

Emerging Concepts of Mental Illness and Models of Treatment: The Psychological Point of View

BY GEORGE W. ALBEE, PH.D.

This author reviews the evidence for the "sickness" model of mental illness and finds it to be inconclusive. Psychiatry, he argues, in insisting on its prerogatives of primary patient responsibility and control of treatment facilities, bases its justification either on rare and uncertain genetic and metabolic conditions or on the common chronic organic conditions it characteristically neglects; the typical person in psychiatric treatment is suffering from neither. The alternative presented here is a social-developmental model, which would emphasize the nurturance of strength rather than the search for and excision of weakness.

IN PREPARING this presentation I had to choose between either: 1) developing a psychological model for disturbed behavior and then spelling out its implications for intervention and prevention or 2) discussing the shortcomings of the sickness model in order to provide a logical groundwork for the subsequent development of alternative models. I chose the second alternative because I have spent more time thinking about this problem and also because I do not think the alternative to the sickness model is likely to be a psychological model! Indeed I believe the new approach will be social-educational, and it is more likely to develop out of the fields of special education or social work than out of psychology.

What Is the "Sickness Model"?

This explanation of disturbed behavior,

Read at the 124th annual meeting of the American Psychiatric Association, Boston, Mass., May 13-17, 1968.

Dr. Albee is professor and chairman, department of psychology, Case Western Reserve University, Cleveland, Ohio 44106.

[42]

briefly stated, holds that "mental illness is an illness like any other." The very fact that strenuous efforts, made for a century and more, have achieved only limited acceptance of this slogan suggests that it is not entirely creditable.

Attempts to explain the origins of neurotic and psychotic behavior, addiction to alcohol, juvenile delinquency, mental deficiency, and even such peripheral problems as marital maladjustment and school learning difficulties as sicknesses inside the person make them discontinuous with normal behavior. The sickness model suggests that these conditions are among a number of separate, discrete mental illnesses, each with a separate cause, prognosis, and potential treatment. We have seen this theme in some of what Dr. Grinker had to say.

The sickness model further suggests that the treatment of these "illnesses" is properly the function of a physician specially trained in their diagnosis and in known methods of intervention. While other professionals may play various useful roles, they will be ancillary to the physician, who is charged with the clinical responsibility for the welfare of the "patient" (who must be "treated" in a hospital or clinic or in the physician's private office). Even the so-called personality disturbances, and all the agonies deriving from a dehumanized and hostile environment, are diagnosed as various kinds of sicknesses or intrapersonal illnesses.

This model, which occupies the center of our clinical stage, places the identification of forces in the individual before consideration of the hostile and damaging forces in his world; it demands that we try to fix him, treat his disease (as we do other diseases), and then send him back to the continuing horrors of his world. Realistically, it causes us to treat only the small number comprising those who believe in our cures or even

worse the much smaller number our cures may work, thereby causing us to neglect all those people with problems we do not understand because they do not fit our model, and those people who participate in, nor accept, our invention methods.

The origins of this explanatory disturbance, like the original human myth systems, are ancient and complex. Sarbin suggests that the word "illness" was first used by Avila in the 16th century to describe mentally disturbed people; it is a useful metaphor to protect disturbed (those who exhibited symptoms) from the Inquisition. "If a person could be accounted for by SI causes, it was to be regarded . . . but *comas enfermas*, 'as if sick' (448).

Werry (14), a research psychologist at the University of Illinois, received the disease model "the great disillusion of psychiatry." Elsewhere he says "The debate . . . between proponents of the disease model and those who believe that emotional and behavioral disturbances belong in the moral sphere and acrimonious but, as you must know, psychiatry in the past hundred years has achieved a substantial victory in this field . . ." (p. 4).

The end of moral treatment of the insane in America seems to have coincided with the middle half of the 19th century, beginning of the enormous wave of immigration into the United States of the Yankee physicians, who sought to extend a kind of Quakerism to the insane, found themselves dealing with the "foreign insane patients" who had inundated the retreats, jails, and houses in the latter part of the 19th century.

It was John P. Gray, superintendent of Utica State Hospital and editor of the *American Journal of Insanity*, in the late 19th century, became the chief spokesman of the position that mental patients were really physically ill with a brain disease. Gray is often awarded the distinction for being the most influential medical man for the rejection of a moral

is and Models of Point of View

holds that "mental illness is an any other." The very fact that efforts, made for a century and achieved only limited acceptance an suggests that it is not entirely

to explain the origins of neurotic behavior, addiction to alcohol, linquency, mental deficiency, and peripheral problems as marital lent and school learning difficulties inside the person make ntinuous with normal behavior. ss model suggests that these con: among a number of separate, ~ntal illnesses, each with a sepa, prognosis, and potential treat- have seen this theme in some of irinker had to say.

mess model further suggests that ~nt of these "illnesses" is properly m of a physician specially trained .agnosis and in known methods ntion. While other professionals various useful roles, they will be to the physician, who is charged :clinical responsibility for the wel- "patient" (who must be "treated" ital or clinic or in the physician's lice). Even the so-called person- Irbances, and all the agonies de- m a dehumanized and hostile !nt, are diagnosed as various icknesses or intrapersonal illnesses. odel, which occupies the center of al stage, places the identification of the individual before consideration)stle and damaging forces in hiS demands that we try to fix him, disease (as we do other diseases), send him back to the continuing If his world. Realistically, it causes t only the small number comprising 10 believe in our cures or even

worse the much smaller number for whom our cures may work, thereby causing us to neglect all those people with problems we do not understand because they do not fit our model, and those people who cannot participate in, nor accept, our verbal intervention methods.

The origins of this explanation of emotional disturbance, like the origins of most human Illyth systems, are overdetermined and complex. Sarbin suggests that the label "illness" was first used by Teresa of Avila in the 16th century to describe emotionally disturbed people; it served as a useful met<;phort to protect disturbed nuns (those who exhibited symptoms of hysteria) from the Inquisition. "If a person's conduct could be accounted for" by such natural causes, it was to be regarded not as evil, but *comas enfermas, 'as if sick'*" (10, p. 448).

Werry(14), a research psychiatrist at the University of Illinois, recently called the disease model "the great operating delusion of psychiatry." Elsewhere Werry(15) says "The debate . . . between the proponents of the disease model and those who believe that emotional and behavioral difficulties belong in the moral sphere was long and acrimonious but, as you must be aware, psychiatry, in the past hundred years, has achieved a substantial victory in this contested field . . ." (p. 4).

The end of moral treatment of the insane in America seems to have coincided, in the middle half of the 19th century, with the beginning of the enormous wave of foreign Un. migration into the United States. Most otthe Yankee physicians, who had been able to extend a kind of Quaker fellowship to the insane, found themselves unable to deal With the "foreign insane paupers" who had inundated the retreats, jails, and almshouses in the latter part of the 19th century. Ut was John P. Gray, superintendent of tica State Hospital and editor of the *American Journal of Insanity*, who in the a 19th century, became the chief advocate of the POSITION that mental patients were ~~ ..PhYSically ill with a b~ai? ~isease. ~s often awarded the dlstmctlon of III~g the most influential medical spokes- ~ for the rejection of a moral approach

to insanity (with its reliance on compassion, reason, kindness, and human interaction) and advancing instead the argument that the insane were victims of some unknown brain disease.

One of the primary arguments used by contemporary psychiatry to support its basic responsibility for the treatment of mental conditions holds that there are underlying organic defects, in most cases still undiscovered, producing the disturbed behavior. Starting from this uncertain platform, psychiatry advances the conclusion that medical training, most of which has not been used since the internship, somehow provides unique qualifications to treat these sicknesses.

The gossamer web of logic is not strong enough to hold the weight of this whole proposition, and many contemporary psychiatrists have rejected this argument. In the first place, there is little substantial evidence supporting the hypothesis of an underlying organic defect in most functional mental disorders. Second, their medical training of most psychiatrists was obtained years in the past and is not especially relevant to their therapeutic activities. In other situations, where the stakes are different, most psychiatrists have refused to practice medicine in any traditional sense. (Most psychiatrists are excused from volunteer duty at community health clinics and from emergency room duty in the military service.)

Third, when a real organic cause is discovered to be the significant underlying factor in the production of disturbed behavior (as has been the case in a few genuine mental diseases), then the treatment of these conditions is removed from the psychiatric field.

As Zubin points out:

As soon as a mental disorder is traced to some organic cause, however, it ceases to belong to the psychiatric fold and is handed over to internal medicine or neurology as was the case with general paresis, pellagra with psychosis, and will probably be the case with phenylpyruvic oligophrenia. Only diseases of unknown origin tend to remain in the psychiatric domain(18, p. 2).

Barbara Wooton (16) has made a searching examination of the interaction between

social and cultural forces and mental disorders. It will be clear to most thoughtful persons who examine her approach that "mental illness" is not "a disease like any other." She has spelled out certain crucial and fundamental differences between mental disorders and true diseases. She points out, quite correctly, that

. . . anti-social behavior is the precipitating factor that leads to mental treatment. But at the same time the fact of the illness is itself inferred from this behavior; indeed it is almost true to say that the illness is the behavior for which it is also the excuse. But any disease, the morbidity of which is established only by the social failure that it involves, must rank as fundamentally different from those with which the symptoms are independent of social norms(17).

In one of her examples Wooton reminds us that we diagnose a mental disease when we observe an individual disregarding the property rights of others, as for example, the adolescent who steals cars, the middle-aged suburban housewife who shoplifts, or the hippie who picks flowers from the city parks, refusing in the process to keep off the grass. Without this observable behavior we would not suspect the existence of an underlying "mental disease." So the identification of this "disease" depends on the violation of social laws which uphold the sanctity of individual or of public ownership. In a society where possessions were held in common such diseases could not exist!

The point of all this is that the social disapproval of the social consequences of behavior usually identifies the underlying "disease." In the absence of these interactions the disease would not exist.

What Evidence Supports the Sickness Model?

There is precious little evidence to support a discontinuity (sickness) model. At the center of the continuity-discontinuity argument stands the mystery condition (or conditions) of schizophrenia. There just must be a biological explanation! While the argument will not be entirely won or lost here, still the causation of schizophrenia is under constant debate, and support for a disease or defect explanation is being sought

most vigorously in the blood, sweat, and tears (as well as all the other fluids) of the schizophrenic.

Recently an entire volume (some 500 pages) of the *Annals of the New York Academy of Sciences* was devoted to "Some Biological Aspects of Schizophrenic Behavior" (11). Even this elaborate production could not obscure the fact that no clear-cut phenotypical defect has yet been found which even comes close to providing a key to a possible molecular basis for this condition. All sorts of profound-sounding statements were made which, on careful examination, turn out to be meaningless. For example:

It has become quite evident that neuropathology and its allied sciences are assuming a progressively important role in the study and understanding of mental disorders. Thus far, the morphologic, histochemical, and cytobiophysical observations in brain biopsies and toponomies appeared to be of a pleomorphic character and non-specific or rather of heterogenetic patterns. Therefore one must look forward to future research investigations(p. 481).

This polysyllabic nonsense says: "We haven't found anything yet, and we're still looking."

Occasionally someone finds a biological measure which does differentiate schizophrenics from controls, but as anyone knows who has followed this literature for the past 20 years, artifacts (like vitamin C deficiency or too much caffeine) have a way of confounding the significance of the differences found.

The discovery that chronic backward schizophrenics have smaller hearts than controls matched for age and sex would hardly prove that small hearts cause schizophrenia. Rather, a more parsimonious explanation in terms of lack of exercise would undoubtedly be suggested. But repeatedly the finding of some blood factor which differentiates backward schizophrenics from normals has been hailed as the long-sought key to the mystery of schizophrenia.

Seymour Kety(8), in an honest and straightforward review of biochemical theories of schizophrenia, refers to "a present consensus that a pathological lesion characteristic of schizophrenia or any of its subgroups remains to be demonstrated" (p. 409).

He reviews the errors and the confoundings or uncontrolled variables of all the new reports on the blood of schizophrenics (p. 418). He considers hypotheses concerning the complex and though, up to this implicating anyone itself is hardly complete.

If there is no clear-cut schizophrenia is an incomplete and far less scientific model explanation (forms of human dev Psychiatric Association statements claim such conditions as venile delinquency, trouble is that the ~ a kind of interventionist and a kind of a vener who is not finally, I predict, the better served!

If the organic approach is to be valid it is justified in demanding in the number of professionals prepared in the battle against the organic approach be convincingly valid seem to hold at least helping many more ther, the supply of fore psychiatrists) population has been years and probably cline(1).

Still another subtle lending support to mental disorder has taken place in the Use of the psychotropic drugs emotional conditions mentioned, beamed at psychiatric journals by keep emphasizing the Drug therapy has been

rously in the blood, sweat, and Nell as all the other fluids) of the nice.

an entire volume (some 500 the *Annals of the New York Academias* was devoted to "Some Biopsies of Schizophrenic Behavior." Even this elaborate production obscure the fact that no clear-cut biological defect has yet been found. It comes close to providing a key molecular basis for this condition of profound-sounding statement made which, on careful examination, turns out to be meaningless. For example,

It is quite evident that neuropathology's allied sciences are assuming a pro- important role in the study and understanding of mental disorders. Thus far, the toxic, histochemical, and cytobiophysical examinations in brain biopsies and post-mortem autopsies have appeared to be of a pleomorphic character, non-specific or rather of heterogenous nature. Therefore one must look forward to further investigations (p. 481).

lysyllabic nonsense says: "We found anything yet, and we're still

onally someone finds a biological factor which does differentiate schizophrenia from controls, but as anyone knows followed this literature for the past artifacts (like vitamin C deficiency, IUCH caffeine) have a way of controlling the significance of the differences

liscovory that chronic back-ward schizophrenics have smaller hearts than controls for age and sex would hardly fit small hearts cause schizophrenia, a more parsimonious explanation is that lack of exercise would undoubtedly be the cause. But repeatedly the finding of a factor which differentiates back-schizophrenics from normals has been the long-sought key to the mystery of schizophrenia.

Dr Kety (8), in an honest and reward review of biochemical theories of schizophrenia, refers to "a present view that a pathological lesion characterizes schizophrenia or any of its subtypes remains to be demonstrated" (p. 409).

GEORGE W. ALBEE

He reviews the errors, the subjective biases, and the confounding effects of unsuspected or uncontrolled variables that have led to premature "discoveries." He concludes that of all the new reports of toxic materials in the blood of schizophrenics "there has been no extensive substantiation of any of them" (p. 418). He continues: "Many of the current hypotheses concerning the schizophrenia complex are original and attractive even though, up to this time, evidence directly implicating anyone of them in the disease itself is hardly compelling" (p. 426).

If there is no convincing evidence that schizophrenia is an identifiable disease, there is far less scientific support for a sickness model explanation of all of the less extreme forms of human deviation, yet the American Psychiatric Association keeps issuing position statements claiming responsibility for such conditions as mental retardation, juvenile delinquency, and alcoholism. The trouble is that the sickness model demands a kind of intervention that is terribly expensive and a kind of highly trained intervenor who is not widely available. Eventually, I predict, the needs of society will be better served!

If the organic approach could be demonstrated to be valid our society would be justified in demanding an enormous increase in the number of medical and paramedical professionals prepared to take their places in the battle against "mental illness." But while organic approach has not been found to be convincingly valid, and alternative models seem to hold at least as much promise for helping many more disturbed people. Further, the supply of physicians (and therefore psychiatrists) in proportion to the population has been declining for many years and probably will continue to decline (1).

Still another subtle but powerful force lending support to the sickness model of schizophrenia has been the steady increase in the use of the psychotropic drugs that have become the common approach to many conditions. Persuasive advertisements beamed at psychiatrists in the psychiatric journals by the drug companies, emphasizing the value of drug therapy, drug therapy has been hailed by the great

popular medical journals—*Time*, *Life*, *Look!*

With hundreds of thousands of daily drug users in the public hospitals, plus millions more seeking tranquility or at least relief from intense anxiety, the psychotropic drugs have become a fantastic growth industry. Understandably any threat to the sickness model is a threat to the drug salesmen. What is good for General Napoleon is good for United Chemical!

By using drugs for the poor in the state hospitals we can get by with practically no professional personnel in these tax-supported settings. (In over one-third of our state hospitals practically no psychiatric time is available, and two-thirds of our 2,000 psychiatric clinics do not have a single full-time psychiatrist on the staff [1]). Eighty percent of psychiatric practice is private office practice with a suburban upper-middle class clientele.

Jules Henry (5) says: "State hospitals today seem to exhale from their antique bricks and dark labyrinths the miasmas of misunderstanding, prejudice, callousness, and hate whose origins lie deep in our history. Who knows what happens in the pit, where their voices do not come up to us?" (p. 48).

The point of all of this argument should not be lost. Psychiatry, in insisting on its prerogatives of primary patient responsibility and control of treatment institutions and intervention efforts of all sorts, bases its argument either on rare and uncertain genetic and metabolic conditions or on those common chronic organic mental conditions which it characteristically neglects. Most of psychiatric practice is private, most of it is suburban, and most hospital psychiatry is practiced in general hospitals. None of the organic mental conditions is the central concern of current psychiatric treatment.

A great majority of the people whom psychiatrists treat are not suffering from genetic, metabolic, and arteriosclerotic conditions, or from alcoholic delirium, or from central nervous system malfunction. If psychiatrists were to devote their primary attention to these kinds of cases there would be little need for today's debate about models. Repeatedly, surveys show that the most common psychiatric patient in 1968 is a college-educated,

ditions which "interfere with current functioning," but also those which, while not affecting in any way current functioning "carry with them the threat of future disability" (2). In other words, with this model an individual may be diagnosed as having a mental disorder although he is functioning adequately as a member of society if, in the principle that a man is innocent until proven guilty and that no one can be convicted for the possible commission of some future criminal act.

What Is the Alternative?

I have been arguing for the past several years that the social-psychiatric model to be replaced with a social-developmental explanation before our society will get off its inertia and begin to do some constructive things about large-scale intervention and prevention of human misery. The intervention will emphasize the nurturance of

What pills will ever dissolve the anxiety and fear that go with life itself? What will psychiatry ever know that it does not know now about the damage done by thoughtless, cruel parents to vulnerable children? What further "frontiers" do we really have to conquer, when it comes to such subjects as despair, brutality, envy?

and yet largely neglect those in greatest need), William Ryan(9) made a proposal so audacious, so revolutionary, so shocking in its implications that in another age he would have been tried for heresy and boiled in oil. He suggested that Boston's mental health establishment forego any further budgetary increases because their services were haJ!ip(l_no si-ifig'2 ..tA~l,J-'Ul~~abl, ?ffiu"u.dt the money saved be put into improved welfare services. (Dr. Ryan recently moved to Connecticut!) But Ryan is right. Casework; group work, and counseling by clergymen are reaching more of the citizens of Boston than are psychiatric facilities.

Freud forced the abandonment of the sickness model. Primarily, I t of the historical accident w

to be trained first as a physician. forces with Freud and the rest believe the evidence supports a new model which holds that it that the same mechanisms are adaptive and maladaptive hurt and will help lead the scientist those who seek to preserve a new sickness model.

.. will WOUlD ne VInerent J
Changed Models?

I have not yet really dealt with sequences that would follow from models. Very briefly, I hold that the nature of the model determines

Amer. J. Psychiat. 125: 7, January 1969

than the search for and extinction, and the prevention will be of social engineering to family.

Let many psychiatrists to agree approach because it is my experience many thoughtful leaders in psychiatry are saying the same Jackson(6) pointed out that:

ata are collected that provide evidence for the fact that mental disorders, schizophrenia, arise out of social relationships. Each year we cover this fact, splicing out the stories with dreams of glory about the cause of schizophrenia, and the like.

Robert Coles(4) said recently respect to what can legitimate psychiatric disorders, I am convinced that anything new will lead to 'cure' them. I am not even ought to call them 'diseases'." I ask the question that every health worker should be forced to

ever dissolve the anxiety and with life itself? What will psychiatry do that it does not know now done by thoughtless, cruel, inerable children? What further we really have to conquer, when subjects as despair, brutality,

completing his dramatic survey of health resources (which exceeds of any city in the world) neglect those in greatest need. Ryan(9) made a proposal, so revolutionary, so shocking that in another age he been tried for heresy and booted. It suggested that Boston's mental shment forego any further budges because their services were significantly beneficial effect on most in need of them and that they be put into improved welfare (Dr. Ryan recently moved to). But Ryan is right. Casework, and counseling by clergymen more of the citizens of Boston psychiatric facilities.

GEORGE W. ALBEE

The psychoanalyst should be in the vanguard, together with the social worker and the learning theorist, in advocating the abandonment of the sickness model and arguing for its replacement with a social-developmental model. Certainly the most fundamental contribution of Freud was his discovery of the continuity between the normal and the abnormal. In discussing Darwin and Freud, Jerome Bruner pointed out that the Victorians, reeling from Darwin's discovery of a perfectly lawful continuity between man and the rest of the animal kingdom, were dealt a second and more terrifying blow by Freud's discovery of the continuity between the sane and the insane. Bruner(3) speaks of the

... lawful continuity between man and the animal kingdom, between dreams and unreason on one side and waking rationality on the other, between madness and sanity, between consciousness and unconsciousness; between the mind of the child and the adult mind, between primitive and civilized man-each of these has been a cherished discontinuity preserved in doctrinal canons.

Freud forced the abandonment of these-cherished discontinuities.

Why, in the face of this central message of Freud's life work, does the latter-day psychoanalyst continue to pay homage to the sickness model? Primarily, I think, because of the historical accident which has required the psychoanalyst in the United States to be trained first as a physician. I look forward to the day when the psychoanalysts, perhaps in continuing self-analysis, will join forces with Freud and the rest of us who believe the evidence supports a continuity model, a model which holds that it is established that the same mechanisms are operating in adaptive and maladaptive human behavior, and will help lead the scientific assault on those who seek to preserve and defend the sickness model.

What Would Be Different If We Changed Models?

I have not yet really dealt with the consequences that would follow from changing models. Very briefly, I hold that: 1) the nature of the model determines 2) the nature

of the institutions we develop for intervention and prevention, which in turn dictates 3) the kind of manpower we use to deliver care. With a social-developmental model our state hospitals and public clinics would be replaced by social intervention centers, largely staffed by people at the bachelor's level-more like special education teachers and social welfare workers, potentially available in vastly greater supply than psychologists and psychiatrists. For prevention, people like ourselves would be needed as teachers, researchers, and especially as radical social activists proselytizing for changes in our society to make it more supportive, less dehumanized.

The massive deterioration of the fabric of society and its institutions results in a complex tangle of pathology. The pathology includes especially the destruction of the emotional integrity of the family. Let me emphasize here something that you already know very well. Many significant research breakthroughs have already been made. Many of the discoveries are already in. We know, for example, that the emotional climate which surrounds the infant and young child is of critical importance in determining his future-including the kind, the severity, and perhaps even the biological concomitants of his later disturbance.

Such knowledge is dangerous. We usually shut our eyes to its implications. We go on trying to fix up damaged adults in one-to-one relationships when a more proper professional function would be to spend a considerable portion of our energies trying to fix up our society in ways that will increase the strength and stability of the family, thereby affecting positively the mental health of generations to come. It is not possible here to further elaborate upon prevention except to say that I believe, because of the nature of the human animal, it must take the form of strengthening the institution of the family.

I believe that history may judge President Johnson to have been one of the most complicated of American presidents. But his speech at Howard University's commencement will be judged among the half-dozen great landmarks in the history of our society. In it the President called for a massive attack on the central problem of our time. He said:

The family is the cornerstone of our society. In years to come, it is unlikely that the beachhead will be extended in any dramatic manner(p.46).

Edward Stainbrook, chairman of the department of psychiatry at the University of Southern California, says:

Many of the impairments due to poor social learning and to inadequate development don't have to be defined as illness, and they don't !;:'\vtfi:fe"p~'Olf!eto\ffaTe-arti',or"fele-arn, social and occupational skills(12).

I am convinced that once society realizes that disturbed behavior reflects the results of social-developmental learning in pathological social environments (rather than intrapersonal sickness), the institutions that will be

PSYCHOLOGICAL POINT OF VIEW

- developed for interventionwillb~ sQciaJ",and Aspects of Schizophrenic Behavior, Ann. N. Y. Acad. Sci. 96: 1-490, 1962.
12. Stainbrook, E.: One Hundred Sixty-Five Beds, Nine Thousand Patients, SK&F Psychiatric Reporter no. 32, 1967, pp. 7-9.
 13. Vail, D.: editorial in the Mental Health Newsletter. Minneapolis: Minnesota Department of Public Welfare, 6: 1, 1966.
 14. Werry, J. S.: Psychotherapy-A Medical Procedure? Canad. Psychiat. Ass. J. 10:278, 1-tl6~1~~u" ""w"" /SIVCII oraUley UnIver-
sity, Peoria, Ill., April 26-27 (processed).
 16. Wooton, B.: Social Science and Social Pathology. London: George Allen and Unwin, 1959.
 17. Wooton, B.: quoted in Zubin, J.: Some Scientific Models for Psychopathology, 1967 (processed).
 18. Zubin, J.: Some Scientific Models for Psychopathology, 1967 (processed).

- IV uc: UU1H..U1L LU UC;U1-
nized by all. However, despite
nition its characteristics are
lesser extent shaped by the
holder. Moreover, as GottscJ
bach (17) have said: "E
what psychotherapy is. But
write a plausible convincing
ing the subject and the m

Psychotherapy clearly aim5
change in the way a person t
Despite such a narrow goa
large and filled with a diversi
and theory. Common to mal
proaches, however, are cJir
compassing case history taki
and diagnosis, interviewing,

Read at the 124th annual meet
ican Psychiatric Association, Bm
13-17,1968.

Dr. Sloane is professor and c
ment of psychiatry, Temple Uni.
MediCinePhiladelphia, Pa. 19140

Amer. J. Psychiat. 125: 7, January 1969