GLOBAL EDITION

Abnormal Psychology

EIGHTH EDITION

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ALWAYS LEARNING

PEARSON

contents

The Big Picture

learning objectives

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Mental disorders touch every realm of human experience; they are part of the human experience. They can disrupt the way we think, the way we feel, and the way we behave. They also affect relationships with other people. These problems often have a devastating impact on people's lives. In countries such as the United States, mental disorders are the second leading cause of disease-related disability and mortality, ranking slightly behind cardiovascular conditions and slightly ahead of cancer (Lopez et al., 2006). The purpose of this book is to help you become familiar with the nature of these disorders and the various ways in which psychologists and other mental health professionals are advancing knowledge of their causes and treatment.

Many of us grow up thinking that mental disorders happen to a few unfortunate people. We don't expect them to happen to us or to those we love. In fact, mental disorders are very common. At least two out of every four people will experience a serious form of abnormal behavior, such as depression, alcoholism, or schizophrenia, at some point during his or her lifetime. When you add up the numbers of people who experience these problems firsthand as well as through relatives and close friends, you realize that, like other health problems, mental disorders affect all of us. That is why, throughout this book, we will try to help you understand not only the kind of disturbed behaviors and thinking that characterize particular disorders, but also the people to whom they occur and the circumstances that can foster them.

Most importantly, this book is about all of us, not "them"—anonymous people with whom we empathize but do not identify. Just as each of us will be affected by medical problems at some point during our lives, it is also likely that we, or someone we love, will have to cope with that aspect of the human experience known as a disorder of the mind.

Overview

The symptoms and signs of mental disorders, including such phenomena as depressed mood, panic attacks, and bizarre beliefs, are known as **psychopathology.** Literally translated, this term means *pathology of the mind.* **Abnormal psychology** is the application of psychological science to the study of mental disorders.

In the first four chapters of this book, we will look at the field of abnormal psychology in general. We will look at the ways in which abnormal behaviors are broken down into categories of mental disorders that can be more clearly defined for diagnostic purposes, and how those behaviors are assessed. We will also discuss current ideas about the causes of these disorders and ways in which they can be treated.

This chapter will help you begin to understand the qualities that define behaviors and experiences as being abnormal. At what point does the diet that a girl follows in order to perform at her peak as a ballerina or gymnast become an eating disorder? When does grief following the end of a relationship become major depression? The line dividing normal from abnormal is not always clear. You will find that the issue is often one of degree rather than exact form or content of behavior.

The case studies in this chapter describe the experiences of two people whose behavior would be considered abnormal by mental health professionals. Our first case will introduce you to a person who suffered from one of the most obvious and disabling forms of mental disorder, known as schizophrenia. Kevin's life had been relatively unremarkable for many years. He had done well in school, was married, and held a good job. Unfortunately, over a period of several months, the fabric of his normal life began to fall apart. The transition wasn't obvious to either Kevin or his family, but it eventually became clear that he was having serious problems.

→ A Husband's Schizophrenia with Paranoid Delusions

Kevin and Joyce Warner (not their real names*) had been married for eight years when they sought help from a psychologist for their marital problems. Joyce was 34 years old, worked full time as a pediatric nurse, and was six months pregnant with her first child. Kevin, who was 35 years old, was finishing his third year working as a librarian at a local university. Joyce was extremely worried about what would happen if Kevin lost his job, especially in light of the baby's imminent arrival.

Although the Warners had come for couples therapy, the psychologist soon became concerned about certain eccentric

*Throughout this text we use fictitious names to protect the identities of the people involved.

aspects of Kevin's behavior. In the first session, Joyce described one recent event that had precipitated a major argument. One day, after eating lunch at work, Kevin had experienced sharp pains in his chest and had difficulty breathing. Fearful, he rushed to the emergency room at the hospital where Joyce worked. The physician who saw Kevin found nothing wrong with him, even after extensive testing. She gave Kevin a few tranquilizers and sent him home to rest. When Joyce arrived home that evening, Kevin told her that he suspected that he had been poisoned at work by his supervisor. He still held this belief.

Kevin's belief about the alleged poisoning raised serious concern in the psychologist's mind about Kevin's mental health. He decided to interview Joyce alone so that he could ask more extensive questions about Kevin's behavior. Joyce realized that the poisoning idea was "crazy." She was not willing, however, to see it as evidence that Kevin had a mental disorder. Joyce had known Kevin for 15 years. As far as she knew, he had never held any strange beliefs before this time. Joyce said that Kevin had always been "a thoughtful and unusually sensitive guy." She did not attach a great deal of significance to Kevin's unusual belief. She was more preoccupied with the couple's present financial concerns and insisted that it was time for Kevin to "face reality."

Kevin's condition deteriorated noticeably over the next few weeks. He became extremely withdrawn, frequently sitting alone in a darkened room after dinner. On several occasions, he told her that he felt as if he had "lost pieces of his thinking." It wasn't that his memory was failing, but rather he felt as though parts of his brain were shut off.

Kevin's problems at work also grew worse. His supervisor informed Kevin that his contract would definitely not be renewed. Joyce exploded when Kevin indifferently told her the bad news. His apparent lack of concern was especially annoying. She called Kevin's supervisor, who confirmed the news. He told her that Kevin was physically present at the library, but he was only completing a few hours of work each day. Kevin sometimes spent long periods of time just sitting at his desk and staring off into space and was sometimes heard mumbling softly to himself.

Kevin's speech was quite odd during the next therapy session. He would sometimes start to speak, drift off into silence, then reestablish eye contact with a bewildered smile and a shrug of his shoulders. He had apparently lost his train of thought completely. His answers to questions were often off the point, and when he did string together several sentences, their meaning was sometimes obscure. For example, at one point during the session, the psychologist asked Kevin if he planned to appeal his supervisor's decision. Kevin said, "I'm feeling pressured, like I'm lost and can't quite get here. But I need more time to explore the deeper side. Like in art. What you see on the surface is much richer when you look closely. I'm like that. An intuitive person. I can't relate in a linear way, and when people expect that from me, I get confused."

Kevin's strange belief about poisoning continued to expand. The Warners received a letter from Kevin's mother, who lived in another city 200 miles away. She had become ill after going out for dinner one night and mentioned that she must have eaten something that made her sick. After reading the letter, Kevin became convinced that his supervisor had tried to poison his mother, too.

When questioned about this new incident, Kevin launched into a long, rambling story. He said that his supervisor was a Vietnam veteran, but he had refused to talk with Kevin about his years in the service. Kevin suspected that this was because the supervisor had been a member of army intelligence. Perhaps he still was a member of some secret organization. Kevin suggested that an agent from this organization had been sent by his supervisor to poison his mother. Kevin thought that he and Joyce were in danger. Kevin also had some concerns about Asians, but he would not specify these worries in more detail.

Kevin's bizarre beliefs and his disorganized behavior convinced the psychologist that he needed to be hospitalized. Joyce reluctantly agreed that this was the most appropriate course of action. She had run out of alternatives. Arrangements were made to have Kevin admitted to a private psychiatric facility, where the psychiatrist prescribed a type of antipsychotic medication. Kevin seemed to respond positively to the drug, because he soon stopped talking about plots and poisoning—but he remained withdrawn and uncommunicative. After three weeks of treatment, Kevin's psychiatrist thought that he had improved significantly. Kevin was discharged from the hospital in time for the birth of their baby girl. Unfortunately, when the couple returned to consult with the psychologist, Kevin's adjustment was still a major concern. He did not talk with Joyce about the poisonings, but she noticed that he remained withdrawn and showed few emotions, even toward the baby.

When the psychologist questioned Kevin in detail, he admitted reluctantly that he still believed that he had been poisoned. Slowly, he revealed more of the plot. Immediately after admission to the hospital, Kevin had decided that his psychiatrist, who happened to be from Korea, could not be trusted. Kevin was sure that he, too, was working for army intelligence or perhaps for a counterintelligence operation. Kevin believed that he was being interrogated by this clever psychiatrist, so he had "played dumb." He did not discuss the suspected poisonings or the secret organization that had planned them. Whenever he could get away with it, Kevin simply pretended to take his medication. He thought that it was either poison or truth serum.

Kevin was admitted to a different psychiatric hospital soon after it became apparent that his paranoid beliefs had expanded. This time, he was given intramuscular injections of antipsychotic medication in order to be sure that the medicine was actually taken. Kevin improved considerably after several weeks in the hospital. He acknowledged that he had experienced paranoid thoughts. Although he still felt suspicious from time to time, wondering whether the plot had actually been real, he recognized that it could not really have happened, and he spent less and less time thinking about it.

Recognizing the Presence of a Disorder

Some mental disorders are so severe that the people who suffer from them are not aware of the implausibility of their beliefs. Schizophrenia is a form of **psychosis,** a general term that refers to several types of severe mental disorders in which the person is considered to be out of contact with reality. Kevin exhibited several psychotic symptoms. For example, Kevin's firm belief that he was being poisoned by his supervisor had no basis in reality. Other disorders, however, are more subtle variations on normal experience. We will shortly consider some of the guidelines that are applied in determining abnormality.

Mental disorders are typically defined by a set of characteristic features; one symptom by itself is seldom sufficient to make a diagnosis. A group of symptoms that appear together and are assumed to represent a specific type of disorder is referred to as a **syndrome.** Kevin's unrealistic and paranoid belief that he was being poisoned, his peculiar and occasionally difficult-to-understand patterns of speech, and his oddly unemotional responses are all symptoms of schizophrenia (see Chapter 13). Each symptom is taken to be a fallible, or imperfect, indicator of the presence of the disorder. The significance of any specific feature depends on whether the person also exhibits additional behaviors that are characteristic of a particular disorder.

The duration of a person's symptoms is also important. Mental disorders are defined in terms of *persistent* maladaptive behaviors. Many unusual behaviors and inexplicable experiences are short lived; if we ignore them, they go away. Unfortunately, some forms of problematic behavior are not transient, and they eventually interfere with the person's social and occupational functioning. In Kevin's case, he had become completely preoccupied with his suspicions about poison. Joyce tried for several weeks to ignore certain aspects of Kevin's behavior, especially his delusional beliefs. She didn't want to think about the possibility that his behavior was abnormal and instead chose to explain his problems in terms of lack of maturity or lack of motivation. But as the problems accumulated, she finally decided to seek professional help. The magnitude of Kevin's problem was measured, in large part, by its persistence.

Impairment in the ability to perform social and occupational roles is another consideration in identifying the presence of a mental disorder. Delusional beliefs and disorganized speech typically lead to a profound disruption of relationships with other people. Like Kevin, people who experience these symptoms will obviously find the world to be a strange, puzzling, and perhaps alarming place. And they often elicit the same reactions in other people. Kevin's odd behavior and his inability to concentrate on his work had eventually cost him his job. His problems also had a negative impact on his relationship with his wife and his ability to help care for their daughter.

Kevin's situation raises several additional questions about abnormal behavior. One of the most difficult issues in the field

People with schizophrenia are sometimes socially withdrawn and find social relationships to be puzzling or threatening.

centers on the processes by which mental disorders are identified. Once Kevin's problems came to the attention of a mental health professional, could he have been tested in some way to confirm the presence or absence of a mental disorder?

Psychologists and other mental health professionals do not at present have laboratory tests that can be used to confirm definitively the presence of psychopathology because the processes that are responsible for mental disorders have not yet been discovered. Unlike specialists in other areas of medicine where many specific disease mechanisms have been discovered by advances in the biological sciences, psychologists and psychiatrists cannot test for the presence of a viral infection or a brain lesion or a genetic defect to confirm a diagnosis of mental disorder. Clinical psychologists must still depend on their observations of the person's behavior and descriptions of personal experience.

Is it possible to move beyond our current dependence on descriptive definitions of psychopathology? Will we someday have valid tests that can be used to establish independently the presence of a mental disorder? If we do, what form might these tests take? The answers to these questions are being sought in many kinds of research studies that will be discussed throughout this book.

Before we leave this section, we must also mention some other terms. You may be familiar with a variety of words that are commonly used in describing abnormal behavior. One term is *insanity,* which years ago referred to mental dysfunction but today is a legal term that refers to judgments about whether a person

Andy Warhol was one of the most influential painters of the 20th century. His colleague, Jean-Michel Basquiat, was also an extremely promising artist. His addiction to heroin, which led to a fatal overdose, provides one example of the destructive impact of mental disorders.

should be held responsible for criminal behavior if he or she is also mentally disturbed (see Chapter 18). If Kevin had murdered his psychiatrist, for example, based on the delusional belief that the psychiatrist was trying to harm him, a court of law might consider whether Kevin should be held to be *not guilty by reason of insanity.*

Another old-fashioned term that you may have heard is *nervous breakdown.* If we said that Kevin had "suffered a nervous breakdown," we would be indicating, in very general terms, that he had developed some sort of incapacitating but otherwise unspecified type of mental disorder. This expression does not convey any specific information about the nature of the person's problems. Some people might also say that Kevin was acting *crazy.* This is an informal, pejorative term that does not convey specific information and carries with it many unfortunate, unfounded, and negative implications. Mental health professionals refer to psychopathological conditions as mental disorders or abnormal behaviors. We will define these terms in the pages that follow.

Defining Abnormal Behavior

Why do we consider Kevin's behavior to be abnormal? By what criteria do we decide whether a particular set of behaviors or emotional reactions should be viewed as a mental disorder? These are important questions because they determine, in many ways, how other people will respond to the person, as well as who will be responsible for providing help (if help is required). Many attempts have been made to define abnormal behavior, but none is entirely satisfactory. No one has been able to provide a consistent definition that easily accounts for all situations in which the concept is invoked (Phillips et al., 2012; Zachar & Kendler, 2007).

One approach to the definition of abnormal behavior places principal emphasis on the individual's experience of personal distress. We might say that abnormal behavior is defined in terms of subjective discomfort that leads the person to seek help from a mental health professional. However, this definition is fraught with problems. Kevin's case illustrates one of the major reasons that this approach does not work. Before his second hospitalization, Kevin was unable or unwilling to appreciate the extent of his problem or the impact his behavior had on other people. A psychologist would say that he did not have *insight* regarding his disorder. The discomfort was primarily experienced by Joyce, and she had attempted for many weeks to deny the nature of the problem. It would be useless to adopt a definition that considered Kevin's behavior to be abnormal only after he had been successfully treated.

Another approach is to define abnormal behavior in terms of statistical norms—how common or rare it is in the general population. By this definition, people with unusually high levels of anxiety or depression would be considered abnormal because their experience deviates from the expected norm. Kevin's paranoid beliefs would be defined as pathological because they are idiosyncratic. Mental disorders are, in fact, defined in terms of experiences that most people do not have.

This approach, however, does not specify *how* unusual the behavior must be before it is considered abnormal. Some conditions that are typically considered to be forms of psychopathology are extremely rare. For example, gender dysphoria, the belief that one is a member of the opposite sex trapped in the wrong body, affects less than 1 person out of every 30,000. In contrast, other mental disorders are much more common. Mood disorders affect 1 out of every 5 people at some point during their lives; alcoholism and other substance use disorders affect approximately 1 out of every 6 people (Kessler et al., 2005; Moffitt et al., 2010).

Another weakness of the statistical approach is that it does not distinguish between deviations that are harmful and those

MyPsychLab VIDEO CASE

Bipolar Disorder

FELIZIANO

"Depression is the worst part. My shoulders feel weighted down, and your blood feels warmer than it is. You sink deeper and deeper."

Watch the **Video** *Feliziano: Bipolar Disorder* on **MyPsychLab**

As you watch the interview and the day-in-the-life segments, ask yourself what impact Feliziano's depression and hypomania seem to have on his ability to function. Are these mood states harmful?

that are not. Many rare behaviors are not pathological. Some "abnormal" qualities have relatively little impact on a person's adjustment. Examples are being extremely pragmatic or unusually talkative. Other abnormal characteristics, such as exceptional intellectual, artistic, or athletic ability, may actually confer an advantage on the individual. For these reasons, the simple fact that a behavior is statistically rare cannot be used to define psychopathology.

Harmful Dysfunction

One useful approach to the definition of mental disorder has been proposed by Jerome Wakefield of Rutgers University (Wakefield, 2010). According to Wakefield, a condition should be considered a mental disorder if, and only if, it meets two criteria:

1. The condition results from the inability of some internal mechanism (mental or physical) to perform its natural function. In other words, something inside the person is not working properly. Examples of such mechanisms include those that regulate levels of emotion, and those that distinguish between real auditory sensations and those that are imagined.
2. The condition causes some harm to the person as judged by the standards of the person's culture. These negative consequences are measured in terms of the person's own subjective distress or difficulty performing expected social or occupational roles.

A mental disorder, therefore, is defined in terms of **harmful dysfunction.** This definition incorporates one element that is based as much as possible on an objective evaluation of performance. The natural function of cognitive and perceptual processes is to allow the person to perceive the world in ways that are shared with other people and to engage in rational thought and problem solving. The dysfunctions in mental disorders are assumed to be the product of disruptions of thought, feeling, communication, perception, and motivation.

In Kevin's case, the most apparent dysfunctions involved failures of mechanisms that are responsible for perception, thinking, and communication. Disruption of these systems was presumably responsible for his delusional beliefs and his disorganized speech. The natural function of cognitive and perceptual processes is to allow the person to perceive the world in ways that are shared with other people and to engage in rational thought and problem solving. The natural function of language abilities is to allow the person to communicate clearly with other people. Therefore, Kevin's abnormal behavior can be viewed as a pervasive dysfunction cutting across several mental mechanisms.

The harmful dysfunction view of mental disorder recognizes that every type of dysfunction does not lead to a disorder. Only dysfunctions that result in significant harm to the person are considered to be disorders. This is the second element of the definition. There are, for example, many types of physical dysfunctions, such as albinism, reversal of heart position, and fused toes, that clearly represent a significant departure from the way that some biological process ordinarily functions. These conditions are not considered to be disorders, however, because they are not necessarily harmful to the person.

Kevin's dysfunctions were, in fact, harmful to his adjustment. They affected both his family relationships—his marriage to Joyce and his ability to function as a parent—and his performance at work. His social and occupational performances were clearly impaired. There are, of course, other types of harm that are also associated with mental disorders. These include subjective distress, such as high levels of anxiety or depression, as well as more tangible outcomes, such as suicide.

The definition of abnormal behavior employed by the official *Diagnostic and Statistical Manual of Mental Disorders,* published by the American Psychiatric Association and currently in its fifth edition—*DSM-5* (APA, 2013)—incorporates many of the factors that we have already discussed. This classification system is discussed in Chapter 4. This definition is summarized in Table 1.1, along with a number of conditions that are specifically excluded from the *DSM-5* definition of mental disorders (Stein et al., 2010).

The *DSM-5* definition places primary emphasis on the consequences of certain behavioral syndromes. Accordingly, mental disorders are defined by clusters of persistent, maladaptive behaviors that are associated with personal distress, such as anxiety or depression, or with impairment in social functioning, such as job performance or personal relationships. The official definition, therefore, recognizes the concept of dysfunction, and it spells out ways in which the harmful consequences of the disorder might be identified.

The *DSM-5* definition excludes voluntary behaviors, as well as beliefs and actions that are shared by religious, political,

TABLE 1.1
Defining Characteristics of Mental Disorders

Features
1. A syndrome (groups of associated features) that is characterized by disturbance of a person's cognition, emotion regulation, or behavior.
2. The consequences of which are clinically significant distress or disability in social, occupational, or other important activities.
3. The syndrome reflects a dysfunction in the psychological, biological, or developmental processes that are associated with mental functioning.
4. Must not be merely an expectable response to common stressors and losses or a culturally sanctioned response to a particular event (e.g., trance states in religious rituals).
5. That is not primarily a result of social deviance or conflicts with society.

Source: Based on Stein, D. J., Phillips, K. A., Bolton, D. D., Fulford, K. M., Sadler, J. Z., & Kendler, K. S. 2010. What is a mental/psychiatric disorder? From DSM-IV to DSM-V. Psychological Medicine, 40, 1759–1765.

or sexual minority groups (e.g., gays and lesbians). In the 1960s, for example, members of the Yippie Party intentionally engaged in disruptive behaviors, such as throwing money off the balcony at a stock exchange. Their purpose was to challenge traditional values. These were, in some ways, maladaptive behaviors that could have resulted in social impairment if those involved had been legally prosecuted. But they were not dysfunctions. They were intentional political gestures. It makes sense to try to distinguish between voluntary behaviors and mental disorders, but the boundaries between these different forms of behavior are difficult to draw. Educated discussions of these issues depend on the consideration of a number of important questions (see Critical Thinking Matters on page 29).

In actual practice, abnormal behavior is defined in terms of an official diagnostic system. Mental health, like medicine, is an applied rather than a theoretical field. It draws on knowledge from research in the psychological and biological sciences in an effort to help people whose behavior is disordered. Mental disorders are, in some respects, those problems with which mental health professionals attempt to deal. As their activities and explanatory concepts expand, so does the list of abnormal behaviors. The practical boundaries of abnormal behavior are defined by the list of disorders that are included in the official *Diagnostic and Statistical Manual of Mental Disorders.* The categories in that manual are listed inside the back cover of this book. The *DSM-5* thus provides another simplistic, although practical, answer to our question as to why Kevin's behavior would be considered abnormal: He would be considered to be exhibiting abnormal behavior because his experiences fit the description of schizophrenia, which is one of the officially recognized forms of mental disorder (see Thinking Critically About *DSM-5*).

Mental Health Versus Absence of Disorder

The process of defining abnormal behavior raises interesting questions about the way we think about the quality of our lives when mental disorders are *not* present. What is mental health? Is optimal mental health more than the absence of mental disorder? The answer is clearly "yes." If you want to know whether one of your friends is physically fit, you would need to determine more than whether he or she is sick. In the realm of psychological functioning, people who function at the highest levels can be described as *flourishing* (Fredrickson & Losada, 2005; Keyes, 2009). They are people who typically experience many positive emotions, are interested in life, and tend to be calm and peaceful. Flourishing people also hold positive attitudes about themselves and other people. They find meaning and direction in their lives and develop trusting relationships with other people. Complete mental health implies the presence of these adaptive characteristics. Therefore, comprehensive approaches to mental health in the community must be concerned both with efforts to diminish the frequency and impact of mental disorders and with activities designed to promote flourishing.

Culture and Diagnostic Practice

The process by which the *Diagnostic and Statistical Manual* is constructed and revised is necessarily influenced by cultural considerations. **Culture** is defined in terms of the values, beliefs, and practices that are shared by a specific community or group of people. These values and beliefs have a profound influence on opinions regarding the difference between normal and abnormal behavior (Bass et al., 2012).

The impact of particular behaviors and experiences on a person's adjustment depends on the culture in which the person

THINKING CRITICALLY about DSM-5

Revising an Imperfect Manual

The official diagnostic manual for mental disorders is revised by the *American Psychiatric Association* on a regular basis, about once every 15 to 20 years. You might be surprised that the classification system changes so often, but these updates reflect the evolution of our understanding regarding these complex problems. Even more well-established and widely accepted classification systems change. You may remember when Pluto was removed from the list of planets, or recall that new elements have been added to the Periodic Table as a result of nuclear science. Classification systems change as knowledge expands.

The fifth and latest version, *DSM-5*[1], was published in 2013, an event surrounded by excitement as well as heated controversy. More than a dozen workgroups concerned with specific disorders (e.g., mood disorders, psychotic disorders) were composed of expert researchers and clinicians who had been appointed to represent current knowledge in their respective areas. Each group produced a series of proposals that were subjected to public comments as well as field trials that were intended to generate data regarding the reliability of the new definitions. In the end, some experts considered the final product to be a major step forward while others viewed it as a serious step back (Kupfer & Regier, 2011; Frances & Widiger, 2012).

We have added a new feature, *Thinking Critically About DSM-5*, to each chapter in this text. These features are designed to

Continued

help you understand ways in which this diagnostic manual has evolved, criteria that are used to judge its progress, and issues that are most controversial following publication of its latest edition. We don't want you to accept the *DSM-5* definitions simply because they were published on the authority of the American Psychiatric Association. On the other hand, we also don't want you to reject the manual because everything in it isn't perfect. Above all else, remember that *DSM-5* is a handbook, not the Bible (Frances, 2012). There are no absolute truths to be found in the classification of mental disorders.

The debates about *DSM-5* generate considerable emotion from people on both sides because changes in the manual affect so many people's lives. Crucial economic resources are clearly at stake. Adding a diagnostic category can create or expand a market for specific treatments (e.g., medications to treat a new disorder may reap enormous profits) while also raising challenging issues about whether insurance companies must pay for those treatments, whether schools will be expected to provide special services, and whether the government must pay disability claims. There are also pressures on the other side. Deleting an existing category, or narrowing the criteria that are used to define it, can create serious hardships for individuals and families who are then unable to find or afford suitable services upon which they depend. Mental health professionals, research scientists, and patient advocacy groups all play a crucial role in these debates.

Everyone agrees that the classification system must evolve, but what principles should guide this process of change? When *DSM-IV* (APA, 1994) was being produced, the process was designed to be conservative. Changes were presumably allowed only when there was substantial evidence to support a shift in the diagnostic criteria for a particular disorder. A few years later, when discussions about *DSM-5* began, the process was designed to be more open. Workgroups were encouraged to make changes that would bring the system in line with contemporary thinking, even if hard evidence was not available to indicate that the change was empirically justified. Reasonable arguments can be made for both approaches to the revision process. Ultimately, the value of these changing definitions will be judged by the outcomes. Are the new definitions meaningful? Can they be used to improve people's lives?

In the midst of public debates about the *DSM-5* process, another issue has taken center stage. What group is best positioned to manage this system? The American Psychiatric Association clearly owns *DSM,* having launched its original version in 1952. Given the fact that other mental health professions also play important roles in treating and studying mental disorders, does it make sense for this one organization to be the sole owner and manager of the classification system that governs so many aspects of our lives? Should decisions to change the system be guided, even in part, by the enormous economic benefits that have fallen to one professional organization? Some critics have argued that the classification system for mental disorders should be governed by some type of government organization, such as the National Institutes of Health, rather than a profit-making professional association. This issue will undoubtedly be debated and explored in coming years.

[1]Previous editions of the manual have been identified using roman numerals, e.g., DSM-III, DSM-IV. The current edition uses Arabic numerals in the hope that more frequent revisions of the text (e.g., DSM-5.1 and so on) can be produced easily and labeled clearly, much like updates to computer software packages.

lives. To use Jerome Wakefield's (1992) terms, "only dysfunctions that are socially disvalued are disorders" (p. 384). Consider, for example, the *DSM-5* concept of female orgasmic disorder, which is defined in terms of the absence of orgasm accompanied by subjective distress or interpersonal difficulties that result from this disturbance (see Chapter 12). A woman who grew up in a society that discouraged female sexuality might not be distressed or impaired by the absence of orgasmic responses. According to *DSM-5,* she would not be considered to have a sexual problem. Therefore, this definition of abnormal behavior is not culturally universal and might lead us to consider a particular pattern of behavior to be abnormal in one society and not in another.

There have been many instances in which groups representing particular social values have brought pressure to bear on decisions shaping the diagnostic manual. The influence of cultural changes on psychiatric classification is perhaps nowhere better illustrated than in the case of homosexuality. In the first and second editions of the *DSM,* homosexuality was, by definition, a form of mental disorder, in spite of arguments expressed by scientists, who argued that homosexual behavior was not abnormal (see Chapter 12). Toward the end of the 1960s, as the gay and lesbian rights movement became more forceful and outspoken, its leaders challenged the assumption that homosexuality was pathological. They opposed the inclusion of homosexuality in the official diagnostic manual. After extended and sometimes heated discussions, the board of trustees of the American Psychiatric Association agreed to remove homosexuality as a form of mental illness. They were impressed by numerous indications, in personal appeals as well as the research literature, that homosexuality, per se, was not invariably associated with impaired functioning. They decided that, in order to

CRITICAL THINKING matters

Is Sexual Addiction a Meaningful Concept?

Stories about mental disorders appear frequently in the popular media. One topic that once again attracted a frenzy of media attention in 2010 was a concept that has been called "sexual addiction." Tiger Woods, the top-ranked golfer in the world and wealthiest professional athlete in history, confessed to having a series of illicit sexual affairs and announced that he would take an indefinite break from the professional tour. At the time, Woods was married to former Swedish model Elin Nordegren, who had given birth to their second child earlier that same year. More than a dozen women came forward to claim publicly that they had sexual relationships with Woods, and several large companies soon cancelled lucrative endorsement deals that paid him millions of dollars to endorse their products. Newspapers, magazines, and television programs sought interviews with professional psychologists who offered their opinions regarding Woods' behavior. Why would this fabulously successful, universally admired, iconic figure risk his marriage, family, and career for a seemingly endless series of casual sexual relationships?

Many experts responded by invoking the concept of mental disorder, specifically "sexual addiction" (some called it "sexual compulsion," and one called it the "Clinton syndrome" in reference to similar problems that had been discussed in the midst of President Clinton's sex scandal in 1998). The symptoms of this disorder presumably include low self-esteem, insecurity, need for reassurance, and sensation seeking, to name only a few. One expert claimed that 20 percent of highly successful men suffer from sexual addiction.

Most of the stories failed to mention that sexual addiction does not appear as an officially recognized mental disorder in *DSM-5*. That, by itself, is not an insurmountable problem. Disorders have come and gone over the years, and it's possible that this one—or some version of it—might eventually turn out to be useful. In fact, the work group that revised the list of sexual disorders for *DSM-5* did consider but ultimately rejected adding a new category called "hypersexual disorder" (Reid et al., 2012) (see Thinking Critically About DSM-5 in Chapter 12). We shouldn't ignore a new concept simply because it hasn't become part of the official classification system (or accept one on faith, simply because it has). The most important thing is that we *think critically* about the issues that are raised by invoking a concept like sexual addiction.

At the broadest possible level, we must ask ourselves "What is a mental disorder?" Is there another explanation for such thoughtless and damaging behavior? Tiger Woods received several weeks of treatment for sexual addiction at a residential mental health facility. Has that treatment been shown to be effective for this kind of behavioral problem? Is it necessary? Does the diagnosis simply provide him with a convenient excuse that might encourage the public to forgive his immoral behavior?

Another important question is whether sexual addiction is more useful than other similar concepts (Moser, 2011). For example, narcissistic personality disorder includes many of the same features (such as lack of empathy, feelings of entitlement, and a history of exploiting others). What evidence supports the value of one concept over another? In posing such questions, we are not arguing for or against a decision to include sexual addiction or hypersexual disorder as a type of mental disorder. Rather, we are encouraging you to think critically.

Students who ask these kinds of questions are engaged in a process in which judgments and decisions are based on a careful analysis of the best available evidence. In order to consider these issues, you need to put aside your own subjective feelings and impressions, such as whether you find a particular kind of behavior disgusting, confusing, or frightening. It may also be necessary to disregard opinions expressed by authorities whom you respect (politicians, journalists, and talk-show hosts). Be skeptical. Ask questions. Consider the evidence from different points of view, and remember that some kinds of evidence are better than others.

be considered a form of mental disorder, a condition ought to be associated with subjective distress or seriously impaired social or occupational functioning. The stage was set for these events by gradual shifts in society's attitudes toward sexual behavior (Bullough, 1976; Minton, 2002). As more and more people came to believe that reproduction was not the main purpose of sexual behavior, tolerance for greater variety in human sexuality grew. The revision of the *DSM*'s system for describing sexual disorders was, therefore, the product of several forces, cultural as well as political. These deliberations are a reflection of the practical nature of the manual and of the health-related professions. Value judgments are an inherent part of any attempt to define "disorder" (Sedgwick, 1981).

Many people think about culture primarily in terms of exotic patterns of behavior in distant lands. The decision regarding homosexuality reminds us that the values of our own culture play an intimate role in our definition of abnormal behavior. These issues also highlight the importance of cultural change. Culture is a dynamic process; it changes continuously as a result of the actions of individuals. To the extent that our definition of abnormal behavior is determined by cultural values and beliefs, we should expect that it will continue to evolve over time.

Who Experiences Abnormal Behavior?

Having introduced many of the issues that are involved in the definition of abnormal behavior, we now turn to another clinical example. The woman in our second case study, Mary Childress, suffered from a serious eating disorder known as *bulimia nervosa.* Her problems raise additional questions about the definition of abnormal behavior.

As you are reading the case, ask yourself about the impact of Mary's eating disorder on her subjective experience and social adjustment. In what ways are these consequences similar to those seen in Kevin Warner's case? How are they different? This case also introduces another important concept associated with the way that we think about abnormal behavior: How can we identify the boundary between normal and abnormal behavior? Is there an obvious distinction between eating patterns that are considered to be part of a mental disorder and those that are not? Or is there a gradual progression from one end of a continuum to the other, with each step fading gradually into the next?

A College Student's Eating Disorder

Mary Childress was, in most respects, a typical 19-year-old sophomore at a large state university. She was a good student, in spite of the fact that she spent little time studying, and was popular with other students. Everything about Mary's life was relatively normal—except for her bingeing and purging.

Mary's eating patterns were wildly erratic. She preferred to skip breakfast entirely and often missed lunch as well. By the middle of the afternoon, she could no longer ignore the hunger pangs. At that point, on two or three days out of the week, Mary would drive her car to the drive-in window of a fast-food restaurant. Her typical order included three or four double cheeseburgers, several orders of french fries, and a large milkshake (or maybe two). Then she binged, devouring all the food as she drove around town by herself. Later she would go to a private bathroom, where she wouldn't be seen by anyone, and purge the food from her stomach by vomiting. Afterward, she returned to her room, feeling angry, frustrated, and ashamed.

Mary was tall and weighed 110 pounds. She believed that her body was unattractive, especially her thighs and hips. She was extremely critical of herself and had worried about her weight for many years. Her weight fluctuated quite a bit, from a low of 97 pounds when she was a senior in high school to a high of 125 during her first year at the university. Her mother was a "full-figured" woman. Mary swore to herself at an early age that she would never let herself gain as much weight as her mother had.

Purging had originally seemed like an ideal solution to the problem of weight control. You could eat whatever you wanted and quickly get rid of it so you wouldn't get fat. Unfortunately, the vomiting became a vicious trap. Disgusted by her own behavior, Mary often promised herself that she would never binge and purge again, but she couldn't stop the cycle.

For the past year, Mary had been vomiting at least once almost every day and occasionally as many as three or four times a day. The impulse to purge was very strong. Mary felt bloated after having only a bowl of cereal and a glass of orange juice. If she ate a sandwich and drank a diet soda, she began to ruminate about what she had eaten, thinking, "I've got to get rid of that!" Usually, before long, she found a bathroom and threw up. Her excessive binges were less frequent than the vomiting. Four or five times a week she experienced an overwhelming urge to eat forbidden foods, especially fast food. Her initial reaction was usually a short-lived attempt to resist the impulse. Then she would space out or "go into a zone," becoming only vaguely aware of what she was doing and feeling. In the midst of a serious binge, Mary felt completely helpless and unable to control herself.

There weren't any obvious physical signs that would alert someone to Mary's eating problems, but the vomiting had begun to wreak havoc with her body, especially her digestive system. She had suffered severe throat infections and frequent, intense stomach pains. Her dentist had noticed problems beginning to develop with her teeth and gums, undoubtedly a consequence of constant exposure to strong stomach acids.

Mary's eating problem started to develop when she was 15 years old. She had been seriously involved in gymnastics for several years, but eventually developed a knee condition that forced her to give up the sport. She gained a few pounds in the next month or two and decided to lose weight by dieting. Buoyed by unrealistic expectations about the immediate, positive benefits of a diet that she had seen advertised on television, Mary initially adhered rigidly to its recommended regimen. Six months later, after three of these fad diets had failed, she started throwing up as a way to control her intake of food.

Mary's problems persisted after she graduated from high school and began her college education. She felt guilty and ashamed about her eating problems. She was much too embarrassed to let anyone know what she was doing and would never eat more than a few mouthfuls of food in a public place, such as the dorm cafeteria. Her roommate, Julie, was from a small town on the other side of the state. They got along reasonably well, but Mary managed to conceal her bingeing and purging, thanks in large part to the fact that she was able to bring her own car to campus. The car allowed her to drive away from campus several times a week so that she could binge.

Mary's case illustrates many of the characteristic features of bulimia nervosa. As in Kevin's case, her behavior could be considered abnormal not only because it fits the criteria for one of the categories in *DSM-5* but also because she suffered from a dysfunction (in this case, of the mechanisms that regulate appetite) that was obviously harmful. The impact of the disorder was greatest in terms of her physical health: Eating disorders can be fatal if they are not properly treated because they affect so many vital organs of the body, including the heart and kidneys. Mary's social

How thin is too thin? Does this dancer suffer from an eating disorder? Some experts maintain that the differences between abnormal and normal behavior are essentially differences in degree, that is, quantitative differences.

functioning and her academic performance were not yet seriously impaired. There are many different ways in which to measure the harmful effects of abnormal behavior.

Mary's case also illustrates the subjective pain that is associated with many types of abnormal behavior. In contrast to Kevin, Mary was acutely aware of her disorder. She was frustrated and unhappy. In an attempt to relieve this emotional distress, she entered psychological treatment. Unfortunately, painful emotions associated with mental disorders can also interfere with, or delay, the decision to look for professional help. Guilt, shame, and embarrassment often accompany psychological problems and sometimes make it difficult to confide in another person, even though the average therapist has seen such problems many times over.

Frequency in and Impact on Community Populations

Many important decisions about mental disorders are based on data regarding the frequency with which these disorders occur. At least 3 percent of college women would meet diagnostic criteria for bulimia nervosa (see Chapter 10). These data are a source of considerable concern, especially among those who are responsible for health services on college campuses.

Epidemiology is the scientific study of the frequency and distribution of disorders within a population (Gordis, 2008). Epidemiologists are concerned with questions, such as whether the frequency of a disorder has increased or decreased during a particular period, whether it is more common in one geographic area than in another, and whether certain types of people—based on such factors as gender, race, and socioeconomic status—are at greater risk than other types for the development of the disorder. Health administrators often use such information to make decisions about the allocation of resources for professional training programs, treatment facilities, and research projects.

Two terms are particularly important in epidemiological research. **Incidence** refers to the number of new cases of a disorder that appear in a population during a specific period of time. **Prevalence** refers to the total number of active cases, both old and new, that are present in a population during a specific period of time (Susser et al., 2006). The *lifetime prevalence* of a disorder is the total proportion of people in a given population who have been affected by the disorder at some point during their lives. Some studies also report 12-month prevalence rates, indicating the proportion of the population that met criteria for the disorder during the year prior to the assessment. Lifetime prevalence rates are higher than 12-month prevalence rates because some people who had problems in the past and then recovered will be counted with regard to lifetime disorders but not be counted for the most recent year.

LIFETIME PREVALENCE AND GENDER DIFFERENCES How prevalent are the various forms of abnormal behavior? The best data regarding this question come from a large-scale study known as the *National Comorbidity Survey Replication* (NCS-R) conducted between 2001 and 2003 (Kessler et al., 2005; Kessler, Merikangas, & Wang, 2007). Members of this research team interviewed a nationally representative sample of approximately 9,000 people living in the continental United States. Questions were asked pertaining to several (but not all) forms of mental disorder. The NCS-R found that 46 percent of the people interviewed received at least one *lifetime* diagnosis, with first onset of symptoms usually occurring during childhood or adolescence. This proportion of the population is much higher than many people expect, and it underscores the point that we made at the beginning of this chapter: All of us can expect to encounter the challenges of a mental disorder—either for ourselves or for someone we love—at some point during our lives.

Figure 1.1 lists some results from this study using lifetime prevalence rates—the number of people who had experienced each disorder at some point during their lives. The most prevalent specific type of disorder was major depression (17 percent). Substance use disorders and various kinds of anxiety disorders were also relatively common. Substantially lower lifetime prevalence rates were found for schizophrenia and eating disorders (bulimia and anorexia), which affects approximately 1 percent of the population. These lifetime prevalence rates are consistent with data reported by earlier epidemiological studies of mental disorders.

Although many mental disorders are quite common, they are not always seriously debilitating, and some people who qualify for a diagnosis do not need immediate treatment. The NCS-R

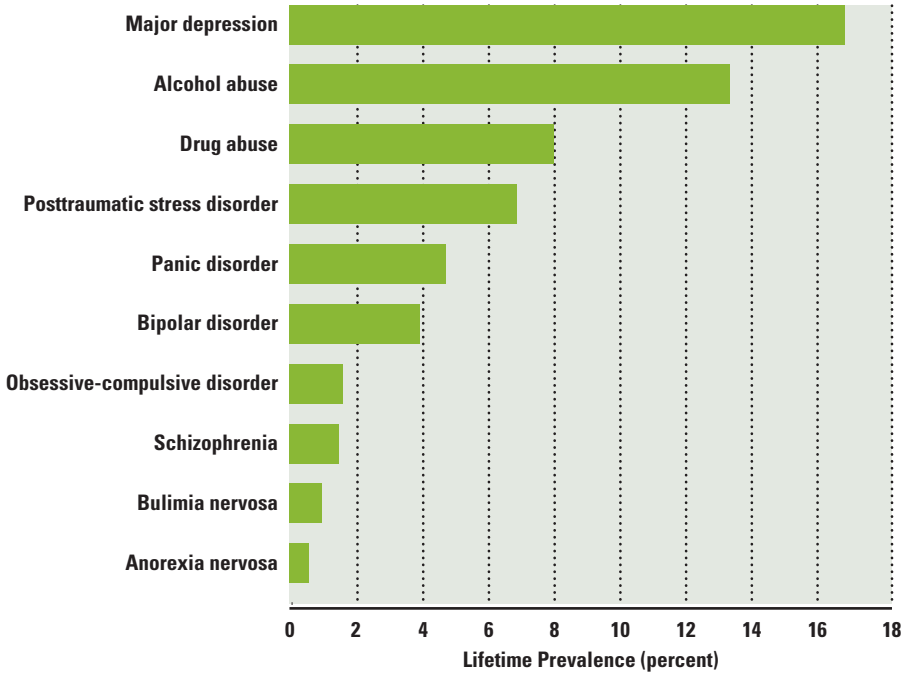


FIGURE 1.1

Frequency of Mental Disorders in the Community
Lifetime prevalence rates for various mental disorders (NCS-R data).
Courtesy of Thomas F. Oltmanns and Robert E. Emery.

investigators assigned each case a score with regard to severity, based on the severity of symptoms as well as the level of occupational and social impairment that the person experienced. Averaged across all of the disorders diagnosed in the past 12 months, 40 percent of cases were rated as "mild," 37 percent as "moderate," and only 22 percent as "severe." Mood disorders were the most likely to be rated as severe (45 percent) while anxiety disorders were less likely to be rated as severe (23 percent).

Epidemiological studies such as the NCS-R have consistently found gender differences for many types of mental disorder: Major depression, anxiety disorders, and eating disorders are more common among women; alcoholism and antisocial personality are more common among men. Some other conditions, such as bipolar disorder, appear with equal frequency in both women and men. Patterns of this sort raise interesting questions about possible causal mechanisms. What conditions would make women more vulnerable to one kind of disorder and men more vulnerable to another? There are many possibilities, including factors such as hormones, patterns of learning, and social pressures. We will discuss gender differences in more detail in subsequent chapters of this book.

Clinical psychologists perform many roles. Some provide direct clinical services. Many are involved in research, teaching, and various administrative activities.

COMORBIDITY AND DISEASE BURDEN Most severe disorders are concentrated in a relatively small segment of the population. Often these are people who simultaneously qualify for more than one diagnosis, such as major depression and alcoholism. The presence of more than one condition within the same period of time is known as **comorbidity** (or co-occurrence). Six percent of the people in the NCS-R sample had three or more 12-month disorders, and 50 percent of those cases were rated as being "severe." While mental disorders occur relatively frequently, the most serious problems are concentrated in a smaller group of people who have more than one disorder. These findings have shifted the emphasis of epidemiological studies from counting the absolute number of people who have any kind of mental disorder to measuring the functional impairment associated with these problems.

Mental disorders are highly prevalent, but how do we measure the extent of their impact on people's lives? And how does that impact compare to the effects of other diseases? These are important questions when policymakers must establish priorities for various types of training, research, and health services (Eaton et al., 2012).

Epidemiologists measure disease burden by combining two factors: mortality and disability. The common measure is based on time: lost years of healthy life, which might be caused by premature death (compared to the person's standard life expectancy) or living with a disability (weighted for severity). For purposes of comparison among different forms of disease and injury, the disability produced by major depression is considered to be equivalent to that associated with blindness or paraplegia. A psychotic disorder such as schizophrenia leads to disability that is comparable to that associated with quadriplegia.

The World Health Organization (WHO) sponsored an ambitious study called the Global Burden of Disease Study, which used these measures to evaluate and compare the impact of more than 100 forms of disease and injury throughout the world (Lopez et al., 2006). Although mental disorders are responsible for only 1 percent of all deaths, they produce 47 percent of all disability in economically developed countries, such as the United States, and 28 percent of all disability worldwide. The combined index (mortality plus disability) reveals that, as a combined category, mental disorders are the second leading source of disease burden in developed countries (see Figure 1.2). Investigators in the WHO study predict that, relative to other types of health problems, the burden of mental disorders will increase by the year 2020. These surprising results strongly indicate that mental disorders are one of the world's greatest health challenges.

Cross-Cultural Comparisons

As the evidence regarding the global burden of disease clearly documents, mental disorders affect people all over the world. That does not mean, however, that the symptoms of psychopathology and the expression of emotional distress take the same form in all cultures. Epidemiological studies comparing the frequency of

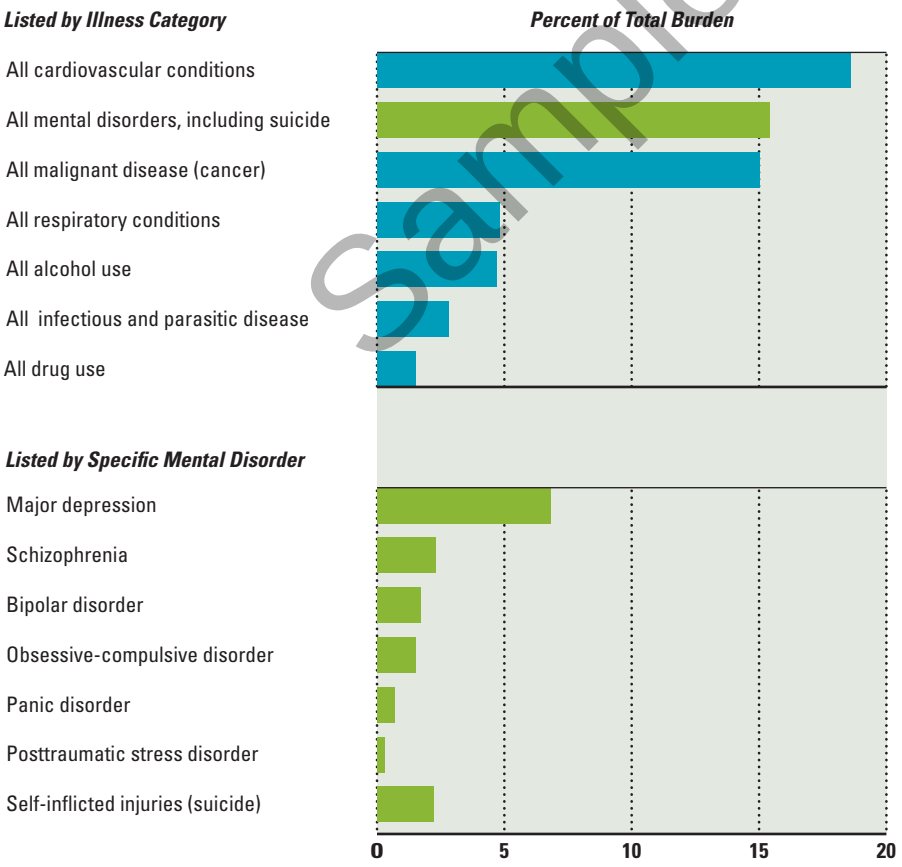


FIGURE 1.2

Comparison of the Impact of Mental Disorders and Other Medical Conditions on People's Lives Disease burden in economically developed countries measured in disability-adjusted life years (DALYs).

Source: Murray, CJLM, Lopez, AD, eds. 1996. The Burden of Global Disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Vol. 1. Cambridge, MA: Harvard University Press.

mental disorders in different cultures suggest that some disorders, such as schizophrenia, show important consistencies in cross-cultural comparisons. They are found in virtually every culture that social scientists have studied.

Other disorders, such as bulimia, are more specifically associated with cultural factors, as revealed by comparisons of prevalence in different parts of the world and changes in prevalence over generations. Almost 90 percent of bulimic patients are women. Within the United States, the incidence of bulimia is much higher among university women than among working women, and it is more common among younger women than among older women. The prevalence of bulimia is much higher in Western nations than in other parts of the world. Furthermore, the number of cases increased dramatically during the latter part of the twentieth century (Keel & Klump, 2003). These patterns suggest that holding particular sets of values related to eating and to women's appearance is an important ingredient in establishing risk for development of an eating disorder.

The strength and nature of the relationship between culture and psychopathology vary from one disorder to the next. Several general conclusions can be drawn from cross-cultural studies of psychopathology (Draguns & Tanaka-Matsumi, 2003), including the following points:

- All mental disorders are shaped, to some extent, by cultural factors.
- No mental disorders are entirely due to cultural or social factors.
- Psychotic disorders are less influenced by culture than are nonpsychotic disorders.
- The symptoms of certain disorders are more likely to vary across cultures than are the disorders themselves.

We will return to these points as we discuss specific disorders, such as depression, phobias, and alcoholism, throughout this book.

The Mental Health Professions

People receive treatment for psychological problems in many different settings and from various kinds of service providers. Specialized mental health professionals, such as psychiatrists, psychologists, and social workers, treat fewer than half (40 percent) of those people who seek help for mental disorders (Kessler & Stafford, 2008). Roughly one-third (34 percent) are treated by primary care physicians, who are most likely to prescribe some form of medication. The remaining 26 percent of mental health services are delivered by social agencies and self-help groups, such as Alcoholics Anonymous.

Many forms of specialized training prepare people to provide professional assistance to those who suffer from mental disorders. Table 1.2 presents estimated numbers of different types of mental health professionals currently practicing in the United States. The overall number of professionals who provide mental health services expanded dramatically during the past two decades, with most of this growth occurring among nonphysicians (Robiner, 2006). Most of these professions require extensive clinical experience in addition to formal academic instruction. In order to provide direct services to clients, psychiatrists, psychologists, social workers, counselors, nurses, and marriage and family therapists must be licensed in their own specialties by state boards of examiners.

TABLE 1.2
Estimated Number of Clinically Trained Professionals Providing Mental Health Services in the United States

Profession	Number
Psychiatrists	30,000
Clinical Psychologists	93,000
Mental Health and Substance Abuse Social Workers	115,000
MH Counselors and Marriage and Family Therapists	156,000
Psychiatric Nurses	18,000
Psychosocial Rehabilitation Providers	100,000

Sources: United States Department of Labor; Bureau of Labor Statistics.

Psychiatry is the branch of medicine that is concerned with the study and treatment of mental disorders. Psychiatrists complete the normal sequence of coursework and internship training in a medical school (usually four years) before going on to receive specialized residency training (another four years) that is focused on abnormal behavior. By virtue of their medical training, psychiatrists are licensed to practice medicine and therefore are able to prescribe medication. Most psychiatrists are also trained in the use of psychosocial intervention.

Clinical psychology is concerned with the application of psychological science to the assessment and treatment of mental disorders. A clinical psychologist typically completes five years of graduate study in a department of psychology, as well as a one-year internship, before receiving a doctoral degree. Clinical psychologists are trained in the use of psychological assessment procedures and in the use of psychotherapy. Within clinical psychology, there are two primary types of clinical training programs. One course of study, which leads to the Ph.D. (doctor of philosophy) degree, involves a traditional sequence of graduate training with major emphasis on research methods. The other approach, which culminates in a Psy.D. (doctor of psychology) degree, places greater emphasis on practical skills of assessment and treatment and does not require an independent research project for the dissertation. One can also obtain a Ph.D. degree in counseling psychology, a more applied field that focuses on training, assessment, and therapy.

Social work is a third profession that is concerned with helping people to achieve an effective level of psychosocial functioning. Most practicing social workers have a master's degree in social work. In contrast to psychology and psychiatry, social work is based

less on a body of scientific knowledge than on a commitment to action. Social work is practiced in a wide range of settings, from courts and prisons to schools and hospitals, as well as other social service agencies. The emphasis tends to be on social and cultural factors, such as the effects of poverty on the availability of educational and health services, rather than on individual differences in personality or psychopathology. Psychiatric social workers receive specialized training in the treatment of mental health problems.

Like social workers, professional counselors work in many different settings, ranging from schools and government agencies to mental health centers and private practice. Most are trained at the master's degree level, and the emphasis of their activity is also on providing direct service. Marriage and family therapy (MFT) is a multidisciplinary field in which professionals are trained to provide psychotherapy. Most MFTs are trained at the master's level, and many hold a degree in social work, counseling, or psychology as well. Although the theoretical orientation is focused on couples and family issues, approximately half of the people treated by MFTs are seen in individual psychotherapy. Psychiatric nursing is a rapidly growing field. Training for this profession typically involves a bachelor's degree in nursing plus graduate level training (at least a master's degree) in the treatment of mental health problems.

Another approach to mental health services that is expanding rapidly in size and influence is psychosocial rehabilitation (PSR). Professionals in this area work in crisis, residential, and case management programs for people with severe forms of disorder, such as schizophrenia. PSR workers teach people practical, day-to-day skills that are necessary for living in the community, thereby reducing the need for long-term hospitalization and minimizing the level of disability experienced by their clients. Graduate training is not required for most PSR positions; three out of four people providing PSR services have either a high school education or a bachelor's degree.

It is difficult to say with certainty what the mental health professions will be like in the future. Boundaries between professions change as a function of progress in the development of therapeutic procedures, economic pressures, legislative action, and courtroom decisions. This has been particularly true in the field of mental health, where enormous changes have taken place over the past few decades. Reform is currently being driven by the pervasive influence of managed care, which refers to the way that services are financed. For example, health insurance companies typically place restrictions on the types of services that will be reimbursed, as well as the specific professionals who can provide them. Managed care places a high priority on cost containment and the evaluation of treatment effectiveness. Legislative issues that determine the scope of clinical practice are also very important. Many psychologists are pursuing the right to prescribe medication (Fox et al., 2009). Decisions regarding this issue will also have a dramatic impact on the boundaries that separate the mental health professions. Ongoing conflicts over the increasing price of health care, priorities for treatment, and access to services suggest that debates over the rights and privileges of patients and their therapists will intensify in coming years.

One thing is certain about the future of the mental health professions: There will always be a demand for people who are trained to help those suffering from abnormal behavior. Many people experience mental disorders. Unfortunately, most of those who are in need of professional treatment do not get it (Kessler et al., 2005; Ormel et al., 2008). Several explanations have been proposed. Some people who qualify for a diagnosis may not be so impaired as to seek treatment; others, as we shall see, may not recognize their disorder. In some cases, treatment may not be available, the person may not have the time or resources to obtain treatment, or the person may have tried treatments in the past that failed (see Getting Help at the end of this chapter.)

Psychopathology in Historical Context

Throughout history, many other societies have held very different views of the problems that we consider to be mental disorders. Before leaving this introductory chapter, we must begin to place contemporary approaches to psychopathology in historical perspective.

The search for explanations of the causes of abnormal behavior dates to ancient times, as do conflicting opinions about the etiology of emotional disorders. References to abnormal behavior have been found in ancient accounts from Chinese, Hebrew, and Egyptian societies. Many of these records explain abnormal behavior as resulting from the disfavor of the gods or the mischief of demons. In fact, abnormal behavior continues to be attributed to demons in some preliterate societies today.

The Greek Tradition in Medicine

More earthly and less supernatural accounts of the etiology of psychopathology can be traced to the Greek physician Hippocrates (460–377 B.C.E.), who ridiculed demonological accounts of illness and insanity. Instead, Hippocrates hypothesized that abnormal behavior, like other forms of disease, had natural causes. Health depended on maintaining a natural balance within the body, specifically a balance of four body fluids (which were also known as the four humors): blood, phlegm, black bile, and yellow bile. Hippocrates argued that various types of disorders, including psychopathology, resulted from either an excess or a deficiency of one of these four fluids. The specifics of Hippocrates' theories obviously have little value today, but his systematic attempt to uncover natural, biological explanations for all types of illness represented an enormously important departure from previous ways of thinking.

The Hippocratic perspective dominated medical thought in Western countries until the middle of the nineteenth century (Golub, 1994). People trained in the Hippocratic tradition viewed "disease" as a unitary concept. In other words, physicians (and others who were given responsibility for healing people who were disturbed or suffering) did not distinguish between mental disorders and other types of illness. All problems were considered to be the result of an imbalance of body fluids, and treatment

procedures were designed in an attempt to restore the ideal balance. These were often called "heroic" treatments because they were drastic (and frequently painful) attempts to quickly reverse the course of an illness. They involved bloodletting (intentionally cutting the person to reduce the amount of blood in the body) and purging (the induction of vomiting), as well as the use of heat and cold. These practices need to be part of standard medical treatments well into the nineteenth century (Starr, 1982).

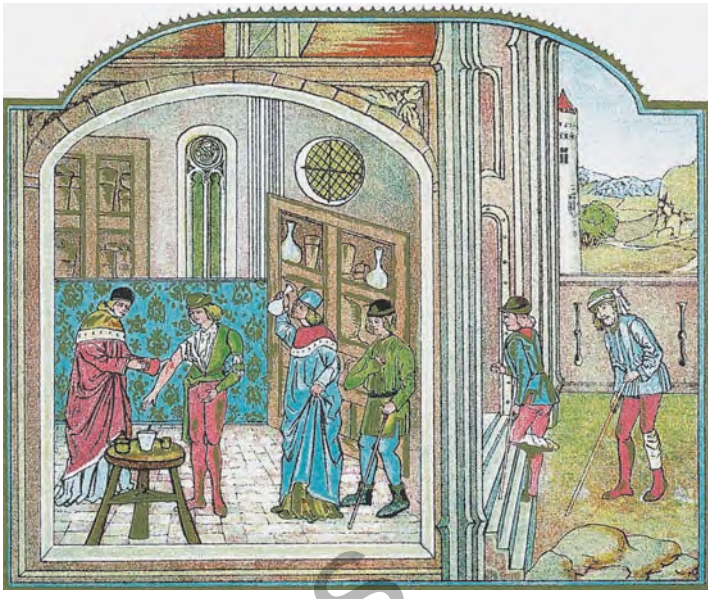
The Creation of the Asylum

In Europe during the Middle Ages, "lunatics" and "idiots," as the mentally ill and intellectually disabled were commonly called, aroused little interest and were given marginal care. Most people lived in rural settings and made their living through agricultural activities. Disturbed behavior was considered to be the responsibility of the family rather than the community or the state. Many people were kept at home by their families, and others roamed freely as beggars. Mentally disturbed people who were violent or appeared dangerous were often imprisoned with criminals. Those who could not subsist on their own were placed in almshouses for the poor.

In the 1600s and 1700s, "insane asylums" were established to house the mentally disturbed. Several factors changed the way that society viewed people with mental disorders and reinforced the relatively new belief that the community as a whole should be responsible for their care (Grob, 2011). Perhaps most important was a change in economic, demographic, and social conditions. Consider, for example, the situation in the United States at the beginning of the nineteenth century. The period between 1790 and 1850 saw rapid population growth and the rise of large cities. The increased urbanization of the American population was accompanied by a shift from an agricultural to an industrial economy. Lunatic asylums—the original mental hospitals—were created to serve heavily populated cities and to assume responsibilities that had previously been performed by individual families.

Early asylums were little more than human warehouses, but as the nineteenth century began, the moral treatment movement led to improved conditions in at least some mental hospitals. Founded on a basic respect for human dignity and the belief that humanistic care would help to relieve mental illness, moral treatment reform efforts were instituted by leading mental health professionals of the day, such as Benjamin Rush in the United States, Philippe Pinel in France, and William Tuke in England. Rather than simply confining mental patients, moral treatment offered support, care, and a degree of freedom. Belief in the importance of reason and the potential benefits of science played an important role in the moral treatment movement. In contrast to the fatalistic, supernatural explanations that had prevailed during the Middle Ages, these reformers touted an optimistic view, arguing that mental disorders could be treated successfully.

Many of the large mental institutions in the United States were built in the nineteenth century as a result of the philosophy of moral treatment. In the middle of the 1800s, the mental health



This 16th century illustration shows sick people going to the doctor who attempts to cure their problems by extracting blood from them using a leech. The rationale for such treatment procedures was to restore the proper balance of bodily fluids.

advocate Dorothea Dix was a leader in this movement. Dix argued that treating the mentally ill in hospitals was both more humane and more economical than caring for them haphazardly in their communities, and she urged that special facilities be built to house mental patients. Dix and like-minded reformers were successful in their efforts. In 1830, there were only four public mental hospitals in the United States that housed a combined total of fewer than 200 patients. By 1880, there were 75 public mental hospitals, with a total population of more than 35,000 residents (Torrey, 1988).

The creation of large institutions for the treatment of mental patients led to the development of a new profession—psychiatry. By the middle of the 1800s, superintendents of asylums for the insane were almost always physicians who had experience in the care of people with severe mental disorders. The Association of Medical Superintendents of American Institutions for the Insane (AMSAII), which later became the American Psychiatric Association (APA), was founded in 1844. The large patient populations within these institutions provided an opportunity for these men to observe various types of psychopathology over an extended period of time. They soon began to publish their ideas regarding the causes of these conditions, and they also experimented with new treatment methods (Grob, 2011).

Worcester Lunatic Hospital: A Model Institution

In 1833, the state of Massachusetts opened a publicly supported asylum for lunatics, a term used at the time to describe people with mental disorders, in Worcester. Samuel Woodward, the asylum's first superintendent, also became the first president of the AMSAII. Woodward became very well known throughout the United States and Europe because of his claims that mental disorders could be cured just like other types of diseases. We will