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The Medical Model of Psychology: Problems and Solutions

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The “medical model” that currently guides the majority of psychological research, assessment, and treatment is a deeply entrenched historical, social, and political phenomenon (Maddux, Snyder, & Lopez, 2004; Laungani, 2002) which has no empirical support whatsoever (Wampold, 2001). This article will outline some of the problems that the widespread acceptance of the medical model poses for the field of psychology.

Wampold, Ahn, & Coleman (2001) list five components of the medical model of psychotherapy: to begin with, the patient presents with symptoms of a classifiable disorder or disease; from the existing research and accepted materials, a psychological explanation for the disorder is available; the knowledge of this specific disorder and the theoretical conceptualization of such are sufficient that a potential mechanism for psychological change can be identified; having identified these properties, the therapist logically derives a set of specific psychotherapeutic ingredients and administers them to the patient; these specific ingredients are responsible for the benefits of the psychotherapy thus administered. “The last component,” Wampold, et al. (2001) explain, “which is often referred to as specificity, is critical to the medical model of psychotherapy and gives primacy to the specific ingredients rather than common or contextual factors.” This is particularly significant in that no research has yet to provide any empirical backing for this principle of specificity in psychotherapeutic interventions, whereas a growing body of research is being accumulated in support of alternative, contextual models of psychotherapy (Wampold, 2001).

It is important to clarify the nature and purpose of the disorders being identified and treated within this context, because the illnesses, categories of illnesses, and entire conceptions of illness, as Maddux, et al. (2004) explain,

are not psychological facts about people, nor are they testable scientific theories. Instead, they are heuristic social artifacts that serve the same sociocultural goals as do our constructions of race, gender, social class, and sexual orientation—maintaining and expanding the power of certain individuals and institutions, as well as maintaining the social order as defined by those in power (Beall, 1993; Becker, 1963; Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995; Rosenblum & Travis, 1996).

These criticisms are not new, but have been gaining momentum as part of the humanistic movement within psychology. Both Rogers and Maslow were strong critics of the medical model of psychology on the grounds that it “might serve to help people in one sense but that it also served to alienate and damage people in another” (Joseph & Linley, 2006).

Furthermore, as Reznick (1987, as cited in Maddux, et al. 2004) demonstrated, even our definition of physical disease suffers this type of socially constructed evaluation “because to call a condition a disease ‘is to judge that the person with that condition is less able to lead a good or worthwhile life.’” The tendency in applying this principle to psychology is therefore the gradual pathologization of all behaviors and characteristics that are not consistent with the ideals of the most powerful individuals and institutions, at the expense of diversity and social evolution, as well as the cause of social justice. This can be seen as a socialized parallel to the accelerating loss of biodiversity that has accompanied the development of civilization along the lines

prescribed by the same scientific and modernistic worldview that gave shape to the medical community itself.

On this basis, a very strong argument could be made that the reliance on the illness ideology is proving equally problematic, and perhaps even equally at issue, in the medical community at large. This is evidenced by the last decade's surge of interest in the areas of preventative and holistic medicine, which each attempt to draw the available store of medical knowledge into broader and more contextually relevant applications. The growing acceptance of health psychology as a specialization applicable to and relevant within the field of medicine is further evidence that a paradigm shift is in progress.

There are, however, powerful forces also at work to maintain the status quo. Laungani (2002) lists four major reasons that the medical model of mental illness maintains its dominant status despite its problems: political influence exerted by multinational corporations whose drugs are more likely to be used in treatment where a disease model is prevalent; increased income potential for psychiatrists due to the decreased consultation time necessary for drug therapy over "non-medical, non-drug related therapeutic intervention"; social and psychological factors which make it desirable for psychiatrists to avoid further alienation from the "medical fraternity" by rejecting the dominant paradigm in the medical field overall; and natural resistance to paradigm shifts in research programmes as described by Kuhn (1962), Lakatos (1971), and Laungani (1999) (as cited in Laungani, 2002).

The stakes in overcoming these obstacles are nothing less than the potential for developing an entire new framework for understanding and working with psychological issues on the individual and social levels. A critical junction in this new development will likely involve

the psychological community's long-delayed empowerment to prescribe medications, a privilege currently reserved for the field of psychiatry, which is settled firmly into the ideologies and traditions of western physical medicine. As such, there is an artificial division between psychotherapeutic treatments and psychopharmacological ones. As Nussbaum (2001) explains,

We psychologists cannot be bound by existing models that we know are not suited to behaviour. However, we need the freedom and expertise to develop integrative biopsychological models to inform our thinking and practice, even our psychotherapy. When psychotherapy is effective, let no one delude themselves into thinking that significant neurobiological alterations have not occurred to allow the beneficial behavioural or subjective experiential effect.

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However, we must also realize that for some individuals suffering from some conditions at some points in time, the regular mechanisms allowing intrinsic production of transmitters or receptor molecules necessary for learning and memory are not functional. At these times, psychotropic medications will be effective where psychotherapy will not, as there is no endogenous currency with which to allow information processing to proceed. Psychologists should be willing to pioneer these new ways of thinking and developing truly integrative psychobiological treatments to capitalize on the drug-behaviour interactions...

While the development and adoption of more appropriate and accurate models of psychology, psychological research, and psychotherapy are vital to the development of an effective and coherent field of clinical psychology, a number of barriers stand in the way of

mainstream adoption of those models in exchange for the flawed and potentially damaging medical model. There are, however, many indications that the field is progressing in this direction, and we can remain hopeful that the coming decade will see an increasing empowerment of the psychological community to assert its authority in applying its increasingly well developed theories and methods toward more effective and consistent psychotherapies that are free from the outmoded frameworks of twentieth-century medicine.

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