CHAPTER 1

Introduction and Historical Overview

LEARNING GOALS

1. Explain the meaning of stigma as it applies to people with psychological disorders.
2. Compare different definitions of psychological disorder.
3. Explain how the causes and treatments of psychological disorders have changed over the course of history.
4. Describe the historical forces that have helped to shape our current view of psychological disorders, including biological, psychoanalytic, behavioral, and cognitive views.
5. Describe the different mental health professions, including the training involved and the expertise developed.

Clinical Case

Jack

Jack dreaded family gatherings. His parents' house would be filled with his brothers and their families, and all the little kids would run around making a lot of noise. His parents would urge him to "be social" and spend time with the family, even though Jack preferred to be alone. He knew that the kids called him "crazy Uncle Jack." In fact, he had even heard his younger brother Kevin call him "crazy Jack" when he'd stopped by to see their mother the other day. Jack's mother admonished Kevin, reminding him that Jack had been doing very well on his new medication. "Schizophrenia is an illness," his mother had said.

Jack had not been hospitalized with an acute episode of schizophrenia for over 2 years. Even though Jack still heard voices, he learned not to talk about them in front of his mother because she would then start hassling him about taking his medication or ask him all sorts of questions about whether he needed to go back to the hospital. He hoped he would soon be able to move out of his parents' house and into his own apartment. The landlord at the last apartment he had tried to rent rejected his application once he learned that Jack had schizophrenia. His mother and father needed to cosign the lease, and they had inadvertently said that Jack was doing very well with his illness. The landlord asked about the illness, and once his parents mentioned schizophrenia, the landlord became visibly uncomfortable. The landlord called later that night and said the apartment had already been rented. When Jack's father pressed him, the landlord admitted he "didn't want any trouble" and that he was worried that people like Jack were violent.

Clinical Case

Felicia

Felicia didn't like to think back to her early school years. Elementary school was not a very fun time. She couldn't sit still or follow directions very well. She often blurted out answers when it wasn't her turn to talk, and she never seemed to be able to finish her class papers without many mistakes. As if that wasn't bad enough, the other girls often laughed at her and called her names. She still remembers the time she tried to join in with a group of girls during recess. They kept running away, whispering to each other, and giggling. When Felicia asked what was so funny, one of the girls laughed and said, "You are hyper, girl! You fidget so much in class, you must have ants in your pants!"

When Felicia started fourth grade, her parents took her to a psychologist. She took several tests and answered all sorts of questions. At the end of these testing sessions, the psychologist diagnosed Felicia with attention-deficit/hyperactivity disorder (ADHD). Felicia began seeing a different psychologist, and her pediatrician prescribed the medication Ritalin. She enjoyed seeing the psychologist because she helped her learn how to deal with the other kids' teasing and how to do a better job of paying attention. The medication helped, too—she could concentrate better and didn't seem to blurt out things as much anymore.

Now in high school, Felicia is much happier. She has a good group of close friends, and her grades are better than they have ever been. Though it is still hard to focus sometimes, she has learned several ways to deal with her distractibility. She is looking forward to college, hoping she can get into the top state school. Her guidance counselor has encouraged her, thinking her grades and extracurricular activities will make for a strong application.

We all try to understand other people. Determining why another person does or feels something is not easy to do. In fact, we do not always understand our own feelings and behavior. Figuring out why people behave in normal, expected ways is difficult enough; understanding seemingly abnormal behavior, such as the behavior of Jack and Felicia, can be even more difficult.

Psychological Disorders and Stigmas

In this book, we will consider the description, causes, and treatments of several different **psychological disorders**. We will also demonstrate the numerous challenges professionals in this field face. As you approach the study of **psychopathology**, the field concerned with the nature, development, and treatment of psychological disorders, keep in mind that the field is continually developing and adding new findings. As we proceed, you will see that the field's interest and importance are ever growing.

Our subject matter, human behavior, is personal and powerfully affecting. Who has not experienced irrational thoughts or feelings? Most of us have known someone, a friend or a relative, whose behavior was upsetting or difficult to understand, and we realize how frustrating it can be to try to understand and help a person with psychological difficulties.

Our closeness to the subject matter also adds to its intrinsic fascination; undergraduate courses in clinical or abnormal psychology are among the most popular in the entire college curriculum, not just in psychology departments. Our feeling of familiarity with the subject matter draws us to the study of psychopathology, but it also has a distinct disadvantage: We bring to the study our preconceived notions of what the subject matter is. Each of us has developed certain ways of thinking and talking about psychological disorders, certain words and concepts that somehow seem to fit. As you read this book and try to understand the psychological disorders it discusses, we may be asking you to adopt different ways of thinking about psychological disorders from those to which you are accustomed.

Perhaps most challenging of all, we must not only recognize our own preconceived notions of psychological disorders, but we must also confront and work to change the **stigma** we often associate with these conditions. Stigma refers to the destructive beliefs and attitudes held by a society that are ascribed to groups considered different in some manner, such as people with psychological disorders. More specifically, stigma has four characteristics (see **Figure 1.1**):

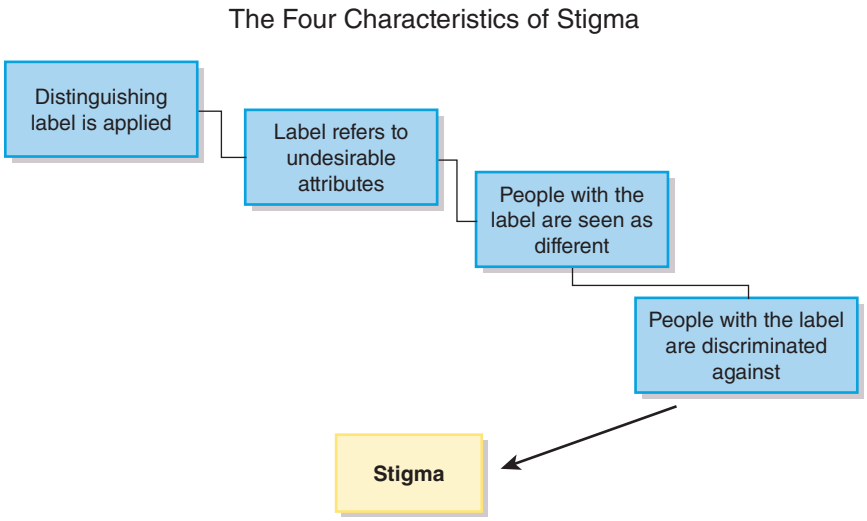

FIGURE 1.1 The four characteristics of stigma.

1. A label is applied to a group of people that distinguishes them from others (e.g., "crazy").
2. The label is linked to deviant or undesirable attributes by society (e.g., crazy people are dangerous).
3. People with the label are seen as essentially different from those without the label, contributing to an "us" versus "them" mentality (e.g., we are not like those crazy people).
4. People with the label are discriminated against unfairly (e.g., a clinic for crazy people can't be built in our neighborhood).

The case of Jack illustrates how stigma can lead to discrimination. Jack was denied an apartment because of his schizophrenia. The landlord believed Jack's schizophrenia meant he would be violent. This belief is based more in fiction than reality, however. A person with a psychological disorder is not necessarily any more likely to be violent than a person without such a disorder (Steadman, Mulvey, et al., 1998; Swanson, Holzer, et al. 1990), even though people with psychological disorders can be violent if they do not receive treatment (Torrey, 2014).

As we will see, the treatment of people with psychological disorders throughout recorded history has not generally been good, and this has contributed to their stigmatization, to the extent that they have often been brutalized and shunned by society. In the past, torturous treatments were held up to the public as miracle cures, and even today, terms such as *crazy*, *insane*, *retard*, and *schizo* are tossed about without thought of the people who have psychological disorders and for whom these insults and the intensely distressing feelings and behaviors they refer to are a reality of daily life. The cases of Jack and Felicia illustrate how hurtful using such careless and mean-spirited names can be.

Psychological disorders remain the most stigmatized of conditions in the twenty-first century, despite advances in the public's knowledge about the origins of psychological disorders (Hinshaw, 2007). In 1999, then Surgeon General of the United States David Satcher, in his groundbreaking report on mental illness, wrote that stigma is the "most formidable obstacle to future progress in the arena of mental illness and mental health" (U.S. Department of Health and Human Services, 1999). Sadly, this is still true today. In 2010, a staff person working with then Wisconsin gubernatorial candidate Scott Walker wrote dismissively about an election opponent's plan to make mental health care a focus of the campaign, "No one cares about crazy people." This awful phrase was turned into something hopeful when author Ron Powers opted to use it as the title of his book, an unflinchingly honest memoir about his two sons with schizophrenia and the current state of mental health care in the United States (Powers, 2017).

Throughout this book, we hope to fight this stigma by showing you the latest evidence about the nature and causes of these disorders, together with treatments, dispelling myths and other misconceptions as we proceed. As part of this effort, we will try to put a human face on psychological disorders by including descriptions of actual people with these disorders. Additional ways to fight stigma are presented in **Focus on Discovery 1.1**.

Focus on Discovery 1.1

Fighting Against Stigma: A Strategic Approach

In 2007, psychologist Stephen Hinshaw published a book entitled *The Mark of Shame: The Stigma of Mental Illness and an Agenda for Change.* In this important book, Hinshaw discusses several steps that can be taken to end stigma surrounding psychological disorders. Here we briefly discuss some of the key suggestions for fighting stigma in many arenas, including community, mental health professions, and individual/family behaviors and attitudes.

Community Strategies

Housing Options Rates of homelessness in people with psychological disorders are too high, and more programs to provide community residences and group homes are needed. However, many neighborhoods are reluctant to embrace the idea of people with a psychological disorder living among them. Lobbying legislatures and community leaders about the importance of adequate housing is a critically important step toward providing housing for people with psychological disorders and reducing stigma.

Education Educating people about psychological disorders (one of the goals of this book!) is an important step toward reducing stigma. Education alone won't completely eradicate stigma, however. By learning about psychological disorders, though, people may be less hesitant to interact with people who have different disorders. Many of you already know someone with a psychological disorder. Sadly, though, stigma often prevents people from disclosing their history with a psychological disorder. Education may help lessen people's hesitancy to talk about their illnesses.

Personal Contact Providing greater housing opportunities for people with psychological disorders will likely mean that people with these disorders will shop and eat in local establishments alongside people without these disorders. Research suggests that this type of contact—where status is relatively equal—can reduce stigma. In fact, personal contact is more effective than education in reducing stigma (Corrigan, Morris, et al., 2012). Informal settings, such as local parks and churches, can also help bridge the personal contact gap between people with and without psychological disorders.

Mental Health and Health Profession Strategies

Mental Health Evaluations Many children see their pediatricians for well-baby or well-child exams. The goal of these visits is to prevent illness before it occurs. Hinshaw (2007) makes a strong case for including similar preventive efforts for psychological disorders among children and adolescents by, for example, including rating scale assessments from parents and teachers to help identify problems before they become more serious.

Education and Training Mental health professionals should receive training in stigma issues. This type of training would undoubtedly help professionals recognize the pernicious signs of stigma, even within the very profession that is charged with helping people with psychological disorders. In addition, mental health professionals need to keep current on the descriptions, causes, and empirically supported treatments for psychological disorders. This would certainly lead to better interactions with people and might also help educate the public about the important work being done by mental health professionals.

Individual and Family Strategies

Education for Individuals and Families It can be frightening and disorienting for families to learn that a loved one has been diagnosed with an illness, and this may be particularly true for psychological disorders. Receiving current information about the causes and treatments of psychological disorders is crucial because it helps to alleviate blame and remove stereotypes families might hold about psychological disorders. Educating people with a psychological disorder is also extremely important. Sometimes termed *psychoeducation*, this type of information is built into many types of treatments, whether pharmacological or psychosocial. For people to understand why they should adhere to certain treatment regimens, it is important for them to know the nature of their illness and the treatment alternatives available.

Support and Advocacy Groups Participating in support or advocacy groups can be a helpful adjunct to treatment for people with psychological disorders and their families. Websites such as Mind Freedom International (http://www.mindfreedom.org) and the Icarus Project (http://www.theicarusproject.net) are designed to provide a forum for people with psychological disorders to find support. These sites, developed and run by people with psychological disorders, contain useful links, blogs, and other helpful resources. In-person support groups are also helpful, and many communities have groups supported by the National Alliance on Mental Illness (http://www.nami.org). Finding peers in the context of support groups can be beneficial, especially for emotional support and empowerment.

But you will have to help in this fight, for the mere acquisition of knowledge does not ensure the end of stigma (Corrigan, 2015). Many mental health practitioners and advocates have hoped that the more people learned about the neurobiological causes of psychological disorders, the less stigmatized these disorders would be. However, results from an important study show that this may not be true (Pescosolido, Martin, et al., 2010). People's knowledge has increased, but unfortunately stigma has not decreased. In the study, researchers surveyed people's attitudes and knowledge about psychological disorders at two points in time: 1996 and 2006. Compared with 1996, people in 2006 were more likely to believe that psychological disorders such as schizophrenia, depression, and alcohol addiction had a neurobiological cause, but stigma toward these disorders did not decrease. In fact, in some cases it increased.

For example, people in 2006 were less likely to want to have a person with schizophrenia as their neighbor compared with people in 1996. Clearly, there is work to be done to reduce stigma.

Recent efforts to reduce stigma have been quite creative in their use of social media and other means to get the message out that psychological disorders are common and affect us all in one way or another. Indeed, close to 44 million people in the United States (i.e., about 1 in 5 people) had some type of psychological disorder according to the Center for Behavioral Health Statistics and Quality (2015) report. For example, the site Bring Change to Mind (http://bringchange2mind.org) is a platform for personal stories that seeks to end stigma associated with psychological disorders, co-founded by the actress Glenn Close and her sister Jessie who has bipolar disorder (see Chapter 5) and her nephew Calen who has schizophrenia (see Chapter 9). Many blogs feature people talking poignantly about their lives with different psychological disorders, and these accounts help to demystify and therefore destigmatize it. For example, Allie Brosh wrote a blog called Hyperbole and a Half about her experiences with depression (http://hyperboleandahalf.blogspot.com) that culminated in a book (Brosh, 2013). The blog that is part of Strong365 (http://strong365.org) features stories of people living with different psychological disorders. The site Patients Like Me (http://www.patientslikeme.com) is a social networking site for people with all sorts of illnesses. Other creative efforts include the design of T-shirts by a graphic designer named Dani Balenson (http://danibalenson.com). In her work, she seeks to use color and graphics to depict the symptoms, behaviors, and struggles that characterize psychological disorders such as ADHD, obsessive-compulsive disorder, depression, and bipolar disorder (http://www.livingwith.co).

Celebrities or public figures with psychological disorders can also help reduce stigma. For example, the singer and songwriter Demi Lovato openly discusses her life with bipolar disorder and has joined the campaign BeVocal (http://www.bevocalspeakup.com/) to help reduce stigma.

In this chapter, we first discuss what we mean by the term *psychological disorder.* Then we look briefly at how our views of psychological disorders have evolved through history to the more scientific perspectives of today. We conclude with a discussion of the current mental health professions.

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Quick Summary

This book focuses on the description, causes, and treatments of several different psychological disorders. It is important to note at the outset that the personal impact of our subject matter requires us to make a conscious, determined effort to remain objective. Stigma remains a central problem in the field of psychopathology. Stigma has four components that involve the labels for psychological disorders and their uses. Even the use of everyday terms such as *crazy* or *schizo* can contribute to the stigmatization of people with psychological disorders.

Check Your Knowledge 1.1
(Answers are at the end of the chapter.)

1. Characteristics of stigma include all the following *except*:

- **a.** a label reflecting desirable characteristics
- **b.** discrimination against those with the label
- **c.** focus on differences between those with and without the label
- **d.** labeling a group of people who are different

2. True/False

Psychological disorders remain the most stigmatized of conditions in the twenty-first century.

3. True/False

Close to 20 million people in the United States had some type of psychological disorder according to the Center for Behavior Health Statistics and Quality (2015) report.

Defining Psychological Disorder

A difficult but fundamental task facing those in the field of psychopathology is to define psychological disorder. The best current definition of psychological disorder is one that contains several characteristics. The definition of *mental disorder* presented in the fifth edition of the American diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), includes several characteristics essential to the concept of psychological disorder (Stein, Phillips, et al., 2010) as shown in **Table 1.1**.

In the following sections, we consider three key characteristics that should be part of any comprehensive psychological disorder definition: personal distress, disability/dysfunction, and violation of social norms (see **Figure 1.2**). We will see that no single characteristic can fully define the concept, although each has merit and each captures some part of what might be a full definition. Consequently, psychological disorder is usually determined based on the presence of several characteristics at one time.

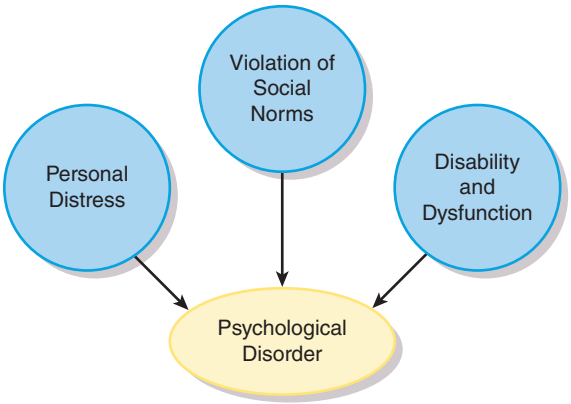
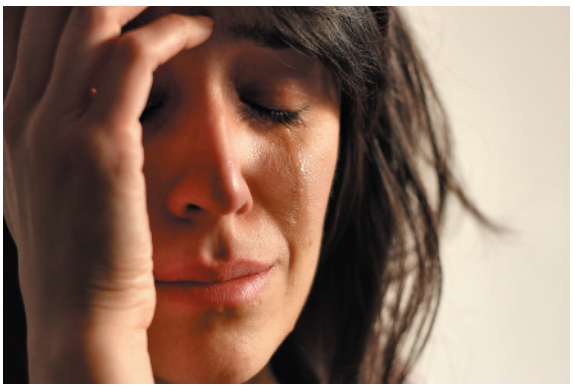


FIGURE 1.2 Three characteristics of a comprehensive definition of psychological disorder.



Personal distress can be part of the definition of psychological disorder.

Personal Distress

One characteristic used to define psychological disorder is personal distress—that is, a person's behavior may be classified as disordered if it causes him or her great distress. Felicia felt distress about her difficulty in paying attention and the social consequences of this difficulty—that is, being called names by other schoolgirls. Personal distress also characterizes many of the forms of psychological disorder considered in this book—people experiencing anxiety disorders and depression suffer greatly. But not all psychological disorders cause distress. For example, an individual with antisocial personality disorder may treat others coldheartedly and violate the law without experiencing any guilt, remorse, anxiety, or other type of distress. And not all behavior that causes distress is disordered—for example, the distress of hunger due to religious fasting or the pain of childbirth.

Disability and Dysfunction

Disability—that is, impairment in some important area of life (e.g., work or personal relationships)—can also characterize psychological disorder. For example, substance use disorders are defined in part by the social or occupational disability (e.g., serious arguments with one's spouse or poor work performance) created by substance abuse. Being rejected by

TABLE 1.1 The DSM-5 Definition of Mental Disorder

The DSM-5 was released in 2013. The definition of mental disorder includes the following:

- The disorder occurs within the individual.
- It involves clinically significant difficulties in thinking, feeling, or behaving.
- It usually involves personal distress of some sort, such as in social relationships or occupational functioning.
- It involves dysfunction in psychological, developmental, and/or neurobiological processes that support mental functioning.
- It is not a culturally specific reaction to an event (e.g., death of a loved one).
- It is not primarily a result of social deviance or conflict with society.

Clinical Case

José

José didn't know what to think about his nightmares. Ever since he returned from the war, he couldn't get the bloody images out of his head. He woke up nearly every night with nightmares about the carnage he witnessed as a soldier stationed in Fallujah. Even during the day, he would have flashbacks to the moment his Humvee was nearly sliced in half by a rocket-propelled grenade. Watching his friend die sitting next to him was the worst part; even the occasional pain from shrapnel still embedded in his shoulder was not as bad as the recurring dreams and flashbacks. He seemed to be sweating all the time now, and whenever he heard a loud noise, he jumped out of his chair. Just the other day, his grandmother stepped on a balloon left over from his "welcome home" party. To José, it sounded like a gunshot, and he immediately dropped to the ground.

His grandmother was worried about him. She thought he must have *ataque de nervios*, just like her father had back home in Puerto Rico. She said her father had been afraid all the time and felt like he was going crazy. She kept going to Mass and praying for José, which he appreciated. The army doctor said he had posttraumatic stress disorder (PTSD). José was supposed to go to the Veterans Administration (VA) hospital for an evaluation, but he didn't really think there was anything wrong with him. Yet his buddy Jorge had been to a group session at the VA, and he said it made him feel better. Maybe he would check it out. He wanted these images to get out of his head.

peers, as Felicia was, is also an example of this characteristic. Phobias can produce both distress and disability—for example, if a severe fear of flying prevents someone living in California from taking a job in New York. Like distress, however, disability alone cannot be used to define psychological disorder because some, but not all, disorders involve disability. For example, the disorder bulimia nervosa involves binge eating and compensatory purging (e.g., vomiting) to control weight, but it does not necessarily involve disability. Many people with bulimia lead lives without impairment, while bingeing and purging in private. Other characteristics that might, in some circumstances, be considered disabilities—such as being blind and wanting to become a professional race car driver—do not fall within the domain of psychopathology. We do not have a rule that tells us which disabilities belong in our domain of study and which do not.

Dysfunction refers to something that has gone wrong and is not working as it should. The DSM-5 definition, shown in Table 1.1, provides a broad concept of dysfunction, which is supported by our current body of evidence. Specifically, the DSM definition of dysfunction refers to the fact that developmental, psychological, and biological dysfunctions are all interrelated. That is, the brain impacts behavior, and behavior impacts the brain; thus, dysfunction in these areas is interrelated.

Violation of Social Norms

In the realm of behavior, social norms are widely held standards (beliefs and attitudes) that people use consciously or intuitively to make judgments about where behaviors are situated on such scales as good–bad, right–wrong, justified–unjustified, and acceptable–unacceptable. Behavior that violates social norms might be classified as disordered. For example, the repetitive rituals performed by people with obsessive-compulsive disorder (see Chapter 7) and the conversations with imaginary voices that some people with schizophrenia engage in (see Chapter 9) are behaviors that violate social norms. José's dropping to the floor at the sound of a popping balloon does not fit within most social norms. Yet this way of defining psychological disorder is both too broad and too narrow. For example, it is too broad in that criminals violate social norms but are not usually studied within the domain of psychopathology; it is too narrow in that highly anxious people typically do not violate social norms.

Also, of course, social norms vary a great deal across cultures and ethnic groups, so behavior that clearly violates a social norm in one group may not do so at all in another. For example, in some cultures but not in others, it violates a social norm to directly disagree with someone. In Puerto Rico, José's behavior would not likely have been interpreted in the same way as it would be in the United States. Throughout this book, we will address this important issue of cultural and ethnic diversity as it applies to the descriptions, causes, and treatments of psychological disorders.

Roger Spooner/Getty Images, Inc.

To some people, extreme tattoos are a violation of the social norm. However, social norm violations are not necessarily signs of a psychological disorder.

Quick Summary

Defining psychological disorder remains difficult. Several different definitions have been offered, but none can entirely account for the full range of disorders. Whether a behavior causes personal distress can be a characteristic of psychological disorder. But not all behaviors that we consider to be part of psychological disorders cause distress. Behaviors that cause a disability or are unexpected can be considered part of a psychological disorder. But again, some behaviors do not cause disability, nor are they unexpected. Behavior that violates social norms can also be considered part of a psychological disorder. However, not all such behavior is considered part of a psychological disorder, and some behaviors that are characteristic of psychological disorders do not necessarily violate social norms. Taken together, each definition of psychological disorder has something helpful to offer in the study of psychopathology.

Check Your Knowledge 1.2

1. True/False

Phobias can produce both distress and disability.

2. Which of the following definitions of psychological disorder is currently thought best?

- **a.** personal distress
- **b.** disability and dysfunction
- **c.** norm violation
- **d.** none of the above

3. What is an advantage of the DSM-5 definition of psychological disorder?

- **a.** It includes information about both violation of social norms and dysfunction.
- **b.** It includes many components, none of which alone can account for psychological disorder.
- **c.** It is part of the current diagnostic system.
- **d.** It recognizes the limits of our current understanding.

History of Psychopathology

Many textbooks begin with a chapter on the history of the field. Why? It is important to consider how concepts and approaches have changed (or not) over time, because we can learn from mistakes made in the past and because we can see that our current concepts and approaches are likely to change in the future. As we consider the history of psychopathology, we will see that many new approaches to the treatment of psychological disorders throughout time appear to go well at first and are heralded with much excitement and fanfare. But these treatments eventually fall into disrepute. These are lessons that should not be forgotten as we consider more contemporary approaches to treatment and their attendant excitement and fanfare.

Supernatural Explanations

Before the age of scientific inquiry, all good and bad manifestations of power beyond human control—eclipses, earthquakes, storms, fire, diseases, the changing seasons—were regarded as supernatural. Behavior seemingly out of individual control was also ascribed to supernatural causes. Many early philosophers, theologians, and physicians who studied the troubled mind believed that disturbed behavior reflected the displeasure of the gods or possession by demons.

Examples of supernatural explanations are found in the records of the early Chinese, Egyptians, Babylonians, and Greeks. Among the Hebrews, odd behavior was attributed to possession of the person by bad spirits, after God in his wrath had withdrawn protection. The New Testament includes the story of Christ curing a man with an unclean spirit by casting out the devils from within him and hurling them onto a herd of swine (Mark 5:8–13).

The belief that odd behavior was caused by possession led to treating it by **exorcism**, the ritualistic casting out of evil spirits. Exorcism typically took the form of elaborate rites of prayer, noisemaking, forcing the afflicted to drink terrible-tasting brews, and on occasion more extreme measures, such as flogging and starvation, to render the body uninhabitable to devils.

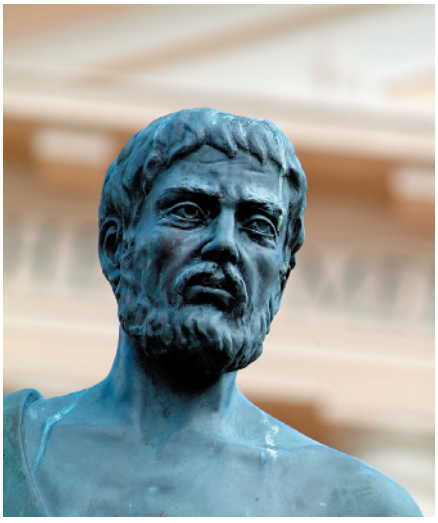
Early Biological Explanations

In the fifth century B.C., Hippocrates (460?–377? B.C.), often called the father of modern medicine, separated medicine from religion, magic, and superstition. He rejected the prevailing Greek belief that the gods sent mental disturbances as punishment and insisted instead that such illnesses had natural causes and hence should be treated like other, more common maladies, such as colds and constipation. Hippocrates regarded the brain as the organ of consciousness, intellectual life, and emotion; thus, he thought that disordered thinking and behavior were indications of some kind of brain pathology. Hippocrates is often considered one of the earliest proponents of the notion that something wrong with the brain contributes to psychological disorders.

Hippocrates (see photo) classified psychological disorders into three categories: mania, melancholia, and phrenitis, or brain fever. He believed that healthy brain functioning, and therefore mental health, depended on a delicate balance among four humors, or fluids of the body, namely, blood, black bile, yellow bile, and phlegm. An imbalance of these humors produced disorders. For example, if a person had a preponderance of black bile, the explanation was melancholia; too much yellow bile explained irritability and anxiousness; and too much blood, changeable temperament.

Through Hippocrates' teachings, the phenomena associated with psychological disorders became more clearly the province of physicians rather than religious figures. The treatments he suggested were quite different from exorcism. For melancholia, for example, he prescribed tranquility, sobriety, care in choosing food and drink, and abstinence from sexual activity. Because Hippocrates believed in natural rather than supernatural causes, he depended on his own keen observations and made valuable contributions as a clinician. He also left behind remarkably detailed records clearly describing many of the symptoms now recognized in seizure disorders, alcohol use disorder, stroke, and paranoia.

Hippocrates' ideas, of course, did not withstand later scientific scrutiny. However, his basic premise—that human behavior is markedly affected by bodily structures or substances and that odd behavior is produced by physical imbalance or even damage—did foreshadow aspects of contemporary thought. In the next seven centuries, Hippocrates' naturalistic approach to disease and disorder was generally accepted by other Greeks as well as by the Romans, who adopted the medicine of the Greeks after the Roman Empire became the major power in the ancient European world.



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The Greek physician Hippocrates held a biological view of psychological disorders, considering psychological disorders to be diseases of the brain.

The Dark Ages: Back to the Supernatural

Historians have often pointed to the death of Galen (A.D. 130–200), the second-century Greek who is regarded as the last great physician of the classical era, as the beginning of the so-called Dark Ages in western European medicine and in the treatment and investigation of psychological disorders (see photo). Over several centuries of decay, Greek and Roman civilization ceased to be. The Church now gained in influence, and the papacy was declared independent of the state. Christian monasteries, through their missionary and educational work, replaced physicians as healers and as authorities on psychological disorder.[1]

The monks in the monasteries cared for and nursed the sick, and a few of the monasteries were repositories for the classic Greek medical manuscripts, even though the

Corbis Historical/Getty Images

Galen was a Greek physician who followed Hippocrates' ideas and is regarded as the last great physician of the classical era.

[1]The teachings of Galen continued to be influential in the Islamic world. For example, the Persian physician al-Razi (865–925) established a facility for the treatment of people with psychological disorders in Baghdad and was an early practitioner of psychotherapy.

monks may not have made use of the knowledge in these works. Monks cared for people with psychological disorders by praying over them and touching them with relics; they also concocted fantastic potions for them to drink in the waning phase of the moon. Many people with psychological disorders roamed the countryside, destitute and progressively becoming worse. During this period, there was a return to a belief in supernatural causes of psychological disorders.

Lunacy Trials From the thirteenth century on, as the cities of Europe grew larger, hospitals began to come under secular jurisdiction. Municipal authorities, gaining in power, tended to supplement or take over some of the activities of the Church, one of these being the care of people with psychological disorders. The foundation deed for the Holy Trinity Hospital in Salisbury, England, dating from the mid-fourteenth century, specified the purposes of the hospital, one of which was that the "mad are kept safe until they are restored of reason." English laws during this period allowed people with psychological disorders to be hospitalized. Notably, the people who were hospitalized were not described as being possessed (Allderidge, 1979).

Bettmann/Getty Images, Inc.

In the dunking test, if the woman did not drown, she was considered to be in league with the devil (and punished accordingly); this is the ultimate no-win situation.

Beginning in the thirteenth century, lunacy trials to determine a person's mental health were held in England. As explained by Neugebauer (1979), the trials were conducted under the Crown's right to protect people with psychological disorders, and a judgment of insanity allowed the Crown to become guardian of the person's estate. The defendant's orientation, memory, intellect, daily life, and habits were at issue in the trial. Usually, strange behavior was attributed to physical illness or injury or to some emotional shock. In all the cases that Neugebauer examined, only one referred to demonic possession. Interestingly, the term *lunacy* comes from a theory espoused by the Swiss physician Paracelsus (1493–1541), who attributed odd behavior to a misalignment of the moon and stars (the Latin word for "moon" is *luna*). Even today, many people believe that a full moon is linked to odd behavior; however, there is no scientific evidence to support this belief.

Development of Asylums

Until the fifteenth century, there were very few hospitals for people with psychological disorders in Europe. However, there were many hospitals for people with leprosy. As leprosy gradually disappeared from Europe (probably because with the end of wars came a break with the sources of the infection), these buildings were now underused. Attention seems to have turned to people with psychological disorders, and the old leprosy hospitals were converted to **asylums**, refuges for the housing and care of people with psychological disorders.

Bethlehem and Other Early Asylums The Priory of St. Mary of Bethlehem was founded in 1243. Records indicate that in 1403 it housed six men with psychological disorders. In 1547, Henry VIII handed it over to the city of London, thereafter to be a hospital devoted solely to the housing of people with psychological disorders. The conditions in Bethlehem were deplorable. Over the years the word *bedlam*, the popular name for this hospital, came to mean a place or scene of wild uproar and confusion. Bethlehem eventually became one of London's great tourist attractions, by the eighteenth century rivaling both Westminster Abbey and the Tower of London. Even as late as the nineteenth century, viewing the people housed in Bethlehem was considered entertainment, and people bought tickets to see them. Similarly, in the Lunatics Tower, which was constructed in Vienna in 1784, people were confined in the spaces between inner square rooms and the outer walls, where they could be viewed by passersby.

Unfortunately, housing people with psychological disorders in hospitals and placing their care in the domain of medicine did not necessarily lead to more humane and effective

treatment. In fact, the medical treatments were often crude and painful. Benjamin Rush (1745–1813), for example, began practicing medicine in Philadelphia in 1769 and is considered the father of American psychiatry. Yet he believed that psychological disorder was caused by an excess of blood in the brain, for which his favored treatment was to draw great quantities of blood from people with psychological disorders (Farina, 1976). Rush also believed that many people with psychological disorders could be cured by being frightened. Thus, one of his recommended procedures was for the physician to convince the patient that death was near!

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In this eighteenth-century painting by Hogarth, two upper-class women find amusement in touring St. Mary's of Bethlehem (Bedlam).

Pinel's Reforms Philippe Pinel (1745–1826) has often been considered a primary figure in the movement for more humane treatment of people with psychological disorders in asylums. In 1793, while the French Revolution raged, he was put in charge of a large asylum in Paris known as La Bicêtre. A historian described the conditions at this particular hospital:

> *[The patients were] shackled to the walls of their cells, by iron collars which held them flat against the wall and permitted little movement. They could not lie down at night, as a rule. Oftentimes there was a hoop of iron around the waist of the patient and in addition chains on both the hands and the feet. These chains [were] sufficiently long so that the patient could feed himself out of a bowl, the food usually being a mushy gruel—bread soaked in a weak soup. Since little was known about dietetics, [no attention] was paid to the type of diet given the patients. They were presumed to be animals and not to care whether the food was good or bad. (Selling, 1940, p. 54)*

Many texts assert that Pinel removed the chains of the people imprisoned in La Bicêtre. Historical research, however, indicates that it was not Pinel who released the people from their chains. Rather, it was a former patient, Jean-Baptiste Pussin, who had become an orderly at the hospital. In fact, Pinel was not even present when the people were released (Weiner, 1994). Several years later, though, Pinel praised Pussin's efforts and began to follow the same practices.

Pinel came to believe that people in his care were first and foremost human beings, and thus these people should be approached with compassion and understanding and treated with dignity. He surmised that if their reason had left them because of severe personal and social problems, it might be restored to them through comforting counsel and purposeful activity. Thus, light and airy rooms replaced dungeons. People formerly considered dangerous now strolled through the hospital and grounds without creating disturbances or harming anyone.

Although Pinel did much good for people with psychological disorders, he was no paragon of enlightenment and egalitarianism. He reserved the more humanitarian treatment for the upper classes; people of the lower classes were still subjected to terror and coercion as a means of control, with straitjackets replacing chains.

Moral Treatment For a time, mental hospitals established in Europe and the United States were relatively small, privately supported, and operated along the lines of the humanitarian changes at La Bicêtre. In the United States, the Friends' Asylum, founded in 1817 in Pennsylvania, and the Hartford Retreat, established in 1824 in Connecticut, were established to provide humane treatment. In accordance with this approach, which became known as **moral treatment**, people had close contact with attendants, who talked and read to them and encouraged them to engage in purposeful activity; residents led lives as close to normal as possible and in general took responsibility for themselves within the constraints of their disorders. Further, there were to be no more than 250 people in any given hospital (Whitaker, 2002).

Moral treatment was largely abandoned in the latter part of the nineteenth century. Ironically, the efforts of Dorothea Dix (1802–1887), a crusader for improved conditions for people with psychological disorders who fought to have hospitals created for their care, helped effect this change (see photo). Dix, a Boston schoolteacher, taught a Sunday school class at the local prison and was shocked at the deplorable conditions in which the inmates lived. Her interest spread to the conditions at mental hospitals and to people with psychological disorders who had nowhere to go for treatment. She campaigned vigorously to improve the lives of people with psychological disorders and personally helped see that 32 hospitals were built. These large public hospitals took in many of the people whom the private hospitals could not accommodate. Unfortunately, the small staffs of these new hospitals were unable to provide the individual attention that was a hallmark of moral treatment (Bockhoven, 1963, Powers; 2017). (See **Focus on Discovery 1.2** for an examination of whether the conditions in today's mental hospitals have improved.)

Focus on Discovery 1.2

The Mental Hospital Today

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More people with psychological disorders are found in jails and prisons than in mental hospitals in the United States—a national disgrace.

In the late 1960s and early 1970s, concerns about the restrictive nature of confinement in a mental hospital along with unrealistic enthusiasm about community-based treatments (Torrey, 2014) led to the so-called deinstitutionalization (i.e., release from the hospital) of a large number of people with psychological disorders. Budget cuts beginning in 1980 and continuing today have caused this trend to continue. But sometimes people with a psychological disorder do need treatment in a hospital setting and, unfortunately, we still do not do a good job of this, even in the twenty-first century (as we will discuss in more detail in Chapter 16). Treatment in public mental hospitals today is often "just enough" to provide some protection, food, shelter, and in most cases medication. Indeed, people with psychological disorders in a public hospital may receive little treatment beyond medication; their existence is monotonous and sedentary for the most part.

Public mental hospitals in the United States are funded either by the federal government or, more likely, by the state in which they are located. Many Veterans Administration hospitals and general medical hospitals also contain units for people with psychological disorders. Since the mid-1950s, the number of public mental hospitals has decreased substantially. In 1955, there were 340 beds in public hospitals for people with psychological disorders for every 100,000 people; by 2010 there were just 14 beds for every 100,000 people (Torrey, 2014).

A somewhat specialized mental hospital, sometimes called a forensic hospital, is reserved for people who have been arrested and judged unable to stand trial and for those who have been acquitted of a crime by reason of insanity (see Chapter 16). Although these people have not been sent to prison, security staff and other tight security measures regiment their lives even as they receive treatment during their stay. There is some evidence to suggest that people who receive treatment at forensic hospitals are less likely to reoffend than people who are sent to regular prisons and do not receive treatment (Harris, 2000).

One of the many unfortunate consequences of fewer mental hospitals today is overcrowding in existing hospitals. One longitudinal study of 13 public mental hospitals in Finland showed that nearly half the hospitals were overcrowded (defined as having 10 percent more occupancy than the hospital was designed for). The researchers also found that overcrowding was associated with an increased risk of violence against hospital staff by patients (Virtanen, Vahtera, et al., 2011). Although we have developed more effective treatments for many psychological disorders, as we will see throughout this book, the mental hospital of today is still in need of improvement.

Another very unfortunate consequence of fewer mental hospitals is the fact that jails have become the *de facto* mental hospitals in many cities in the United States (Baillargeon, Binswanger, et al., 2009; Torrey, 2014). Sadly, jails in Los Angeles County and Cook County (in Chicago) are now the largest "mental hospitals" in the United States, housing 10 times more people with psychological disorders than any actual mental hospital (Steinberg, Mills, & Romano, 2015). Moreover, a report from the Treatment Advocacy Center and the National Sheriffs Association that drew from 2004–2005 data in the United States indicated that there are more people with psychological disorders in jails or prisons than in mental hospitals (Torrey, Kennard, et al., 2010). Furthermore, of the people currently in prison or jail, over half have a psychological disorder (James & Glaze, 2006).

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Most rooms at state mental hospitals are bleak and unstimulating.

Quick Summary

Early concepts of psychological disorders included not only supernatural but also biological approaches, as evidenced by the ideas of Hippocrates. During the Dark Ages, some people with psychological disorders were cared for in monasteries, but many simply roamed the countryside. Treatments for people with psychological disorders have changed over time, though not always for the better. Exorcisms did not help. Treatments in asylums could also be cruel and unhelpful, but pioneering work by Dix and others made asylums more humane places for treatment. Unfortunately, their good ideas did not last, as the mental hospitals became overcrowded and understaffed.

Check Your Knowledge 1.3

True or false?

1. Benjamin Rush is credited with beginning moral treatment in the United States.
2. Exorcism was an early biological treatment.
3. Hippocrates was one of the first to propose that psychological disorders had a biological cause.
4. The term *lunatic* is derived from the ideas of Paracelsus.

Corbis Historical/Getty Images

In the nineteenth century, Dorothea Dix played a major role in establishing more mental hospitals in the United States.

The Evolution of Contemporary Thought

As horrific as the conditions in Bethlehem Hospital were (and in some ways, continue to be; see Focus on Discovery 1.2), the physicians at the time were nonetheless interested in what caused the maladies of their patients. **Table 1.2** lists the hypothesized causes of the illnesses exhibited

TABLE 1.2 Causes of Maladies Observed Among People in Bethlehem in 1810

Cause	Number of People
Childbed*	79
Contusions/fractures of skull	12
Drink/intoxication	58
Family/hereditary	115
Fevers	110
Fright	31
Grief	206
Jealousy	9
Love	90
Obstruction	10
Pride	8
Religion/Methodism	90
Smallpox	7
Study	15
Venereal	14
Ulcers/scabs dried up	5

Source: Adapated from Appignanesi (2008), Hunter & Macalpine (1963).

*Childbed refers to childbirth—perhaps akin to what we now call postpartum depression.

by people in 1810 that were recorded by William Black, a physician working at Bethlehem at the time (Appignanesi, 2008). It is interesting to observe that about half of the presumed causes were biological (e.g., fever, hereditary, venereal) and half were psychological (e.g., grief, love, jealousy). Only around 10 percent of the causes were supernatural.

Contemporary developments in biological and psychological approaches to the causes and treatments of psychological disorders were heavily influenced by theorists and scientists working in the late nineteenth and early twentieth centuries. We will discuss, compare, and evaluate these approaches more fully in Chapter 2. In this section, we review the historical antecedents of these more contemporary approaches.

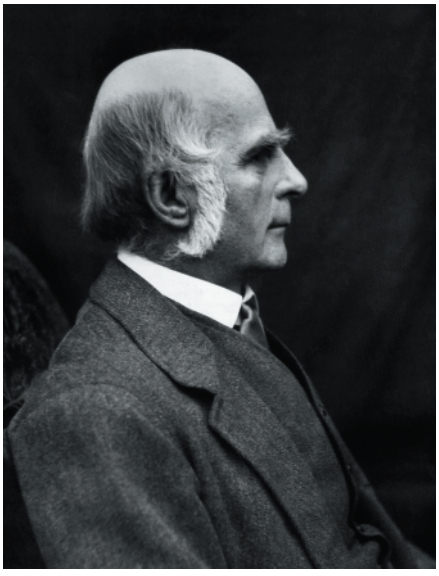
Recall that in the West, the death of Galen and the decline of Greco-Roman civilization temporarily ended inquiries into the nature of both physical and mental illness. Not until much later did any new facts begin to come to light, thanks to an emerging empirical approach to medical science, which emphasized gathering knowledge by direct observation.

Biological Approaches

Discovering Biological Origins in General Paresis and Syphilis The anatomy and workings of the nervous system were partially understood by the mid-1800s, but not enough was known to let investigators conclude whether or not the structural brain abnormalities presumed to cause various psychological disorders were present. One striking medical success was the elucidation of the nature and origin of syphilis, a sexually transmitted disease that had been recognized for several centuries.

The story of this discovery regarding syphilis provides a good illustration of how an empirical approach, the basis for contemporary science, works. Since the late 1700s, it had been known that a number of people with psychological disorders manifested a syndrome characterized by a steady deterioration of both mental and physical abilities, and progressive paralysis; the presumed disease associated with this syndrome was given the name general paresis. By the mid-1800s, it had been established that some people with general paresis also had syphilis, but a connection between the two conditions had not yet been made.

In the 1860s and 1870s, Louis Pasteur established the germ theory of disease, which posited that disease is caused by infection of the body by minute organisms. This theory laid the groundwork for demonstrating the relation between syphilis and general paresis. Finally, in 1905, the specific microorganism that causes syphilis was discovered. For the first time, a causal link had been established between infection, damage to certain areas of the brain, and a form of psychopathology (general paresis). If one type of psychopathology had a biological cause, so could others. Biological approaches gained credibility, and searches for more biological causes were off and running.



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Francis Galton is considered the originator of genetics research.

Genetics Francis Galton (1822–1911), often considered the originator of genetic research with twins because of his study of twins in the late 1800s in England, attributed many behavioral characteristics to heredity (see photo). He is credited with coining the terms *nature* and *nurture* to talk about differences in genetics (nature) and environment (nurture). In the early twentieth century, investigators became intrigued by the idea that psychological disorders may run in families, and beginning at that time, many studies documented the heritability of psychological disorders such as schizophrenia, bipolar disorder, and depression. These studies would set the stage for later theories about the causes of psychological disorders.

Unfortunately, Galton is also credited with creating the eugenics movement in 1883 (Brooks, 2004). Advocates of this movement sought to eliminate undesirable characteristics from the population by restricting the ability of certain people to have children (e.g., by enforced sterilization). Many of the early efforts in the United States to determine whether psychological disorders could be inherited were associated with the eugenics movement, and this stalled research progress. Indeed, in a sad page from U.S. history, state laws in the late 1800s and early 1900s prohibited people with psychological disorders from marrying and forced them to be sterilized to prevent

them from "passing on" their illness. Such laws were upheld by the U.S. Supreme Court in 1927 (Stern, 2015), and it wasn't until much later that these abhorrent practices were halted. For example, the eugenics law in California was not repealed until 1979. Still, investigative reporting uncovered 148 sterilizations of women in California prisons between 2006 and 2010, prompting a new law signed in 2014 that bans the practice in prisons. In the past 10 years, some states have provided compensation to survivors of this horrible practice (Stern, Novak, et al., 2017).

Biological Treatments The general warehousing of people in mental hospitals earlier in the twentieth century, coupled with the shortage of professional staff, created a climate that allowed, perhaps even subtly encouraged, experimentation with radical interventions. In the early 1930s, the practice of inducing a coma with large dosages of insulin was introduced by Sakel (1938), who claimed that up to three-quarters of the people with schizophrenia whom he treated showed significant improvement. Later findings by other researchers were less encouraging, and insulin-coma therapy—which presented serious risks to health, including irreversible coma and death—was gradually abandoned.

In the early twentieth century, **electroconvulsive therapy (ECT)** was originated by two Italian physicians, Ugo Cerletti and Lucino Bini. Cerletti was interested in epilepsy and was seeking a way to induce seizures experimentally. Shortly thereafter he found that by applying electric shocks to the sides of the human head, he could produce full epileptic seizures. Then, in Rome in 1938, he used the technique on a person with schizophrenia.

In the decades that followed, ECT was administered to people with schizophrenia and severe depression, usually in hospital settings. As we will discuss in Chapter 5, it is still used today for people with severe depression. Fortunately, important refinements in the ECT procedures have made it less problematic, and it can be an effective treatment.

Michael Ochs Archives/Stringer/Getty Images

Scene from *One Flew Over the Cuckoo's Nest.* The character portrayed by Jack Nicholson was lobotomized in the film.

In 1935, Egas Moniz, a Portuguese psychiatrist, introduced the *prefrontal lobotomy*, a surgical procedure that destroys the tracts connecting the frontal lobes to other areas of the brain. His initial reports claimed high rates of success (Moniz, 1936), and for 20 years thereafter thousands of people with psychological disorders underwent variations of this psychosurgery. The procedure was used especially for those whose behavior was violent. Many people did indeed quiet down and could even be discharged from hospitals, but largely because their brains were damaged. During the 1950s, this intervention fell into disrepute for several reasons. After surgery, many people became dull and listless and suffered serious losses in their emotional experience and cognitive capacities—for example, becoming unable to carry on a coherent conversation with another person—which is not surprising given the destruction of parts of their brains that support emotion, thought, and language.

Psychological Approaches

The search for biological causes dominated the field of psychopathology until well into the twentieth century, no doubt partly because of the discoveries made about the brain and genetics. But beginning in the late eighteenth century, various psychological points of view emerged that attributed psychological disorders to psychological malfunctions. These theories were fashionable first in France and Austria, and later in the United States, leading to the development of psychotherapeutic interventions based on the tenets of the individual theories.

Mesmer and Charcot During the eighteenth century in western Europe, many people were observed to be subject to *hysteria*, which referred to physical incapacities, such as blindness or paralysis, for which no physical cause could be found. Franz Anton Mesmer (1734–1815), an Austrian physician practicing in Vienna and Paris in the late eighteenth century, believed that hysteria was caused by a distribution of a universal magnetic fluid in the body. Moreover,

he felt that one person could influence the fluid of another to bring about a change in the other's behavior.

Mesmer conducted meetings cloaked in mystery and mysticism, and he originally developed a technique using rods to influence a person's alleged magnetic fields. Later, Mesmer perfected his routines by simply looking at people rather than using rods.

Although Mesmer regarded hysteria as having strictly biological causes, we discuss his work here because he is generally considered one of the earlier practitioners of modern-day hypnosis. (The word *mesmerism* is a synonym for *hypnotism*; the phenomenon itself was known to the ancients of many cultures, where it was part of the sorcery and magic of conjurers and faith healers.)

Mesmer came to be regarded as a quack by his contemporaries, which is ironic, since he had earlier helped discredit an exorcist, Father Johann Joseph Gassner, who was performing similar rituals (Harrington, 2008). Nevertheless, hypnosis gradually became respectable. The great Parisian neurologist Jean-Martin Charcot (1825–1893) also studied hysterical states. Although Charcot believed that hysteria was a problem with the nervous system and had a biological cause, he was also persuaded by psychological explanations. One day, some of his enterprising students hypnotized a healthy woman and, by suggestion, induced her to display certain hysterical symptoms. Charcot was deceived into believing that she was an actual patient with hysteria. When the students showed him how readily they could remove the symptoms by waking the woman, Charcot became interested in psychological interpretations of these very puzzling phenomena. Given Charcot's prominence in Parisian society, his support of hypnosis as a worthy treatment for hysteria helped to legitimize this form of treatment among medical professionals of the time (Harrington, 2008; Hustvedt, 2011).

Jean-Loup Charmet/Science Source

Mesmer's procedure for manipulating magnetism was generally considered a form of hypnosis.

Breuer and the Cathartic Method

In the nineteenth century, a Viennese physician, Josef Breuer (1842–1925) (see photo), treated a young woman, whose identity was disguised under the pseudonym Anna O., with a number of hysterical symptoms, including partial paralysis, impairment of sight and hearing, and often difficulty speaking. She also sometimes went into a dreamlike state, or "absence," during which she mumbled to herself, seemingly preoccupied with troubling thoughts. Breuer hypnotized her, and while hypnotized, she began talking more freely and, ultimately, with considerable emotion about upsetting events from her past. Frequently, on awakening from a hypnotic session she felt much better. Breuer found that the relief of a particular symptom seemed to last longer if, under hypnosis, she was able to recall the event associated with the first appearance of that symptom and if she was able to express the emotion she had felt at the time. Reliving an earlier emotional trauma and releasing emotional tension by expressing previously forgotten thoughts about the event was called catharsis, and Breuer's method became known as the **cathartic method**. In 1895, Breuer and a younger colleague, Sigmund Freud (1856–1939), jointly published *Studies in Hysteria*, partly based on the case of Anna O.

Bettmann/Getty Images

Josef Breuer, an Austrian physician and physiologist, collaborated with Freud in the early development of psychoanalysis.

The case of Anna O. became one of the best-known clinical cases in the psychoanalytic literature. Ironically, later investigation revealed that Breuer and Freud reported the case incorrectly. Historical study by Ellenberger (1972) indicates that Breuer's talking cure helped the young woman only temporarily. This claim is supported by Carl Jung, a renowned colleague of Freud's, who is quoted as saying that during a conference in 1925, Freud told him that Anna O. had never been cured. Hospital records discovered by Ellenberger confirmed that Anna O. continued to rely on morphine to ease the "hysterical" problems that Breuer is reputed to have cured by catharsis.

Freud and Psychoanalysis

The apparently powerful role played by factors of which people seemed unaware led Freud to postulate that much of human behavior is determined by forces that are inaccessible to awareness. The central assumption of Freud's theorizing, often

referred to as **psychoanalytic theory**, is that psychopathology results from **unconscious** conflicts in the individual. In the next sections, we take a look at Freud's theory.

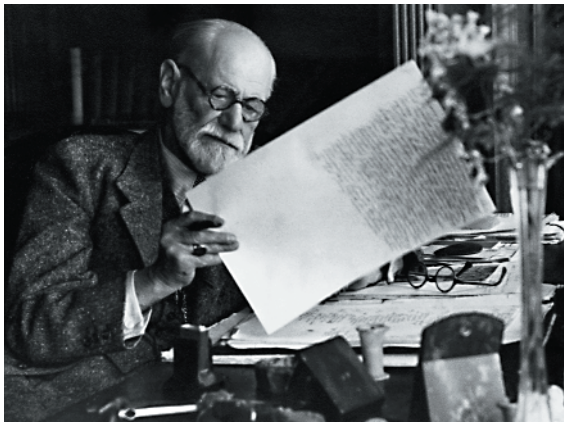
Structure of the Mind

Freud divided the mind into three principal parts: id, ego, and superego. According to Freud, the id is present at birth and is the repository of all the energy needed to run the mind, including the basic urges for food, water, elimination, warmth, affection, and sex. Trained as a neurologist, Freud saw the source of the id's energy as biological and unconscious. That is, a person cannot consciously perceive this energy—it is below the level of awareness.

The **id** seeks immediate gratification of its urges. When the id is not satisfied, tension is produced, and the id drives a person to get rid of this tension as quickly as possible. For example, a baby feels hunger and is impelled to move about, sucking, in an attempt to reduce the tension arising from the hunger urge.

According to Freud, the **ego** begins to develop from the id during the second 6 months of life. Unlike the contents of the id, those of the ego are primarily conscious. The task of the ego is to deal with reality, and it mediates between the demands of reality and the id's demands for immediate gratification.

The **superego**—the third part of the mind in Freud's theory—can be roughly conceived of as a person's conscience. Freud believed that the superego develops throughout childhood, arising from the ego much as the ego arises from the id. As children discover that many of their impulses—for example, biting—are not acceptable to their parents, they begin to incorporate parental values as their own to receive the pleasure of parental approval and avoid the pain of disapproval.



Corbis Historical/Getty Images

Sigmund Freud developed psychoanalytic theory, a theory of the structure and functions of the mind (including explanations of the causes of psychological disorders), and psychoanalysis, a method of therapy based on it.

Defense Mechanisms

According to Freud, and as elaborated by his daughter Anna (A. A. Freud, 1946/1966), herself an influential psychoanalyst, discomforts experienced by the ego as it attempts to resolve conflicts and satisfy the demands of the id and superego can be reduced in several ways. A **defense mechanism** is a strategy used by the ego to protect itself from anxiety. Examples of defense mechanisms are presented in **Table 1.3**.

TABLE 1.3 Selected Defense Mechanisms

Defense Mechanism	Definition	Example
Repression	Keeping unacceptable impulses or wishes from conscious awareness	A professor starting a lecture she dreaded giving says, "In conclusion."
Denial	Not accepting a painful reality into conscious awareness	A victim of childhood abuse does not acknowledge it as an adult.
Projection	Attributing to someone else one's own unacceptable thoughts or feelings	A man who hates members of a racial group believes that it is they who dislike him.
Displacement	Redirecting emotional responses from their real target to someone else	A child gets mad at her brother but instead acts angrily toward her friend.
Reaction formation	Converting an unacceptable feeling into its opposite	A person with sexual feelings toward children leads a campaign against child sexual abuse.
Regression	Retreating to the behavioral patterns of an earlier stage of development	An adolescent dealing with unacceptable feelings of social inadequacy attempts to mask those feelings by seeking oral gratification.
Rationalization	Offering acceptable reasons for an unacceptable action or attitude	A parent berates a child out of impatience, then indicates that she did so to "build character."
Sublimation	Converting unacceptable aggressive or sexual impulses into socially valued behaviors	Someone who has aggressive feelings toward his father becomes a surgeon.

TABLE 1.4 Major Techniques of Psychoanalysis

Technique	Description
Free association	A person tries to say whatever comes to mind without censoring anything.
Interpretation	The analyst points out the meaning of certain of a person's behaviors.
Analysis of transference	The person responds to the analyst in ways that the person has previously responded to other important figures in his or her life, and the analyst helps the person understand and interpret these responses.

Psychoanalytic Therapy

Psychotherapy based on Freud's theory is called **psychoanalysis** or psychoanalytic therapy. It is still practiced today, although not as commonly as it once was. In psychoanalytic and newer psychodynamic treatments, the goal of the therapist is to understand the person's early-childhood experiences, the nature of key relationships, and the patterns in current relationships. The therapist is listening for core emotional and relationship themes that surface again and again (see **Table 1.4** for a summary of psychoanalysis techniques).

Freud developed several techniques in his efforts to help people resolve repressed conflicts. With *free association*, a person reclines on a couch, facing away from the analyst, and is encouraged to give free rein to his or her thoughts, verbalizing whatever comes to mind, without censoring anything.

Another key component of psychoanalytic therapy is the analysis of **transference**. Transference refers to the person's responses to his or her analyst that seem to reflect attitudes and ways of behaving toward important people in the person's past. For example, a person might feel that the analyst is generally bored by what he or she is saying and as a result might struggle to be entertaining; this pattern of response might reflect the person's childhood relationship with a parent rather than what's going on between the person and the analyst. Through careful observation and analysis of these transferred attitudes, Freud believed the analyst could gain insight into the childhood origins of a person's repressed conflicts. In the example above, the analyst might suggest that the person was made to feel boring and unimportant as a child and could only gain parental attention through humor.

In the technique of *interpretation*, the analyst points out the meanings of a person's behavior. Defense mechanisms (see Table 1.3) are a principal focus of interpretation. For instance, a man who appears to have trouble with intimacy may look out the window and change the subject whenever the conversation touches on closeness during the course of a session.

The analyst will attempt at some point to interpret the person's behavior, pointing out its defensive nature in the hope of helping the person acknowledge that he is in fact avoiding the topic.

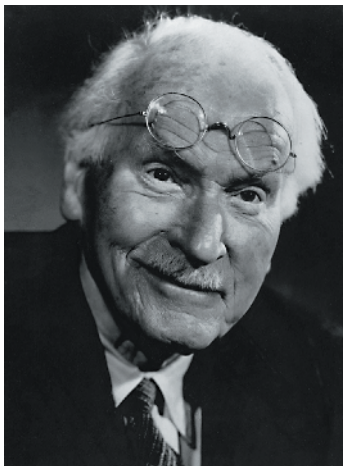
Continuing Influences of Freud and His Followers

Freud's original ideas and methods have been heavily criticized over the years. For example, Freud conducted no formal research on the causes and treatments of psychological disorders. This remains one of the main criticisms today: because they are based on anecdotal evidence gathered during therapy sessions, some psychodynamic theories are not grounded in objectivity and therefore are not scientific. However, other contemporary psychodynamic theories, such as object relations theory (discussed in Chapter 2), have built a limited base of supportive research. Offshoots of object relations theory, such as attachment theory and the idea of the relational self (discussed in Chapter 2), have accumulated research support, both in children and adults. In **Focus on Discovery 1.3**, we discuss two influential theorists who began with Freud but then developed their own theories.

Focus on Discovery 1.3

Extensions and Variations on Freud's Theories

Several of Freud's contemporaries met with him periodically to discuss psychoanalytic theory and therapy. As often happens when a brilliant leader attracts brilliant followers and colleagues, disagreements arose about many general issues, such as the relative importance of id versus ego, of biological versus sociocultural forces on psychological development, of unconscious versus conscious processes, and of childhood versus adult experiences. We discuss two influential historical figures here: Carl Jung and Alfred Adler.



Topham/The Image Works

Carl Jung was the founder of analytical psychology.

Jung and Analytical Psychology

Carl Gustav Jung (1875–1961) (see photo) originally considered Freud's heir apparent, broke with Freud in 1914 over many issues. After a 7-year period of intense correspondence about their disagreements. Jung proposed ideas radically different from Freud's, ultimately establishing *analytical psychology.*

Jung hypothesized that in addition to the personal unconscious postulated by Freud, there is a *collective unconscious*, the part of the unconscious that is common to all human beings and that consists primarily of what Jung called *archetypes*, or basic categories that all human beings use in conceptualizing about the world.

Adler and Individual Psychology

Alfred Adler (1870–1937) (see photo), also an early adherent of Freud's theories, came to be even less dependent on Freud's views than was Jung, and Freud remained quite bitter toward Adler after their relationship ended. Adler's theory, which came to be known as *individual psychology*, regarded people as inextricably tied to their society because he believed that fulfillment was found in doing things for the social good. Like Jung, he stressed the importance of working toward goals (Adler, 1930).

A central element in Adler's work was his focus on helping people change their illogical and mistaken ideas and expectations. He believed that feeling and behaving better depend on thinking more rationally, an approach that anticipated contemporary developments in cognitive behavior therapy (discussed in Chapter 2).

Bettmann/Getty Images

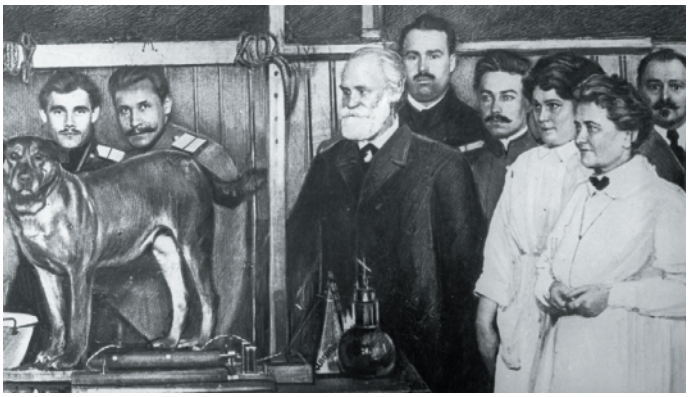
Alfred Adler was the founder of individual psychology.

Though perhaps not as influential as it once was, the work of Freud and his followers continues to have an impact on the field of psychopathology (Westen, 1998). This influence is most evident in the following three commonly held assumptions:

1. *Childhood experiences help shape adult personality.* Contemporary clinicians and researchers still view childhood experiences and other environmental events as crucial. They seldom focus on the psychosexual stages about which Freud wrote, but some emphasize problematic parent–child relationships in general and how they can influence later adult relationships in negative ways.
2. *There are unconscious influences on behavior.* As we will discuss in Chapter 2, the unconscious is a focus of contemporary research in cognitive neuroscience and psychopathology. This research shows that people can be unaware of the causes of their behavior. However, most current researchers and clinicians do not think of the unconscious as a repository of id instincts.
3. *The causes and purposes of human behavior are not always obvious.* Freud and his followers sensitized generations of clinicians and researchers to the nonobviousness of the causes and purposes of human behavior. Contemporary psychodynamic theorists continue to caution us against taking everything at face value. A person expressing disdain for another, for example, may actually like the other person very much, yet be fearful of admitting positive feelings. This tendency to look under the surface, to find hidden meanings in behavior, is perhaps Freud's best-known legacy.

The Rise of Behaviorism

After some years, many in the field began to lose faith in Freud's approach. Instead, the experimental procedures of the psychologists who were investigating learning in animals became a more dominant focus of psychology. **Behaviorism** focuses on observable behavior rather than on consciousness or mental functioning. We will look at three types of learning that influenced the behaviorist approach in the early and middle parts of the twentieth century and that continue to be influential today: **classical conditioning**, **operant conditioning**, and **modeling**.



SVF2/Contributor/Getty Images

Ivan Pavlov, a Russian physiologist and Nobel laureate, made important contributions to the research and theory of classical conditioning.

Classical Conditioning

Around the turn of the twentieth century, the Russian physiologist and Nobel laureate Ivan Pavlov (1849–1936) (see photo) discovered classical conditioning, quite by accident. As part of his study of the digestive system, Pavlov gave a dog meat powder to make it salivate. Before long, Pavlov's laboratory assistants became aware that the dog began salivating when it saw the person who fed it. As the experiment continued, the dog began to salivate even earlier, when it heard the footsteps of its feeder. Pavlov was intrigued by these findings and decided to study the dog's reactions systematically. In the first of many experiments, a bell was rung behind the dog and then the meat powder was placed in its mouth. After this procedure had been repeated several times, the dog began salivating as soon as it heard the bell and before it received the meat powder.

In this experiment, because the meat powder automatically elicits salivation with no prior learning, the powder is termed an **unconditioned stimulus (UCS)** and the response of salivation an **unconditioned response (UCR)**. When the offering of meat powder is preceded several times by a neutral stimulus, the ringing of a bell, the sound of the bell alone (the **conditioned stimulus**, or **CS**) can elicit the salivary response (the **conditioned response**, or **CR**) (see **Figure 1.3**). As the number of paired presentations of the bell and the meat powder increases, the number of salivations elicited by the bell alone increases. What happens to an established CR if the CS is no longer followed by the UCS—for example, if repeated soundings of the bell are not followed by meat powder? The answer is that fewer and fewer CRs (salivations) are elicited, and the CR gradually disappears. This is termed **extinction**.

Classical conditioning can even instill fear. A famous but ethically questionable experiment conducted by John Watson (see photo) and Rosalie Rayner (Watson & Rayner, 1920) involved introducing a white rat to an 11-month-old boy, Little Albert. The boy showed no fear of the animal and appeared to want to play with it. But whenever

Corbis Historical/Getty Images

John B. Watson, an American psychologist, was a major figure in establishing behaviorism.

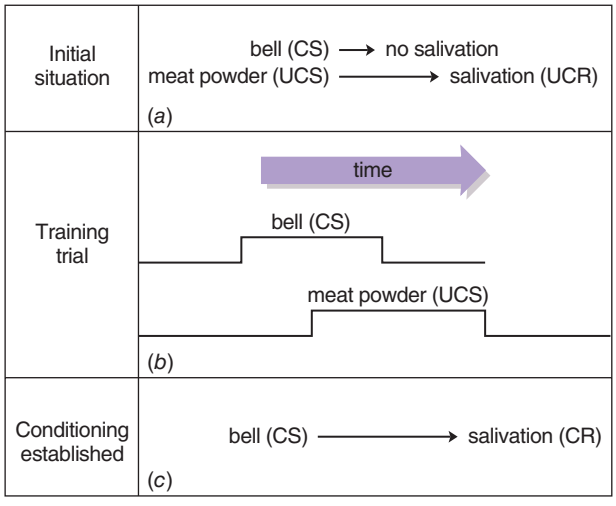


FIGURE 1.3 The process of classical conditioning. (**a**) Before learning, the meat powder (UCS) elicits salivation (UCR), but the bell (CS) does not. (**b**) A training or learning trial consists of presentations of the CS, followed closely by the UCS. (**c**) Classical conditioning has been accomplished when the previously neutral bell elicits salivation (CR).

the boy reached for the rat, the experimenter made a loud noise (the UCS) by striking a steel bar behind Albert's head. This caused Little Albert great fright (the UCR). After five such experiences, Albert became very frightened (the CR) by the sight of the white rat, even when the steel bar was not struck. The fear initially associated with the loud noise had come to be elicited by the previously neutral stimulus, the white rat (now the CS). This study suggests a possible relationship between classical conditioning and the development of certain disorders, in this instance a phobia. It is important to note that this type of study could never be done today because it breaches ethical standards. However, the work of John Watson (1878–1958) helped to establish the promise of behavioral approaches.

Operant Conditioning In the 1890s, Edward Thorndike (1874–1949) began work that led to the discovery of another type of learning. Rather than investigate the association between stimuli, as Pavlov did, Thorndike studied the effects of consequences on behavior. Thorndike formulated what was to become an extremely important principle, the **law of effect**: Behavior that is followed by consequences satisfying to the organism will be repeated, and behavior that is followed by unpleasant consequences will be discouraged.

B. F. Skinner (1904–1990) (see photo) introduced the concept of operant conditioning, so called because it applies to behavior that operates on the environment. Renaming Thorndike's "law of effect" the "principle of reinforcement," Skinner distinguished two types of reinforcement. **Positive reinforcement** refers to the strengthening of a tendency to respond by virtue of the presentation of a pleasant event, called a positive reinforcer. For example, a puppy will be more likely to sit if it is given a treat after doing so. **Negative reinforcement** also strengthens a response, but it does so via the removal of an aversive event, such as when the beeping noise in your car stops once you fasten your seatbelt.

Kathy Bendo for John Wiley & Sons

B. F. Skinner originated the study of operant conditioning and the extension of this approach to education, psychotherapy, and society as a whole.

Operant conditioning principles may contribute to the persistence of aggressive behavior, a key feature of conduct disorder (see Chapter 13). Aggression is often rewarded, as when one child hits another to secure the possession of a toy (getting the toy is the reinforcer). Parents may also unwittingly reinforce aggression by giving in when their child becomes angry or threatens violence to achieve some goal, such as staying up late to watch Netflix or play video games.

Modeling Learning often goes on even in the absence of reinforcers. We all learn by watching and imitating others, a process called modeling. In the 1960s, experimental work demonstrated that witnessing someone perform certain activities can increase or decrease diverse kinds of behavior, such as sharing, aggression, and fear. For example, Bandura and Menlove (1968) used a modeling treatment to reduce fear of dogs in children. After witnessing a fearless model engage in various activities with a dog, initially fearful children showed an increased willingness to approach and touch a dog. Children of parents with phobias or substance use problems may acquire similar behavior patterns in part by observing their parents' behavior.

Behavior Therapy

Behavior therapy emerged in the 1950s. In its initial form, this therapy applied procedures based on classical and operant conditioning to alter clinical problems.

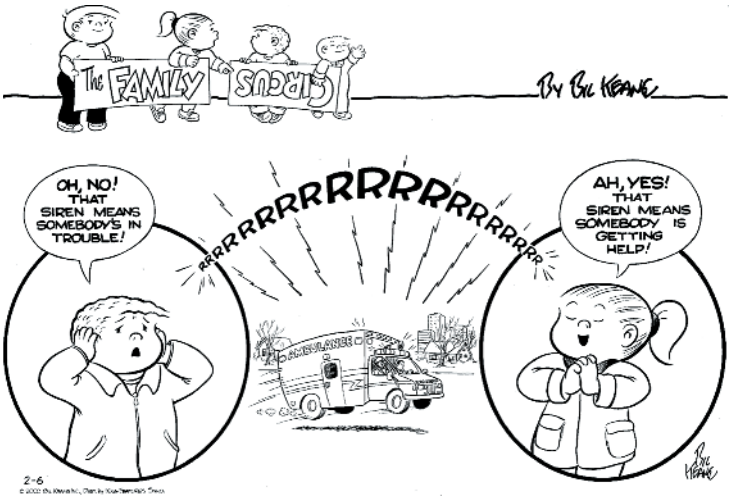
One important behavior therapy technique that is still used to treat phobias and anxiety today is called **systematic desensitization**. Developed by Joseph Wolpe in 1958, it includes two components: (1) deep muscle relaxation and (2) gradual exposure to a list of feared situations, starting with those that arouse minimal anxiety and progressing to those that are the most frightening. Wolpe hypothesized that a state or response opposite to anxiety is substituted for anxiety as the person is exposed gradually to stronger and stronger doses of what he or she fears.

Ken Cavanagh/Science Source

Aggressive responses in children are often rewarded, which makes them more likely to occur in the future. In this photo, the more aggressive child gets to keep the toy.

Operant techniques such as systematically rewarding desirable behavior and extinguishing undesirable behavior have been particularly successful in the treatment of many childhood problems (Kazdin & Weisz, 1998). One challenge with these approaches is maintaining the effects of treatment. After all, a therapist or teacher cannot keep providing reinforcement forever! This issue has been addressed in several ways. Because laboratory findings indicate that intermittent reinforcement—rewarding a response only a portion of the times it appears—makes new behavior more enduring, many behavior therapies move away from reinforcing a desired behavior every time it occurs. For example, if a teacher has succeeded in helping a child spend more time sitting by praising the child generously for each math problem finished while seated, the teacher will gradually reward the child for every other success, and ultimately only infrequently.

The Importance of Cognition Although behaviorism remains influential in many ways today, clinicians and researchers have recognized the limitations of focusing only on behavior. Human beings don't just behave; they think and feel, too! Early behavior theories did not leave much room for cognition and emotion. Beginning in the 1960s, the study of cognition began to become very prominent. Researchers and clinicians realized that the ways in which people think about, or *appraise*, situations can influence behavior in dramatic ways. For example, walking into a room of strangers can elicit thoughts such as "Great! I am so excited to meet all sorts of new and interesting people" or "I do not know any of these people and I am going to look and sound like a complete moron!" A person who has the first thought is likely to join a group of people enthusiastically and join in the conversation. The person who has the second thought, however, is likely to turn right around and leave the room.



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Appraisals are an important part of cognitive therapy. As illustrated, appraisals can change the meaning of a situation.

Cognitive Therapy Cognitive therapy, as mentioned earlier, is based on the idea that people not only behave, but also think and feel. All cognitive approaches have one thing in common. They emphasize that how people construe themselves and the world is a major determinant of psychological disorders. In cognitive therapy, the therapist typically begins by helping clients become more aware of their maladaptive thoughts. By changing cognition, therapists hope that people can change their feelings, behaviors, and symptoms.

The roots of cognitive therapy included Aaron Beck's cognitive therapy (discussed in Chapter 2) and Albert Ellis's *rational-emotive behavior therapy (REBT).* Ellis's (1913–2007) principal thesis was that sustained emotional reactions are caused by internal sentences that people repeat to themselves; these self-statements reflect sometimes unspoken assumptions—irrational beliefs—about what is necessary to lead a meaningful life. In Ellis's REBT (Ellis, 1993, 1995), the aim is to eliminate these ultimately self-defeating beliefs. A person with depression, for example, may say several times a day, "What a worthless jerk I am." Ellis proposed that people interpret what is happening around them, that sometimes these interpretations can cause emotional turmoil, and that a therapist's attention should be focused on these beliefs rather than on historical causes or, indeed, on overt behavior.

Have We Learned From History?

Many students of psychopathology grumble about having to read about the history of our field; they are excited to get right into learning about the clinical descriptions, causes, and treatments for psychological disorders. After all, many students of psychopathology aspire to a career as a mental health professional, not a historian. As we began our tour of history, however, we noted that it was important for us to consider the history of our field so that we could see how things have and have not changed over time. Ideally, we will learn from our historical mistakes.

Certainly, we have made many advancements over the centuries. We've learned that many people will experience a psychological disorder in their lifetime, and major models are available that integrate biology, psychology, and social influences for almost every psychological disorder we will cover in this book. Many psychological treatments have been developed, and thousands of publications each year focus on the genetic, neurobiological, and psychosocial causes of psychological disorders.

Despite these advances, we still have much to learn from history when it comes to reducing stigma and treating people with psychological disorders with respect, compassion, and dignity. Consider, for example, recent popular "reality" television shows of today such as *Hoarders*, *Beyond Scared Straight*, *Obsessed*, or *Intervention* that, respectively, showcase the lives of people with hoarding disorder (see Chapter 7), conduct disorder (see Chapter 13), obsessive compulsive disorder (see Chapter 7), or substance use disorder (see Chapter 10). Perhaps these shows help to educate people about psychological disorders, but perhaps also they perpetuate stigma by serving as the twenty-first-century version of viewing people in asylums for entertainment, as was done in the eighteenth century. On the other hand, other television shows present realistic and compassionate portrayals of psychological disorders, such as *Homeland* (bipolar disorder; see Chapter 5) or *The United States of Tara* (dissociative identity disorder; see Chapter 8). Yet even these shows can simplify or magnify some of the rarer aspects of psychological disorders, perhaps to amplify their entertainment value.

Joel Koyama/MCT/Newscom

Are contemporary television shows such as *Hoarders* a modern equivalent of aristocrats viewing people in St. Mary's of Bethlehem (aka Bedlam) for entertainment?

What about the living conditions for people with psychological disorders? People with serious disorders, such as schizophrenia, bipolar disorder, or severe depression, are often in need of short stays in hospitals. Unfortunately, many hospitals have closed since the 1950s, making it extremely difficult to be able to stay in a hospital when needed. As we will discuss in more detail in Chapter 16, many of the conditions inside the hospitals were deplorable. Yet, instead of improving these conditions, many hospitals simply closed, leaving a large gap in treatment services for people with particularly severe disorders. In 2014, the new "hospital" for psychological disorders is jail. That is, people with severe psychological disorders are more likely to be housed in jails than in a hospital (Torrey, 2014). Many people with psychological disorders are not able to work and thus have very little income. These economic realities increase the likelihood of living in low-income housing, such as a single-room occupancy hotel, or SRO, to avoid homelessness. A recent study of such living accommodations found that nearly 75 percent of the residents of an SRO in Vancouver, Canada, had some type of psychological disorder and that 95 percent of the residents had a substance use disorder (Vila-Rodriguez, Panenka, et al., 2013).

As we will see in the following chapters, we still have some way to go when it comes to finding effective treatments with a tolerable set of side effects. Many people take medications to help with the symptoms of psychological disorders: In 2013, nearly 17 percent of adults in the United States had at least one prescription for such a medication (Moore & Mattison, 2017). However, these medications can have some very unpleasant side effects. For example, medications commonly used to treat schizophrenia can cause weight gain, dry mouth, blurred

vision, and extreme fatigue. Imagine your life as a student if you had blurred vision nearly all the time! Some of these side effects contribute to the development of other health problems (e.g., weight gain increases the risk of developing type 2 diabetes). It is perhaps not surprising then, that some people with schizophrenia opt not to take these medications to avoid the side effects. Of course, current medications may not be as horrid as treatments of old like bleeding or prefrontal lobotomy. In addition, there are effective psychotherapy treatments that do not involve medication at all for some psychological disorders. However, even though we will see in the coming chapters that cognitive behavior therapy is an effective treatment for several psychological disorders, it does not help all people.

Have we learned from history? It seems that the answer is both yes and no. These lessons of history are therefore important for those who are headed toward careers as clinical scientists and mental health professionals. And we hope that readers of this book, regardless of their current or future careers, will recognize that we can all do something to reduce stigma, first and foremost by understanding that our current approaches to psychological disorders can and must continue to improve.

Quick Summary

The nineteenth and twentieth centuries saw a return to biological explanations for psychological disorders. Developments outside the field of psychopathology, such as the germ theory of disease and the discovery of the cause of syphilis, illustrated how the brain and behavior are linked. Early investigations into the genetics of psychological disorders led to a tragic emphasis on eugenics and the enforced sterilization of many thousands of people with psychological disorders. Biological approaches to treatment such as induced insulin coma and lobotomy eventually gave way to drug treatments. Psychological approaches to psychopathology began with Mesmer's manipulation of "magnetism" to treat hysteria (late eighteenth century), proceeded through Breuer's conceptualization of the cathartic method in his treatment of Anna O. (late nineteenth century), and culminated in Freud's psychoanalytic theories and treatment techniques (early twentieth century). The theories of Freud and other psychodynamic theorists do not lend themselves to systematic study, which has limited their acceptance by some in the field. Although Freud's early work is often criticized, his theorizing has been influential in the study of psychopathology in that it has made clear the importance of early experiences, the notion that we can do things without conscious awareness, and the insight that the causes of behavior are not always obvious.

Behaviorism began its ascendancy in the 1920s and continues to be an important part of various psychotherapies. John Watson built on the work of Ivan Pavlov in showing how some behaviors can be conditioned. B. F. Skinner, building on the work of Edward Thorndike, emphasized the contingencies associated with behavior, showing how positive and negative reinforcement could shape behavior. Research on modeling helped to explain how people can learn even when no obvious reinforcers are present. Early behavior therapy techniques that are still used today include systematic desensitization, intermittent reinforcement, and modeling. The study of cognition became popular beginning in the 1960s. Cognitive therapy was developed, and one of its pioneers, Albert Ellis, developed a cognitive treatment that focuses on beliefs. Rational-emotive behavior therapy emphasizes that the thoughts and "demands" that people impose on themselves (I should do this; I must do that) are counterproductive and lead to different types of emotional distress.

Check Your Knowledge 1.4

Fill in the blanks.

1. _____ was a French neurologist who was influenced by the work of _____.

2. _____ developed the cathartic method, which _____ later built on in the development of psychoanalysis.

3. The _____ is driven by the pleasure principle, but the _____ is driven by the reality principle.

4. In psychoanalysis, _____ refers to interpreting the relationship between therapist and client as indicative of the client's relationship to others.

True or false?

1. Positive reinforcement refers to increasing a desired behavior, while negative reinforcement refers to eliminating an undesirable behavior.

2. Systematic desensitization involves meditation and relaxation.

3. A cat comes running at the sound of a treat jar rattling, and his human friend then gives him a treat. The conditioned stimulus in this example is the sound of the jar rattling.

4. REBT focuses on changing emotions first so that thoughts can then change.

The Mental Health Professions

As views of psychological disorders have evolved, so, too, have the professions associated with the field. Professionals authorized to provide psychological services include clinical psychologists, psychiatrists, psychiatric nurses, and social workers. The need for such professions has never been greater. For example, the cost of psychological disorders in the United States is nearly $200 billion a year in lost earnings (Kessler, Heeringa, et al., 2008). People with serious psychological disorders are often not able to work due to their illness, and as a result their yearly earnings are substantially less than those of people without psychological disorders (by as much as $16,000 a year!). In addition, people with psychological disorders used to be much more likely to be without health insurance than people without psychological disorders (Garfield, Zuvekas, et al., 2011), a situation that changed in the United States with the Affordable Care Act passed in 2010 that mandated mental health treatment be covered as an "essential health benefit." In this section, we discuss the different types of mental health professionals who treat people with psychological disorders and the different types of training they receive.

Clinical psychologists (such as the authors of this textbook) must have a Ph.D. (or Psy.D.) degree, which entails 4 to 8 years of graduate study. Training for the Ph.D. in clinical psychology is similar to the training in other psychological specialties, such as developmental or cognitive neuroscience. It requires a heavy emphasis on research, statistics, and the empirically based study of human behavior. As in other fields of psychology, the Ph.D. is basically a research degree, and candidates are required to produce independent research. But candidates in clinical psychology learn skills in two additional areas, which distinguish them from other Ph.D. candidates in psychology. First, they learn techniques of assessment and diagnosis of psychopathology; that is, they learn the skills necessary to determine whether a person's symptoms or problems indicate a particular disorder. Second, they learn how to practice psychotherapy, a primarily verbal means of helping people change their thoughts, feelings, and behavior to reduce distress and to achieve greater life satisfaction. Students take courses in which they master specific techniques and treat people under close professional supervision; then, during an intensive internship, they assume increasing responsibility for the care of people. As we shall see throughout the book, many psychotherapies have research support showing that they are effective for many psychological disorders. According to a recent meta-analysis (see Chapter 4 for more on this method) of 34 studies, people with depression or anxiety were three times more likely to prefer psychotherapeutic treatment over medication (McHugh, Whitton, et al., 2013).

© PhotoStock-Israel/Alamy

Clinical psychologists are trained to deliver psychotherapy.

Another degree option for clinical psychologists is the Psy.D. (doctor of psychology), for which the curriculum is similar to that required of Ph.D. students, but with less emphasis on research and more on clinical training. The thinking behind this approach is that clinical psychology has advanced to a level of knowledge and certainty that justifies intensive training in specific techniques of assessment and therapeutic intervention rather than combining practice with research. On the other hand, conducting assessment or therapy without a sufficient research basis is professionally dubious.

Psychiatrists hold an M.D. degree and have had postgraduate training, called a residency, in which they have received supervision in the practice of diagnosis and pharmacotherapy

(administering medications). By virtue of the medical degree, and in contrast to psychologists, psychiatrists can function as physicians—giving physical examinations, diagnosing medical problems, and the like. Most often, however, the only aspect of medical practice in which psychiatrists engage is prescribing medications, chemical compounds that can influence how people feel and think. Psychiatrists may receive some training in psychotherapy as well, though this is not a strong focus of their training.

A **psychiatric nurse** typically receives training at the bachelor's or master's level. Nurses can also receive more specialized training as a nurse practitioner that will allow them to prescribe psychoactive medications. There are currently over 18,000 psychiatric nurses in the United States, but the trend appears to be more toward emphasizing training as a nurse practitioner in order to secure prescription privileges (Robiner, 2006).

Social workers have an M.S.W. (master of social work) degree. Training programs are shorter than Ph.D. programs, typically requiring 2 years of graduate study. The focus of training is on psychotherapy. Those in social work graduate programs do not receive training in psychological assessment. Some M.S.W. programs offer specialized training and certification in marriage and family therapy.

Summary

- The study of psychopathology is a search to explain why people behave, think, and feel in unexpected, sometimes odd, and possibly self-defeating ways. Unfortunately, people who have a psychological disorder are often stigmatized. Reducing the stigma associated with psychological disorders remains a great challenge for the field.
- In evaluating whether a behavior is part of a psychological disorder, psychologists consider several different characteristics, notably, personal distress, disability/dysfunction, and violation of social norms. Each characteristic tells us something about what can be considered psychological disorder, but no one by itself provides a fully satisfactory definition.
- Since the beginning of scientific inquiry into psychological disorders, supernatural, biological, and psychological points of view have vied for attention. More supernatural viewpoints posited that people with psychological disorders are possessed by demons or evil spirits, leading to treatments such as exorcism. Early biological viewpoints originated in the writings of Hippocrates. After the fall of Greco-Roman civilization, the biological perspective became less prominent in western Europe, and supernatural thinking regained ascendancy. Beginning in the fifteenth century, people with psychological disorders were often confined in asylums, such as London's Bethlehem; treatment in asylums was generally poor or nonexistent until various humanitarian reforms were instituted in the eighteenth century. In the twentieth century, genetics and psychological disorders became an important area of inquiry, though the findings from genetic studies were used to the detriment of people with psychological disorders during the eugenics movement.
- Psychological viewpoints emerged in the nineteenth century from the work of Charcot and the writings of Breuer and Freud. Freud's theory emphasized the importance of unconscious processes and defense mechanisms. Therapeutic interventions based on psychoanalytic theory make use of techniques such as free association and the analysis of transference in attempting to overcome repression so that people can confront and understand their conflicts and find healthier ways of dealing with them.
- Behaviorism suggested that behavior develops through classical conditioning, operant conditioning, or modeling. B. F. Skinner introduced the ideas of positive and negative reinforcement and showed that operant conditioning can influence behavior. Behavior therapists try to apply these ideas to change undesired behavior, thoughts, and feelings.
- The study of cognition became widespread in the 1960s. Appraisals and thinking are part of cognitive therapy. Ellis was an influential theorist in cognitive therapy.
- There are several different mental health professions, including clinical psychologist, psychiatrist, psychiatric nurse, social worker, and marriage and family therapist. Each involves different training programs of different lengths and with different emphases on research, psychological assessment, psychotherapy, and psychopharmacology.

Answers to Check Your Knowledge Questions

1.1 1. a; 2. T; 3. F

1.2 1. T; 2. d; 3. b

1.3 1. F; 2. F; 3. T; 4. T

1.4 1. Charcot, Mesmer; 2. Breuer, Freud; 3. id, ego; 4. transference; 5. F; 6. F; 7. T; 4 F

Key Terms

asylums
behaviorism
cathartic method
classical conditioning
clinical psychologist
conditioned response (CR)
conditioned stimulus (CS)
defense mechanism
ego
electroconvulsive therapy (ECT)
exorcism
extinction
id
law of effect
modeling
moral treatment
negative reinforcement
operant conditioning
positive reinforcement
psychiatric nurse
psychiatrist
psychoanalysis
psychoanalytic theory
psychological disorder
psychopathology
psychotherapy
social worker
stigma
superego
systematic desensitization
transference
unconditioned response (UCR)
unconditioned stimulus (UCS)
unconscious