conducted a nationwide survey of psychotherapists in the United States. They concluded from their survey that psychotherapists tend much more to foster social control than the self-actualization of their patients.

Rosenhan's (1973) outstanding in vivo study of psychiatric diagnosis and treatment of "pseudomental patients" led him to conclude, ". . . we cannot distinguish the sane from the insane in psychiatric hospitals. The hospital itself imposes a special environment in which the meanings of behavior can easily be misunderstood. The consequences to patients hospitalized in such an environment—the powerlessness, depersonalization, segregation, mortification, and self-labeling—seem undoubtedly countertherapeutic (p. 257)."

Abramowitz, Abramowitz, Jackson, and Gomey (1973) demonstrated that the political and sexual biases of professional counselors clearly influenced

their judgments of "adjustment/maladjustment." In their study the clinical protocol of a "left-oriented, politically active female client" was rated significantly more "psychologically maladjusted" than matched protocols that differed only in terms of the "client's" sex and political inclination.

Recent studies have clearly documented a strong sex bias among mental health professionals. Neulinger (1968) and Chesler (1971), for example, have demonstrated that the sex orientation of our society is promoted by its clinical personnel. Broverman, Vogel, Broverman, Clarkson, and Rosenkrantz (1972) found evidence of negative stereotyping of women even among experienced professionals. Haan and Livson (1973), moreover, observed that even among "left-oriented, experienced" mental health professionals of both sexes, sex-related biases were in evidence. They concluded that professional status per se is no guarantee of invulnerability to cognitive bias. Both Chesler (1972) and Weisstein (1971) have written eloquently about the insidious and devious ways that sexism manifests itself when women seek therapy from mental health practitioners.

Langer and Abelson (1974) demonstrated that the label affixed to a person does much to influence clinical judgment. Using the same audiotape, but with two different labels, "patient" and "job interviewee," they observed that two groups of matched judges evaluated the former as "disturbed" and the latter in basically "positive" terms. They also observed that the more traditional the judges' training, the more they tended to judge the "patient" as "disturbed."

INTERIM SUMMARY

It is quite clear from the above that the concept of "mental illness" is being seriously questioned and challenged on philosophical, moral, ethical, and experiential grounds. In addition, mounting research evidence indicates that the concept is not associated with a reliable degree of scientific objectivity, but rather is subject to considerable bias, distortion, and misunderstanding.

These conclusions might lead us to ask what concept(s) will replace 'mental illness," and how would alcoholism and addiction relate to these alternative conceptual models?

Alternative Theoretical Frames of References

To appreciate fully the significance of these emerging models, the impact of two phenomena needs to be examined: the emergence of specialized, "self-help" services and the more significant social reform movements of the 1960s and 1970s.

Today there is a plethora of self-help services manned for the most part by nondegreed therapeutic helpers who are effectively assisting countless men and women to cope with a staggering array of serious human problems. Many of these same problems in the past would have been taken to traditional mental health caretakers, assuming there were sufficient funds to pay for such services.

Few, if any, of these self-help services are oriented around the "mental illness" concept. The manner in which services are dispensed is very much influenced by the fact that the helping person and the recipient of services

have shared a common, painful fate. This common history promotes a sense of equality and facilitates authentic communications, as well as suggests numerous nonmedical remediative strategies.

This phenomenon would seem to suggest that the emerging alternative models are most likely to be far less medical in their orientation and feature much more involvement of local, nondegreed therapeutic helpers in the administration and programmatic aspects of the service.

Some of the more significant social reform movements of the 1960s and 1970s include the human rights, antiwar, student dissent, women's, and gay liberation movements. Each of these has forced the mental health field to reexamine and question very fundamental assumptions and values underlying our understanding of "mental illness."

Certain behaviors that once were confidently labeled as "sick" are now considered as a healthy alternative life style, for example, the American Psychiatric Association has officially sanctioned the removal of homosexuality as a classification of mental disorder. The restlessness, boredom, and depression that many women experience in the traditional housewife-mother role are no longer believed to be due solely to intrapsychic events. Thus the newly emerging models are likely to be more balanced in terms of intrapsychic and situational or extrapsychic factors, and thus much more sophisticated and comprehensive in terms of their sociological, economic, and political components.

I have found two of the merging alternative models to be particularly enlightening, namely, the human ecological systems approach (Auerswald, 1968; Ryan, 1971; Caplan & Nelson, 1973; Carroll, 1973) and the "third force" movement in psychology (Goble, 1970; Otto, 1973). By synthesizing these two models, alcoholism, addiction, and "mental illness" would be perceived to be of a similar nature.

Their occurrence would be presumed to be due to an individual's belonging to and participating in several social systems that make contradictory, incompatible, impossible, or inhumane demands on him, or which tend to operate in such a manner as to retard or block the person's progress toward the fulfillment of his potentials (self-actualization).

As most people know, frustration produces pain and anger. Alcoholism, drug addiction, and "mental illness" are merely different routes by which people attempt to deal with the pain and anger. For this reason, I prefer not to employ the labels "addict," "alcoholic," "psychotic," "neurotic," and so on. Each is strongly "titled" toward the medical model that emphasizes the disease concept, intrapsychic causation, and people blaming (Caplan & Nelson, 1973). These labels, furthermore, have a static quality about them and tend to magnify and accentuate what are often superficial differences while attenuating or obliterating important similarities. If such concepts and labels must be employed, I prefer that they be used as adverbs, for example, he is behaving addictively, or neurotically. This usage has a more dynamic, here-and-now quality and implicitly predisposes the treator to consider that improvement may occur.

Remediation, according to this approach, would focus on both the frustrating social systems and the frustrated individual. Whereas some members of

the remediation team would attempt to ameliorate the frustrating aspects of the relevant social systems, others would be attempting to teach the individual how to exercise real, personal power within these systems in such a manner as to facilitate his or her self-actualization.

One reasonably good measure of the degree to which the person is or is not making progress in the direction of self-actualization is the self concept. Basically, the self concept is how an individual views and values himself (Jourard, 1963). When and if a person is making real progress in the direction of self-actualization, he tends to like himself.

The self concept is also an effective, unifying conceptual theme for addiction, alcoholism, and "mental illness." Our assessment program at the Eagleville Hospital and Rehabilitation Center clearly indicates that alcoholics and addicts have very little genuine self-esteem, especially with respect to their family relationships and moral-ethical standards (Kutner, 1974). My own experience with hospitalized mental patients leads me to conclude that they too share this experience of self.

INTERIM SUMMARY

The alternative models likely to replace the present, dominant medical model with its emphasis on "mental illness" are likely to be less medically oriented and better balanced in terms of emphasizing both intrapsychic and extrapsychic factors and thus more sophisticated and comprehensive with respect to sociology, political science, and economics. Nondegreed therapeutic helpers who have shared a common painful fate with the help-seekers will likely be the principal personnel force for the delivery of services. Human ecological systems and "third-force" approaches, with special emphasis on self-actualization and the self concept, were offered as useful concepts in evolving a unifying conceptual frame of reference for understanding alcoholism, addiction, and "mental illness." According to this perspective, the distinction among the three forms of deviant behavior would be less important than their commonalities.

This leads us to the next logical question, "Can alcoholics, addicts, and nonaddicted mental patients be effectively treated together?" My answer is that they are being treated together successfully in many facilities, every day, although the administration and program staff may not be aware of this fact.

Poze (1972) and Pokorny, Rumbaut, Wiggins, and Kyle-Vega (1973), despite their encountering some initial difficulties, reported that they did successfully treat mixed groups of addicts, alcoholics, and nonaddicted mental patients. Poze, however, did mention having received some personal correspondence from a colleague in New York City who had met with "severe behavioral and drug-taking problems" when the groups were mixed.

Typical problems encountered by these two independent ventures in mixed treatment were that addicts had difficulty identifying themselves as "patients"; the mental patients did not want to associate with "criminals"; the addicts were "institution wise" and attempted to "stay cool"; there were significant age differences (addicts being much younger than the other two groups); and the addicts tended to be demanding and manipulative. Staff apprehensions and disapproval of addicts had to be dealt with, as was their

belief that addictions are practically incurable. In addition, record keeping became more complicated.

Gains from mixing the three groups included an increase in energy and spirit brought to the combined groups by the addicts; less obsessive talk by the addicts about their drug use and less use of drug jargon; and a new awareness by alcoholics, addicts, and nonaddicted psychiatric patients that they all have problems in common, especially in the interpersonal sphere.

Both groups recommended maintaining the addicts as a minority in the combined groups (Pokorny, et al., 1973), suggested two addicts for every three nonaddicted patients in therapy groups).

Many of the gains and problems cited above are quite familiar to the Eagleville Hospital and Rehabilitation Center staff who first began to treat alcoholics and addicts together in 1968. Interestingly, apprehension by the staff regarding the presumed dire consequences of mixing alcoholics and addicts was also encountered at the hospital and center (Ottenberg & Rosen, 1971).

If experience seems to indicate that some alcoholics, addicts, and nonaddicted psychiatric patients can be treated together successfully in some programs, does this mean that the three groups should be mixed everywhere? The answer to this question is no.

First there is the matter of training. Many professionals are sorely lacking in education, training, and interest regarding alcoholism and drug abuse (Einstein, Garitano, Quinones, Havenhar, & Doroff, 1972; Bosma, 1973; Ottenberg & Carpey, 1974). On the other hand many nondegreed caretakers in the addiction problems field are inadequately trained to recognize and cope with severe emotional problems. This situation would have to be corrected before more widespread combined treatment could be undertaken.

Second, there is the matter of expenses. Mental health professionals receive considerably more money for their services than do the majority of therapeutic helpers in the addiction problems field, especially the nondegreed, recovering staff member. The discrepancies between the income of these two groups would have to be significantly reduced, otherwise there would be a continuing source of friction to contend with.

Third, the mental health professionals would have to be willing to let go or at least loosen their grip on the medical model and their obsession with intrapsychic phenomena.

Fourth, people who abuse alcohol or other drugs, or a combination of them, do not use mental health facilities (Cohen, 1974), therefore they would have to be attracted to or brought to such facilities, or the mental patients might be allowed out of their institutions for combined treatment.

If these problems could be solved, there are obvious benefits that would follow from a combined treatment approach.

1. The breath of understanding of human problems for mental health professionals and therapeutic helpers in the addiction problems field would be significantly broadened. Under favorable conditions, the combination of these two groups is most effective.
2. Money could be saved by avoiding unnecessary duplication in facilities, staffing, and programs (Ottenberg & Carpey, 1974).

3. The mental health field provides a rich continuum of services which could be adapted to meet many of the needs of the recovering alcoholic and addict (Ottenberg & Carpey, 1974).
4. The mental health field is especially well prepared to provide program evaluation and research services to the addiction problems field (Ottenberg & Carpey, 1974).
5. I believe a considerable amount of the mythology in both the mental health and addiction problems fields would be more rapidly dissipated as a result of combined treatment. Representatives from both fields would be quick to blow the whistle on the other side's myths. In the long run, knowledge would thus be advanced more rapidly and rigorously.
6. Finally, the emotionally distressed and those who abuse alcohol or other drugs—frustrated men and women in pain—would benefit from the cross-fertilization of these two vital fields. Caretakers from both fields would bring a rich array of skills, knowledge, and experience to a common undertaking. The combined efforts of both groups would most likely have a synergistic effect on existing programs.

CONCLUSIONS

The basic question addressed in this paper has been "Are the addict and alcoholic mentally ill?" If we choose to answer the question within the frame of reference of "mental illness," then the answer is yes. A concerted effort has been made throughout this paper, however, to disclose the serious limitations and dangers associated with the "mental illness" concept.

Alternative conceptual frames of references to the medical model have been discussed with a particular emphasis on the human ecological systems and "third force" approaches. According to these points of view, which I strongly endorse, "alcoholism," "addiction," and other forms of "mental illness" can be attributed to an individual's belonging to and participating in social systems that have frustrated his efforts to self-actualize his potentials. All three forms of deviant behaviors can thus be viewed as similar, in that they represent a maladaptive effort to cope with the pain and anger associated with the frustration of self-actualization.

The "self" concept is also recommended as a useful concept common to alcoholism, addiction, and "mental illness" and could be used as an indicator of the extent to which the individual was or was not moving in the direction of self-actualization.

Finally, the notion of treating alcoholics, addicts, and nonaddicted psychiatric patients together is generally supported. Along these lines, a greater degree of cooperation between the mental health and addiction problems fields is advocated, providing the two fields realistically, sincerely, and honestly addressed themselves to certain specified problem areas.

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1. TITLE OF PUBLICATION: COMMUNITY MENTAL HEALTH JOURNAL	2. DATE OF FILING: Sept. 19, 1975
3. FREQUENCY OF ISSUE: Quarterly	3A. ANNUAL SUBSCRIPTION PRICE: $15 indiv./$35 inst

4. LOCATION OF KNOWN OFFICE OF PUBLICATION *(Street, city, county, state and ZIP code) (Not printers)*: 72 Fifth Ave. N.Y. N.Y. 10011

5. LOCATION OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS *(Not printers)*: 72 Fifth Ave. N.Y., N.Y. 10011

6. NAMES AND ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR

PUBLISHER *(Name and address)*: Behavioral Publications, Inc. 72 Fifth Ave. N.Y., N.Y. 10011

EDITOR *(Name and address)*: Lenin Baler, PhD CMH Program, M.5108 SPH 11, University of Mich. School of Public Health. Ann Arbor, Mich. 48104

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