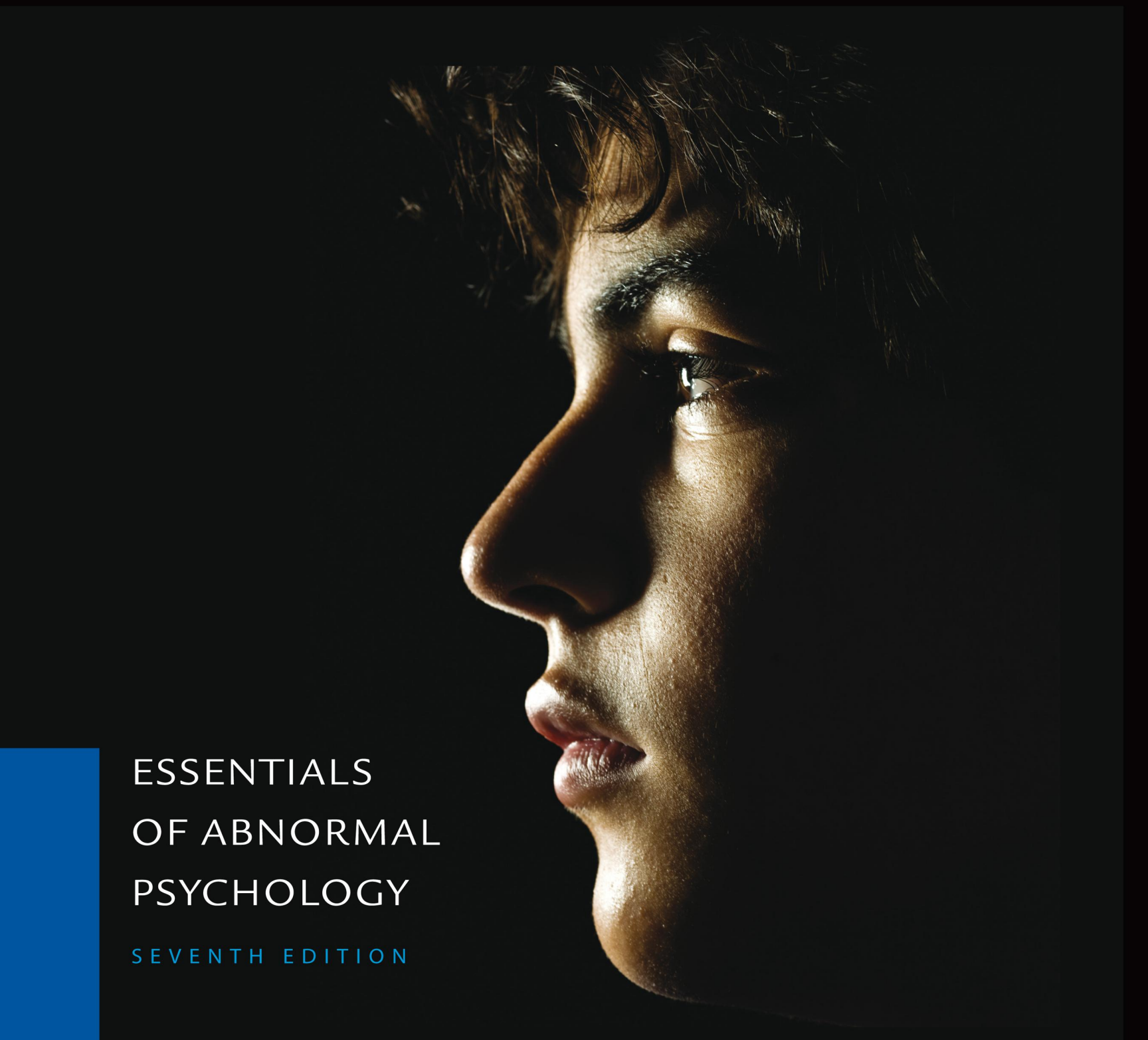

ESSENTIALS OF ABNORMAL PSYCHOLOGY

SEVENTH EDITION

V. Mark Durand
David H. Barlow

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SEVENTH EDITION

Essentials of Abnormal Psychology

V. Mark Durand
University of South Florida–St. Petersburg

David H. Barlow
Boston University

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To Wendy and Jonathan, whose patience, understanding, and love provided me the opportunity to complete such an ambitious project.

—V. M. D.

I dedicate this book to my mother, Doris Elinor Barlow-Lanigan, for her multidimensional influence across my life span.

—D. H. B.

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About the Authors

V. Mark Durand

V. Mark Durand

V. Mark Durand is known worldwide as an authority in the area of autism spectrum disorder. He is a professor of psychology at the University of South Florida–St. Petersburg, where he was the founding Dean of Arts & Sciences and Vice Chancellor for Academic Affairs. Dr. Durand is a fellow of the American Psychological Association. He has received more than $4 million in federal funding since the beginning of his career to study the nature, assessment, and treatment of behavior problems in children with disabilities. Before moving to Florida, he served in a variety of leadership positions at the University at Albany, including Associate Director for clinical training for the doctoral psychology program from 1987 to 1990, chair of the psychology department from 1995 to 1998, and interim dean of Arts and Sciences from 2001 to 2002. There he established the Center for Autism and Related Disabilities at the University at Albany, SUNY. He received his B.A., M.A., and Ph.D.—all in psychology—at the State University of New York–Stony Brook.

Dr. Durand was awarded the University Award for Excellence in Teaching at SUNY–Albany in 1991 and was given the Chancellor's Award for Excellence in Research and Creative Scholarship at the University of South Florida–St. Petersburg in 2007. He was named a 2014 Princeton Lecture Series Fellow for his body of work in the field of autism spectrum disorder. Dr. Durand is currently a member of the Professional Advisory Board for the Autism Society of America and is on the board of directors of the International Association of Positive Behavioral Support. He is co-editor of the *Journal of Positive Behavior Interventions*, serves on a number of editorial boards, and has more than 125 publications on functional communication, educational programming, and behavior therapy. His books include *Severe Behavior Problems: A Functional Communication Training Approach*; *Sleep Better! A Guide to Improving Sleep for Children with Special Needs; Helping Parents with Challenging Children: Positive Family Intervention;* the multiple national award-winning *Optimistic Parenting: Hope and Help for You and Your Challenging Child;* and most recently, *Autism Spectrum Disorder: A Clinical Guide for General Practitioners*.

Dr. Durand developed a unique treatment for severe behavior problems that is currently mandated by states across the country and is used worldwide. He also developed an assessment tool that is used internationally and has been translated into more than 15 languages. Most recently he developed an innovative approach to help families work with their challenging child (Optimistic Parenting), which was validated in a 5-year clinical trial. He has been consulted by the departments of education in numerous states and by the U.S. Departments of Justice and Education. His current research program includes the study of prevention models and treatments for such serious problems as self-injurious behavior.

In his leisure time, he enjoys long-distance running and has completed three marathons.

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David H. Barlow

David H. Barlow

David H. Barlow is an internationally recognized pioneer and leader in clinical psychology. A professor of psychology and psychiatry at Boston University, Dr. Barlow is Founder and Director Emeritus of the Center for Anxiety and Related Disorders, one of the largest research clinics of its kind in the world. From 1996 to 2004, he directed the clinical psychology programs at Boston University. From 1979 to 1996, he was distinguished professor at the University at Albany–State University of New York. From 1975 to 1979, he was professor of psychiatry and psychology at Brown University, where he also founded the clinical psychology internship program. From 1969 to 1975, he was professor of psychiatry at the University of Mississippi, where he founded the Medical School psychology residency program. Dr. Barlow received his B.A. from the University of Notre Dame, his M.A. from Boston College, and his Ph.D. from the University of Vermont.

A fellow of every major psychological association, Dr. Barlow has received many awards in honor of his excellence in scholarship, including the National Institute of Mental Health Merit Award for his long-term contributions to the clinical research effort; the Distinguished Scientist Award for applications of psychology from the American Psychological Association; and the James McKeen Cattell Fellow Award from the Association for Psychological Science, honoring individuals for their lifetime of significant intellectual achievements in applied psychological research. Other awards include the Distinguished Scientist Award from the Society of Clinical Psychology of the American Psychological Association and a certificate of appreciation from the APA section on the clinical psychology of women for "outstanding commitment to the advancement of women in psychology." In 2004, he received the C. Charles Burlingame Award from the Institute of Living and was awarded an Honorary Doctorate of Humane Letters degree from the Massachusetts School of Professional Psychology. He also received career contribution awards from the Massachusetts, Connecticut, and California Psychological Associations, and, in 2000, was named Honorary Visiting Professor at the Chinese People's Liberation Army General Hospital and Postgraduate Medical School in Beijing, China. In addition, the annual Grand Rounds in Clinical Psychology at Brown University was named in his honor, and he was awarded the first graduate alumni scholar award at the University of Vermont. During the 1997–1998 academic year, he was Fritz Redlich Fellow at the Center for Advanced Study in the Behavioral Sciences in Menlo Park, California. His research has been continually funded by the National Institute of Mental Health for over 40 years.

Dr. Barlow has edited three journals, has served on the editorial boards of more than 20 different journals, and is currently editor in chief of the "Treatments That Work" series for Oxford University Press.

He has published more than 500 scholarly articles and written more than 65 books and clinical manuals, including *Anxiety and Its Disorders,* 2nd edition, Guilford Press; *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual,* 5th edition, Guilford Press; *Single-Case Experimental Designs: Strategies for Studying Behavior Change,* 3rd edition, Allyn & Bacon (with Matthew Nock and Michael Hersen); *The Scientist–Practitioner: Research and Accountability in the Age of Managed Care,* 2nd edition, Allyn & Bacon (with Steve Hayes and Rosemary Nelson-Gray); *Mastery of Your Anxiety and Panic,* Oxford University Press (with Michelle Craske); and more recently, *The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders* with the Unified Team at BU. The book and manuals have been translated into more than 20 languages, including Arabic, Chinese, and Russian.

Dr. Barlow was one of three psychologists on the task force that was responsible for reviewing the work of more than 1,000 mental health professionals who participated in the creation of *DSM-IV,* and he continued on as an Advisor to the *DSM-5* Task Force. He also chaired the APA Task Force on Psychological Intervention Guidelines, which created a template for clinical practice guidelines. His current research program focuses on the nature and treatment of anxiety and related emotional disorders.

At leisure, he plays golf, skis, and retreats to his home in Nantucket, where he loves to write, walk on the beach, and visit with his island friends.

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Brief Contents

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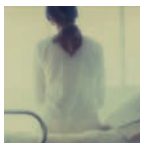

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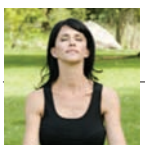

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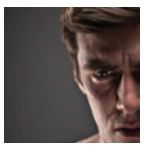

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Preface

Science is a constantly evolving field, but every now and then something groundbreaking occurs that alters our way of thinking. For example, evolutionary biologists, who long assumed that the process of evolution was gradual, suddenly had to adjust to evidence that says evolution happens in fits and starts in response to such cataclysmic environmental events as meteor impacts. Similarly, geology has been revolutionized by the discovery of plate tectonics.

Until recently, the science of psychopathology had been compartmentalized, with psychopathologists examining the separate effects of psychological, biological, and social influences. This approach is still reflected in popular media accounts that describe, for example, a newly discovered gene, a biological dysfunction (chemical imbalance), or early childhood experiences as a "cause" of a psychological disorder. This way of thinking still dominates discussions of causality and treatment in some psychology textbooks: "The psychoanalytic views of this disorder are…," "the biological views are…" and, often in a separate chapter, "psychoanalytic treatment approaches for this disorder are… ," "cognitive behavioral treatment approaches are…," or "biological treatment approaches are…"

In the first edition of this text, we tried to do something very different. We thought the field had advanced to the point that it was ready for an integrative approach in which the intricate interactions of biological, psychological, and social factors are explicated in as clear and convincing a manner as possible. Recent explosive advances in knowledge confirm this approach as the only viable way of understanding psychopathology. To take just two examples, Chapter 2 contains a description of a study demonstrating that stressful life events can lead to depression but that not everyone shows this response. Rather, stress is more likely to cause depression in individuals who already carry a particular gene that influences serotonin at the brain synapses. Similarly, Chapter 7 describes how the pain of social rejection activates the same neural mechanisms in the brain as physical pain. In addition, the entire section on genetics has been rewritten to highlight the new emphasis on gene–environment interaction, along with recent thinking from leading behavioral geneticists that the goal of basing the classification of psychological disorders on the firm foundation of genetics is fundamentally flawed. Descriptions of the emerging field of epigenetics, or the influence of the environment on gene expression, are also woven into the chapter, along with new studies on the seeming ability of extreme environments to largely override the effects of genetic contributions. Studies elucidating the mechanisms of epigenetics or specifically how environmental events influence gene expression are described.

These results confirm the integrative approach in this book: Psychological disorders cannot be explained by genetic or environmental factors alone but rather arise from their interaction. We now understand that psychological and social factors directly affect neurotransmitter function and even genetic expression. Similarly, we cannot study behavioral, cognitive, or emotional processes without appreciating the contribution of biological and social factors to psychological and psychopathological expression. Instead of compartmentalizing psychopathology, we use a more accessible approach that accurately reflects the current state of our clinical science.

As colleagues, you are aware that we understand some disorders better than others. But we hope you will share our excitement in conveying to students both what we currently know about the causes and treatments of psychopathology and how far we have yet to go in understanding these complex interactions.

Integrative Approach

As noted earlier, the first edition of *Abnormal Psychology* pioneered a new generation of abnormal psychology textbooks, which offer an integrative and multidimensional perspective. (We acknowledge such one-dimensional approaches as biological, psychosocial, and supernatural historic trends.) We include substantial current evidence of the reciprocal influences of biology and behavior and of psychological and social influences on biology. Our examples hold students' attention; for example, we discuss genetic contributions to divorce, the effects of early social and behavioral experience on later brain function and structure, new information on the relation of social networks to the common cold, and new data on psychosocial treatments for cancer. We note that in the phenomenon of implicit memory and blind sight, which may have parallels in dissociative experiences, psychological science verifies the existence of the unconscious (although it does not much resemble the seething caldron of conflicts envisioned by Freud). We present new evidence confirming the effects of psychological

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treatments on neurotransmitter flow and brain function. We acknowledge the often-neglected area of emotion theory for its rich contributions to psychopathology (e.g., the effects of anger on cardiovascular disease). We weave scientific findings from the study of emotions together with behavioral, biological, cognitive, and social discoveries to create an integrated tapestry of psychopathology.

Life-Span Developmental Influences

No modern view of abnormal psychology can ignore the importance of life-span developmental factors in the manifestation and treatment of psychopathology. Studies highlighting developmental windows for the influence of the environment on gene expression are explained. Accordingly, although we include a Neurodevelopmental and Neurocognitive Disorders chapter (Chapter 13), we consider the importance of development throughout the text; we discuss childhood and geriatric anxiety, for example, in the context of the Anxiety, Trauma- and Stressor-Related, and Obsessive-Compulsive and Related Disorders chapter. This system of organization, which is for the most part consistent with *DSM-5*, helps students appreciate the need to study each disorder from childhood through adulthood and old age. We note findings on developmental considerations in separate sections of each disorder chapter and, as appropriate, discuss how specific developmental factors affect causation and treatment.

Scientist–Practitioner Approach

We go to some lengths to explain why the scientist–practitioner approach to psychopathology is both practical and ideal. Like most of our colleagues, we view this as something more than simple awareness of how scientific findings apply to psychopathology. We show how every clinician contributes to general scientific knowledge through astute and systematic clinical observations, functional analyses of individual case studies, and systematic observations of series of cases in clinical settings. For example, we explain how information on dissociative phenomena provided by early psychoanalytic theorists remains relevant today. We also describe the formal methods used by scientist–practitioners, showing how abstract research designs are actually implemented in research programs.

Clinical Cases of Real People

We have enriched the book with authentic clinical histories to illustrate scientific findings on the causes and treatment of psychopathology. We have both run active clinics for years, so 95% of the cases are from our own files, and they provide a fascinating frame of reference for the findings we describe. The beginnings of most chapters include a case description, and most of the discussion of the latest theory and research is related to these very human cases.

Disorders in Detail

We cover the major psychological disorders in 11 chapters, focusing on three broad categories: clinical description, causal factors, and treatment and outcomes. We pay considerable attention to case studies and *DSM-5* criteria, and we include statistical data, such as prevalence and incidence rates, sex ratio, age of onset, and the general course or pattern for the disorder as a whole. Since one of us (DHB) was an appointed Advisor to the *DSM-5* task force, we are able to include the reasons for changes as well as the changes themselves. Throughout, we explore how biological, psychological, and social dimensions may interact to cause a particular disorder. Finally, by covering treatment and outcomes within the context of specific disorders, we provide a realistic sense of clinical practice.

Treatment

One of the best received innovations in the first six editions was our discussing treatments in the same chapter as the disorders themselves instead of in a separate chapter, an approach that is supported by the development of specific psychosocial and pharmacological treatment procedures for specific disorders. We have retained this integrative format and have improved upon it, and we include treatment procedures in the key terms and glossary.

Legal and Ethical Issues

In our closing chapter, we integrate many of the approaches and themes that have been discussed throughout the text. We include case studies of people who have been involved directly with many legal and ethical issues and with the delivery of mental health services. We also provide a historical context for current perspectives so students will understand the effects of social and cultural influences on legal and ethical issues.

Diversity

Issues of culture and gender are integral to the study of psychopathology. Throughout the text we describe current thinking about which aspects of the disorders are culturally specific and which are universal and about the strong and sometimes puzzling effects of gender roles. For instance, we discuss the current information on such topics as the gender imbalance in depression, how panic disorders are expressed differently in various Asian cultures, the ethnic differences in eating disorders, treatment of schizophrenia across cultures, and the diagnostic differences of attention deficit/hyperactivity disorder (ADHD) in boys and girls. Clearly, our field will grow in depth and detail as these subjects and others become standard research topics. For example, why do some disorders overwhelmingly affect females and others appear predominantly in males? And

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why does this apportionment sometimes change from one culture to another? In answering questions like these, we adhere closely to science, emphasizing that gender and culture are each one dimension among several that constitute psychopathology.

New to This Edition

A Thorough Update

This exciting field moves at a rapid pace, and we take particular pride in how our book reflects the most recent developments. Therefore, once again, every chapter has been carefully revised to reflect the latest research studies on psychological disorders. Hundreds of new references from 2011 to 2014 (and some still "in press") appear for the first time in this edition, and some of the information they contain stuns the imagination. Nonessential material has been eliminated, some new headings have been added, and *DSM-5* criteria are included in their entirety as tables in the appropriate disorder chapters.

Anxiety, Trauma- and Stressor-Related, and Obsessive-Compulsive and Related Disorders (Chapter 4), Mood Disorders and Suicide (Chapter 6), Physical Disorders and Health Psychology (Chapter 7), Eating and Sleep–Wake Disorders (Chapter 8), Substance-Related, Addictive, and Impulse-Control Disorders (Chapter 10), Schizophrenia Spectrum and Other Psychotic Disorders (Chapter 12), and Neurodevelopmental and Neurocognitive Disorders (Chapter 13) have been the most heavily revised to reflect new research, but all chapters have been significantly updated and freshened.

Chapter 1, Abnormal Behavior in Historical Context, features updated nomenclature to reflect new titles in *DSM-5,* updated descriptions of research on defense mechanisms, and fuller and deeper descriptions of the historical development of psychodynamic and psychoanalytic approaches.

Chapter 2, An Integrative Approach to Psychopathology, includes an updated discussion of developments in the study of genes and behavior with a focus on gene–environment interaction; new data illustrating the gene–environment correlation model; updated information in the quickly developing area of genetics; new studies illustrating the psychosocial influence on brain structure and function in general and on neurotransmitter systems specifically; new studies illustrating psychosocial influences on the development of brain structure and function; updated, revised, and refreshed sections on behavioral and cognitive science including new studies illustrating the influence of positive psychology on physical health and longevity; new studies supporting the strong influence of emotions, specifically anger, on cardiovascular health; new studies illustrating the influence of gender on the presentation and treatment of psychopathology; a variety of powerful new studies confirming strong social effects on health and behavior; and new studies confirming the puzzling "drift" phenomenon resulting in a higher prevalence of schizophrenia among individuals living in urban areas.

Chapter 3, Clinical Assessment, Diagnosis, and Research in Psychopathology now presents references to "intellectual disability" instead of "mental retardation" to be consistent with *DSM-5* and changes within the field; a new discussion about how information from the MMPI-2—although informative—does not necessarily change how clients are treated and may not improve their outcomes (Lima et al., 2005); a description of the organization and structure of *DSM-5* along with major changes from *DSM-IV;* a description of methods to coordinate the development of *DSM-5* with the forthcoming ICD-11; and a description of likely directions of research as we begin to head toward *DSM-6*. In addition, a new example of how behavioral scientists develop research hypotheses is presented, as well as a new cautionary discussion of the Virginia Tech massacre in the section on case study method, and a new example of longitudinal designs that look at how the use of spanking predicts later behavior problems in children (Gershoff, Lansford, Sexton, Davis-Kean, & Sameroff, 2012).

Chapter 4, now titled Anxiety, Trauma- and Stressor-Related, and Obsessive-Compulsive and Related Disorders, was reorganized according to the three major groups of disorders: anxiety disorders, trauma- and stressor-related disorders, and obsessive-compulsive and related disorders. Two new disorders (separation anxiety disorder and selective mutism) are presented, and the Trauma and Stressor-Related Disorders section includes not only posttraumatic stress disorder and acute stress disorder but also adjustment disorder and attachment disorders. The final new grouping, Obsessive-Compulsive and Related Disorders, includes not only obsessive-compulsive disorder but also body dysmorphic disorder, hoarding disorder, and finally trichotillomania (hair pulling disorder) and excoriation (skin picking disorder). Other revisions to Chapter 4 include the following:

- Updated descriptions of the nature of anxiety, fear, and panic, and an integrated etiological model of anxiety and related disorders
- Updated information on the relationship of anxiety and related disorders to suicide
- A description of modifications to types of panic attacks, which has been reduced from 3 to 2 in *DSM-5*
- Updated discussion of generalized anxiety disorder, one of the few disorders incurring no changes in diagnostic criteria in *DSM-5*
- Updated information on description, etiology, and treatment for specific phobia and social anxiety disorder
- Updated discussion of Obsessive-Compulsive and Related Disorders, including description, statistics, etiology, and treatment for OCD
- Added discussion of newly repositioned body dysmorphic disorder from the somatoform disorders, as well as the rationale of the *DSM-5* task force for making this change

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- Updated and more detailed description of hoarding disorder, previously thought to be a variation of OCD but now accorded its own status as a separate disorder in *DSM-5*
- Reorganized discussion of trichotillomania (hair pulling disorder) and excoriation (skin picking disorder), previously located under impulse control disorders in *DSM-IV* but repositioned because of similarities with Obsessive-Compulsive and other Related Disorders in *DSM-5*

The grouping of disorders in Chapter 5, now titled Somatic Symptom and Related Disorders and Dissociative Disorders, reflects a major overarching change, specifically for somatic symptom disorder, illness anxiety disorder, and psychological factors affecting medical condition. In addition, Chapter 5 now has an update to culturally specific somatic symptom disorders; updated discussions on the causes and treatment of somatic symptom disorders; updated discussion on conversion disorder and its new subtitle "functional neurological symptom disorder"; a full description of the reorganization of dissociative disorders; new discussion of conceptualization of depersonalization disorder, which is now known as *depersonalization-derealization disorder,* as a condition encompassing both types of dissociative phenomena; new definitions of dissociative amnesia, which now encompasses dissociative fugue states; and updated discussion of dissociative identity disorder (DID), including new information on personality characteristics associated with the development of this disorder and the incorporation of possession states into the definition of this disorder.

Chapter 6, Mood Disorders and Suicide, is fully consistent with *DSM-5* and now includes a full description of mood disorders new to *DSM-5* such as disruptive mood dysregulation disorder and premenstrual dysphoric disorder, a full description of the new emphasis in mood disorders on chronicity, the creation of persistent depressive disorder as a major new classification of mood disorders, and the latest developments in mood disorders and suicide prevention.

In Chapter 7, Physical Disorders and Health Psychology, the following have been added: updated data on the leading causes of death in the United States; a review of the increasing depth of knowledge on the influence of psychological and social factors on brain structures and function; new data on the positive effects of reducing depressive symptoms on survival in patients with metastatic breast cancer; an updated review of developments into causes and treatment of chronic pain; updated information eliminating the XMRV virus as a possible cause of chronic fatigue syndrome; and updated review of psychological and behavioral procedures for preventing injuries.

Thoroughly rewritten and updated, Chapter 8, Eating and Sleep–Wake Disorders, contains new information on mortality rates in anorexia nervosa; new epidemiological information on the prevalence of eating disorders in adolescents; new information on the increasing globalization of eating disorders and obesity; updated information on typical patterns of comorbidity accompanying eating disorders; and new and updated research on changes in the incidence of eating disorders among males, racial and ethnic differences on the thin-ideal body image associated with eating disorders, the role of friendship cliques in the etiology of eating disorders, mothers with eating disorders who also restrict their children's food intake, the contribution of parents and family factors in the etiology of eating disorders, biological and genetic contributions to causes of eating disorders, transdiagnostic treatment applicable to all eating disorders, the effects of combining Prozac with CBT in the treatment of eating disorders, racial and ethnic differences in people with binge eating disorder seeking treatment, and the phenomenon of night eating syndrome and its role in the development of obesity.

Realigned coverage of Sleep–Wake Disorders, also in Chapter 8, with new information on sleep in women is now reported—including risk and protective factors, an updated section on narcolepsy to describe new research on the causes of this disorder, and new research on the nature and treatment of nightmares.

In Chapter 9, Sexual Dysfunctions, Paraphilic Disorders, and Gender Dysphoria, a revised organization of sexual dysfunctions, paraphilic disorders, and gender dysphoria was undertaken to reflect the fact that both paraphilic disorders and gender dysphoria are separate chapters in *DSM-5,* and gender dysphoria, is, of course, not a sexual disorder but a disorder reflecting incongruence between natal sex and expressed gender. This chapter also incorporates new data on developmental changes in sexual behavior from age of first intercourse to prevalence and frequency of sexual behavior in old age; new reports contrasting differing attitudes and engagement in sexual activity across cultures even within North America; updated information on the development of sexual orientation; and a thoroughly updated description of gender dysphoria with an emphasis on emerging conceptualizations of gender expression that are on a continuum.

Chapter 9 also includes updated information on contributing factors to gender dysphoria as well as the latest recommendations on treatment options, recommended treatment options (or not to treat) for gender nonconformity in children, a full description of disorders of sex development (formerly called intersexuality), and a thoroughly revamped description of paraphilic disorders to reflect the updated system of classification with a discussion of the controversial change in the name of these disorders from paraphilia to paraphilic disorders.

A thoroughly revised Chapter 10, Substance-Related, Addictive, and Impulse-Control Disorders, features new discussion of how the trend to mix caffeinated energy drinks with alcohol may increase the likelihood of later abuse of alcohol; new research on chronic use of MDMA ("Ecstasy") leading to lasting memory problems (Wagner, Becker, Koester, Gouzoulis-Mayfrank, & Daumann, 2013); and new

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research on several factors predicting early alcohol use, including when best friends have started drinking, whether family members are at high risk for alcohol dependence, and the presence of behavior problems in these children (Kuperman et al., 2013).

Chapter 11, Personality Disorders, now features a completely new section on gender differences to reflect newer, more sophisticated analyses of prevalence data, and a new section on criminality and antisocial personality disorder is now revised to better reflect changes in *DSM-5*.

Chapter 12, Schizophrenia Spectrum and Other Psychotic Disorders, presents a new discussion of schizophrenia spectrum disorder and the dropping of subtypes of schizophrenia from *DSM-5;* new research on deficits in emotional prosody comprehension and its role in auditory hallucinations (Alba-Ferrara, Fernyhough, Weis, Mitchell, & Hausmann, 2012); a discussion of a new proposed psychotic disorder suggested in *DSM-5* for further study—Attenuated Psychosis Syndrome; and a new discussion of the use of transcranial magnetic stimulation.

In Chapter 13, Neurodevelopmental and Neurocognitive Disorders, *neurodevelopmental disorders* are presented, instead of *pervasive developmental disorders,* to be consistent with the major changes in *DSM-5.* In addition, Chapter 13 now describes new research to show that gene–environment interaction can lead to later behavior problems in children with ADHD (Thapar, Cooper, Jefferies, & Stergiakouli, 2012; Thapar, et al., 2005); new research on ADHD (and on other disorders) that is finding that in many cases mutations occur that either create extra copies of a gene on one chromosome or result in the deletion of genes (called *copy number variants* or CNVs) (Elia et al., 2009; Lesch et al., 2010); and new research findings that show a variety of genetic mutations, including de novo disorders (genetic mutations occurring in the sperm or egg or after fertilization), are present in those children with intellectual disability (ID) of previously unknown origin (Rauch et al., 2012). Also in Chapter 13 is a discussion of the newly named *neurocognitive disorders,* featuring descriptions of research assessing brain activity (fMRI) in individuals during active episodes of delirium as well as after these episodes; data from the Einstein Aging study concerning the prevalence of a disorder new in *DSM-5,* mild neurocognitive disorder (Katz et al., 2012); and a discussion of new neurocognitive disorders (e.g., neurocognitive disorder due to Lewy bodies or prion disease).

And Chapter 14, Mental Health Services: Legal and Ethical Issues, presents a brief, but new, discussion of the recent trend to provide individuals needing emergency treatment with court-ordered assisted outpatient treatment (AOT) to avoid commitment in a mental health facility (Nunley, Nunley, Cutleh, Dentingeh, & McFahland, 2013); a new discussion of a major meta-analysis showing that current risk assessment tools are best at identifying persons at low risk of being violent but only marginally successful at accurately detecting who will be violent at a later point (Fazel, Singh, Doll, & Grann, 2012); and an updated section on legal rulings on involuntary medication.

New Features

In addition to the changes highlighted earlier, we have added three new features to the seventh edition:

- New *Student Learning Outcomes* at the start of each chapter assist instructors in accurately assessing and mapping questions throughout the chapter. The outcomes are mapped to core American Psychological Association goals and are integrated throughout the instructor resources and testing program.
- In each disorder chapter is a new feature called *DSM Controversies*, which discusses some of the contentious and thorny decisions made in the process of creating *DSM-5.* Examples include the creation of new and sometimes controversial disorders appearing for the first time in *DSM-5,* such as premenstrual dysphoric disorder, binge eating disorder, and disruptive mood dysregulation disorder. Another example is removing the "grief" exclusion criteria for diagnosing major depressive disorder so that someone can be diagnosed with major depression even if the trigger was the death of a loved one. Finally, changing the title of the "paraphilia" chapter to "paraphilic disorders" implies that paraphilic sexual arousal patterns such as pedophilia are not disorders in themselves, but only become disorders if they cause impairment or harm to others.

DSM-IV, DSM-IV-TR, and DSM-5

Much has been said about the mix of political and scientific considerations that resulted in *DSM-5*, and naturally we have our own opinions. (DHB had the interesting experience of sitting on the task force for *DSM-IV* and was an advisor to the *DSM-5* task force.) Psychologists are often concerned about "turf issues" in what has become—for better or worse—the nosological standard in our field, and with good reason: In previous *DSM* editions, scientific findings sometimes gave way to personal opinions. For *DSM-IV* and *DSM-5*, however, most professional biases were left at the door while the task force almost endlessly debated the data. This process produced enough new information to fill every psychopathology journal for a year with integrative reviews, reanalysis of existing databases, and new data from field trials. From a scholarly point of view, the process was both stimulating and exhausting. This book contains highlights of various debates that created the nomenclature, as well as recent updates. For example, in addition to the controversies described above, we summarize and update the data and discussion of premenstrual dysphoric disorder, which was designated a new disorder in *DSM-5,* and mixed anxiety depression, a disorder that did not make it into the final criteria. Students can thus see the process of making diagnoses, as well as the combination of data and inferences that are part of it.

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We also discuss the intense continuing debate on categorical and dimensional approaches to classification. We describe some of the compromises the task force made to accommodate data, such as why dimensional approaches to personality disorders did not make it into *DSM-5,* and why the proposal to do so was rejected at the last minute and included in Section III under "Conditions for Further Study" even though almost everyone agrees that these disorders should not be categorical but rather dimensional.

Prevention

Looking into the future of abnormal psychology as a field, it seems our ability to prevent psychological disorders may help the most. Although this has long been a goal of many, we now appear to be at the cusp of a new age in prevention research. Scientists from all over the globe are developing the methodologies and techniques that may at long last provide us with the means to interrupt the debilitating toll of emotional distress caused by the disorders chronicled in this book. We therefore highlight these cutting-edge prevention efforts—such as preventing eating disorders, suicide, and health problems, including HIV and injuries—in appropriate chapters as a means to celebrate these important advancements, as well as to spur on the field to continue this important work.

Retained Features

Visual Summaries

At the end of each disorder chapter is a colorful, two-page visual overview that succinctly summarizes the causes, development, symptoms, and treatment of each disorder covered in the chapter. Our integrative approach is instantly evident in these diagrams, which show the interaction of biological, psychological, and social factors in the etiology and treatment of disorders. The visual summaries will help instructors wrap up discussions, and students will appreciate them as study aids.

Pedagogy

Each chapter contains several Concept Checks, which let students verify their comprehension at regular intervals. Answers are listed at the end of each chapter along with a more detailed Summary; the Key Terms are listed in the order they appear in the text and thus form a sort of outline that students can study.

MindTap for Durand and Barlow's *Essentials of Abnormal Psychology*

MindTap for Durand and Barlow's *Essentials of Abnormal Psychology* engages and empowers students to produce their best work—consistently. By seamlessly integrating course material with videos, activities, apps, and much more, MindTap creates a unique learning path that fosters increased comprehension and efficiency.

For students:

- MindTap delivers real-world relevance with activities and assignments that help students build critical thinking and analytic skills that will transfer to other courses and their professional lives.
- MindTap helps students stay organized and efficient with a single destination that reflects what's important to the instructor, along with the tools students need to master the content.
- MindTap empowers and motivates students with information that shows where they stand at all times—both individually and compared to the highest performers in class.

Additionally, for instructors, MindTap allows you to:

- Control what content students see and when they see it, with a learning path that can be used as-is or matched to your syllabus exactly.
- Create a unique learning path of relevant readings and multimedia and activities that move students up the learning taxonomy from basic knowledge and comprehension to analysis, application, and critical thinking.
- Integrate your own content into the MindTap Reader using your own documents or by pulling from sources like RSS feeds, YouTube videos, websites, Google Docs, and more.
- Use powerful analytics and reports that provide a snapshot of class progress, time in course, engagement, and completion.

In addition to the benefits of the platform, MindTap for Durand and Barlow's *Essentials of Abnormal Psychology* features:

- Videos from the *Continuum Video Project*.
- Case studies to help students humanize psychological disorders and connect content to the real world.

Supplements

Continuum Video Project

The Continuum Video Project provides holistic, three-dimensional portraits of individuals dealing with psychopathologies. Videos show clients living their daily lives, interacting with family and friends, and displaying—rather than just describing—their symptoms. Before each video segment, students are asked to make observations about the individual's symptoms, emotions, and behaviors, and then rate them on the spectrum from normal to severe. The Continuum Video Project allows students to "see" the disorder and the person, humanly; the videos also illuminate student understanding that abnormal behavior can be viewed along a continuum.

Videos

Videos are also available in MindTap at **www.cengagebrain.com**, as well as on *Abnormal Psychology: Inside/Out,* DVD Volumes 1–4. ISBN: 97849503214

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Cengage Learning Testing Powered by Cognero is a flexible online system that allows you to author, edit, and manage test bank content from multiple Cengage Learning solutions, create multiple test versions in an instant, and deliver tests from your LMS, your classroom, or wherever you want. ISBN: 9781305501485

Instructor's Manual

The Online Instructor's Manual contains chapter overviews, learning objectives, lecture outlines with discussion points, key terms, classroom activities, demonstrations, and lecture topics, suggested supplemental reading material, handouts, video resources, and Internet resources. ISBN: 9781305501461

PowerPoints

The Online PowerPoints feature lecture outlines, key figures from the text, and relevant video clips. ISBN: 9781305493476

Titles of Interest

- *DSM-5 Supplement* by Wu, Boettcher, Barlow and Durand is a thorough comparison of the changes made in *DSM-5* with the previous criteria and language in *DSM-IV-TR*. Also includes discussion of major controversies resulting from the proposed and realized modifications to the latest diagnostic manual. ISBN: 978-1-285-84818-1
- *Looking into Abnormal Psychology: Contemporary Readings* by Scott O. Lilienfeld is a fascinating 234-page reader consisting of 40 articles from popular magazines and journals. Each article explores ongoing controversies regarding mental illness and its treatment. ISBN: 0-534-35416-5
- *Casebook in Abnormal Psychology,* 4th edition, by Timothy A. Brown and David H. Barlow, is a comprehensive casebook that reflects the integrative approach, which considers the multiple influences of genetic, biological, familial, and environmental factors into a unified model of causality as well as maintenance and treatment of the disorder. The casebook discusses treatment methods that are the most effective interventions developed for a particular disorder. It also presents three undiagnosed cases in order to give students an appreciation for the complexity of disorders. The cases are strictly teaching/learning exercises, similar to what many instructors use on their examinations. ISBN: 0-495-60438-0

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Finally, you share with us the task of communicating knowledge and discoveries in the exciting field of psychopathology, a challenge that none of us takes lightly. In the spirit of collegiality, we would greatly appreciate your comments on the content and style of this book and recommendations for improving it further.

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Reviewers

Creating this book has been both stimulating and exhausting, and we could not have done it without the valuable assistance of colleagues who read one or more chapters and provided extraordinarily perceptive critical comments, corrected errors, pointed to relevant information, and, on occasion, offered new insights that helped us achieve a successful, integrative model of each disorder.

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1 Abnormal Behavior in Historical Context

CHAPTER OUTLINE

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STUDENT LEARNING OUTCOMES*

Describe key concepts, principles, and overarching themes in psychology.	◗ Explain why psychology is a science with the primary objectives of describing, understanding, predicting, and controlling behavior and mental processes (APA SLO 5.1b) **(see textbook pages 2–6, 23)**. ◗ Use basic psychological terminology, concepts, and theories in psychology to explain behavior and mental processes (APA SLO 5.1a) **(see textbook pages 6–22)**.
Develop a working knowledge of the content domains of psychology.	◗ Summarize important aspects of history of psychology, including key figures, central concerns, methods used, and theoretical conflicts (APA SLO 5.2c) **(see textbook pages 6–22)**. ◗ Identify key characteristics of major content domains in psychology (e.g., cognition and learning, developmental, biological, and sociocultural) (APA SLO 5.2a) **(see textbook pages 15–19)**.
Use scientific reasoning to interpret behavior.	◗ See APA SLO 5.1a listed above. ◗ Incorporate several appropriate levels of complexity (e.g., cellular, individual, group/system, society/cultural) to explain behavior (APA SLO 1.1c) **(see textbook pages 10-21)**

* Portions of this chapter cover learning outcomes suggested by the American Psychological Association (2012) in their guidelines for the undergraduate psychology major. Chapter coverage of these outcomes is identified above by APA Goal and APA Suggested Learning Outcome (SLO).

Understanding Psychopathology

- **How do psychologists define a psychological disorder?**
- **What is a scientist–practitioner?**

Today you may have gotten out of bed, had breakfast, gone to class, studied, and enjoyed the company of your friends before dropping off to sleep. It probably did not occur to you that many people are not able to do some or any of these things. What they have in common is a **psychological disorder**, a psychological dysfunction associated with distress or impairment in functioning and a response that is not typical or culturally expected. Before examining exactly what this means, let's look at one individual's situation.

Judy • *The Girl Who Fainted at the Sight of Blood*

Judy, a 16 year old, was referred to our anxiety disorders clinic after increasing episodes of fainting. About 2 years earlier, in Judy's first biology class, the teacher had shown a movie of a frog dissection.

This was a graphic film, with vivid images of blood, tissue, and muscle. About halfway through, Judy felt lightheaded and left the room. But the images did not leave her. She continued to be bothered by them and occasionally felt queasy. She began to avoid situations in which she might see blood or injury. She found it difficult to look at raw meat, or even Band-Aids, because they brought the feared images to mind. Eventually, anything anyone said that evoked an image of blood or injury caused Judy to feel lightheaded. It got so bad that if one of her friends exclaimed, "Cut it out!" she felt faint.

Beginning about 6 months before her visit to the clinic, Judy fainted when she unavoidably encountered something bloody. Physicians could find nothing wrong with her. By the time she was referred to our clinic, she was fainting 5 to 10 times a week, often in class. Clearly, this was problematic and disruptive; each time Judy fainted, the other students flocked around her, trying to help, and class was interrupted. The principal finally concluded that she was being manipulative and suspended her from school, even though she was an honor student.

Judy was suffering from what we now call *blood–injection–injury phobia*. Her reaction was severe, thereby meeting the criteria for **phobia**, a psychological disorder characterized by marked and persistent fear of an object or situation. But many people have similar reactions that are not as severe when they receive an injection or see someone who is injured. For people who react as severely as Judy, this phobia can be disabling. They may avoid certain careers, such as medicine or nursing, and, if they are so afraid of needles and injections that they avoid them even when they need them, they put their health at risk.

psychological disorder Psychological dysfunction associated with distress or impairment in functioning that is not a typical or culturally expected response.

phobia **Psychological disorder** characterized by marked and persistent **fear** of an object or situation.

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What Is a Psychological Disorder?

A psychological disorder, or **abnormal behavior**, is a psychological dysfunction that is associated with distress or impairment in functioning and a response that is not typical or culturally expected (see ● Figure 1.1). These three criteria may seem obvious, but they were not easily arrived at and it is worth a moment to explore what they mean.

Psychological Dysfunction

Psychological dysfunction refers to a breakdown in cognitive, emotional, or behavioral functioning. For example, if you are out on a date, it should be fun. But if you experience severe fear all evening, even though there is nothing to be afraid of, and the fear happens on every date, your emotions are not functioning properly. However, if your friends agree that the person who asked you out is unpredictable and dangerous in some way, it would not be dysfunctional to be fearful.

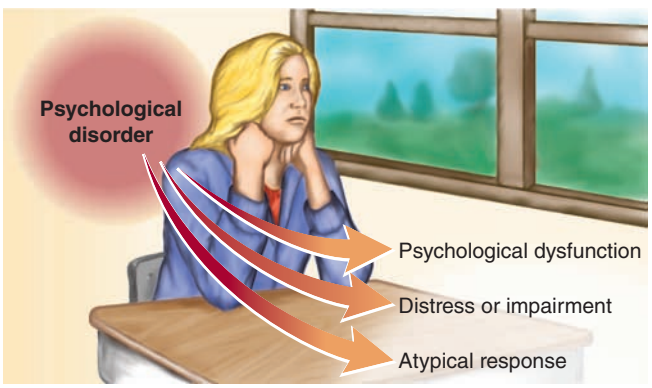
A dysfunction was clearly present for Judy. But many people experience a mild version of this reaction (feeling queasy at the sight of blood) without meeting the criteria for the disorder. Drawing the line between normal and abnormal dysfunction is often difficult. For this reason, these problems are often considered to be on a continuum rather than either present or absent (McNally, 2011; Widiger & Crego, 2013). This, too, is a reason why just having a dysfunction is not enough to meet the criteria for a psychological disorder.

Personal Distress or Impairment

That the behavior must be associated with distress to be classified as abnormal seems clear: the criterion is satisfied if the individual is extremely upset. We can certainly say that Judy was distressed. But remember, by itself this criterion does not define abnormal behavior. It is often normal to be distressed—for example, if someone close to you dies. Suffering and distress are very much a part of life. Furthermore, for some disorders, by definition, suffering and distress are absent. Consider the person who feels elated and may act impulsively as part of a manic episode. As you will see in Chapter 6, one of the major difficulties with this problem is that some people enjoy the manic state so much they are reluctant to receive treatment for it. Thus, defining psychological disorder by distress alone doesn't work.

The concept of *impairment* is useful, although not entirely satisfactory. For example, many people consider themselves shy or lazy. This doesn't mean they're abnormal. But if you are so shy that you find it impossible to interact with people even though you would like to have friends, your social functioning is impaired.

Judy was clearly impaired by her phobia, but many people with less severe reactions are not impaired. This difference again illustrates the important point that most psychological disorders are extreme expressions of otherwise normal emotions, behaviors, and cognitive processes.



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● **FIGURE 1.1** The criteria defining a psychological disorder.

Atypical or Not Culturally Expected

The criterion that the response be *atypical* or *not culturally expected* is also insufficient to determine abnormality by itself. At times, something is considered abnormal because it deviates from the average. The greater the deviation, the more abnormal it is. You might say that someone is abnormally short or abnormally tall, but this obviously isn't a definition of disorder. Many people's behavior is far from average, but we call them talented or eccentric, not disordered. For example, it's not normal to plan to have blood spurt from your clothes, but when Lady Gaga did this while performing, it only enhanced her celebrity. In most cases, the more productive you are in the eyes of society, the more eccentricities society will tolerate. Therefore, *deviating from the average* doesn't work well as a definition for abnormal behavior.

Another view is that your behavior is abnormal if you are violating social norms. This definition is useful in considering cultural differences in psychological disorders. For example, to enter a trance state and believe you are possessed reflects a psychological disorder in most Western cultures but not in many other societies, where the behavior is accepted and expected (see Chapter 5). An example is provided by Robert Sapolsky (2002), a neuroscientist who worked closely with the Maasai tribe in East Africa. One day, Sapolsky's Maasai friend Rhoda asked him to bring his jeep to the village where a woman had been acting aggressively and hearing voices. The woman had killed a goat with her own hands. Sapolsky and several Maasai were able to subdue her and transport her to a local health center. Realizing that this was an opportunity to learn more of the Maasai's view of psychological disorders, Sapolsky had the following discussion:

> "So, Rhoda," I began laconically, "what do you suppose was wrong with that woman?"
>
> She looked at me as if I was mad.
>
> "She is crazy."
>
> "But how can you tell?"
>
> "She's crazy. Can't you just see from how she acts?"
>
> "But how do you decide that she is crazy? What did she do?"

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"She killed that goat."

"Oh," I said with anthropological detachment, "but Maasai kill goats all the time."

She looked at me as if I were an idiot. "Only the men kill goats," she said.

"Well, how else do you know that she is crazy?"

"She hears voices."

Again, I made a pain of myself. "Oh, but the Maasai hear voices sometimes." (At ceremonies before long cattle drives, the Maasai trance-dance and claim to hear voices.) And in one sentence, Rhoda summed up half of what anyone needs to know about cross-cultural psychiatry.

"But she hears voices at the wrong time." (p. 138)

A social standard of *normal* can be misused, however. Consider the practice of committing political dissidents to mental institutions because they protest the policies of their government, which was common in Iraq before the fall of Saddam Hussein. Although such behavior clearly violates social norms, it should not alone be cause for commitment.

Jerome Wakefield (1999, 2009) uses the shorthand definition of harmful dysfunction. A related concept is to determine whether the behavior is out of the individual's control (Widiger & Crego, 2013; Widiger & Sankis, 2000). Variants of these approaches are most often used in current diagnostic practice, as outlined in the fifth edition of the *Diagnostic and Statistical Manual* (American Psychiatric Association, 2013), which contains the current listing of criteria for psychological disorders (Stein et al., 2010).

An Accepted Definition

In conclusion, it is difficult to define "normal" and "abnormal" (Lilienfeld & Marino, 1995, 1999)—and the debate continues (McNally, 2011; Stein et al., 2010). The most widely accepted definition used in *DSM-5* describes behavioral, psychological, or biological dysfunctions that are unexpected in their cultural context and associated with present distress and impairment in functioning, or increased risk of suffering, death, pain, or impairment. This definition can be useful across cultures if we pay attention to what is dysfunctional (or out of control) in a given society. But it is never easy to decide what represents dysfunction, and some scholars have argued that we can never satisfactorily define *disease* or *disorder* (see, for example, Lilienfeld & Marino, 1995, 1999). The best we may be able to do is to consider how the apparent disease or disorder matches a "typical" profile of a disorder—for example, major depression or schizophrenia—when most or all symptoms that experts would agree are part of the disorder are present. We call this typical profile a *prototype,* and, as described in Chapter 3, the diagnostic criteria from *DSM-IV-TR* as well as the emerging criteria for *DSM-5* found throughout this book are all prototypes. This means that the patient may have only some features or symptoms of the disorder and still meet criteria for the disorder because those symptoms are close to the prototype. But one of the differences between *DSM-IV* and *DSM-5* is the addition of dimensional estimates of the severity of specific disorders in *DSM-5* (American Psychiatric Association, 2013; Regier et al., 2009). Thus, in anxiety disorders for example, the intensity and frequency of anxiety within a given disorder is rated on a 0 to 4 scale, where a rating of 0 indicates the absence of symptoms, a rating of 1 indicates mild or occasional symptoms, and a rating of 4 indicates continual and severe symptoms (Beesdo-Baum et al., 2012; LeBeau et al., 2012).

Christopher Polk/Getty Images

We accept extreme behaviors by entertainers, such as Lady Gaga, that would not typically be tolerated in other members of our society.

The Science of Psychopathology

Psychopathology is the scientific study of psychological disorders. Within this field are clinical and counseling psychologists, psychiatrists, psychiatric social workers, and psychiatric nurses, as well as marriage and family therapists and mental health counselors. *Clinical psychologists* and *counseling psychologists* receive the PhD degree, doctor of philosophy (or sometimes an EdD, doctor of education,

abnormal behavior Actions that are unexpected and often evaluated negatively because they differ from typical or usual behavior.

psychopathology Scientific study of **psychological disorders**.

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or PsyD, doctor of psychology) and follow a course of graduate-level study lasting approximately 5 years, which prepares them to conduct research into the causes and treatment of psychological disorders and to diagnose, assess, and treat these disorders. Counseling psychologists tend to study and treat adjustment and vocational issues encountered by relatively healthy individuals, and clinical psychologists usually concentrate on more severe psychological disorders. Psychologists with other specialty training, such as experimental and social psychologists, investigate the basic determinants of behavior but do not assess or treat psychological disorders.

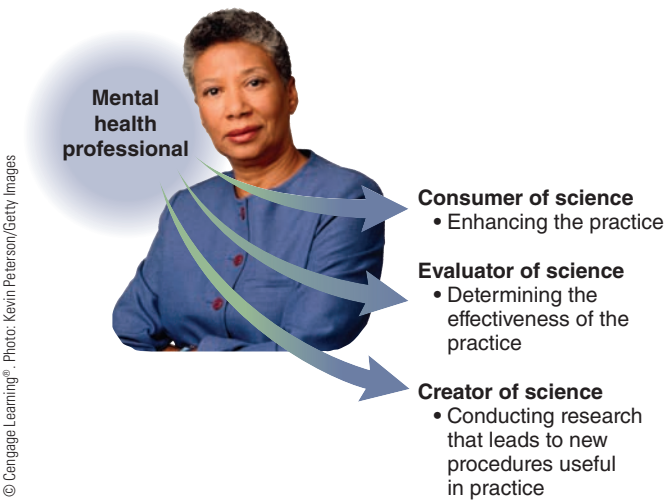
Psychiatrists first earn an MD degree in medical school and then specialize in psychiatry during residency training that lasts 3 to 4 years. Psychiatrists also investigate the nature and causes of psychological disorders, make diagnoses, and offer treatments. Many psychiatrists emphasize drugs or other biological treatments, although most use psychosocial treatments as well.

Psychiatric social workers typically earn a master's degree in social work as they develop expertise in collecting information relevant to the social and family situation of the individual with a psychological disorder. Social workers also treat disorders, often concentrating on family problems associated with them. *Psychiatric nurses* have advanced degrees and specialize in the care and treatment of patients with psychological disorders, usually in hospitals as part of a treatment team.

Finally, *marriage and family therapists* and *mental health counselors* typically spend 1–2 years earning a master's degree and are employed to provide clinical services by hospitals or clinics.

The Scientist–Practitioner

The most important recent development in psychopathology is the adoption of scientific methods to learn more about psychological disorders, their causes, and their treatment. Many mental health professionals take a scientific approach to their clinical work and therefore are called **scientist–practitioners** (Barlow, Hayes, & Nelson, 1984; Hayes, Barlow, & Nelson-Gray, 1999). Mental health practitioners function as scientist–practitioners in three ways (see ● Figure 1.2). First, they keep up with the latest developments in their field and therefore use the most current diagnostic and treatment procedures. In this sense, they are consumers of the science of psychopathology. Second, they evaluate their own assessments or treatment procedures to see whether they work. They are accountable not only to their patients but also to government agencies and insurance companies that pay for the treatments, so they must demonstrate that their treatments work. Third, scientist–practitioners conduct research that produces new information about disorders or their treatment. Such research attempts to do three basic things: describe psychological disorders, determine their causes, and treat them (see ● Figure 1.3). These three categories compose an organizational structure that recurs throughout this book. A general overview of each will give you a clearer perspective on our efforts to understand abnormality.



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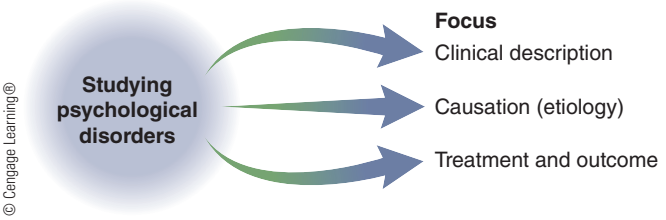
● **FIGURE 1.2** Functioning as a scientist–practitioner.



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● **FIGURE 1.3** Three major categories make up the study and discussion of psychological disorders.

Clinical Description

In hospitals and clinics, we often say that a patient "presents" with a specific problem or we discuss the **presenting problem**. Describing Judy's presenting problem is the first step in determining her **clinical description**, the unique combination of behaviors, thoughts, and feelings that make up a specific disorder. The word *clinical* refers both to the types of disorders you would find in a clinic or hospital and to the activities connected with assessment and treatment.

An important function of the clinical description is to specify what makes the disorder different from normal behavior or from other disorders. Statistical data may also be relevant. For example, how many people in the population as a whole have the disorder? This figure is called the **prevalence** of the disorder. Statistics on how many new cases occur during a given period, such as a year, represent the **incidence** of the disorder. Other statistics include the *sex ratio*—that is, what percentage of males and females have the disorder—and the typical age of onset, which often differs from one disorder to another.

In addition, most disorders follow a particular pattern, or **course**. For example, some disorders, such as schizophrenia (see Chapter 12), follow a *chronic course,* meaning

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that they tend to last a long time. Other disorders, like mood disorders (see Chapter 6), follow an *episodic course,* in that the individual is likely to recover within a few months only to suffer a recurrence of the disorder at a later time. Still other disorders may have a *time-limited course,* meaning they will improve without treatment in a relatively short period.

Closely related to differences in course of disorders are differences in onset. Some disorders have an *acute onset,* meaning they begin suddenly; others develop gradually over an extended period, which is sometimes called an *insidious onset*. It is important to know the typical course of a disorder so we can know what to expect and how best to deal with the problem. For example, if someone is suffering from a mild disorder with acute onset that we know is time limited, we might advise the individual not to bother with expensive treatment. If the disorder is likely to last a long time (become chronic), however, the individual might want to seek treatment. The anticipated course of a disorder is called the **prognosis**.

The patient's age may be an important part of the clinical description. A psychological disorder occurring in childhood may present differently from the same disorder in adulthood or old age. For example, children experiencing severe anxiety often assume they are physically ill. Because their thoughts and feelings are different from those experienced by adults with anxiety, children are often misdiagnosed and treated for a medical disorder.

We call the study of changes in behavior over time *developmental psychology,* and we refer to the study of changes in abnormal behavior as *developmental psychopathology*. Because we change throughout our lives, researchers study development in adolescents, adults, and older adults as well as in children. Study of abnormal behavior across the entire age span is referred to as *life-span developmental psychopathology*.

Causation, Treatment, and Etiology Outcomes

Etiology, or the study of origins, has to do with why a disorder begins and includes biological, psychological, and social dimensions. Chapter 2 is devoted to this key aspect of abnormal psychology.

Treatment is also important to the study of psychological disorders. If a new drug or psychosocial treatment is successful in treating a disorder, it may give us some hints about the nature of the disorder and its causes. For example, if a drug with a specific known effect within the nervous system alleviates a specific disorder, we know that something in that part of the nervous system might either be causing the disorder or helping maintain it. As you will see in the next chapter, psychopathology is rarely simple because the *effect* does not necessarily imply the *cause*. To use a common example, you might take an aspirin to relieve a headache you developed while taking an exam. If you then feel better, that does not mean the headache was caused by a lack of aspirin. Nevertheless, many people

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Children experience panic and anxiety differently from adults, so their reactions may be mistaken for symptoms of physical illness.

seek treatment for psychological disorders, and treatment can provide hints about the nature of the disorder.

In the past, textbooks emphasized treatment approaches in a general sense, with little attention to the disorder being treated. For example, a mental health professional might be thoroughly trained in a single theoretical approach, such as psychoanalysis or behavior therapy (both described later in the chapter), and then use that approach on every disorder. More recently, as our science has advanced, we have developed specific effective treatments that do not always adhere

scientist–practitioner Mental health professional expected to apply scientific methods to his or her work. A scientist–practitioner must know the latest research on **diagnosis** and treatment, must evaluate his or her methods for effectiveness, and may generate research to discover information about disorders and their treatment.

presenting problem Original complaint reported by the client to the therapist. The actual treated problem may be a modification derived from the presenting problem.

clinical description Details of the combination of behaviors, thoughts, and feelings of an individual that make up a particular disorder.

prevalence Number of people displaying a disorder in the total population at any given time (compare with **incidence**).

incidence Number of new cases of a disorder appearing during a specific period (compare with **prevalence**).

course Pattern of development and change of a disorder over time.

prognosis Predicted development of a disorder over time.

etiology Cause or source of a disorder.

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neatly to one theoretical approach or another but that have grown out of a deeper understanding of the disorder in question. For this reason, there are no separate chapters in this book on such types of treatment approaches as psychodynamic, cognitive behavioral, or humanistic. Rather, the latest and most effective drug and psychosocial treatments (nonmedical treatments that focus on psychological, social, and cultural factors) are described in the context of specific disorders in keeping with our integrative multidimensional perspective.

We now survey many early attempts to describe and treat abnormal behavior and to comprehend its causes. In Chapter 2, we examine contemporary views of causation and treatment. In Chapter 3, we discuss efforts to describe, or classify, abnormal behavior. In Chapter 3, we review research methods. In Chapters 4 through 13, we examine specific disorders. Finally, in Chapter 14 we examine legal, professional, and ethical issues relevant to psychological disorders and their treatment. With that overview in mind, let us turn to the past.

Historical Conceptions of Abnormal Behavior

For thousands of years, humans have tried to explain and control problematic behavior. But our efforts always derive from the theories or models of behavior popular at the time. The purpose of these models is to explain why someone is "acting like that." Three major models that have guided us date back to the beginnings of civilization.

Humans have always supposed that agents outside our bodies and environment influence our behavior, thinking, and emotions. These agents—which might be divinities, demons, spirits, or other phenomena such as magnetic fields or the moon or the stars—are the driving forces behind the *supernatural model*. In addition, the mind has often been called the *soul* or the *psyche* and considered separate from the body. Although many have thought that the mind can influence the body and, in turn, the body can influence the mind, most philosophers looked for causes of abnormal behavior in one or the other. This split gave rise to two traditions of thought about abnormal behavior, the *biological model* and the *psychological model*.

Concept Check 1.1

Part A

Write the letter for any or all of the following definitions of abnormality in the blanks: (a) societal norm violation, (b) impairment in functioning, (c) dysfunction, and (d) distress.

1. Miguel recently began feeling sad and lonely. Although still able to function, he finds himself feeling down much of the time and worries about what is happening to him. Which of the definitions of abnormality apply to Miguel's situation? _____
2. Three weeks ago, Jane, a 35-year-old business executive, stopped showering, refused to leave her apartment, and started watching television talk shows. Threats of being fired have failed to bring Jane back to reality. Which of the definitions seems to describe Jane's behavior? _____

Part B

Match the following words that are used in clinical descriptions with their corresponding examples: (a) presenting problem, (b) prevalence, (c) incidence, (d) prognosis, (e) course, and (f) etiology.

3. Maria should recover quickly with no intervention. Without treatment, John will deteriorate rapidly. _____
4. Three new cases of bulimia have been reported in this county during the past month and only one in the next county. _____
5. Elizabeth visited the campus mental health center because of her increasing feelings of guilt and anxiety. _____
6. Biological, psychological, and social influences all contribute to a variety of disorders. _____
7. The pattern a disorder follows can be chronic, time limited, or episodic. _____
8. How many people in the population as a whole suffer from obsessive-compulsive disorder? _____

The Supernatural Tradition

What supernatural influences were formerly believed to explain abnormal behavior?

For much of our recorded history, deviant behavior has been considered a reflection of the battle between good and evil. When confronted with unexplainable, irrational behavior, and through their suffering and upheaval, people have perceived evil.

Demons and Witches

One strong current of opinion put the causes and treatment of psychological disorders squarely in the realm of the supernatural. During the last quarter of the 14th century, religious

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and lay authorities supported these popular superstitions and society as a whole began to believe more strongly in the existence and power of demons and witches.

The bizarre behavior of people afflicted with psychological disorders was seen as the work of the devil and witches. It followed that individuals "possessed" by evil spirits were probably responsible for any misfortune experienced by people in the local community, which inspired drastic action against the possessed. Treatments included **exorcism**, in which various religious rituals were performed to rid the victim of evil spirits. Other approaches included shaving the pattern of a cross in the hair of the victim's head and securing sufferers to a wall near the front of a church so that they might benefit from hearing Mass.

The conviction that sorcery and witches are causes of madness and other evils continued into the 15th century, and evil continued to be blamed for unexplainable behavior, even after the founding of the United States, as evidenced by the Salem, Massachusetts, witch trials in the late 17th century.

Stress and Melancholy

An equally strong opinion reflected the view that insanity was a natural phenomenon, caused by mental or emotional stress, and was curable (Alexander & Selesnick, 1966; Maher & Maher, 1985a). Mental depression and anxiety were recognized as illnesses (Kemp, 1990; Schoeneman, 1977), although symptoms such as despair and lethargy were often identified by the church with the sin of *acedia,* or sloth (Tuchman, 1978). Common treatments were rest, sleep, and a healthy environment. Other treatments included baths, ointments, and various potions. Indeed, during the 14th and 15th centuries, people with insanity, along with those with physical deformities or disabilities, were often moved from house to house in medieval villages as neighbors took turns caring for them. We now know that this medieval practice of keeping people with psychological disturbances in their own community is beneficial (see Chapter 13).

In the 14th century, one of the chief advisers to the king of France, Nicholas Oresme, suggested that melancholy (depression) was the source of some bizarre behavior, rather than demons. Oresme pointed out that much of the evidence for the existence of sorcery and witchcraft, particularly among those considered insane, was obtained from people who were tortured and who, quite understandably, confessed to anything.

These conflicting natural and supernatural explanations for mental disorders are represented more or less strongly in historical works, depending on the sources consulted by historians. Some assumed that demonic influences were the predominant explanations of abnormal behavior during the Middle Ages (for example, Zilboorg & Henry, 1941); others believed that the supernatural had little or no influence. As we see in the handling of the severe psychological disorder experienced by late-14th-century King Charles VI of France, both influences were strong, sometimes alternating in the treatment of the same case.

Mary Evans Picture Library/The Image Works

During the Middle Ages, individuals with psychological disorders were sometimes thought to be possessed by evil spirits and exorcisms were attempted through rituals.

Charles VI • *The Mad King*

In the summer of 1392, King Charles VI of France was under a great deal of stress. As he rode with his army to the province of Brittany, a nearby aide dropped his lance with a loud clatter and the king, thinking he was under attack, turned on his own army, killing several prominent knights before being subdued from behind. The army immediately marched back to Paris. The king's lieutenants and advisers concluded that he was mad.

During the following years, at his worst the king hid in a corner of his castle believing he was made of glass or roamed the corridors howling like a wolf. At other times, he couldn't remember who or what he was. He became fearful and enraged whenever he saw his own royal coat of arms and would try to destroy it if it was brought near him.

The people of Paris were devastated by their leader's apparent madness. Some thought it reflected God's anger; others thought it was divine punishment for heavy taxes. But most thought the king's madness was caused by sorcery, a belief strengthened by a drought that dried up ponds and rivers, causing cattle to die of thirst. Merchants claimed their worst losses in 20 years.

(Continued next page)

exorcism Religious ritual that attributes disordered behavior to possession by demons and seeks to treat the individual by driving the demons from the body.

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Naturally, the king was given the best care available at the time. The most famous healer in the land was a 92-year-old physician whose treatment program included moving the king to one of his residences in the country where the air was thought to be the cleanest in the land. The physician prescribed rest, relaxation, and recreation. After some time, the king seemed to recover. Unfortunately, the physician died and the insanity of King Charles VI returned more seriously than before. This time, however, he came under the influence of the conflicting crosscurrent of supernatural causation. "An unkempt evil-eyed charlatan and pseudo-mystic named Arnaut Guilhem was allowed to treat Charles on his claim of possessing a book given by God to Adam by means of which man could overcome all affliction resulting from original sin" (Tuchman, 1978, p. 514). Guilhem insisted that the king's malady was caused by sorcery, but his treatments failed to bring about a cure.

A variety of remedies and rituals of all kinds were tried, but none worked. High-ranking officials and doctors of the university called for the "sorcerers" to be discovered and punished. "On one occasion, two Augustinian friars, after getting no results from magic incantations and a liquid made from powdered pearls, proposed to cut incisions in the king's head. When this was not allowed by the king's council, the friars accused those who opposed their recommendation of sorcery" (Tuchman, 1978, p. 514). Even the king himself, during his lucid moments, came to believe that the source of madness was evil and sorcery.

Treatments for Possession

Exorcisms at least have the virtue of being relatively painless. Interestingly, they sometimes work, as do other forms of faith healing, for reasons we explore in subsequent chapters. But what if they did not? In the Middle Ages, if exorcism failed, some authorities thought that steps were necessary to make the body uninhabitable by evil spirits, and many people were subjected to confinement, beatings, and other forms of torture (Kemp, 1990).

Somewhere along the way, a creative "therapist" decided that hanging people over a pit full of poisonous snakes might scare the evil spirits right out of their bodies. Strangely, this approach sometimes worked; the most disturbed individuals would suddenly come to their senses and experience relief from their symptoms, if only temporarily. Many other treatments based on the hypothesized therapeutic element of shock were developed, including dunkings in ice-cold water.

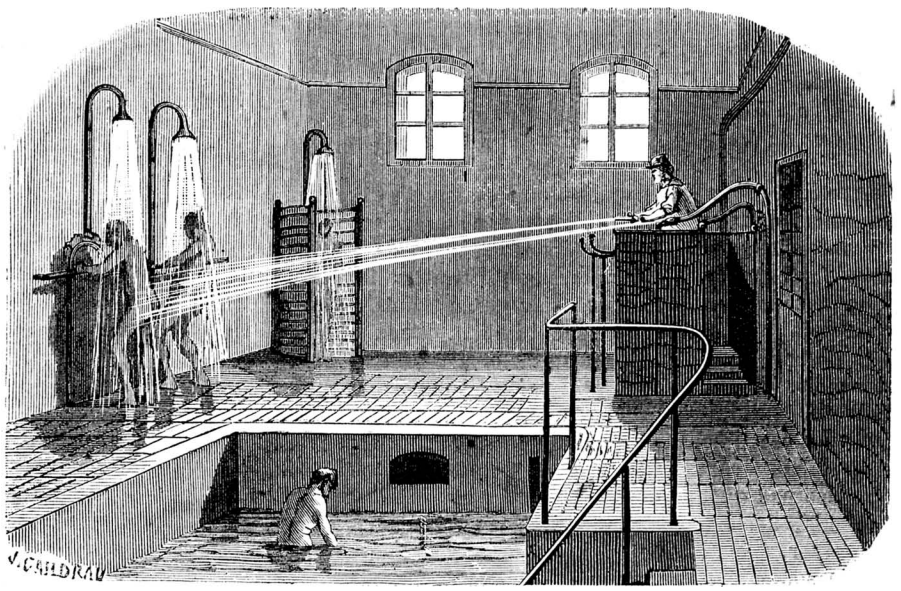
Mass Hysteria

Another fascinating phenomenon is characterized by large-scale outbreaks of bizarre behavior. During the Middle Ages, they lent support to the notion of possession. In Europe, whole groups of people were simultaneously compelled to run out in the streets, dance, shout, rave, and jump around in patterns as if they were at a particularly wild party (still called a *rave* today, but with music). This behavior was known by several names, including Saint Vitus's Dance and tarantism. Several reasons were offered in addition to possession. One reasonable guess was reaction to insect bites. Another possibility was what we now call *mass hysteria.* Consider the following example.

Modern Mass Hysteria

One Friday afternoon an alarm sounded over the public address system of a community hospital calling all physicians to the emergency room. Arriving from a local school in a fleet of ambulances were 17 students and 4 teachers who reported dizziness, headache, nausea, and stomach pains. Some were vomiting; most were hyperventilating.

All the students and teachers had been in four classrooms, two on each side of the hallway. The incident began when a 14-year-old girl reported a smell that seemed to be coming from a vent. She fell to the floor, crying and complaining that her stomach hurt and her eyes stung. Soon, many of the students and most of the teachers in the four adjoining classrooms, who could see and hear what was happening, experienced similar symptoms. Of 86 susceptible people (82 students and 4 teachers in the four classrooms), 21 patients (17 students and 4 teachers) experienced symptoms severe enough to be evaluated at the hospital. Inspection of the school building by public health authorities



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In hydrotherapy, patients were shocked back to their senses by applications of ice-cold water.

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revealed no apparent cause for the reactions, and physical examinations revealed no physical abnormalities. All the patients were sent home and quickly recovered (Rockney & Lemke, 1992).

Mass hysteria may simply demonstrate the phenomenon of *emotion contagion,* in which the experience of an emotion seems to spread to those around us (Hatfield, Cacioppo, & Rapson, 1994; Wang, 2006). If someone nearby becomes frightened or sad, chances are that, for the moment, you also will feel fear or sadness. When this kind of experience escalates into full-blown panic, whole communities are affected (Barlow, 2002). People are also suggestible when they are in states of high emotion. Therefore, if one person identifies a "cause" of the problem, others will probably assume that their own reactions have the same source. In popular language, this shared response is sometimes referred to as *mob psychology.*

The Moon and the Stars

Paracelsus, a Swiss physician who lived from 1493 to 1541, rejected notions of possession by the devil, suggesting instead that the movements of the moon and stars had profound effects on people's psychological functioning. This influential theory inspired the word *lunatic,* which is derived from the Latin word for moon, *luna*. You might hear some of your friends explain something crazy they did one night by saying, "It must have been the full moon." Despite much ridicule, millions of people around the world are convinced that their behaviors are influenced by the stages of the moon or the positions of the stars. This belief is most noticeable today in followers of astrology, who hold that their behavior and the major events in their lives can be predicted by their day-to-day relationship to the position of the planets. No serious evidence has ever confirmed such a connection, however.

Comments

The supernatural tradition in psychopathology is alive and well, although it is relegated, for the most part, to small religious sects and primitive cultures. Members of organized religions look to psychology and medical science for help with psychological disorders; in fact, the Roman Catholic Church requires that all health-care resources be exhausted before spiritual solutions such as exorcism can be considered. Nonetheless, miraculous cures are sometimes achieved by exorcism, rituals, and other methods that seem to have little connection with modern science. But such cases are relatively rare, and almost no one would advocate supernatural treatment for severe psychological disorders except, perhaps, as a last resort.

Discussing Diversity: Biological Explanations for Psychopathology in Women: A Brief History of Hysteria

Adriana is an 18-year-old woman who has become concerned about her increasingly excessive nervousness, irritability, loss of appetite, and insomnia. According to the biological tradition of abnormal behavior, what is the best explanation for Adriana's experiences? How should they be treated?

As the understanding of human biology has changed over time, so too have the biological models that guide the conceptualization and treatment of psychopathology. Unfortunately, some approaches to understanding and treating psychopathology have been unfavorable for women. An interesting and relevant case is the diagnosis of hysteria to describe general psychological complaints among women. In ancient times, the Greek physician Hippocrates would have attributed Adriana's symptoms to a biological condition known as *wandering womb,* or the movement of Adriana's uterus around her body because of a lack of sexual intercourse. Hippocrates often prescribed marriage as an effective treatment for hysteria. Although this idea may seem absurd in retrospect, hysteria was a popular diagnosis for a range of psychological complaints expressed by women. As recently as the late 19th century, Adriana's complaints still would have been attributed to hysteria, although by that time the idea of a wandering womb had been replaced with the belief that hysteria was caused by sexual dissatisfaction. As a result, the prescribed treatment often was vaginal massage to enhance sexual satisfaction.

In the early 20th century, Sigmund Freud (1856–1939) proposed that hysteria actually worked in the opposite direction and suggested that many general physical complaints reported by young women in the 1900s were the result of the "conversion" of unacceptable sexual fantasies into more acceptable outlets. This was an influential theory and one that ultimately led to the inclusion of a diagnosis of conversion hysteria in the *DSM.*

More recent scientific advances have abandoned the concept of hysteria, which has been replaced with more objective, specific, and gender-neutral diagnoses such as anxiety disorders, depressive disorders, and somatoform disorders. As a result of research on genetics and neuroscience, simple biological explanations such as the wandering womb theory also have been replaced with more sophisticated models of biological influences on psychopathology. Despite these modern-day advances, history suggests that our current approaches to conceptualizing and treating psychopathology will someday be looked upon as primitive and naïve. In the meantime, psychologists continue to use currently available science as a guide to explaining and treating psychopathology. ■

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The Biological Tradition

What are the underlying assumptions of the biological approach to understanding abnormal behavior?

Physical causes of mental disorders have been sought since antiquity. Important to the biological tradition are a man, Hippocrates; a disease, syphilis; and the early consequences of believing that psychological disorders are biologically caused.

Hippocrates and Galen

The Greek physician Hippocrates (460–377 B.C.) is considered to be the father of modern Western medicine. In a body of work called the *Hippocratic Corpus,* written between 450 and 350 B.C. (Maher & Maher, 1985a), he and others suggested that psychological disorders could be treated like any other disease. They did not limit their search for the causes of psychopathology to the general area of "disease"; they believed that psychological disorders might also be caused by brain pathology or head trauma and could be influenced by heredity (genetics). Hippocrates considered the brain to be the seat of wisdom, consciousness, intelligence, and emotion. Therefore, disorders involving these functions would logically be located in the brain. Hippocrates also recognized the importance of psychological and interpersonal contributions to psychopathology.

The Roman physician Galen (approximately A.D. 129–198) adopted these ideas and developed them further, creating an influential school of thought that extended well into the 19th century. One of the more influential legacies of the Hippocratic–Galenic approach is the *humoral theory* of disorders. Hippocrates assumed that normal brain functioning was related to four bodily fluids or *humors:* blood, black bile, yellow bile, and phlegm. Blood came from the heart, black bile from the spleen, phlegm from the brain, and choler or yellow bile from the liver. Physicians believed that disease resulted from too much or too little of one of the humors; for example, too much black bile was thought to cause melancholia (depression). In fact, the term *melancholy,* from *melancholer,* which means "black bile," is still used to refer to aspects of depression. The humoral theory was, perhaps, the first example of associating psychological disorders with a "chemical imbalance," an approach that is widespread today.

The four humors were related to the Greeks' conception of the four basic qualities: heat, dryness, moisture, and cold. Each humor was associated with one of these qualities. Terms derived from the four humors are still sometimes applied to personality traits. For example, *sanguine* (literal meaning "red, like blood") describes someone who is ruddy in complvexion, presumably from copious blood flowing through the body, and cheerful and optimistic, although insomnia and delirium were thought to be caused by excessive blood in the brain. *Melancholic* means depressive (depression was thought to be caused by black bile flooding the brain). A *phlegmatic* personality (from the humor phlegm) indicates apathy and sluggishness but can also mean being calm under stress. A *choleric* person (from yellow bile or choler) is hot tempered (Maher & Maher, 1985a).

Excess humors were treated by regulating the environment to increase or decrease heat, dryness, moisture, or cold, depending on which humor was out of balance. One reason King Charles VI's physician moved him to the countryside was to restore the balance in his humors (Kemp, 1990). In addition to rest, good nutrition, and exercise, two treatments were developed. In one, *bleeding* or *bloodletting,* a carefully measured amount of blood was removed from the body, often with leeches. The other was to induce vomiting; indeed, in a well-known treatise on depression published in 1621, *Anatomy of Melancholy,* Robert Burton recommended eating tobacco and a half-boiled cabbage to induce vomiting (Burton, 1621/1977). If Judy had lived 300 years ago, she might have been diagnosed with an illness, a brain disorder, or some other physical problem, perhaps related to excessive humors, and been given the proper medical treatments of the day, including bed rest, a healthful diet, and exercise.

In ancient China and throughout Asia, a similar idea existed. But rather than "humors," the Chinese focused on the movement of air or "wind" throughout the body. Unexplained mental disorders were caused by blockages of wind or the presence of cold, dark wind (yin) as opposed to warm, life-sustaining wind (yang). Treatment involved restoring proper flow of wind through various methods, including acupuncture.

Hippocrates also coined the word *hysteria* to describe a concept he learned about from the Egyptians, who had identified what we now call the *somatic symptom disorders.* In these disorders, symptoms, such as paralysis and some kinds of blindness, appear to be the result of a problem for

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Bloodletting, the extraction of blood from patients, was intended to restore the balance of humors in the body.

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which no physical cause can be found, Because these disorders occurred primarily in women, the Egyptians (and Hippocrates) mistakenly assumed that they were restricted to women. They also presumed a cause: The empty uterus wandered to various parts of the body in search of conception (the Greek word for "uterus" is *hysteron*). Numerous physical symptoms reflected the location of the wandering uterus. The prescribed cure might be marriage or, occasionally, fumigation of the vagina to lure the uterus back to its natural location (Alexander & Selesnick, 1966). Knowledge of physiology eventually disproved the wandering uterus theory; however, the tendency to stigmatize dramatic women as hysterical continued into the 1970s. As you will learn in Chapter 5, somatic symptom disorders are not limited to one sex.

The 19th Century

The biological tradition waxed and waned during the centuries after Hippocrates and Galen but was reinvigorated in the 19th century because of two factors: the discovery of the nature and cause of syphilis and strong support from the well-respected American psychiatrist John P. Grey.

Syphilis

Behavioral and cognitive symptoms of what we now know as *advanced syphilis,* a sexually transmitted disease caused by a bacterial microorganism entering the brain, include believing that everyone is plotting against you (delusion of persecution) or that you are God (delusion of grandeur). Although these symptoms are similar to those of *psychosis*—psychological disorders characterized in part by beliefs that are not based in reality (delusions), and perceptions that are not based in reality (hallucinations), or both—researchers recognized that a subgroup of apparently psychotic patients deteriorated steadily, becoming paralyzed and dying within 5 years of onset. This course of events contrasted with that of most psychotic patients, who remained fairly stable. In 1825, the condition was designated a disease, *general paresis,* because it had consistent symptoms (presentation) and a consistent course that resulted in death. The relationship between general paresis and syphilis was only gradually established. Louis Pasteur's germ theory of disease, developed in about 1870, facilitated the identification of the microorganism that caused syphilis.

Of equal importance was the discovery of a cure for general paresis. Physicians observed a surprising recovery in patients with general paresis who had contracted malaria, so they injected other patients with blood from a soldier who was ill with malaria. Many recovered because the high fever "burned out" the syphilis bacteria. Obviously, this type of experiment would not be ethically possible today. Ultimately, investigators discovered that penicillin cures syphilis, but with the malaria cure, "madness" and associated symptoms for the first time were traced directly to a curable infection. Many mental health professionals assumed that comparable causes and cures might be discovered for all psychological disorders.

John P. Grey

The champion of the biological tradition in the United States was the most influential American psychiatrist of the time, John P. Grey (Bockoven, 1963). In 1854, Grey was appointed superintendent of the Utica State Hospital in New York and became editor of the *American Journal of Insanity,* the precursor of the *American Journal of Psychiatry*. Grey held that the causes of insanity were *always* physical. Therefore, mentally ill patients should be treated as physically ill, with treatment including rest, diet, and proper room temperature and ventilation. Grey even invented the rotary fan to ventilate his large hospital.

Under Grey's leadership, conditions in hospitals improved and they became more humane institutions. But in subsequent years they also became so large that individual attention was not possible. In fact, leaders in psychiatry became alarmed at the increasing size and impersonality of mental hospitals and recommended that they be downsized. It was almost 100 years before the community mental health movement was successful in reducing the population of mental hospitals with the controversial policy of deinstitutionalization, in which patients were released into their communities. Unfortunately, this practice has as many negative consequences as positive ones, including a large increase in the number of chronically disabled patients homeless on city streets.

The Development of Biological Treatments

Renewed interest in the biological origin of psychological disorders led to increased understanding of biological contributions to psychopathology and to the development of

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In the 19th century, psychological disorders were attributed to mental or emotional stress, so patients were often treated sympathetically in a restful and hygienic environment.

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new treatments. In the 1930s, electric shock and brain surgery were often used. Their effects, and the effects of new drugs, were discovered by accident. For example, insulin was occasionally given to stimulate appetite in psychotic patients who were not eating, but it also seemed to calm them down. In 1927, a Viennese physician, Manfred Sakel, began using increasingly higher dosages until, finally, patients convulsed and became temporarily comatose (Sakel, 1958). Some actually recovered their mental health, much to the surprise of everybody, and their recovery was attributed to the convulsions. The procedure became known as *insulin shock therapy,* but it was abandoned because it was too dangerous, often resulting in prolonged coma or death. Other methods of producing convulsions had to be found.

In the 1920s, Hungarian psychiatrist Joseph von Meduna suggested that schizophrenia was rarely found in individuals with epilepsy (which ultimately did not prove to be true). Some of his followers concluded that induced brain seizures might cure schizophrenia. Following suggestions on the possible benefits of applying electric shock directly to the brain—notably, by two Italian physicians, Ugo Cerletti and Lucio Bini, in 1938—a surgeon in London treated a depressed patient by sending six small shocks directly through his brain, producing convulsions (Hunt, 1980). The patient recovered. Although greatly modified, shock treatment is still used. The controversial modern uses of *electroconvulsive therapy* are described in Chapter 6.

During the 1950s, the first effective drugs for severe psychotic disorders were developed in a systematic way. Before that time, a number of medicinal substances, including opium, had been used as sedatives, along with countless herbs and folk remedies (Alexander & Selesnick, 1966). With the discovery of *Rauwolfia serpentina* (later renamed *reserpine*) and another class of drugs called *neuroleptics* (major tranquilizers), for the first time hallucinatory and delusional thought processes could be diminished in some patients; these drugs also controlled agitation and aggressiveness. Other discoveries included *benzodiazepines* (minor tranquilizers), which seemed to reduce anxiety. By the 1970s, the benzodiazepines (such as Valium and Librium) were among the most widely prescribed drugs in the world. As drawbacks of tranquilizers became apparent, prescriptions decreased somewhat (we discuss the benzodiazepines in more detail in Chapters 4 and 10).

Throughout the centuries, as Alexander and Selesnick point out, "[t]he general pattern of drug therapy for mental illness has been one of initial enthusiasm followed by disappointment" (1966, p. 287). For example, bromides, a class of sedating drugs, were used at the end of the 19th century and beginning of the 20th century to treat anxiety and other psychological disorders. By the 1920s, they were reported as being effective for many serious psychological and emotional symptoms. When their side effects became widely known, and experience began to show that their overall effectiveness was modest, bromides largely disappeared from the scene.

Neuroleptics have also been used less as attention has focused on their side effects, such as tremors and shaking. However, the positive effects of these drugs on some patients' psychotic symptoms revitalized the search both for biological contributions to psychological disorders and for new and more powerful drugs.

Consequences of the Biological Tradition

In the late 19th century, Grey and his colleagues ironically reduced or eliminated interest in treating mental patients, because they thought mental disorders were the result of some as-yet-undiscovered brain pathology and were therefore incurable. The only available course of action was to hospitalize these patients. Around the turn of the century, some nurses documented clinical success in treating mental patients but were prevented from treating others for fear of raising hopes of a cure among family members. In place of treatment, interest centered on diagnosis and the study of brain pathology itself.

Emil Kraepelin (1856–1926) was the dominant figure during this period. He was influential in advocating the major ideas of the biological tradition, but he was little involved in treatment. His lasting contribution was in the area of diagnosis and classification. Kraepelin (1913) was one of the first to distinguish among various psychological disorders, seeing that each may have a different age of onset, different symptoms, and probably a different cause.

By the end of the 1800s, a scientific approach to psychological disorders and their classifications had begun with the search for biological causes. Furthermore, treatment was based on humane principles. There were many drawbacks, however, the most unfortunate being that treatment was all but eliminated in some settings, despite the availability of some effective approaches. It is to these that we now turn.

Concept Check 1.2

Check your understanding of these historical theories and match them to the treatments used to "cure" abnormal behavior: (a) bloodletting; induced vomiting; (b) patient placed in socially facilitative environments; and (c) exorcism; burning at the stake.

1. Supernatural causes; evil demons took over victims' bodies and controlled their behaviors. _____
2. The humoral theory reflected the belief that normal functioning of the brain required a balance of four bodily fluids or humors. _____
3. Maladaptive behavior was caused by poor social and cultural influences within the environment. _____

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The Psychological Tradition

How do the psychological approaches of psychoanalysis, humanism, and behaviorism explain abnormal behavior?

It is a long leap from evil spirits to brain pathology as the cause of psychological disorders. In the intervening centuries, how did psychological development come to be viewed in an interpersonal and social context? In fact, this approach has a long tradition. Plato, for example, thought that the two causes of maladaptive behavior were the social and cultural influences in one's life and the learning that took place in that environment. If something was wrong in the environment, such as abusive parents, one's impulses and emotions would overcome reason. The best treatment was to reeducate the individual through rational discussion so that the power of reason would predominate (Maher & Maher, 1985a). This was a precursor to modern **psychosocial treatment** approaches to the causation of psychopathology, which focus not only on psychological factors but also on social and cultural ones as well. Other early philosophers, including Aristotle, also emphasized the influence of social environment and early learning on later psychopathology. These philosophers wrote about the importance of fantasies, dreams, and cognitions and thus anticipated later developments in psychoanalytic thought and cognitive science. They also advocated humane care for individuals with psychological disturbances.

Moral Therapy

During the first half of the 19th century, a psychosocial approach to mental disorders called **moral therapy** became influential. The term *moral* actually referred more to emotional or psychological factors rather than to a code of conduct. Its tenets included treating institutionalized patients as normally as possible in a setting that encouraged normal social interaction (Bockoven, 1963). Relationships were carefully nurtured. Individual attention emphasized positive consequences for appropriate interactions and behavior, and restraint and seclusion were eliminated.

As with the biological tradition, the principles of moral therapy date back to Plato and beyond. For example, the Greek Asclepiad Temples of the 6th century B.C. housed the chronically ill, including those with psychological disorders. Here, patients were well cared for, massaged, and provided with soothing music. Similar practices were evident in Muslim countries in the Middle East (Millon, 2004). But moral therapy as a system originated with French psychiatrist Philippe Pinel (1745–1826) and his associate Jean-Baptiste Pussin (1746–1811), the superintendent of the Parisian hospital La Bicêtre (Gerard, 1997; Zilboorg & Henry, 1941).

North Wind Picture Archives/Alamy

Patients with psychological disorders were freed from chains and shackles as a result of the influence of Philippe Pinel (1745–1826), a pioneer in making mental institutions more humane.

When Pinel arrived in 1791, Pussin had already instituted reforms by removing all chains used to restrain patients and instituting humane psychological interventions. Pussin persuaded Pinel to go along with the changes. Much to Pinel's credit, he did, first at La Bicêtre and then at the women's hospital Salpétrière (Gerard, 1997; Maher & Maher, 1985b).

After William Tuke (1732–1822) followed Pinel's lead in England, Benjamin Rush (1745–1813), often considered the founder of U.S. psychiatry, introduced moral therapy at Pennsylvania Hospital. *Asylums* had appeared in the 16th century, but they were more like prisons than hospitals. It was the rise of moral therapy in Europe and the United States that made asylums habitable and even therapeutic.

In 1833, Horace Mann, chairman of the board of trustees of the Worcester State Hospital, reported on 32 patients who had been given up as incurable. These patients were treated with moral therapy, cured, and released to their families. Of 100 patients who were viciously assaultive before treatment, no more than 12 continued to be violent a year after beginning treatment. Before treatment, 40 patients had routinely

psychosocial treatment Treatment practices that focus on social and cultural factors (such as family experience), as well as psychological influences. These approaches include cognitive, behavioral, and interpersonal methods.

moral therapy Psychosocial approach in the 19th century that involved treating patients as normally as possible in normal environments.

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torn off clothes provided by attendants; only 8 continued this behavior after treatment. These statistics would be remarkable even today (Bockoven, 1963).

Asylum Reform and the Decline of Moral Therapy

Unfortunately, after the mid-19th century, humane treatment declined. It was widely recognized that moral therapy worked best when the number of patients in an institution was 200 or fewer, allowing for a great deal of individual attention. But after the Civil War, enormous waves of immigrants arrived in the United States, and patient loads in hospitals increased to 1,000 or 2,000, and even more. Because immigrant groups were thought not to deserve the same privileges as native-born Americans (whose ancestors had immigrated perhaps only 50 or 100 years earlier!), they were not given moral treatments even when there were sufficient hospital personnel.

A second reason for the decline of moral therapy has an unlikely source. The great crusader Dorothea Dix (1802–1887) campaigned for reform in the treatment of insanity. Having worked in various institutions, she had firsthand knowledge of the deplorable conditions imposed on patients with insanity, and she made it her life's work to inform the American public and their leaders of these abuses. Her work became known as the **mental hygiene movement**.

In addition to improving the standards of care, Dix worked to make sure everyone who needed care received it. Through her efforts, humane treatment became more widely available in U.S. institutions. Unfortunately, an unforeseen consequence of Dix's efforts was a substantial increase in the number of mental patients. This influx led to a rapid transition from moral therapy to custodial care. Dix reformed our asylums and inspired the construction of new institutions here and abroad. But even her tireless efforts could not ensure sufficient staffing to allow the individual attention necessary to moral therapy. A final blow to the practice of moral therapy was the decision, in the middle of the 19th century, that mental illness was caused by brain pathology and, therefore, was incurable.

Encyclopaedia Britannica/UIG Vi/Getty images

Dorothea Dix (1802–1887) began the mental hygiene movement and spent much of her life campaigning for reform in the treatment of the mentally ill.

The psychological tradition lay dormant for a time, only to reemerge in several different schools of thought in the 20th century. The first major approach was **psychoanalysis**, based on Sigmund Freud's (1856–1939) theory of the structure of the mind and the role of unconscious processes in determining behavior. The second was **behaviorism**, associated with John B. Watson, Ivan Pavlov, and B. F. Skinner, which focuses on how learning and adaptation affect the development of psychopathology.

Psychoanalytic Theory

Have you ever felt as if someone cast a spell on you? Have you ever been mesmerized by a look across the classroom from a beautiful man or woman, or a stare from a rock musician as you sat down in front at a concert? If so, you have something in common with the patients of Franz Anton Mesmer (1734–1815) and with millions of people who have been hypnotized. Mesmer suggested to his patients that their problem was caused by an undetectable fluid found in all living organisms called "animal magnetism," which could become blocked.

Mesmer had his patients sit in a dark room around a large vat of chemicals with rods extending from it and touching them. Dressed in flowing robes, he might then identify and tap various areas of their bodies where their "animal magnetism" was blocked, while suggesting strongly that they were being cured. Because of his unusual techniques, Mesmer was considered an oddity and strongly opposed by the medical establishment (Winter, 1998). However, many scientists and physicians were interested in Mesmer's powerful methods of suggestion. One of the best known, Jean-Martin Charcot (1825–1893), was head of the Salpétrière Hospital in Paris, where Philippe Pinel had introduced psychological treatments several generations earlier. A distinguished neurologist, Charcot demonstrated that some techniques of mesmerism were effective with a number of psychological disorders, and he did much to legitimize the practice of hypnosis. In 1885 a young man named Sigmund Freud came from Vienna to study with Charcot.

Eric Lessing/Art Resource, NY

Franz Anton Mesmer (1734–1815) and other early therapists used strong suggestions to cure their patients, who were often hypnotized.

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After returning from France, Freud teamed up with Josef Breuer (1842–1925), who had experimented with a somewhat different hypnotic procedure. While his patients were in the highly suggestible state of hypnosis, Breuer asked them to describe their problems, conflicts, and fears. Breuer observed two important phenomena during this process. First, patients often became extremely emotional as they talked and felt relieved and improved after emerging from the hypnotic state. Second, seldom would they have gained an understanding of the relationship between their emotional problems and their psychological disorder. In fact, it was difficult or impossible for them to recall some details they had described under hypnosis. In other words, the material seemed to be beyond the awareness of the patient. With this observation, Breuer and Freud had "discovered" the **unconscious** mind and its apparent influence on the production of psychological disorders.

They also discovered that it is therapeutic to recall and relive emotional trauma that has been made unconscious and to release the accompanying tension. This release of emotional material became known as **catharsis**. A fuller understanding of the relationship between current emotions and earlier events is referred to as *insight*. As you shall see throughout this book, the existence of "unconscious" memories and feelings and the importance of processing emotion-filled information have been verified.

Freud and Breuer's theories were based on case observations. An example is Breuer's description of his treatment of "hysterical" symptoms in Anna O. in 1895 (Breuer & Freud, 1895/1957). Anna O. was a bright, attractive young woman who was perfectly healthy until she reached 21 years of age. Shortly before her problems began, her father developed a chronic illness that led to his death. Throughout his illness, Anna O. cared for him, spending endless hours at his bedside. Five months after her father became ill, Anna noticed that during the day her vision blurred and that from time to time she had difficulty moving her right arm and both legs. Soon, she began to experience difficulty speaking, and her behavior became unpredictable. Shortly thereafter, she consulted Breuer.

In a series of treatment sessions, Breuer dealt with one symptom at a time through hypnosis and subsequent "talking through," tracing each symptom to its hypothetical causation in circumstances surrounding the death of Anna's father. One at a time, her "hysterical" ailments disappeared, but only after treatment was administered for each respective behavior. This process of treating one behavior at a time fulfills a basic requirement for drawing scientific conclusions about the effects of treatment in an individual case study. Freud expanded these basic observations into the **psychoanalytic model**, the most comprehensive theory yet constructed on the development and structure of our personalities. He also speculated on where this development could go wrong and produce psychological disorders. Although many of Freud's views changed over time, the basic principles of mental functioning that he originally proposed remained constant through his writings and are still applied by psychoanalysts today.

Although most of it remains unproven, psychoanalytic theory has had a strong influence, and it is important to be familiar with its basic ideas; what follows is a brief outline of the theory. We focus on its three major facets: (1) the structure of the mind and the distinct functions of personality that sometimes clash with one another; (2) the defense mechanisms with which the mind defends itself from these conflicts; and (3) the stages of psychosexual development that contribute to our inner conflicts.

Mary Evans Picture Library/Alamy

▲ Bertha Pappenheim (1859–1936), famous as Anna O., was described as "hysterical" by Breuer.

The Structure of the Mind

The mind, according to Freud, has three major parts or functions: the id, the ego, and the superego (see ● Figure 1.4). Although you may have heard these terms, you may not be aware of their meanings. The **id** is the source of our strong sexual and aggressive feelings or energies. It is, basically, the animal within us; if totally unchecked, it would make us all rapists or killers. The energy or drive within the id is the *libido*. Even today, some people explain low sex drive as an absence of libido. A less important source of energy is the death instinct, or *thanatos*. These two basic drives, toward life and

mental hygiene movement Mid-19th-century effort to improve care of the mentally disordered by informing the public of their mistreatment.

psychoanalysis Assessment and therapy pioneered by Sigmund Freud that emphasizes exploration of, and insight into, **unconscious** processes and conflicts.

behaviorism Explanation of human behavior, including dysfunction, based on principles of learning and adaptation derived from experimental psychology.

unconscious Part of the psychic makeup that is outside the awareness of the person.

catharsis Rapid or sudden release of emotional tension thought to be an important factor in psychoanalytic therapy.

psychoanalytic model Complex and comprehensive theory originally advanced by Sigmund Freud that seeks to account for the development and structure of personality, as well as the origin of **abnormal behavior**, based primarily on inferred inner entities and forces.

id In **psychoanalysis**, the **unconscious** psychic entity present at birth representing basic drives.

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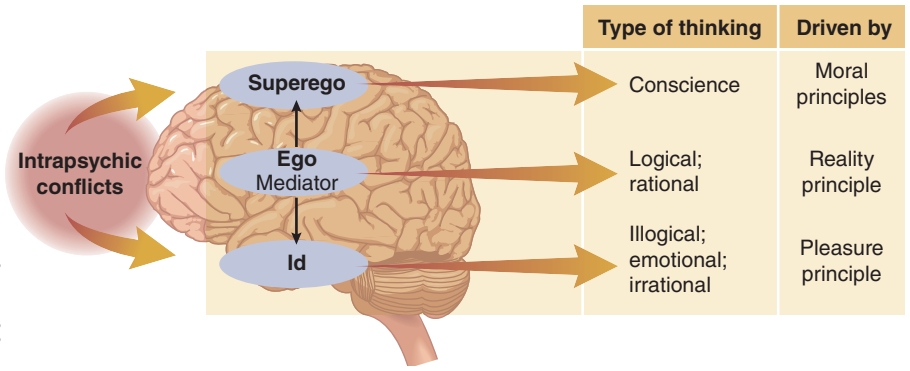

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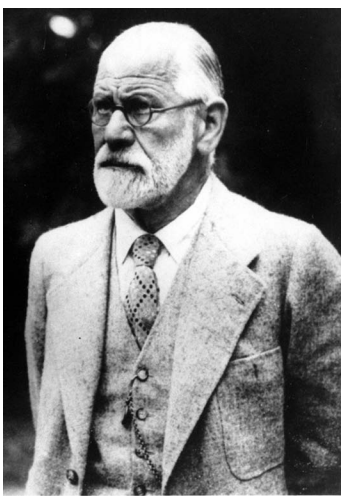
● **FIGURE 1.4** Freud's structure of the mind.

fulfillment on the one hand and death and destruction on the other, are continually in opposition.

The id operates according to the *pleasure principle,* with a goal of maximizing pleasure and eliminating any associated tension or conflicts. The goal of pleasure, which is particularly prominent in childhood, often conflicts with social rules. The id has its own characteristic way of processing information; referred to as the *primary process,* this type of thinking is emotional, irrational, illogical, filled with fantasies, and preoccupied with sex, aggression, selfishness, and envy.

Fortunately for all of us, in Freud's view, the id's selfish and sometimes dangerous drives do not go unchecked. In fact, only a few months into life, we know we must find ways to meet our basic needs without offending everyone around us. Put yet another way, we must act realistically. The part of our mind that ensures that we act realistically is called the **ego**, and it operates according to the *reality principle* instead of the pleasure principle. The cognitive operations or thinking styles of the ego are characterized by logic and reason and are referred to as the *secondary process,* as opposed to the illogical and irrational primary process of the id.



AP Images

▲ Sigmund Freud (1856–1939) is considered the founder of psychoanalysis.

The third important structure within the mind, the **superego**, or what we might call conscience, represents the *moral principles* instilled in us by our parents and our culture. It is the voice within us that nags at us when we know we're doing something wrong. Because the purpose of the superego is to counteract the potentially dangerous aggressive and sexual drives of the id, the basis for conflict is apparent.

The role of the ego is to mediate conflict between the id and the superego. The ego is often referred to as the executive or manager of our minds. If it mediates successfully, we can go on to higher intellectual and creative pursuits. If it is unsuccessful, and the id or superego becomes too strong, conflict will overtake us and psychological disorders will develop. Because these conflicts are all within the mind, they are referred to as **intrapsychic conflicts**. Freud believed that the id and the superego are almost entirely unconscious. We are fully aware only of the secondary processes of the ego, which is a relatively small part of the mind.

Defense Mechanisms

The ego fights a continual battle to stay on top of the warring id and superego. Occasionally, their conflicts produce anxiety. The anxiety alerts the ego to marshal **defense mechanisms**, unconscious protective processes that keep emotions associated with conflicts in check so that the ego can continue to function. Although Freud first conceptualized defense mechanisms, it was his daughter, Anna Freud, who developed the ideas more fully.

Defense mechanisms may be adaptive or maladaptive. For example, have you ever done poorly on a test because the grading was unfair? And then when you got home you yelled at your younger brother or perhaps your dog? This is an example of the defense mechanism of *displacement*. The ego adaptively decides that expressing anger at your professor might not be in your best interest. Because your brother and your dog don't have the authority to affect you in an adverse way, your anger is displaced to one of them. Some people may redirect energy from conflict or underlying anxiety into a more constructive outlet such as work. This process is called *sublimation*.

More severe internal conflicts that produce a lot of anxiety or other emotions can trigger self-defeating defensive processes or symptoms. Phobic and obsessive symptoms are especially common self-defeating defensive reactions that, according to Freud, reflect an inadequate attempt to deal with such conflicts. Phobic symptoms typically incorporate elements of the conflict. For example, a dog phobia may be connected to an infantile fear of castration; that is, a man's internal conflict involves a fear of being attacked and castrated, a fear that is consciously expressed as a fear of being attacked and bitten by a dog, even if he knows the dog is harmless.

Examples of defense mechanisms are listed below (APA, 2000a):

Denial: Refuses to acknowledge some aspect of objective reality or subjective experience that is apparent to others

Displacement: Transfers a feeling about, or a response to, an object that causes discomfort onto another, usually less-threatening, object or person

Projection: Falsely attributes own unacceptable feelings, impulses, or thoughts to another individual or object

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Rationalization: Conceals the true motivations for actions, thoughts, or feelings through elaborate reassuring or self-serving but incorrect explanations

Reaction formation: Substitutes behavior, thoughts, or feelings that are the direct opposite of unacceptable ones

Repression: Blocks disturbing wishes, thoughts, or experiences from conscious awareness

Sublimation: Directs potentially maladaptive feelings or impulses into socially acceptable behavior

Psychosexual Stages of Development

Freud also theorized that during infancy and early childhood we pass through a number of **psychosexual stages of development**. The stages—oral, anal, phallic, latency, and genital—represent distinctive patterns of gratifying our basic needs and satisfying our drive for physical pleasure. For example, the oral stage (birth to about age 2) is characterized by a focus on the need for food. In the act of sucking, necessary for feeding, the lips, tongue, and mouth become the focus of libidinal drives and, therefore, the principal source of pleasure. Freud hypothesized that if we did not receive appropriate gratification during a specific stage or if a specific stage left a particularly strong impression (which he termed *fixation*), an individual's personality would reflect the stage throughout adult life. For example, fixation at the oral stage might result in excessive thumb sucking and emphasis on oral stimulation through eating, chewing pencils, or biting fingernails. Adult personality characteristics theoretically associated with oral fixation include dependency and passivity or, in reaction to these tendencies, rebelliousness and cynicism.

One of the more controversial psychosexual conflicts occurs during the phallic stage (from age 3 to age 5 or 6), which is characterized by early genital self-stimulation. This conflict is the subject of the Greek tragedy *Oedipus Rex,* in which Oedipus is fated to kill his father and, unknowingly, to marry his mother. Freud asserted that all young boys relive this fantasy when genital self-stimulation is accompanied by images of sexual interactions with their mothers. These fantasies, in turn, are accompanied by strong feelings of envy and perhaps anger toward their fathers, with whom they identify but whose place they wish to take. Furthermore, strong fears develop that the father may punish that lust by removing the son's penis—thus, the phenomenon of **castration anxiety**. This fear helps the boy keep his lustful impulses toward his mother in check. The battle of the lustful impulses on the one hand and castration anxiety on the other creates a conflict that is internal, or intrapsychic, called the *Oedipus complex.* The phallic stage passes uneventfully only if several things happen. First, the child must resolve his ambivalent relationship with his parents. If this happens, he may channel his libidinal impulses into heterosexual relationships while retaining harmless affection for his mother.

The counterpart conflict in girls, called the *Electra complex,* is even more controversial. Freud viewed the young girl as wanting to replace her mother and possess her father. Central to this possession is the girl's desire for a penis—hence the term *penis envy.* According to Freud, the conflict is resolved when females develop heterosexual relationships and look forward to having a baby, which he viewed as a healthy substitute for having a penis. Needless to say, this particular theory has provoked marked consternation over the years as being sexist and demeaning. It is important to remember that it is theory, not fact; no systematic research exists to support it.

In Freud's view, all nonpsychotic psychological disorders resulted from unconscious conflicts, the anxiety that resulted

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Anna Freud (1895–1982), here with her father, contributed the concept of defense mechanisms to the field of psychoanalysis.

ego In **psychoanalysis**, the psychic entity responsible for finding realistic and practical ways to satisfy **id** drives.

superego In **psychoanalysis**, the psychic entity representing the internalized moral standards of parents and society.

intrapsychic conflicts In psychoanalytic theory, a struggle among the **id**, **ego**, and **superego**.

defense mechanism Common pattern of behavior, often an adaptive coping style when it occurs in moderation, observed in response to a particular situation. Psychoanalytic theory suggests that defense mechanisms are **unconscious** processes originating in the **ego**.

psychosexual stages of development Psychoanalytic concept of the sequence of phases a person passes through during development. Each stage is named for the location on the body where **id** gratification is maximal at that time.

castration anxiety In **psychoanalysis**, the **fear** in young boys that they will be mutilated genitally because of their lust for their mothers.

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from those conflicts, and the implementation of defense mechanisms. Freud called such disorders **neuroses**, or *neurotic disorders*.

Later Developments in Psychoanalytic Thought

Freud's original psychoanalytic theories have been modified and developed in different directions. Some theorists simply took one component of psychoanalytic theory and developed it more fully. Others broke with Freud and went in entirely new directions.

Anna Freud (1895–1982), Freud's daughter, concentrated on how defense mechanisms determine behavior. In doing so, she was the first proponent of the modern field of **ego psychology**. According to Anna Freud, the individual slowly accumulates adaptational capacities, skills in reality testing, and defenses. Abnormal behavior develops when the ego is deficient in regulating such functions as controlling impulses or in marshaling appropriate defenses to internal conflicts. In another modification of Freud's theories, Heinz Kohut (1913–1981) focused on the formation of self-concept and the attributes of the self that allow an individual to progress toward health, or conversely, to develop neurosis. This psychoanalytic approach became known as **self-psychology** (Kohut, 1977).

A related area is **object relations—**the study of how children incorporate the images, the memories, and sometimes the values of a person to whom they were (or are) emotionally attached. *Object* in this sense refers to these important people, and the process of incorporation is called *introjection*. Introjected objects can become an integrated part of the ego or may assume conflicting roles in determining the identity, or self. For example, your parents may have conflicting views on relationships or careers, which, in turn, may differ from your own. To the extent that these varying positions have been incorporated, the potential for conflict arises. One day you may feel one way about your career direction, and the next day you may feel quite differently. According to object relations theory, you tend to see the world through the eyes of the person incorporated into your self. Object relations theorists focus on how these disparate images come together to make up a person's identity.

Carl Jung (1875–1961) and Alfred Adler (1870–1937) were students of Freud who formed their own schools of thought. Jung, rejecting many of the sexual aspects of Freud's theory, introduced the concept of the **collective unconscious**, a wisdom stored deep in individual memories and passed down from generation to generation. Jung also suggested that spiritual and religious drives are as much a part of human nature as are sexual drives; this emphasis and the idea of the collective unconscious continue to draw the attention of mystics.

Adler focused on feelings of inferiority and the striving for superiority; he created the term *inferiority complex*. Unlike Freud, both Jung and Adler believed that the basic quality of human nature is positive and that there is a strong drive toward self-actualization (realizing one's full potential). Jung and Adler believed that by removing barriers to both internal and external growth, the individual would flourish.

Others emphasized development over the life span and the influence of culture and society on personality. Karen Horney (1885–1952) and Erich Fromm (1900–1980) are associated with these ideas, but the best-known theorist is Erik Erikson (1902–1994). Erikson's greatest contribution was his theory of development across the life span, in which he described the crises and conflicts that accompany eight specific stages. For example, in the *mature stage,* beginning about age 65, individuals review their lives, experiencing both satisfaction at having completed goals and despair at having failed at others. Scientific developments have borne out the wisdom of considering psychopathology from a developmental point of view.

Psychoanalytic Psychotherapy

Many techniques of psychoanalytic psychotherapy, or psychoanalysis, are designed to reveal the nature of unconscious mental processes through catharsis and insight. Freud developed techniques of **free association**, in which patients are instructed to say whatever comes to mind. Free association is intended to reveal emotionally charged material that may be repressed because it is too painful or threatening to bring into consciousness. Freud's patients lay on a couch, and he sat behind them so that they would not be distracted. Other techniques include **dream analysis** (still quite popular), in which the therapist interprets the content of dreams, supposedly reflecting the primary-process thinking of the id, and relates the dreams to symbolic aspects of unconscious conflicts. This procedure is often difficult because the patient may resist the efforts of the therapist to uncover repressed conflicts and may deny the interpretations. The goal of this stage of therapy is to help the patient gain insight into the nature of the conflicts.

The relationship between the therapist, called the **psychoanalyst**, and the patient is important. In the context of this relationship, the therapist may discover the nature of the patient's intrapsychic conflict. This is because, in a phenomenon called **transference**, patients come to relate to the therapist much as they did to important figures in their childhood, particularly their parents. Patients who resent the therapist but can verbalize no good reason for it may be reenacting childhood resentment toward a parent. More often, the patient will fall deeply in love with the therapist, which reflects strong positive feelings that existed earlier for a parent. In the phenomenon of *countertransference,* therapists project some of their own personal issues and feelings, usually positive, onto the patient. Therapists are trained to deal with their own feelings as well as those of their patients, whatever the mode of therapy, and relationships outside therapy are forbidden.

Classical psychoanalysis requires therapy four to five times a week for 2 to 5 years to analyze unconscious conflicts, resolve them, and restructure the personality to put

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the ego back in charge. Reduction of symptoms (psychological disorders) is relatively inconsequential because they are only expressions of underlying intrapsychic conflicts that arise from psychosexual developmental stages. Thus, eliminating a phobia or depressive episode would be of little use unless the underlying conflict was dealt with adequately, because another set of symptoms would almost certainly emerge *(symptom substitution)*. Because of the extraordinary expense of classical psychoanalysis, and the lack of evidence that it is effective, this approach is seldom used today.

Psychoanalysis is still practiced, but many psychotherapists employ a loosely related set of approaches referred to as **psychodynamic psychotherapy**. Although conflicts and unconscious processes are still emphasized, and efforts are made to identify trauma and defense mechanisms, therapists use a mixture of tactics, including (1) a focus on affect and the expression of patients' emotions; (2) an exploration of patients' attempts to avoid topics or hinder the progress of therapy; (3) the identification of patterns in patients' actions, thoughts, feelings, experiences, and relationships; (4) an emphasis on past experiences; (5) a focus on interpersonal experiences; (6) an emphasis on the therapeutic relationship; and (7) an exploration of patients' wishes, dreams, or fantasies (Blagys & Hilsenroth, 2000). Two additional features characterize psychodynamic psychotherapy. First, it is significantly briefer than classical psychoanalysis. Second, psychodynamic therapists deemphasize the goal of personality reconstruction, focusing instead on relieving the suffering associated with psychological disorders.

Comments

Classical psychoanalysis as a treatment has been diminishing in popularity for years. A major criticism of psychoanalysis is that it is unscientific, relying on reports by the patient of events that happened years ago. These events have been filtered through the experience of the observer and then interpreted by the psychoanalyst in ways that could be questioned and might differ from one analyst to the next. Finally, there has been no careful measurement of any of these phenomena and no obvious way to prove or disprove the basic hypotheses of psychoanalysis. This is important because measurement and the ability to prove or disprove a theory are the foundations of the scientific approach.

Nevertheless, psychoanalytic concepts and observations have been valuable. Scientific studies of psychopathology have supported the observation of unconscious mental processes, the notion that emotional responses are often triggered by hidden or symbolic cues, and the understanding that memories can be repressed and otherwise avoided in a variety of ways. The relationship of the therapist and the patient, called the *therapeutic alliance,* is an important area of study. These concepts, along with the importance of various coping styles or defense mechanisms, will appear throughout this book.

Many of these psychodynamic ideas had been in development for more than a century, culminating in Freud's influential writings (e.g., Lehrer, 1995), and they stood in stark contrast to witch trials and ideas of incurable brain pathology. In early years, the source of good and evil and of urges and prohibitions was conceived as external and spiritual, usually in the guise of demons confronting the forces of good. From the psychoanalytic point of view, we ourselves became the battleground for these forces, and we are inexorably caught up in the battle, sometimes for better and sometimes for worse.

Humanistic Theory

We have already seen that Jung and Adler broke sharply with Freud. Their fundamental disagreement concerned the very nature of humanity. Freud portrayed life as a battleground where we are continually in danger of being overwhelmed by our darkest forces. Jung and Adler, by contrast, emphasized the positive, optimistic side of human nature. Jung talked about setting goals, looking toward the future, and realizing one's fullest potential. Adler believed that human nature reaches its fullest potential when we contribute to the welfare of other individuals and to society as a whole. He believed that we all strive to reach superior levels of intellectual and moral development. Nevertheless, both Jung and Adler retained many of the principles of psychodynamic thought. Their general philosophies were

neurosis (neuroses plural**)** Obsolete psychodynamic term for a **psychological disorder** thought to result from an **unconscious** conflict and the **anxiety** it causes. Plural is *neuroses*.

ego psychology Psychoanalytic theory that emphasizes the role of the **ego** in development and attributes **psychological disorders** to failure of the ego to manage impulses and internal conflicts. Also known as *self-psychology*.

self-psychology See **ego psychology**.

object relations Modern development in psychodynamic theory involving the study of how children incorporate the memories and values of people who are close and important to them.

collective unconscious Accumulated wisdom of a culture collected and remembered across generations, a psychodynamic concept introduced by Carl Jung.

free association Psychoanalytic therapy technique intended to explore threatening material repressed into the **unconscious**. The patient is instructed to say whatever comes to mind without censoring.

dream analysis Psychoanalytic therapy method in which dream content is examined as symbolic of **id** impulses and **intrapsychic conflicts**.

psychoanalyst Therapist who practices **psychoanalysis** after earning either an MD or a PhD degree and receiving additional specialized postdoctoral training.

transference Psychoanalytic concept suggesting that clients may seek to relate to the therapist as they do to important authority figures, particularly their parents.

psychodynamic psychotherapy Contemporary version of **psychoanalysis** that still emphasizes **unconscious** processes and conflicts but is briefer and more focused on specific problems.

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adopted in the middle of the century by personality theorists and became known as *humanistic psychology.*

Self-actualizing was the watchword for this movement. The underlying assumption is that all of us could reach our highest potential if only we had the freedom to grow. Inevitably, a variety of conditions may block our actualization, usually originating outside the individual. Difficult living conditions or stressful experiences may move you away from your true self.

Abraham Maslow (1908–1970) was most systematic in describing the structure of personality. He postulated a *hierarchy of needs,* beginning with our most basic needs for food and sex and ranging upward to our needs for self-actualization, love, and self-esteem. Social needs such as friendship fall somewhere between. Maslow hypothesized that we cannot progress up the hierarchy until we have satisfied the needs at lower levels.

Carl Rogers (1902–1987) is the most influential humanist. Rogers (1951) originated client-centered therapy, later known as **person-centered therapy**. In this approach, the therapist takes a passive role, making as few interpretations as possible. The point is to give the individual a chance to develop, unfettered by threats to the self. **Unconditional positive regard**, the complete acceptance of most of the client's feelings and actions, is critical to the humanistic approach. *Empathy* is the sympathetic understanding of the individual's view of the world. The hoped-for result of person-centered therapy is that clients will be more straightforward and honest with themselves and will access their innate tendencies toward growth.

Like psychoanalysis, the humanistic approach has had a substantial effect on theories of interpersonal relationships. For example, the human potential movements so popular in the 1960s and 1970s were a direct result of humanistic theorizing. This approach also emphasized the importance of the therapeutic relationship in a way quite different from Freud's approach. Rather than seeing the relationship as a means to an end (transference), humanistic therapists believed that relationships, including the therapeutic relationship, were the single most positive influence in facilitating human growth. Nevertheless, the humanistic model contributed relatively little new information to the field of psychopathology. One reason for this is that its proponents stressed the unique, nonquantifiable experiences of the individual, emphasizing that people are more different than alike. As Maslow noted, the humanistic model found its greatest application among individuals without psychological disorders. The application of person-centered therapy to more severe psychological disorders has decreased substantially over the decades.

The Behavioral Model

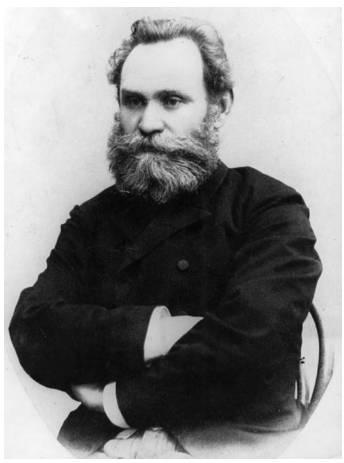
The **behavioral model**, also known as the *cognitive-behavioral model* or *social learning model,* brought a more scientific approach to psychological aspects of psychopathology.

Pavlov and Classical Conditioning

In his classic study examining why dogs salivate before the presentation of food, physiologist Ivan Petrovich Pavlov (1849–1936) of St. Petersburg, Russia, initiated the study of **classical conditioning**, a type of learning in which a neutral stimulus is paired with a response until it elicits that response. Conditioning is one way in which we acquire new information. This process is not as simple as it first seems, and we continue to uncover many more facts about its complexity (Craske, Hermans, & Vansteenwegen, 2006; Rescorla, 1988). But it can be quite automatic. Let's look at a powerful contemporary example.

Chemotherapy, a common treatment for some forms of cancer, has side effects including severe nausea and vomiting. But patients often experience these effects when they merely see the person who administered the chemotherapy or any equipment associated with the treatment (Morrow & Dobkin, 1988; Roscoe, Morrow, Aapro, Molassiotis, & Olver, 2011). For some patients, this reaction becomes associated with stimuli that evoke people or things present during chemotherapy—anybody in a nurse's uniform or even the sight of the hospital. This phenomenon is called *stimulus generalization* because the response generalizes to similar stimuli. Psychologists have had to develop specific treatments to overcome this response (Mustian et al., 2011).

Whether the stimulus is food, as in Pavlov's laboratory, or chemotherapy, the classical conditioning process begins with a stimulus that would elicit a response in almost anyone and requires no learning; no conditions must be present for the response to occur. For these reasons, the food or chemotherapy is called the *unconditioned stimulus (UCS).* The natural or unlearned response to this stimulus—in these cases, salivation or nausea—is called the *unconditioned response (UCR).* Now the learning comes in. As we have seen, any person or object associated with the unconditioned stimulus (food or chemotherapy) acquires the power to elicit the same response, but now the response, because it was elicited by the conditional or *conditioned stimulus (CS),* is termed a *conditioned response (CR).* Thus, the nurse associated with the chemotherapy becomes a conditioned stimulus. The nauseous sensation (upon seeing the nurse), which is almost the same as that experienced during chemotherapy, becomes the conditioned response.



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Ivan Pavlov (1849–1936) identified the process of classical conditioning, which is important to many emotional disorders.

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With unconditioned stimuli as powerful as chemotherapy, a conditioned response can be learned in one trial. Most learning of this type, however, requires repeated pairing of the unconditioned stimulus (for example, chemotherapy) and the conditioned stimulus (for instance, nurses' uniforms or hospital equipment). When Pavlov began to investigate this phenomenon, he substituted a metronome for the footsteps of his assistants so that he could quantify the stimulus more accurately. He found that presentation of the conditioned stimulus (for example, the metronome) *without* the food for a long enough period would eventually eliminate the conditioned response to the food. In other words, the dog learned that the metronome no longer meant that a meal might be on the way. This process was called **extinction**.

Because Pavlov was a physiologist, it was natural for him to study these processes in a laboratory and to be scientific about it. This required precision in measuring and observing relationships and in ruling out alternative explanations. Although this scientific approach is common in biology, it was uncommon in psychology at that time. For example, it was impossible for psychoanalysts to measure unconscious conflicts precisely, or even observe them. Even early experimental psychologists such as Edward Titchener (1867–1927) emphasized the study of **introspection**. Subjects reported on their thoughts and feelings after experiencing certain stimuli, but the results of this "armchair" psychology were inconsistent.

Watson and the Rise of Behaviorism

American psychologist John B. Watson (1878–1958) is considered the founder of behaviorism. Watson decided that to base psychology on introspection was to head in the wrong direction; that psychology could be made as scientific as physiology (Watson, 1913). Most of Watson's time was spent developing behavioral psychology as an empirical science, but he did dabble briefly in the study of psychopathology. In 1920, he and a student, Rosalie Rayner, presented an 11-month-old boy named Albert with a harmless fluffy white rat to play with. Albert was not afraid of the animal and enjoyed playing with it. Every time Albert reached for the rat, however, the experimenters made a loud noise behind him. After only five trials, Albert showed signs of fear if the white rat came near. The experimenters then determined that Albert displayed mild fear of any white furry object, even a Santa Claus beard. You may not think this is surprising, but keep in mind that this was one of the first examples ever recorded in a laboratory of producing fear of an object not previously feared. Of course, this experiment would be considered unethical by today's standards, and it turns out Albert may have also had some neurological impairment that could have contributed to developing fear (Fridlund, Beck, Goldie, & Irons, 2012), but the study remains a classic one.

Another student of Watson's, Mary Cover Jones (1896–1987), thought that if fear could be conditioned in this way, perhaps it could also be unlearned or extinguished. She worked with a boy named Peter, who at 2 years, 10 months old was already afraid of furry objects. Jones decided to bring a white rabbit into the room where Peter was playing for a short time each day. She also arranged for other children, who did not fear rabbits, to be in the same room. Peter's fear gradually diminished. Each time it diminished, Jones brought the rabbit closer. Eventually Peter was touching and even playing with the rabbit (Jones, 1924a, 1924b), and years later the fear had not returned.

The Beginnings of Behavior Therapy

The implications of Jones's research were largely ignored for two decades, but in the late 1940s and early 1950s, South African psychiatrist Joseph Wolpe (1915–1997) became dissatisfied with psychoanalytic interpretations of psychopathology. He turned to the field of behavioral psychology and developed a variety of behavioral procedures for treating his patients, many of whom suffered from phobias. His best-known technique was termed **systematic desensitization**. It was similar to the treatment of little Peter: individuals were gradually introduced to the objects or situations they feared so that their fear could extinguish; that is, they could test reality and see that nothing bad happened in the presence of the phobic object or scene. Wolpe also had his patients do something that was incompatible with fear while they were in the presence of the dreaded object or situation. Because he could not always reproduce the phobic object in his office, Wolpe had his patients carefully and systematically *imagine* the phobic scene while relaxing. For example, Wolpe treated a young man with a phobia of dogs by training him first to relax

self-actualizing Process emphasized in humanistic psychology in which people strive to achieve their highest potential against difficult life experiences.

person-centered therapy Therapy method in which the client, rather than the counselor, primarily directs the course of discussion, seeking self-discovery and self-responsibility.

unconditional positive regard Acceptance by the counselor of the client's feelings and actions without judgment or condemnation.

behavioral model Explanation of human behavior, including dysfunction, based on principles of learning and adaptation derived from experimental psychology.

classical conditioning Fundamental learning process first described by Ivan Pavlov. An event that automatically elicits a response is paired with another stimulus event that does not (a neutral stimulus). After repeated pairings, the neutral stimulus becomes a **conditioned stimulus** that by itself can elicit the desired response.

extinction Learning process in which a response maintained by **reinforcement** in **operant conditioning** or pairing in **classical conditioning** decreases when that reinforcement or pairing is removed; also the procedure of removing that reinforcement or pairing.

introspection Early, nonscientific approach to the study of psychology involving systematic attempts to report thoughts and feelings that specific stimuli evoked.

systematic desensitization Behavioral therapy technique to diminish excessive **fears**, involving gradual exposure to the feared stimulus paired with a positive coping experience, usually relaxation.

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Archives of the History of American Psychology, The Center for the History of Psychology, The University of Akron

Mary Cover Jones (1896–1987) was one of the first psychologists to use behavioral techniques to free a patient from phobia.

deeply and then imagine he was looking at a dog across the park. Gradually, he could imagine the dog across the park and remain relaxed, experiencing little or no fear. Wolpe then had him imagine that he was closer to the dog. Eventually, the young man imagined that he was touching the dog while maintaining a relaxed, almost trancelike state.

Wolpe reported great success with systematic desensitization, one of the first wide-scale applications of the new science of behaviorism to psychopathology. Wolpe, working with fellow pioneers Hans Eysenck and Stanley Rachman in London, called this approach **behavior therapy**. Although Wolpe's procedures are seldom used today, they paved the way for modern-day procedures in which severe phobias can be eliminated in as little as 1 day (see Chapter 4).

B. F. Skinner and Operant Conditioning

Freud's influence extended far beyond psychopathology into many aspects of our cultural and intellectual history. Only one other behavioral scientist has made a similar impact: Burrhus Frederic (B. F.) Skinner (1904–1990). In 1938 he published *The Behavior of Organisms,* in which he laid out the principles of *operant conditioning,* a type of learning in which behavior changes as a function of what follows the behavior. Skinner was strongly influenced by Watson's conviction that a science of human behavior must be based on observable events and relationships among those events; he was also influenced by the work of psychologist Edward L. Thorndike (1874–1949).

Thorndike is best known for the *law of effect,* which states that behavior is either strengthened (likely to occur more frequently) or weakened (likely to occur less frequently) depending on its consequences. Skinner took the simple notions that Thorndike had tested in the animal laboratories, using food as a reinforcer, and developed them in a variety of ways to apply to much of our behavior. For example, if a 5-year-old boy starts shouting at the top of his lungs in a restaurant, it is unlikely that his behavior was automatically elicited by an unconditioned stimulus. Also, he will be less likely to do it in the future if his parents scold him, take him out to the car, or consistently reinforce more appropriate behavior. Then again, if the parents think his behavior is cute and laugh at it, chances are he will do it again.

Skinner coined the term *operant conditioning* because behavior operates on the environment and changes it in some way. For example, the boy's behavior affects his parents' behavior and probably the behavior of other customers. Most things that we do socially provide the context for other people to respond to us, thereby providing consequences for our behavior. The same is true of our physical environment, although the consequences may be long term (polluting the air eventually will poison us). Skinner preferred the term **reinforcement** to "reward" because it connotes the effect on the behavior. He pointed out that all of our behavior is governed to some degree by reinforcement, which can be arranged in a variety of *schedules of reinforcement* (Ferster & Skinner, 1957). He also believed that using punishment as a consequence is relatively ineffective and that the primary way to develop new behavior is to positively reinforce desired behavior. Skinner did not deny the influence of biology or the existence of subjective states of emotion or cognition; he simply explained these phenomena as relatively inconsequential side effects of a particular history of reinforcement.

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B. F. Skinner (1904–1990) studied operant conditioning, a form of learning that is central to psychopathology.

The subjects of Skinner's research were usually pigeons or rats. Skinner taught the animals a variety of tricks, including dancing, playing Ping-Pong, and playing a toy piano. To do this he used **shaping**, a process of reinforcing successive approximations to a final behavior or set of behaviors. For example, if you want a pigeon to play Ping-Pong, first you provide it with a pellet of food every time it moves its head slightly toward a Ping-Pong ball tossed in its direction. Gradually you require the pigeon to move its head ever closer to the Ping-Pong ball until it touches it. Finally, receiving the food pellet is contingent on the pigeon hitting the ball back with its head.

Comments

The behavioral model has contributed greatly to the understanding and treatment of psychopathology. Nevertheless, this model is incomplete and inadequate to account for what we now know about psychopathology. In the past, there was little or no room for biology in behaviorism, because disorders were considered, for the most part, environmentally determined reactions. The model also fails to account for development of psychopathology across the life span. Recent advances in our knowledge of how information is processed have added a layer of complexity. Integrating all these dimensions requires a new model of psychopathology.

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An Integrative Approach

Why is the scientific method so important in studying abnormal behavior?

We have reviewed three traditions or ways of thinking about causes of psychopathology: the supernatural, the biological, and the psychological (further subdivided into two major historical components: psychoanalytic and behavioral).

Supernatural explanations of psychopathology are still with us. This tradition has little influence on scientists and other professionals, however. Biological, psychoanalytic, and behavioral models, by contrast, continue to further our knowledge of psychopathology.

Each tradition has failed in important ways. First, scientific methods were not often applied to the theories and treatments within a tradition, mostly because methods that would have produced the evidence necessary to confirm or disprove the theories and treatments had not been developed. Lacking such evidence, many people accepted various fads and superstitions that ultimately proved to be untrue or useless. New fads often superseded truly useful theories and treatment procedures. King Charles VI was subjected to a variety of procedures, some of which have since been proved useful and others that were mere fads or even harmful. How we use scientific methods to confirm or disconfirm findings in psychopathology is described in Chapter 3.

Second, health professionals tend to look at psychological disorders from their own point of view alone. Grey assumed that psychological disorders were the result of brain disease and that other factors had no influence. Watson assumed that all behaviors, including disordered behavior, were the result of psychological and social influences and that the contribution of biological factors was inconsequential.

In the 1990s, two developments came together to shed light on the nature of psychopathology: (1) the increasing sophistication of scientific tools and methodology and (2) the realization that no one influence—biological, behavioral, cognitive, emotional, or social—ever occurs in isolation. Every time we think, feel, or do something, the brain and the rest of the body are hard at work. Perhaps not as obvious, however, is that our thoughts, feelings, and actions influence the function and even the structure of the brain. In other words, our behavior, both normal and abnormal, is the product of a continual interaction of psychological, biological, and social influences.

By 2000, the young fields of cognitive science and neuroscience were growing rapidly as we learned more about the brain and about how we process, remember, and use information. At the same time, new findings from behavioral science revealed the importance of early experience in determining later development. It was clear that a new model was needed that would consider biological, psychological, and social influences on behavior. This approach to psychopathology would combine findings from all areas with our rapidly growing understanding of how we experience life during different developmental periods. In 2010, the National Institute of Mental Health (NIMH) instituted a plan to support further research and development on the interrelationship of these factors with the aim of translating research findings to treatment settings (Insel, 2009). In the remainder of this book, we therefore explore the reciprocal influences among neuroscience, cognitive science, behavior science, and developmental science and demonstrate that the only currently valid model of psychopathology is multidimensional and integrative.

Concept Check 1.3

Match the treatment with the corresponding theory of behavior: (a) behavioral model, (b) moral therapy, (c) psychoanalytic theory, and (d) humanistic theory.

1. Treating institutionalized patients as normally as possible and encouraging social interaction and relationship development. _____
2. Hypnosis, psychoanalysis-like free association and dream analysis, and balance of the id, ego, and superego. _____
3. Person-centered therapy with unconditional positive regard. _____
4. Classical conditioning, systematic desensitization, and operant conditioning. _____

behavior therapy Array of therapeutic methods based on the principles of behavioral and **cognitive science**, as well as principles of learning as applied to clinical problems. It considers specific behaviors rather than inferred conflicts as legitimate targets for change.

reinforcement In **operant conditioning**, consequences for behavior that strengthen it or increase its frequency. Positive reinforcement involves the contingent delivery of a desired consequence. Negative reinforcement is the contingent escape from an aversive consequence. Unwanted behaviors may result from reinforcement of those behaviors or the failure to reinforce desired behaviors.

shaping In **operant conditioning**, the development of a new response by reinforcing successively more similar versions of that response. Both desirable and undesirable behaviors may be learned in this manner.

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Summary

Understanding Psychopathology

How do psychologists define a psychological disorder?

- A psychological disorder is (1) a psychological dysfunction that is (2) associated with distress or impairment in functioning and (3) a response that is not typical or culturally expected. All three basic criteria must be met; no one criterion alone has yet been identified that defines the essence of abnormality.
- Psychopathology is concerned with the scientific study of psychological disorders. Mental health professionals range from clinical and counseling psychologists to psychiatrists and psychiatric social workers and nurses. Each profession requires a specific type of training.

Who is a scientist–practitioner?

- Mental health professionals can function as scientist–practitioners. They not only keep up with the latest findings but also use scientific data to evaluate their own work, and they often conduct research within their clinics or hospitals.
- Research about psychological disorders falls into three categories: description, causation, and treatment and outcomes.

The Supernatural, Biological, and Psychological Traditions

What supernatural influences were formerly believed to explain abnormal behavior?

What are the underlying assumptions of the biological approach to understanding abnormal behavior?

How do the psychological approaches of psychoanalysis, humanism, and behaviorism explain abnormal behavior?

- Historically, there have been three approaches to abnormal behavior. In the supernatural tradition, abnormal behavior is attributed to outside agents, such as demons or spirits; this tradition has been largely replaced by biological and psychological perspectives. In the biological tradition, disorders are attributed to disease or biochemical imbalances. In the psychological tradition, abnormal behavior is attributed to faulty psychological development and to social context.
- Each tradition has its own forms of treatment. Supernatural treatments include exorcism to rid the body of the supernatural spirits. Biological treatments emphasize physical care and medical cures, especially drugs. Psychological approaches use psychosocial treatments, beginning with moral therapy and including modern psychotherapy.
- Sigmund Freud, the founder of psychoanalytic therapy, offered an elaborate conception of the unconscious mind. In therapy, Freud focused on tapping into the unconscious through such techniques as catharsis, free association, and dream analysis. Although Freud's followers steered from his path in many ways, Freud's influence can still be felt today.
- One outgrowth of Freudian therapy is humanistic psychology, which focuses on human potential and self-actualizing. Therapy that has evolved from this approach is known as person-centered therapy; the therapist shows almost unconditional positive regard for the client's feelings and thoughts.
- The behavioral model moved psychology into the realm of science. Both research and therapy focus on things that are measurable, including such techniques as systematic desensitization, reinforcement, and shaping.

An Integrative Approach

Why is the scientific method so important in studying abnormal behavior?

- With the increasing sophistication of our scientific tools, and new knowledge from cognitive science, behavioral science, and neuroscience, we now realize that no contribution to psychological disorders occurs in isolation. Our behavior, both normal and abnormal, is a product of a continual interaction of psychological, biological, and social influences.

Key Terms

psychological disorder, 1
phobia, 1
abnormal behavior, 2
psychopathology, 3
scientist–practitioner, 4
presenting problem, 4
clinical description, 4
prevalence, 4
incidence, 4
course, 4
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moral therapy, 13
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