MENTAL DISORDER AND CHOICE pdf

1: Mental Illness: It's Not About Choice | HuffPost UK

Regardless, whether any given mental illness is a choice or not, it remains a mental illness As the choice to cope with stress in a manner that is harmful to oneself demonstrates mental illness. As such, thinking about mental illness as a choice would serve to inform the manner in which one would/should approach a mental illness, but it does.

When I talk about difficult things in therapy my therapist refers to my tears and strong emotions as a choice. I so automatically begin to cry, feelings of abandonment, of how awful I am to be this way, and all sort sorts of negative feelings about myself take over. I can be okay one minute and then a certain topic just sweeps me into the sea of emotions and nothing makes sense. I sense my therapist becoming frustrated with me. He seems to view my emotions and reactions as a choice. Where is the choice in all this? How is this a choice? My therapist thinks I want to stay sick so that I have control of things and no one expects much of me. Sometimes I feel I have to call to my therapist. That provides so much relief for meâ€”and frustration for my therapist. I feel so crazy and lost and confused. This Disclaimer applies to the Answer Below Dr. Dombeck responds to questions about psychotherapy and mental health problems, from the perspective of his training in clinical psychology. Dombeck intends his responses to provide general educational information to the readership of this website; answers should not be understood to be specific advice intended for any particular individual s. Questions submitted to this column are not guaranteed to receive responses. No correspondence takes place. No ongoing relationship of any sort including but not limited to any form of professional relationship is implied or offered by Dr. Dombeck to people submitting questions. Dombeck and Mental Help Net disclaim any and all merchantability or warranty of fitness for a particular purpose or liability in connection with the use or misuse of this service. Always consult with your psychotherapist, physician, or psychiatrist first before changing any aspect of your treatment regimen. Do not stop your medication or change the dose of your medication without first consulting with your physician. Your question gets right to the heart of a core philosophical issue that people have struggled with for thousands of years, namely the nature of human freedom, and the debate between free will and determinism. People who believe in free will believe as a consequence that it is possible for people to change. People who believe in determinism believe that free will is an illusion, and that change is impossible. Most people these days believe that people are both a little free and also a little determined at the same time, and it is only the relative percentage of how much freedom they think people have that separates them. Based on your life experiences, you have developed a very deterministic world view. You believe that you do not have control over your emotions and cannot change. What is happening is that you two are experiencing a culture clash. This is a confusing issue! The truth of the matter, as it so often does, can probably be found in between your own understanding and that of your therapist. Human nature is not nearly so deterministic and unchanging as you see it presently, and also not free for instant change as your therapist seems to be making it out to be. Change for you is very possible, but it will need to happen gradually, and with some effort. Think about how straightening your teeth works, and you will know how straightening your emotions works too. Teeth cannot be straightened in a day. To do that would be to break your teeth! Instead, a dentist applies consistent gentle pressure to your teeth over long periods of time so as to straighten them gradually. Similarly, it is impossible for you to regulate your emotions today, but if you work at it consistently, over time you will be able to gain some control. Your therapist is essentially correct that you are making choices that are causing you to feel particular ways. The choice process you are missing and unconscious about right now is known as cognitive appraisal, and it happens in the background of the mind every time something happens and you interpret the meaning of that event. Strongly ingrained habits of thought and interpretation cause you to focus on certain information and ignore other information, which leads you to experience particular moods. The essential skill you need to learn how to gain control over this process is called cognitive restructuring. In order to do cognitive restructuring effectively, however, you have to be able to think rationally about emotional topics. There is a precursor skill set to master before you take on cognitive restructuring, then, which helps you to learn how to sooth yourself and gain some control over your moods. The form of therapy that best teaches these skills to people like yourself is known as Dialectical

Behavioral Therapy, or DBT. Stay in therapy, for therapy is where you will learn these important skills. Both of you are correct then about your respective positions. What is problematic here is that there is a space of experience and skill between the two of you which is not being talked about. If I practice emotional control skills diligently, I will gradually become better at controlling my emotions". No one can do that without becoming numb inside, which is a bad outcome. Rather, success is measured by being able to feel something but not to allow it to overwhelm you completely. They reflect an underlying sensitivity towards the possibility of abandonment, and a desire to remain connected to safe figures who play a role in helping you to feel calm. As you progress in your therapy and develop the ability to become more self-regulating, these urges and fears will likely relax some, perhaps becoming a problem again just before it is time to graduate out of therapy. Believe it or not, many people have abandonment fears and have spent parts of their lives worried that they will be abandoned. They also will tend to have developed ways to cope with the anxiety of the possibility of loss which makes it easier for them to make their way in life. As you develop your own coping skill set, you will feel more confident and your own fear will lessen in intensity.

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2: Free will and mental disorder: Exploring the relationship

Mental illnesses aren't a choice. They're medical conditions, illnesses of the brain, for which the causes are complex. People don't choose to live with the symptoms and effects of mental disorders, and for good reason: any type of mental illness affects thoughts, emotions, actions, physical.

Am I to blame for my eating disorder? Responsibility is a thorny issue when it comes to eating disorders, as it tends to be with mental illnesses in general. There is no talk of blame when it comes to physical illness like cancer, or lupus, or pneumonia. This is true for supporters and patients alike. I have often felt like a prisoner to this intangible illness, brainwashed by a voice in my head that sounds frighteningly similar to my own. And yet, despite feeling out of control, I know deep down that no one forced an eating disorder upon me. My disordered behaviors were just that â€" mine. Without any solid evidence otherwise, I inevitably asked myself: The guilt and confusion from this conflict can be paralyzing. Hills, who recovered from the disorder, is haunted by the possibility that she brought her illness upon herself. She writes that she has felt anger both toward for the thin-obsessed culture that seduced her, and toward herself for portraying herself as a victim of that culture, when she was partly responsible for her own suffering. I too am haunted by the possibility that I am to blame for the years of agony I have caused my loved ones and myself. I want so badly to point the finger at a dysfunctional family, or an unstable environment, or a virus that hijacked my mental faculties. At times, I liked being anorexic. Eating disorders are messy illnesses. And if you lack the psychological tools to deal with life stressors, then you will seek relief in any way possible. Unless you are a natural-born psychologist who can troubleshoot those stressors before they warp your thoughts and actions, chances are you did not see your eating disorder looming on the horizon. There is a delicate balance to strike. But accepting too little responsibility tricks you into believing you have no control over your thoughts and behaviors, which also ends in helplessness. So how do you strike that balance? First, you have to forgive yourself for developing an eating disorder, because it was not your fault. Then, you have to take responsibility for how you want your life to be going forward. The hard truth is that you cannot make anyone recover from an eating disorder. Yes, it is an illness just like cancer, or lupus, or pneumonia. Clinicians can help patients reduce symptoms, but mere symptom-reduction will not necessarily amount to recovery. That responsibility belongs to the eating disorder patient alone. Recovery only happens once you decide to let it happen. Eating disorders are an outward sign of an inward unrest. That means you will have to deal with the unrest that has driven you into an eating disorder. You will take every step that takes you a little further from your eating disorder, no matter how overwhelming, or frightening, or silly it seems. And then, every time you eat a meal, or banish a negative thought, or talk to a friend instead of isolating yourself â€" all of these moments weave together until a net has formed to keep you from descending back into disorder. And in doing so, you let recovery happen to you. Of course, all of this is easier said than done, as the saying goes. At some point, though, you are the one who has to take the baton and keep running with it. But I have heard over and over again from therapists, mentors, and peers that recovery is a process â€" and a conscious one, at that. Is Anorexia a Choice? Hello again â€" I just wanted to add one point after getting feedback yesterday about this post. Lots of people face life stressors and lack coping mechanism to deal with them properly, but they do not develop eating disorders. Tens of millions of people in our country are unhappy with their bodies and go to extreme measures to alter them, but they do not develop eating disorders. Eating disorders are dangerous. Treatment can never wait. But as I have moved further into recovery, I have found that coming to a better understanding of WHY I slipped into an eating disorder has helped me to now be vigilant about when those same factors start bugging me again. I may never fully understand what happened to me and why it happened. Again, thank you for reading, and thank you for your feedback.

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3: Anxiety and Depression: Mental Illness Is Not a Choice | The Mighty

Mental illness is not a choice nor is, generally, physical illness. In any case, there is no reason for the vast majority of people to make themselves mentally ill, even if they could. In most cases mental illness is painful and very unpleasant.

I had never heard of the man before I signed up for the class and had no idea that he was a psychiatrist with some controversial ideas. Until recently, when I read that Dr. Glasser had passed away, I had completely forgotten about choice theory and my experience in the class. After I read Dr. The first thing I learned about Dr. Glasser was that he did not believe in mental illness. He believed that everything was a choice â€" that we choose everything we do even to be unhappy or mentally ill. This included everything from feeling mildly depressed to being schizophrenic. He also was against pharmacologic therapy for mental illness. He thought that if mental illness was not real, it did not make sense to take medication for it. I was immediately turned off by this theory. I do believe in mental illness and that some people absolutely require medication. Because I disagreed with this major theory, I spent most of my course feeling like Dr. Glasser was simply wrong. Could every idea the man had be faulty simply because I disagreed with a piece of it? I was curious, so keeping an open mind, I pulled out my books from the class and started reading. An introductory chapter on choice theory introduced its major ideas: They can only give us information that we process, then decide what to do. I am fine with this. It sounds like a reiteration of not being able to change the behavior of others, you can only change your own reaction to it. All right, score one for Dr. We are more in control of our lives than we realize we are. You should stop seeing yourself as a victim or that your brain has insurmountable imbalances. I am fine with this one too. Being a victim can take on all forms, but sometimes people have more strength and power than they realize. Glasser also made the point that medications may make you feel better, but they will not actually solve the problems of your life. I like this one! When I think of reasons I am sometimes unhappy, my thoughts often lead back to some of my relationships not being what I would like them to be. External control causes misery. For this one, Dr. Glasser talks a lot about the concepts of coercion and punishment. He talks about it on a greater scale, like the government, but also on a smaller scale, like parents trying to get kids to do chores. I think some external control is necessary to keep the world running. After revisiting choice theory, I think I was wrong to completely discount Dr. Glasser because of his stance on mental illness and medication. Glasser seems to think that all people do is behave and make choices. I can get on board with this basic statement. I have no doubt that there is much more to what Dr. Choice theory is certainly worth learning about and I should have made more of my course when I was in it. I did not select to take the class on Dr.

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4: Is Mental Illness a Choice? - Mindfulness Muse

Mental illness is a part of who I am, but it isn't my choice. My choice lies in the courage and the strength I have to speak out about mental health in the face of stigma, discrimination and pure hate.

In order to get a clearer view on the relationship between mental disorder and a loss of freedom, in this article, I will explore the link between mental disorder and free will. I examine two domains in which a connection between mental disorder and free will is present: As it turns out, philosophers of free will frequently refer to mental disorders as conditions that compromise free will and reduce moral responsibility. In addition, in forensic psychiatry, the rationale for the assessment of criminal responsibility is often explained by referring to the fact that mental disorders can compromise free will. Yet, in both domains, it remains unclear in what way free will is compromised by mental disorders. Based on the philosophical debate, I discuss three senses of free will and explore their relevance to mental disorders. I conclude that in order to further clarify the relationship between free will and mental disorder, the accounts of people who have actually experienced the impact of a mental disorder should be included in future research. In any case, the meaning of freedom within the context of the DSM-IV quotation remains unarticulated. This article seeks to explore the possible link between mental disorder and free will by looking at two domains in which such a link is clearly present: The article consists of five parts. In the first section, the main themes of the current philosophical free will debate are discussed. Based on an account suggested by Henrik Walter, a distinction will be made between three senses of free will [2]. In the second section, it will turn out that, in fact, mental disorders often feature in the philosophical discussions on free will in the sense that persons are considered to be free and responsible unless they suffer from a mental disorder. In the third section, attention will be shifted to another domain, forensic psychiatry, in particular, to discussions on criminal responsibility. When a person performs a criminal act as a result of a mental disorder we intuit that this person is not responsible for the act. In forensic literature, one type of answer to this question points to free will. In the fourth section, I will take stock of the discussions described in the first three sections. I will argue that, in both domainsâ€”philosophy of free will and forensic psychiatryâ€”mental disorders are taken to be related to free will in a well-defined manner: Based on the previous sections, I explore the relevance of the three senses of free will with respect to mental disorders. In the fifth section, I will argue that in order to further clarify the relationship between free will and mental disorder, the accounts of people who have actually experienced the impact of a mental disorder should be included in future research. Free will in current philosophical debates Based on an account suggested by Walter, we can distinguish three main aspects, or components, of free will in the contemporary philosophical debate [2]. The first element is that to act freely, one must be able to act otherwise; one must have alternative possibilities open to one [3]. Second, acting freely can also be understood as acting or choosing for a reason. For instance, when an agent is being manipulated or hypnotized the agent cannot be said to act freely; although the agent performs the action, she is not the genuine source of it. The free will debate in philosophy is largely concerned with the question of to what extent each of these aspects is, indeed, essential to the concept of free will. In addition, we should note that these conceptions are certainly not exhaustive; there are various competing conceptions of free will [4 , 7]. For instance, being the source of an action can be explained in a libertarian account [3 , 6], but also in what can be considered a more naturalist account [8]. This being said, within the context of this article, the distinctions proposed by Walter provide a useful entrance to the complicated and multifaceted philosophical debate on free will. A special case of the philosophical free will discussion is the compatibility problem. Philosophers have not been able to establish whether or not free will is compatible with determinism [4]. Determinism is the thesis that there is one physically possible future [9]. Whatever happens is inevitable or necessary because of, for example, fate, the will of God, or the laws of nature [5]. Philosophers have not been able to reach consensus on whether free will can exist in such a deterministic world. The discussion on free will and determinism has not only taken place among philosophers; especially in the last decades, neuroscientists and psychologists have been participating in the debate also [2 â€” 4 , 10]. The compatibility debate has been going on for centuries. And

in fact, not only determinism but also indeterminism appears to be problematic for free will, for what room would be left for free will, if everything happened by chance? Yet, the complexity of the concept of free will and related issues apparently has not undermined the value and significance attached to it by many. In this article, I will not take a specific position on whether free will is compatible with determinism. But it is important to note a particular characteristic of free will: It appears that if anything is important to moral responsibility, it is free will [9]. Free will may be defined in many ways, but time after time, the central question is, does this specific concept of free will enable us to explain our moral intuitions? Free will and mental disorder in philosophical debates Interestingly, mental disorders actually feature in philosophical discussions of free will and moral responsibility. Mental disorders and references to psychiatric signs and symptoms even feature in crucial papers that have shaped the debates on moral responsibility and free will over the last decades. In the latter paper, in order to explain a hierarchical account of freedom, Frankfurt describes an addict as a person who is not free. An addict who has the will or first order desire to use heroin but who does not want to have this will is not free when using heroin. Another example of the way in which mental disorders or psychopathological symptoms are used in the debate can be found in Galen Strawson: Compatibilists believe that one can be a free and morally responsible agent even if determinism is true. Roughly, they claim, with many variations of detail, that one may correctly be said to be truly responsible for what one does, when one acts, just so long as one is not caused to act by any of a certain set of constraints kleptomaniac impulses, obsessional neuroses, desires that are experienced as alien, post-hypnotic commands, threats, instances of force majeure, and so on. Peter Strawson previously made an almost identical claim with respect to a certain compatibilist position: They [certain compatibilists] have in mind conditions like compulsion by another, or innate incapacity, or insanity, or other less extreme forms of psychological disorder. According to Kalis et al. Yet, combining several strands of observations and research, Fingarette aims to prove that this view is, at least in part, falsified by empirical data by emphasizing that there is still some form of self-control present in alcoholism e. This would imply that there is still a voluntary aspect preserved in heavy drinking, and that it does not involve an all-out loss of control and the ability to choose freely. His actions are mechanically dictated by stereotyped scripts, from which he cannot escape. OCD patients often indicate that they wish to be rid of hand-washing or footstep counting behavior, but cannot stop. Finally, within the context of an argument on the requirement of alternative possibilities one of the elements of free will mentioned earlier , Daniel Dennett even refers to fear of flying as an excusing condition [22 , p. This implies that more common mental traits like phobias have a bearing on responsibility. As it appears, according to philosophers, mental disorder implies that free will and responsibility are compromised. Addiction and compulsion are kinds of disorders philosophers particularly refer to, but, in fact, all mental disorders, ranging from insanity to less extreme forms of psychological disorder, have some detrimental effect on free will and responsibility. Philosophers of free will seem to be primarily interested in describing responsibility and freedom in subjects whose free will and responsibility are not affected. Less attention has been paid to identifying the precise reasons why certain mental disorders would diminish free will; a detailed analysis of what it is that mental disorders do that has such an effect on free will is lacking. And while several of the quotations refer to mental disorders within the context of a compatibilist argument or view which would mean that what mental disorders do to free will is explicable also in a deterministic world , it does not become clear how exactly the effect of mental disorder on free will should be understood in a deterministic world Strawson and perhaps Wolf may be considered to provide the beginning of such an account [12 , 15]. The topic of the next section is free will in forensic psychiatry, in particular, in theoretical reflections on the conceptual underpinnings of forensic assessment of criminal responsibility. It turns out that there are significant similarities between philosophical debates and forensic psychiatric views on free will and mental disorder. Free will in forensic psychiatry In legal procedures, forensic psychiatrists may be asked to assess the defendant with regard to criminal responsibility. For the court is not only interested in whether or not the defendant was the person who performed the legally relevant act but also in whether the defendant can be held accountable for that act. Although the issue at stake is considered to be criminal responsibility, an area of dispute concerns the question, should forensic psychiatrists indeed express their view on whether the

defendant is actually responsible or not responsible for the crime? Some hold that psychiatrists should not state whether or not a defendant is actually responsible or not; this judgment should be left to the jury or judge [24]. For instance, we intuit that the mother who kills her baby because of a delusional state in a postpartum psychosis is not morally and legally responsible for the act. She should be treated, not punished. One important consideration explicitly refers to free will. A clear example is provided by Reich in Psychiatric Ethics. Because of the perceived role of free will in forensic assessment, some theorists even consider the compatibility question to be relevant to forensic psychiatry [27]. Morse suggests that the idea among forensic practitioners that free will is a specific or foundational criterion for responsibility in morality and law is widespread [28]. Psychotic disorders, especially, are considered to have potentially decisive influence on human action [23 , 29]. However, there are no clear arguments that state that other mental disorders other than psychosis could not, in principle, provide grounds for an insanity defense [23]. In sum, the way in which free will is relevant to the forensic debate is in line with the way mental disorders are relevant to the philosophical debates on free will see previous section. For the overall idea derived from the philosophy of free will is thatâ€”if anythingâ€”free will is required for moral responsibility and that free will can be compromised by mental disorder. This appears to be the line of thought present in the literature on forensic psychiatry as well. Yet, there also seems to be a difference between both domains. In forensic psychiatry the idea is clearly expressed that while mental disorders can, in certain cases, compromise free will, they do not necessarily undermine responsibility. The mere presence of a mental disorder is certainly not sufficient for concluding that the defendant cannot be held accountable for the act. This view is less explicitly present in the philosophical debate. Three senses of free will As pointed out, given the current philosophical discussions, we can distinguish at least three senses of free will. In what follows, mental disorder will be tentatively linked to each of these three different senses of free will. Acting for intelligible reasons. In such cases, people may flex their arms or utter sounds or words without any particular reason or motive. Also, in catatonia there may be movements for which there are no apparent reasons. For instance, there may be a stereotypical, repetitive behavior that does not seem to be explicable in terms of reasons [31]. For example, a person who acts because of a paranoid delusion, acts for reasons influenced by a delusion: So, on this account, except for, e. The genuine source of the action origination. According to this view of free will, only actions whose source lies in the agent himself can be considered to be free actions. Now, actions performed because of delusions might not be considered to stem from the person himself. In fact, in forensic psychiatry it is sometimes said that the mental disorder caused the crime [32]. The attribution of blame and responsibility, therefore, should not be directed at the person properâ€”for he or she is not the genuine source of the action. In one of the quotes from the philosophical debate by Galen Strawson, see above this can indeed be found: On this view, the person apparently is not the genuine source of the act in the sense that it was the mental disorder that caused the offense. For instance, consider an otherwise highly responsible person who is suffering from a bipolar disorder and who is convinced that he is entitled to harm innocent individuals, and via associative thinking, he comes up with a plan which results in a crime.

5: Mental Illness (Stanford Encyclopedia of Philosophy)

Welcome! This is a place for discussing mental health and mental illness. If you are in need of immediate help, please check out this list of resources.

What is Mental Illness? While there is debate over how to define mental illness, it is generally accepted that mental illnesses are real and involve disturbances of thought, experience, and emotion serious enough to cause functional impairment in people, making it more difficult for them to sustain interpersonal relationships and carry on their jobs, and sometimes leading to self-destructive behavior and even suicide. The most serious mental illnesses, such as schizophrenia, bipolar disorder, major depression, and schizoaffective disorder are often chronic and can cause serious disability. What we now call mental illness was not always treated as a medical problem. Descriptions of the behaviors now labeled as symptomatic of mental illness or disorder were sometimes framed in quite different terms, such as possession by supernatural forces. Anthropological work in non-Western cultures suggests that there are many cases of behavior that Western psychiatry would classify as symptomatic of mental disorder, which are not seen within their own cultures as signs of mental illness Warner, , p. One may even raise the question whether all other cultures even have a concept of mental illness that corresponds even approximately to the Western concept, although, as Kleinman points out, this question is closely tied to that of adequately translating from other languages, and in societies without equivalent medical technology to the west, it will be hard to settle what counts as a concept of disease. The mainstream view in the West is that the changes in our description and treatment of mental illness are a result of our increasing knowledge and greater conceptual sophistication. On this view, we have conquered our former ignorance and now know that mental illness exists, even though there is a great deal of further research to be done on the causes and treatment of mental illness. Evidence from anthropological studies makes it clear that some mental illnesses are expressed differently in different cultures and it is also clear that non-Western cultures often have a different way of thinking about mental illness. For example, some cultures may see trance-like states as a form of possession. This has led some to argue that Western psychiatry also needs to change its approach to mental illness. Kleinman, , Simons and Hughes, However, the anthropological research is not set in the same conceptual terms as philosophy, and so it is unclear to what extent it implies that mental illness is primarily a Western concept. A more extreme view, most closely associated with the psychiatrist Thomas Szasz, is that there is no such thing as mental illness because the very notion is based on a fundamental set of mistakes. He has also argued that the concept of mental illness is based on a confusion. More recent critics of psychiatry have been more focused on particular purported mental illnesses. The most heated controversies about the existence of particular mental illnesses are often over ones that seem to involve culturally-specific or moral judgments, such as homosexuality, pedophilia, antisocial personality disorder, and premenstrual dysphoric disorder. Other controversies exist over disorders that are milder in character and are on the borderline between normality and pathology, such as dysthymia, a low level chronic form of depression Radden, To reiterate, however, the dominant view is that mental illness exists and there is a variety of ways to understand it. Modern psychiatry has primarily embraced a scientific approach, looking for causes such as traumatic experiences or genetic vulnerabilities, establishing the typical course of different illnesses, gaining an understanding of the changes in the brain and nervous system that underlie the illnesses, and investigating which treatments are effective at alleviating symptoms and ending the illness. One of the central issues within this scientific framework is how different kinds of theory relate to each other Ghaemi, ; Perring, As alternatives to reductionist approaches there is also the first-person phenomenology and narrative understanding of mental illness. These focus on the personal experience of living and struggling with mental illness, and give careful descriptions of the associated symptoms. Some see a careful phenomenology as essential to scientific psychiatry e. The work in this phenomenological tradition is especially important in pressing the question of what it is to understand or explain mental illness, and how a phenomenological approach can relate to scientific approaches. See for example, Ratcliffe, and Gallagher, 2. There has been considerable discussion of how to draw a distinction between the two. Given the current debate, the prospects

of finding a principled way of drawing the distinction that matches our current practices may be slim. The main practical reason for trying to draw distinctions between physical and mental illnesses comes from demarcating boundaries between professional competencies, and, in particular, from distinguishing the domain of neurology from that of psychiatry. However, this boundary is not sharply drawn and has moved over time. It is likely that as neuroscience progresses, the domains of neurology and psychiatry will start to merge. Most agree that the distinction between mental and physical illness cannot be drawn purely in terms of the causes of the condition, with mental illnesses having psychological causes and physical illnesses having non-psychological causes. Conversely, psychological factors such as stress are reliably associated with increased susceptibility to physical illness, which strongly suggests that those psychological factors are, directly or indirectly, part of the cause of the illness. First, it is often unclear whether to categorize symptoms as mental or physical. For example, intuitions are mixed as to whether pain is a physical or mental symptom. It is also unclear whether we would want to classify insomnia and fatigue as physical or mental symptoms. However we classify fatigue, it is a symptom of illnesses normally characterized as physical such as influenza and those characterized as mental such as depression. Furthermore, distinguishing between physical and mental illness in terms of symptoms may give counterintuitive results. A person who suffers a stroke can have emotional lability, and a person who has experienced a brain injury may become disinhibited; both may suffer memory loss. Yet stroke and brain injury would generally be classified as physical rather than mental disorders. In the light of these problems, some recommend doing away with any principled distinction between physical and mental disorder. First, certain researchers with a strong reductionist inclination argue that mental disorders are ultimately brain disorders; mental disorders are best explored through neuroscience. Others defend retaining the distinction between physical and mental disorders, but to non-traditional ends. Murphy , for instance, argues that it is important to have a distinction between physical and mental disorder so that it is possible to have a distinctive science of psychiatry. He argues for an expansive definition that includes problems in all psychological mechanisms. While this would entail that forms of blindness due to neural dysfunction count as mental disorders, which goes against our normal usage, his goal is not to completely capture our intuitions, but rather to have an adequate set of definitions to accommodate a theory of psychiatric explanation within the field of cognitive neuroscience. Thus we see that there are few defenders of the traditional distinction between mental and physical illnesses. Some theorists advocate refiguring the distinction so that it becomes that between brain-based and non-brain-based disorders. Others who take a more holistic view are skeptical that even this distinction is a useful way to separate illnesses into two groups. Classification of Mental Illness There is ongoing debate concerning the way that mental illnesses should be classified. There are two aspects to this: Controversial diagnostic categories have historically included homosexuality, personality disorders, attention deficit hyperactivity disorder, dysthymia, and pre-menstrual dysphoric disorder. For example, in , the American Psychiatric Association voted to remove homosexuality from its diagnostic manual, after much internal argument and intensive lobbying from activist groups. For both autism and schizophrenia, it has been suggested that these are not unitary conditions but rather collections of quite difference disorders lumped together in one category. These kinds of debates span both empirical and philosophical issues, and it is the former aspect, and the distinction between normality and psychopathology, that has gained the most philosophical scrutiny. The primary questions of concern are: Will it be possible in the future to classify mental illnesses according to their causes, as we do in much of the rest of medicine? Given that we currently classify most mental illnesses according to their symptoms rather than their causes, is there any reason to think that our current diagnostic categories e. Is it possible for any classification scheme of mental illnesses to be purely scientific, and is it possible for a classification scheme to be independent of valuesâ€”or to ask the reverse, do our classification schemes in psychiatry always rest on some non-scientific conception, normative of what should count as a normal life? This last question can be extended to all illnesses, not just those with a psychiatric classification. Many have urged, though, that it is in psychiatry that there is most reason to believe that values enter into the classification scheme, and that there is concern that the profession might be medicalizing what should be seen as normal conditions. Fulford, , Horwitz, The concepts of disease, illness, abnormality, malady, disorder and malfunction are closely related, but they are not

the same. Much careful work has been done trying to find if one of these is more basic than any of the others, or if some of these concepts can be completely analyzed in terms of the others. For our purposes here, we shall gloss over the differences between these concepts. For the most part, we will simply refer to the concept of illness. The best-known defender of such an approach is Christopher Boorse, in a series of influential papers , , , At the other end of the spectrum are theories that psychiatric classification depends solely on the whim or values of those doing the classification, that there is nothing objective about it at all, and that there are no facts about what is normal. These subjective theories are generally proposed in a spirit of criticizing or undermining psychiatry, and are often very sympathetic to the Szaszian view that there is really no such thing as mental illness, and so there could not be a legitimate objective classification of different kinds of mental illness. Accompanying these theories, often, is the at least implicit suggestion that classification schemes suit the needs of those in power see, for instance, the work of sociological theorists Peter Sedwick and Thomas Scheff. See Reznek, , Chapters 6 and 7. Michel Foucault argued in a similar vein that the growth of psychiatry as a supposedly scientific discipline was really a way to impose bourgeois morality on people who did not accept it. Gutting, As for its plausibility, the view that the classification is totally subjective or arbitrary stands or falls with antirealism about mental illness, and it has not received much support in the last twenty years. It would be highly implausible for a defender of the medical model to insist that values have never in fact entered into the psychiatric taxonomyâ€”a brief study of the history of various categories show that empirical research and neutral scientific facts are certainly not the only things that have been played a role in the formation of classification schemes. Sadler, ; Bayer, ; Potter, ; Thomas and Sillen, The medical model claims a that it is possible to have a value-neutral classification scheme and b it is best to use a value-neutral classification scheme. In justifying part b of their claim, some defenders of the medical model might claim we can discover a conceptual truth of the form: They are either too broad, too narrow, or both. See Wakefield, An alternative approach to defending b is to argue that medicine, and psychiatry especially, should be value-neutral and so its classification scheme should be value-neutral. Of course, there are obvious ways in which we want medicine to not be neutral: We can distinguish different forms of neutrality of diagnostic categories. The ones that are dominant in the psychiatric and psychological literature concern validity and reliability of diagnostic criteria. The validity of a category is a measure of how well it measures what it is intended to measure, while the reliability concerns how well the criteria enable those using them to consistently diagnose people with the condition. Validity and reliability are certainly virtues of diagnostic categories, although there are debates on exactly how objective they are Sadler, ; Thornton, At the same time, there are ways in which theorists embrace the values behind psychiatric categorizing, and argue that they should simply be made public. See Fulford et al, Those who argue that psychiatry and the rest of medicine are inevitably normative do not infer from this that medicine is always biased; instead, their view is that the nature of psychiatric classification requires that some normative rather than purely scientific assumptions be made about what counts as health and what counts as illness. They generally then suggest that, since medicine and psychiatry have to make such assumptions, they should be as open and honest about it as possible so that debates about certain categories of psychopathology are not based on a misunderstanding of the kind of enterprise involved. Such theorists often add the suggestion that in a democracy, there should be public debate about what values should be at the heart of medicine and psychiatry. Sadler, ; Fulford, Those who argue that psychiatric classification is necessarily value-laden rarely rest their argument on the claim that all of science is value-laden, or even more controversially, that all of science is subjective. For the sake of argument, it is possible for all sides of the debate to concede that we can know facts about the causes and consequences of the conditions we label as illnesses, and that these facts are entirely value-neutral. There are of course some who would dispute the possibility of there being, or our knowing, any value-neutral facts, but this is an extreme view, and it does not single out medical classification as an interesting and unusual case of value-ladenness. So we will set it aside. We now can ask why those who think that psychiatric classification must be value-laden think so, and how those who think it can be value-neutral propose to find such a classification. If a theory can, by itself, provide us with a way of demarcating human health from pathology, then the theory must, on its own, have some account of what healthy function is, and what should count as a malfunction of a human being. Thus Boorse,

who argues for the value-neutral view of classification, suggests that evolutionary theory can tell us what conditions are healthy. In one paper, he gives the following definition of health: An organism is healthy at any moment in proportion as it is not diseased; and a disease is a type of internal state of the organism which: Boorse, , page Those in opposition mount three kinds of claims: C1 In much of medicine, and especially psychiatry, we do not know with any certainty what is evolutionarily natural, because our scientific studies are still in their early stages or highly programmatic, and it can be very difficult to find data that will settle scientific controversies.

MENTAL DISORDER AND CHOICE pdf

6: Mental Disorders - Teen Mental Health

Imagine suffering from an illness that could kill you but getting heaps of praise from everyone â€" including doctors â€" for the very symptoms that are destroying your body and mind. That's the.

Adam Zvanovec If I could stick a sign that said this to my forehead and parade around on national television, I would. This cannot be emphasized enough. People all too often get mixed up with where the choice lies when it comes to mental illness. Mental illness is not, never has been, and never will be a choice. The list goes on and on. But no matter which way you shape or turn the hell that is being mentally illâ€"one thing remains. And that is this; it is NOT a choice. I think the reason people get this so confused sometimes is because mental illness does come with a choice. You are not wrong there. Where the wrong comes in is where the choice resides. One can not simply choose to be or not to be sick, one can not choose to simply snap there fingers and make it all go away. But, what one can choose is the choice of recovery. At any second of any day, all of us who suffer from any form of mental illness have the power to decide we are no longer going to live as slaves to these horrid diseases. To not be a victim. To walk in the light of life, instead of in the shadows of darkness of death. Because the thing about mental illness isâ€"it is EVIL. It has no mercy. And it will stop at nothing to take everything from you. Until it steals what it has wanted all along, not just your lightâ€"but your life. It hisses lies into the ears of the strong and convinces them that they are weak and defeated. It uses deceit to trick the brave, loved, and worthy into thinking they are helpless, hopeless, and worthless. Mental illness is nearly impossible to accurately describe in words. And perhaps that is because it is a special kind of evil, an evil that is so abstract it cannot be put into earthly terms. Because mental illness is not of this world at allâ€"if you have suffered from it you know what I mean when I say suffering from one is like living in an alternate reality. The best way I can describe it though, is with one simple noun. And that is thisâ€"mental illness is a coward. But those who suffer from, and even more so those who fight mental illness are among the most courageous of all. Mental illness is a pit of darkness. A black hole waiting to suck anyone and everyone down into its depths. But you see, it is afraid of the light. And it does not want you to know or believe that. Because if you choose light over darkness, no matter how dim the light may be, mental illness can not hold you captive any longer. When we realize this we are left with two paths. The path to continue to lifelessly walk through this world as a helpless captive of the sickness. Or, the path of light. A path that is full of pain and turmoil, a path that is uncomfortable, that is hard, but a path that makes you stronger with every step, and will illuminate the light at the end of the tunnel until one day you realize you were the light all along. Mental illness is not a choiceâ€"but recovery is. The choice is yours my friend. What will you choose? More From Thought Catalog.

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The 'choice' notion in relation to mental illness is one that needs to be challenged. Now. MORE: winston churchill mental illness Paul Burstow bipolar disorder alastair campbell mental health time.

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9: Revisiting Glasser's Controversial Choice Theory

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MENTAL DISORDER AND CHOICE pdf

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