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JONATHAN D. RASKIN

PSYCHOPATHOLOGY AND MENTAL DISTRESS

CONTRASTING PERSPECTIVES

B L O O M S B U R Y

“Jonathan Raskin’s *Psychopathology and Mental Distress* is a one-of-a-kind textbook that fills a major gap in the literature on mental disorders. First, it is the only textbook on the market that successfully covers a wide range of approaches, including biological, psychological, and sociological perspectives, in a fair-minded way which carefully examines the strengths and weakness of each approach. The sections on the psychological approaches also provide a rare survey of a broad range of theories of psychopathology, including psychodynamic, cognitive, behavioral, and humanistic approaches. In addition, Raskin brings an unparalleled expertise in various nosologies of psychopathology, and he expands the reader’s appreciation of a wide range of diagnostic practices that go beyond the usual focus on the DSM-5. The textbook is written in a lucid style that lends itself to use in undergraduate classes as well as more advanced graduate courses in psychopathology. Raskin’s text is one that I will be using in my doctoral-level course in psychopathology, because it provides the broadest possible scope to the study of mental distress and offers essential conceptual tools to help students think critically about conventional approaches to diagnosis.”

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Distinguished McKnight University Professor, University of Minnesota, USA

“Raskin’s writing style is both enjoyable to read and accessible to students, without sacrificing a comprehensive presentation of the current data on psychopathology. His strong appreciation of the socio-historical context, infused throughout the text, is incredibly important for students in the field.”

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“This up-to-date and comprehensive textbook offers multiple perspectives on psychopathology and mental distress, including those of people with lived experience. This textbook does not shy away from some of the trickier contemporary debates and questions about mental distress. A valuable resource for psychology students – or anyone interested in mental health!”

– **Dr. Alyson Dodd**, Northumbria University, UK

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Second edition

JONATHAN D. RASKIN

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TOUR OF THE BOOK

Accomplishing the goals outlined above is a difficult task! So, how does this book do so? Key features are outlined below. Each one helps students master the material while offering instructors ways to assist them in the learning process.

- **A Perspectives Approach:** Chapters are organized by perspectives, allowing students to “try on” each way of looking at problems in the field. The perspectives typically covered in comparable textbooks (e.g., neurochemical, genetic, cognitive-behavioral, and classic psychoanalytic) are given extensive attention, but so are perspectives that often receive less consideration (e.g., immunological, evolutionary, modern psychodynamic, humanistic, social justice, cross-cultural, and systems). Further, rather than presenting traditional mental disorder categories as givens that other perspectives unquestioningly treat, they too are framed as perspectival products—hence the grouping of DSM and ICD as diagnostic perspectives. This subtle shift allows mental disorder categories to be explored more fully and fairly without enshrining them as universally accepted (after all, the other perspectives covered have widely divergent opinions about them). The idea is to place all perspectives side by side, presenting them (as well as critiques lodged against them) in a dispassionate and even-handed manner. In so doing, students should come to understand each perspective’s strengths and weaknesses while also developing their own educated points of view.
- **Numbered Sections:** Chapters are divided into numbered sections. Instructors can assign these sections in the order provided or in whatever order they deem best. Specific numbered sections can easily be assigned for different class dates (e.g., “Read Chapter 1, Sections 1.1–1.3”). This gives instructors latitude to spend more than one class on a chapter, mix and match material across chapters, or omit material from chapters they don’t have the time or inclination to cover.

LEARNING OBJECTIVES

After reading this chapter, you should be able to:

1. Explain why contradictory perspectives are common when studying mental distress.
2. Define psychopathology, mental illness, harmful internal dysfunction, deviance, and social oppression.
3. Summarize common criteria for making judgments about what is “abnormal.”
4. Describe historical perspectives on mental distress from the Stone Age to the present day.
5. Distinguish and explain the many types of quantitative and qualitative research perspectives.

Learning Objectives

Each chapter begins with clearly defined learning objectives. By the time they finish studying each chapter, students should be able to fulfill these objectives.

Case Examples

Each chapter presents one or more case examples. Typically introduced at the beginning of the chapter, these cases are regularly revisited to provide concrete instances of the theories and interventions discussed.

Sara and Brian

In the marriage counseling of Sara and Brian, Sara insists that her mother-in-law is “out to get her” by putting her down and manipulating Brian to spend more time with her than Sara. Brian sees no evidence of this, arguing that his mother only wants what is best for him and Sara. Whose perceptions of reality are correct? If we could determine this, would it matter? Is the person whose perceptions are less correct more psychologically disturbed? Finally, who is the ultimate authority on reality? Is it Sara, Brian, Brian’s mother, their therapist, or someone else altogether?

In Depth

This feature zeros in on interesting topics to provide detailed explorations of areas currently garnering attention. Going in depth on select topics affords students the chance to gain a richer appreciation for the kinds of clinical and research explorations occurring in the field.

In Depth: Ignorance and Psychology

A 2015 *New York Times* opinion piece by Jamie Holmes advocates acknowledging that we often know less than we claim. In other words, ignorance is a lot more rampant than most of us wish to admit—even in academic subjects where we usually are told otherwise. Holmes describes how, in the 1980s, University of Arizona surgery professor Professor Marlys H. Witte created controversy when she began teaching a class called “Introduction to Medical and Other Ignorance.” She wanted to include ignorance in her class because she believed we often ignore or minimize how little we know about many topics (J. Holmes, 2015b). In Witte’s view, textbooks often contribute to the problem. For example, she pointed out that surgery textbooks usually discuss pancreatic cancer without ever mentioning that our present understanding of it is extremely limited. Her goal? Helping students appreciate that questions are as important as answers (J. Holmes, 2015b).

Some might deem it foolish of me to share Holmes’ opinion piece at the very start of a textbook on psychopathology and mental distress. Yet my experience teaching this course over the years fits nicely with Holmes’ thesis. I once had a student who, several weeks into the class, said she was going back to being a math major. “At least in math, there are clear right answers,” she exclaimed. “In studying psychology, there are so many conflicting viewpoints that it’s hard to know what the right answer is.” Admittedly, despite all the attempts to combine rigorous research into an integrative perspective, all too often most psychology textbooks overstate how much we know. But acknowledging our ignorance up front potentially opens, rather than closes, possibilities. Holmes notes that we often think of ignorance as something to be eliminated, viewing it as simply lack of knowledge. Yet answers don’t put an end to questions. They simply give rise to new questions (J. Holmes, 2015b)! As you read this text, here’s to the many questions you will hopefully begin to ask.

Critical Thinking Questions

1. Do you think Witte’s contention that ignorance is more rampant than we usually admit applies to the field of psychology?
2. Does recognizing the limits of our knowledge about psychopathology and mental distress help us? If so, how?

Controversial Question

Posing controversial questions invites students to grapple with issues that have often bedeviled researchers and clinicians. The goal is to expose students to prominent and ongoing debates about pathology and distress.

Controversial Question: Should There Be Warning Labels on Unrealistic Images in Fashion Magazines and on Social Media?

Fashion magazines and social media are filled with unrealistic photos. These snapshots are digitally altered, airbrushed, and tweaked to present an idealized (and often unattainable) image of the perfect body. Because exposure to images that celebrate unrealistically thin bodies is positively correlated with body dissatisfaction and eating disorders, it has been suggested that warning labels be added to them to educate people about their damaging impact. Unfortunately, there is little evidence this works. Research consistently finds that warning labels or disclaimers on unrealistic fashion magazine images are ineffective in reducing body dissatisfaction—and sometimes might even make things worse (Bury et al., 2017; Di Gesto et al., 2022; Fardouly & Holland, 2018; Kwan et al., 2018; Naderer et al., 2022; Tiggemann & Brown, 2018; S. Weber et al., 2022). Studies on warning labels exemplify how research can test whether commonsense ideas hold up to scrutiny. Disclaimers on altered media sound like they should work, but they don’t. For better or worse, most researchers have reluctantly concluded that warning labels are ineffective at countering the negative impact of unrealistic images in magazines and on social media—and that it is time to explore and assess other solutions.

Critical Thinking Questions

1. Are you surprised by the results of research on warning labels? Why or why not?
2. Irrespective of the effectiveness of warning labels, is it ethical for advertisers to digitally alter ads? Should they be prevented from doing so?
3. What other interventions might we develop to reduce the negative impact of unrealistic magazine and social media images? How might you go about testing their effectiveness?

The Lived Experience: Grief Ten Years Later



This September, it will be ten years since my mother died of cancer. It seems as if it were a lifetime ago and it seems as if it were yesterday. That is the nature of grief; it has its own rhythm. It is both present and in the past and it appears that it continues to stay that way no matter how much time has gone by.

A few years ago when my friend Meghan O'Rourke and I published a series of articles on grief and loss in *Slate* magazine, some criticized the findings because some of the respondents had experienced a loss many years before taking the survey. In psychology we call this phenomenon "recall bias," where people filling out surveys wrongly or incompletely remember experiences from the past.

Memory is certainly pliable, and it is possible that people made errors in recalling what their grief was really like for them. Methodologically and intuitively that makes sense, but as a griever, I am not so sure.

The idea that the more years have passed since a loss, the less likely someone is to recall their grief rests on the assumption that grief is a static event in time that will eventually fade. This view is aligned with what many researchers in the field of psychology and psychiatry believe: that grief has a starting point, a middle point, and an end point. The heated debates in the media and in the field about when grief becomes pathological rest on the assumption that at some point, grief becomes "too much" and needs to be treated with medication or a mental health professional. If grief is a static event in time, then it certainly makes sense that it would be hard for people to remember what their experience was like five or ten years after a loss.

Having spent years studying grief, and being a griever myself now entering her tenth year of loss, I know that grief does not work this way. It is not an event in time. It is not even just an emotional response to a loss. It is a process that changes us permanently but also constantly as we ourselves change and grow. In this sense, grief is just like love. It is not something that happens once and goes away—it is something that evolves, expands and contracts, and changes in shape, depth, and intensity as time goes on.

Grief is a lifelong, ever-changing companion. It is both in the present and in the past. Moments of intense yearning and pain for the deceased can come and go even ten or twenty or thirty years after a person we love has died. It is cliché to say it, but it is also true: Grief is the price we pay for love. Grief is still with me because my mother is still with me. To deny one is inevitably to deny the other.

Interestingly, between mothers and children, there is a biological correlate to "the being with and in each other" called fetal microchimerism. It is an amazing phenomenon where fetal cells from the baby make their way into their mother's bodies and vice versa, mother's cells become intertwined into the baby's body. In other words, my mother is literally part of me biologically and emotionally and my cells were with, and in her when she died.

To be sure, microchimerism is just a metaphor—this being with and part of each other is not just for biological mothers and children. It is for everyone who has loved and lost. When I present my professional work, I often say I am a grief researcher, but actually, grief is just a stand in for what I am really studying—love and attachment. One cannot come without the other. Just like love, grief is an experience that evolves and changes with time; but one thing is for sure, it is not forgettable, because it never goes away.

By Leeat Granek, Ph.D. Reprinted with permission.

The Lived Experience

This feature brings topics to life by providing first-hand (and often deeply personal) accounts from clients and clinicians alike of their lived experiences dealing with the presenting problems the book explores.

Diagnostic Box 6.2 Social Anxiety Disorder



DSM-5-TR and ICD-11

- Disproportionate fear and avoidance of social situation(s) where the person might be scrutinized.
- Overly concerned about behaving anxiously and being evaluated negatively for it.
- Symptom duration:
 - **DSM-5-TR:** At least six months.
 - **ICD-11:** At least several months.

Information from American Psychiatric Association (2022, pp. 229–230) and World Health Organization (2022a).

Diagnostic Boxes

Appearing in most chapters, these succinctly present DSM and ICD definitions of disorders, helping students grasp their similarities and differences.

CHAPTER SUMMARY

Chapter Summaries

Brief summaries are provided at the conclusion of each chapter that highlight the main themes covered. These summaries review what students have read and guide them as they begin to study.

Overview

- *Feeding problems* involve concern over food preferences.
- *Eating problems* are characterized by disturbed body image.

Diagnostic Perspectives

- DSM-5-TR and ICD-11 identify three eating disorders (anorexia nervosa, bulimia nervosa, and binge-eating disorder) and three feeding disorders (avoidant/restrictive food intake disorder, pica, and rumination disorder).
- PDM-2 links eating disorders to the psychological need for care and affection, HiTOP locates them on its “Somatoform” spectrum, and PTMF reframes them as responses to mistreatment and trauma.

Historical Perspectives

- The term “anorexia” has Greek origins and means “without appetite” and was first used to describe patients in 1873.
- Bulimia was first described in the 1950s but did not gain attention until the 1970s.

NEW VOCABULARY

New Vocabulary and Glossary

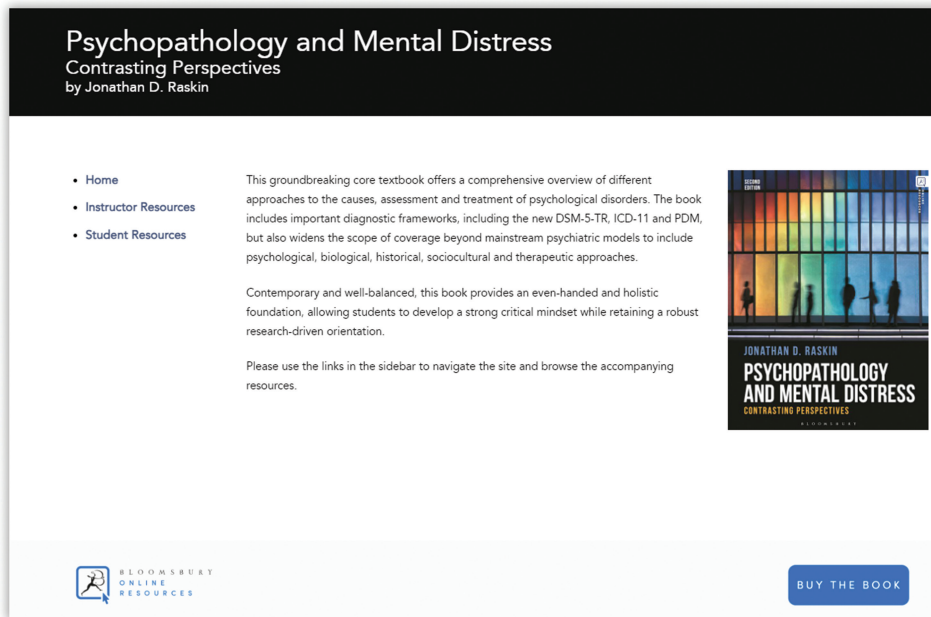
New vocabulary terms are bolded in each chapter and defined in the margins. A comprehensive glossary containing all new vocabulary items is also provided at the end of the book. Lists of these terms are available online too.

- | | | |
|---|-----------------------------------|--|
| 1. Abnormal psychology | 22. Harmful internal dysfunction | 42. Presenting problems |
| 2. Analogue experiment | 23. Harmfulness to self or others | 43. Prevalence |
| 3. Antipsychiatry | 24. Hypothesis | 44. Psychological perspectives |
| 4. Biological perspectives | 25. Hysteria | 45. Psychopathology |
| 5. Bodily humors | 26. Incidence | 46. Purposive sampling |
| 6. Case study | 27. Independent variable | 47. Qualitative methods |
| 7. Common criteria of “abnormality” | 28. Internal validity | 48. Quantitative methods |
| 8. Confounding variable | 29. Lobotomy | 49. Quasi-experiment |
| 9. Control group | 30. <i>Malleus Maleficarum</i> | 50. Random assignment |
| 10. Correlation | 31. Medicalization | 51. Random sample |
| 11. Correlational research | 32. Mental disorder | 52. Randomized controlled trial (RCT) |
| 12. Deinstitutionalization | 33. Mental distress | 53. Sample |
| 13. Demonological perspective | 34. Medical model | 54. Single-subject experiments |
| 14. Dependent variable | 35. Mental illness | 55. Snowball sampling |
| 15. Deviance | 36. Mixed methods | 56. Social oppression |
| 16. Double-blind studies | 37. Moral therapy | 57. Sociocultural perspectives |
| 17. Empirically supported treatments (ESTs) | 38. Phenomenological methods | 58. Trepanation |
| 18. Epidemiological research | 39. Placebo control group | 59. Trustworthiness |
| 19. Experiments | 40. Placebo effect | 60. Variables |
| 20. External validity | 41. Population | 61. Violation of social norms and values |
| 21. Grounded theory methods | | 62. Wandering womb theory |

ONLINE LEARNING AND TEACHING RESOURCES

Accompanying this book is a full suite of supportive resources to help both students and lecturers get the most out of their learning and teaching.

Access the digital resources here: bloomsbury.pub/psychopathology-and-mental-distress-2e



Resources for lecturers include:

- **Test Bank:** Includes multiple-choice, matching, and essay questions. In devising the test bank, the goal was to create materials that target key ideas in the book. As a long-time instructor aware of how often test banks disappoint, much effort was put into providing test items that effectively discriminate student understanding of key concepts.
- **Instructor's Manual:** For each chapter, detailed lecture notes are provided, along with PowerPoint slides to accompany them.
- **Lecture Slides:** MS PowerPoint slides for instructors to use during class lectures.

Resources for students include:

- **Knowledge Checks:** Each chapter has an accompanying online “knowledge-check” quiz that students can complete to quickly assess their understanding. Results can easily be sent to instructors.
- **Videos:** Relevant YouTube videos and video lectures by the author are available on the online companion website.
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- **Online Study Guide (for students):** The online companion site includes a study guide, consisting of questions to help students develop study materials. By sketching answers to study guide questions, students will be able to concisely summarize content from the chapters as they prepare for exams.

PREFACE

THE CHALLENGE OF CONTRASTING PERSPECTIVES

When it comes to psychopathology and mental distress, we can probably agree that there isn't much agreement. On the contrary, there are many contrasting perspectives—different lenses that, when looked through, inevitably shape our definitions of psychopathology and mental distress, the research questions asked about them, and the clinical interventions undertaken to alleviate them. Are pathology and distress mainly attributable to neurochemical imbalances or other brain disorders, genetic inheritance, immune system reactions to stress, evolutionary mismatches between our ancestral environments and modern society, unconscious conflicts, faulty attachment relationships, irrational thinking, conditioned learning, a failure to self-actualize, cultural differences, economic adversity, social oppression, or some combination thereof? To students' dismay, the number of explanations can be dizzying!

As we shall see, those advancing these contrasting perspectives on psychopathology and mental distress are passionate about their divergent outlooks. This book tries to capture that passion by examining how advocates of contrasting perspectives often strongly and loudly disagree. The idea is to present these disagreements fully and thoroughly—but without being disagreeable! To accomplish this, the book adopts a *credulous approach* (Kelly, 1955/1991a), in which—rather than immediately judging the contrasting perspectives presented—students are encouraged to understand and appreciate every perspective on its own. To that end, it sympathetically discusses each perspective's theoretical rationale for viewing various problems in certain ways, and how this gives rise to specific intervention strategies. It also examines research on each perspective to help students make comparisons. However, rather than me—as your humble guide in this endeavor—declaring some perspectives as winners and others as losers, my goal is more modest: to provide the necessary information, pose challenging questions, and encourage you to draw your own conclusions.

Some might question this approach. “Aren't you the expert? Shouldn't you be informing students about which perspectives are most correct?” The trouble with offering definitive answers is that, in my experience, different students inevitably draw different conclusions about the material, no matter how hard (or not) I advocate for some perspectives over others. This is so even when exposed to the same theories, research, and practice aspects of these perspectives. In many respects, this isn't surprising. Deciding what is pathological and determining what to do about it are not simply dry academic endeavors. They touch on people's core beliefs about what it means to be a person and to live a healthy and productive life. They also tap into students' ideas about themselves and their own personal problems. In this regard, student disagreements about what counts as mental distress, what should be done about it, and what the research recommends mirror fundamental disagreements in the field. This book proposes a modest and exciting (but challenging) goal: After digesting the relevant information and trying to understand each perspective fairly and openly, students are encouraged to decide which perspectives on psychopathology and mental distress they most agree with and why.

PEDAGOGICAL FEATURES OF THE BOOK

Accomplishing the goals outlined above is a difficult task! So, how does this book do so? Key features are outlined below. Each one helps students master the material while offering instructors ways to assist them in the learning process.

- **A Perspectives Approach:** Chapters are organized by perspectives, allowing students to “try on” each way of looking at problems in the field. The perspectives typically covered in comparable textbooks (e.g., neurochemical, genetic, cognitive-behavioral, and classic psychoanalytic) are given extensive attention, but so are perspectives that often receive less consideration (e.g., immunological, evolutionary, modern psychodynamic, humanistic, social justice, cross-cultural, and systems). Further, rather than presenting traditional mental disorder categories as givens that other perspectives unquestioningly treat, they too are framed as perspectival products—hence the grouping of DSM and ICD as diagnostic perspectives. This subtle shift allows mental disorder categories to be explored more fully and fairly without enshrining them as universally accepted (after all, the other perspectives covered have widely divergent opinions about them). The idea is to place all perspectives side by side, presenting them (as well as critiques lodged against them) in a dispassionate and even-handed manner. In so doing, students should come to understand each perspective’s strengths and weaknesses while also developing their own educated points of view.
- **Numbered Sections:** Chapters are divided into numbered sections. Instructors can assign these sections in the order provided or in whatever order they deem best. Specific numbered sections can easily be assigned for different class dates (e.g., “Read Chapter 1, Sections 1.1–1.3”). This gives instructors latitude to spend more than one class on a chapter, mix and match material across chapters, or omit material from chapters they don’t have the time or inclination to cover.
- **Learning Objectives:** Each chapter begins with clearly defined learning objectives. By the time they finish studying each chapter, students should be able to fulfill these objectives.
- **Case Examples:** Each chapter presents one or more case examples. Typically introduced at the beginning of the chapter, these cases are regularly revisited to provide concrete instances of the theories and interventions discussed.
- **In Depth:** This feature zeros in on interesting topics to provide detailed explorations of areas currently garnering attention. Going in depth on select topics affords students the chance to gain a richer appreciation for the kinds of clinical and research explorations occurring in the field.
- **Controversial Questions:** Posing controversial questions invites students to grapple with issues that have often bedeviled researchers and clinicians. The goal is to expose students to prominent and ongoing debates about pathology and distress.
- **The Lived Experience:** This feature brings topics to life by providing first-hand (and often deeply personal) accounts from clients and clinicians alike of their lived experiences dealing with the presenting problems the book explores.
- **Diagnostic Boxes:** Appearing in most chapters, these succinctly present DSM and ICD definitions of disorders, helping students grasp their similarities and differences.
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- **Online Instructor’s Manual** (for instructors): For each chapter, detailed lecture notes are provided, along with PowerPoint slides to accompany them.

ABOUT THE AUTHOR



Jonathan D. Raskin earned his undergraduate degree in psychology from Vassar College and his Ph.D. in counseling psychology at the University of Florida. He completed his doctoral internship at Emory University's Counseling Center. Dr. Raskin is a professor at the State University of New York at New Paltz, where he is chair of the Department of Psychology and teaches psychology and counselor education courses. In addition to his academic work, Dr. Raskin maintains an active private practice as a psychologist.

Dr. Raskin's scholarship addresses constructions of mental distress, attitudes toward and alternatives to psychiatric diagnosis, and meaning-oriented approaches to psychotherapy. He has also co-edited six books: *Constructions of Disorder: Meaning-Making Frameworks for Psychotherapy* (published by the American Psychological Association) and all five volumes of the *Studies in Meaning* series (published by Pace University Press). He is currently working on a book and video on constructive psychotherapies for the American Psychological Association Press. A past president of the Society for Humanistic Psychology (Division 32 of the American Psychological Association), Dr. Raskin is coeditor of the *Journal of Constructivist Psychology* and serves on several journal editorial boards. He is a fellow of the American

Psychological Association, as well as a recipient of the SUNY Chancellor's Award for Excellence in Scholarship and the SUNY Research Foundation Research and Scholarship Award.

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Professionally, there are too many colleagues to thank, so I'll just name a few. First and foremost, I would like to dedicate this edition of the book to my doctoral advisor, Franz Epting, who passed away in June 2023. Franz was a great advisor, mentor, and friend. He taught me a lot, and I will miss him. In many respects, this book is a culmination of his many years of mentorship.

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Okay, now go read the book.

CONCEPTUAL, HISTORICAL, AND RESEARCH PERSPECTIVES



Photo 1.1
We Are/Getty Images.

LEARNING OBJECTIVES

After reading this chapter, you should be able to:

1. Explain why contradictory perspectives are common when studying mental distress.
2. Define psychopathology, mental illness, harmful internal dysfunction, deviance, and social oppression.
3. Summarize common criteria for making judgments about what is “abnormal.”
4. Describe historical perspectives on mental distress from the Stone Age to the present day.
5. Distinguish and explain the many types of quantitative and qualitative research perspectives.

OVERVIEW

1.1 Getting Started: Psychopathology and Mental Distress

Basic Definitions

This book examines the field of **psychopathology**, which studies dysfunctions or disorders that lead to cognitive and emotional upset—that is, **mental distress**. Sad, anxious, or angry thoughts and feelings, sometimes accompanied by physical symptoms, are examples of mental distress. Mental distress can be caused by psychopathology, but it doesn’t have to be. For instance, mental distress over missing a train is expected—there is nothing “wrong” with experiencing it, and we don’t see those who do as suffering from a disorder. On the other hand, distress over believing the government is monitoring us via radio transponders in our breakfast cereal does seem pathological to most people. Nonetheless, in most cases distinguishing psychopathology from normal and expected mental distress is no easy task. To illustrate this, consider the case examples below. Which ones do you believe are good examples of psychopathology? Of mental distress? Of neither?

Psychopathology:

Attributes mental distress to internal dysfunction or sickness inside the individual.

Mental distress:

Cognitive and/or emotional upset; considered expected/normal in some cases and a sign of psychopathology in others.

Case Examples

Jim

Jim is a 20-year-old university student studying psychology. Though he is a good student with excellent grades, Jim begins to behave erratically a few months before graduation. He claims to hear voices, which tell him that his professors are spying on him. He insists that the university police have planted listening devices in his bedroom to monitor his activities. He stops bathing and combing his hair. His friends start to worry about him and so does one of his instructors, who alerts the campus health center. Jim is diagnosed with schizophrenia, sent home to his parents, and placed on antipsychotic drugs. After six months on the drugs, Jim gets a part-time job while living at home with his parents but does not feel ready to return to his university.

Michelle

Michelle, a 14-year-old girl, has always been outspoken, but recently she has become downright rebellious. She initiates arguments with her parents and refuses to obey their eleven o'clock curfew. In fact, Michelle stays out all night and when she comes home she ignores her parents entirely or yells at them about how unfair they are to her. Exasperated, her parents take Michelle to a local psychiatrist, who diagnoses her with oppositional defiant disorder. Michelle is briefly hospitalized, and her behavior temporarily takes a turn for the better after she is released. However, within a month she returns to her rebellious ways, much to the chagrin of her overwhelmed parents.

Sam

Sam, who is 13 years old and was born biologically female, has recently come out as transgender. Sam has stopped using the name assigned them at birth (Sandra) and begun using they, them, and their pronouns. Sam's parents have refused to pay for hormone therapy that will give Sam a more masculine appearance, lamenting that their "beautiful daughter" is too young and immature to "decide to become a boy."

Mary

Mary is a 70-year-old grandmother of three. Her husband of thirty years, Phil, recently passed away. Mary feels isolated and depressed. She increasingly spends time alone in her apartment, has trouble sleeping, and loses her appetite. After several months, Mary tells her family doctor about her sadness, and he writes her a prescription for antidepressants. Mary does not fill the prescription and instead seeks psychotherapy to talk about her loneliness and depression. The therapy raises her spirits some and she establishes a more active daily schedule and social life. However, though she is happier than before therapy, her mood remains tinged with occasional sadness, as she continues to miss her husband. Her doctor keeps encouraging her to try the antidepressants, but she doesn't want to.

Jesse

Jesse is a 37-year-old Black man living in an urban area of the United States that has recently been rocked by racial tension over police profiling and mistreatment of people of color. Jesse goes to see a psychotherapist and states that he is worried that the police are monitoring his movements. "They're out to get me," he says. "I know they're watching." Jesse's therapist, a white woman, is unsure what to make of Jesse's assertions.

Some of the cases above may seem obviously pathological, while the very inclusion of others may offend you. Although they all reflect situations viewed, at one point or another, as pathological by mental health professionals or the public, do not assume that sharing them here means endorsing such interpretations. Rather, the cases are offered to get you thinking about what you consider psychopathology versus reasonable distress. Your reactions are welcome and important—and

something to discuss (sensitively and respectfully) with your instructor and fellow students. As you read this book, you will regularly be asked to distinguish psychopathology (disorder in the person) from normal and expected mental distress. But realize that not everyone will agree with your assessments—and vice versa.

The Challenge: Experts often Disagree

This lack of consensus isn't just confined to students. Experts in the field regularly disagree. For example, consider the notion of **mental illness**. Despite this term's ubiquity in daily life, its definition is hotly debated. For instance, the American Psychiatric Association (APA), the professional organization of American psychiatry, says:

Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these) Many people who have a mental illness do not want to talk about it. But mental illness is nothing to be ashamed of! It is a medical condition, just like heart disease or diabetes. And mental health conditions are treatable. We are continually expanding our understanding of how the human brain works, and treatments are available to help people successfully manage mental health conditions. (American Psychiatric Association, 2018, para. 7)

The APA defines mental illnesses as *medical* conditions. This sounds quite definitive and that may be comforting. The problem is that not all professionals agree with this view. Consider the perspective of the Division of Clinical Psychology of the British Psychological Society (BPS), the professional association of psychologists in the United Kingdom. It takes a very different stance on mental illness, worrying about the **medicalization** of everyday problems (British Psychological Society, 2011). Medicalization occurs when we inappropriately classify non-medical issues as medical. The BPS directly challenges the APA's medical conception of mental distress:

It is often assumed that there is a straightforward dividing line between "mental health" and "mental illness" (normality and abnormality) and that discrete, identified disease processes (for example "schizophrenia") are responsible for experiences such as hearing voices. However, recent research suggests that this is not the case. Viewing experiences as symptoms of illnesses is only one way of seeing them, and one that not everyone finds helpful. (British Psychological Society, 2017a, p. 18)

What's going on here? We have two mainstream organizations taking completely different—and contradictory—positions on mental illness! One group says that mental illness is a medical condition. The other group says just the opposite, namely that many of the things we call mental illnesses are instead reasonable responses to challenging life circumstances and oppressive social conditions—and we often incorrectly classify them as medical problems.

At this point, I wouldn't be surprised to find you flipping a few pages ahead to figure out which view is the right one. Realizing that a definitive answer isn't provided, you might ask your instructor. But this merely gives you one person's opinion (albeit a person who has a big say over your grade!). It doesn't resolve the fact that we have two prominent groups with extensive mental health expertise holding seemingly irreconcilable views. While textbooks and professors can (and often do) offer their opinions, on many issues there is admittedly no clear consensus. What constitutes "pathology" or "distress," how to best identify each, and how to deal with them effectively are questions that receive different answers depending on who is asked. In other words, when it comes to psychopathology and mental distress, there are many *contrasting perspectives*. The goal of this book is to help you make sense of them all, so you can decide which you believe are best. Let's define some basic terms to get you started with this task.

Mental illness: Defined by the American Psychiatric Association as an illness affecting or located in a person's brain that affects how a person thinks, behaves, and interacts with other people.

Medicalization: Inappropriately classifying non-medical problems as medical.

1.2 Basic Terms

Some of these terms are mainly descriptive. Others have assumptions about psychopathology and mental distress embedded within them that reflect broader perspectives encountered throughout the book. All are important for navigating the terrain ahead.

Psychiatry vs. Psychology

Students are often confused about the difference between psychiatry and psychology, two of the major mental health professions. Psychiatry is a medical specialty concerned with mental disorders and their treatment. *Psychiatrists* are physicians who have completed specialized training in psychiatry (American Psychiatric Association, n.d.-d). Not surprisingly, because they are medical doctors, psychiatrists generally adhere to a **medical model**, which views psychiatric problems as illnesses (B. J. Deacon, 2013; Huda, 2021; Joyce, 1980; Patil & Giordano, 2010).

Unlike psychiatrists, *psychologists* don't have medical degrees. Instead, they have graduate degrees (usually doctorates) in psychology, a discipline that studies mental processes and behavior. Clinical psychologists and counseling psychologists conduct *psychotherapy*, which involves talking with clients/patients about their problems as a means of remediating their distress. *Clinical psychologists* are typically trained to see mental distress as a dysfunction in the individual, usually of a psychological nature (G. J. Neimeyer et al., 2011). Like psychiatrists, many but not all clinical psychologists adopt a medical model. This “places a premium on assessment, diagnosis, and treatment within a broad range of hospital and community contexts” (G. J. Neimeyer et al., 2011, p. 44). *Counseling psychologists* differ from clinical psychologists in that their training tends to focus less on pathology and more on the everyday problems of otherwise well-adjusted people (G. J. Neimeyer et al., 2011; Norcross, 2000; Society of Counseling Psychology, n.d.).

In practice, clinical and counseling psychologists are often hired to do the same kinds of jobs, sometimes making it difficult to discern the difference between them (G. J. Neimeyer et al., 2011). Compared to clinical psychology, counseling psychology generally places less emphasis on assessment and diagnosis and more on the emotional strengths and positive aspects of client functioning (G. J. Neimeyer et al., 2011; Norcross, 2000). Like clinical psychologists, counseling psychologists work in private practice and mental health agencies. They are somewhat less likely to work in hospitals than clinical psychologists and more likely to be employed at university counseling centers and other sites where client issues are deemed less severe (G. J. Neimeyer et al., 2011).

Mental Illness and Mental Disorder

As alluded to earlier, mental illness and **mental disorder** are terms rooted in the psychopathology perspective. Both imply something wrong inside the person being diagnosed. However, distinguishing between them can prove difficult. In public discourse, mental illness usually has a more biological connotation than mental disorder. Recall APA's (2018) definition of mental illness as “a medical condition, just like heart disease or diabetes.” This is decidedly more medical than the definition of mental disorder that APA gives in its *Diagnostic and Statistical Manual of Mental Disorders* (DSM), a comprehensive book that lists and describes all APA-recognized disorders (see Chapter 3). The DSM defines a mental disorder as “a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (American Psychiatric Association, 2022, p. 14). Though this definition defines mental disorder as psychopathology (i.e., a dysfunction in the person), it leaves room for those who do not see all mental disorders as brain diseases. However, as we shall see, even the broader DSM definition is sometimes controversial (A. Frances, 2013a; Paris, 2015).

Medical model: Views psychiatric problems as categorical syndromes reflecting underlying biological illnesses that must be accurately diagnosed before they can be effectively treated.

Mental disorder: Defined by the American Psychiatric Association as a syndrome characterized by clinically significant disturbance in a person's cognition, emotional regulation, or behavior reflecting a dysfunction in psychological, biological, or developmental processes.

Harmful Internal Dysfunction

The notion of **harmful internal dysfunction** is central to the psychopathology perspective on mental disorder. It holds that mental disorders are best viewed as having two components: (a) a mental mechanism that fails to operate according to its naturally designed function (i.e., an internal dysfunction), and (b) behavior society deems harmful that is caused by the internal dysfunction (J. C. Wakefield, 1992a, 1992b, 1999). Importantly, both harm and dysfunction are necessary conditions for something to be a disorder. For example, “a dysfunction in one kidney often has no effect on the overall well-being of a person and so is not considered to be a disorder” (J. C. Wakefield, 1992b, p. 384). At the same time, social deviance in the absence of internal dysfunction is also insufficient for something to qualify as a disorder. A biological or psychological mechanism inside the person must be malfunctioning—that is, operating in a way nature did not intend. Requiring both social judgment and an internal dysfunction is supposed to protect against incorrectly labeling social deviance as psychopathology:

The requirement that a disorder must involve a dysfunction places severe constraints on which negative conditions can be considered disorders and thus protects against arbitrary labeling of socially disvalued conditions as disorders Diagnoses such as “drapetomania” (the “disorder” of runaway slaves), “childhood masturbation disorder,” and “lack of vaginal orgasm” can be seen as unsound applications of a perfectly coherent concept that can be correctly applied to other conditions [T]he harmful dysfunction view allows us to reject these diagnoses on scientific grounds, namely, that the beliefs about natural functioning that underlie them—for example, that slaves are naturally designed to serve, that children are naturally designed to be nonsexual, and that women are naturally designed to have orgasms from vaginal stimulation in intercourse alone—are false. (J. C. Wakefield, 1992b, p. 386)

Though influential, the harmful internal dysfunction model hasn’t been explicitly incorporated into the DSM definition of mental disorder. Further, some people complain that it doesn’t consistently identify disorder in everyday life (S. O. Lilienfeld & Marino, 1995, 1999). One explanation for this is that it relies on social judgments about harmfulness. When these judgments change, so does what counts as a disorder (Sadler & Agich, 1995). Additionally, the concept of “mental mechanism” strikes some critics as fuzzy (Houts, 1996; D. Murphy & Woolfolk, 2000). These critics contend that the model treats a mental mechanism as something biologically broken in the brain (G. R. Henriques, 2002), even though what is “mental” is by definition not physical and therefore can’t literally be found in someone’s brain. Something mental also cannot be scientifically observed or measured. If a mechanism is mental rather than physical, we can’t see it. Consequently, we can never know if mental mechanisms truly exist (Houts, 1996).

Deviance

Not everyone subscribes to the internal dysfunction/psychopathology perspective. Some prefer the notion of deviance instead. **Deviance**, a word often used by sociologists, refers to socially unacceptable behavior—but, like the term mental distress, without presuming the behavior is disordered (Endleman, 1990). Deviant behavior does not necessarily stem from pathology inside individuals. In fact, sociologist Thomas Scheff (1999) famously (and controversially) argued that what gets called mental illness is more a product of society labeling behavior as deviant than it is a product of internal psychopathology. From this viewpoint, how different social groups define suitable behavior is central in determining who is considered pathological. For example, in some conservative Muslim countries a woman who does not veil her face in public may be acting in a socially deviant manner, but most people would not consider her behavior a sign of psychopathology.

Harmful internal dysfunction: Definition of mental disorder that has two components: (a) a mental mechanism that fails to operate according to its naturally designed function (i.e., an internal dysfunction), and (b) behavior that society deems harmful which is caused by the internal dysfunction.

Deviance: Behavior that violates social norms and values.

Social oppression:

Unjust social conditions, which lead to mental distress.

Social Oppression

Those emphasizing **social oppression** attribute mental distress to unjust societal conditions. Sometimes they accept the notion of individual psychopathology, but they believe it is caused by social oppression (i.e., prolonged exposure to economic inequality and discrimination produces ongoing stress, which fosters illnesses inside people). However, other times they contend that ongoing oppression merely produces deviant behavior (i.e., oppressed people act out not because they are ill, but because they can no longer abide by the norms of a tyrannical society). The key point to those emphasizing social oppression is that mental distress originates in social conditions, not individuals. From this perspective, we too often conceptualize distress as an individual, rather than social, problem:

Oppression contributes to mental health problems in the form of depression, suicidal ideation, learned helplessness, surplus powerlessness, emotional isolation, and other difficulties. Although the link between oppressive societal conditions and psychological health may seem obvious to us now, this has not always been the case. Historically, psychology and psychiatry ascribed mental health problems to internal mechanisms that were thought to be quite independent from the social circumstances in which the person lived. (Prilleltensky, 1999, p. 107)



Photo 1.2 The English National Opera's Production of Atwood's *The Handmaid's Tale* at The London Coliseum. We can read *The Handmaid's Tale* as a representation of oppressed people acting out and being perceived as "ill" because they can no longer abide by the norms of a tyrannical society.

Robbie Jack/Getty Images.

Some who emphasize social oppression reject the idea of individual psychopathology entirely. They question attributing mental distress to disorders inside people. In this view,

services should be based on the premise that the origins of distress are largely social. The guiding idea underpinning mental health services needs to change from assuming that our role is to treat "disease" to appreciating that our role is to help and support people who are distressed as a result of their life circumstances, and how they have made sense of and reacted to them. (Kinderman, 2014b, para. 14)

Others take a middle ground position in which internal dysfunctions are accepted as real but greatly influenced by social and cultural factors like gender, race, and class (López & Guarnaccia, 2020; Winstead & Sanchez-Hucles, 2020). The degree to which mental distress is caused by internal dysfunction versus social oppression is a question we return to repeatedly. The "Lived Experience" feature examines the sharp rise in mental distress among teens and young adults and its connection to social adversity.



The Lived Experience: “Generation Disaster”

People in the United States born between 1990 and 2001 have lived through the 9/11 attacks, prolonged wars in Afghanistan and Iraq, the 2008 economic crisis, an ongoing and worsening climate crisis, regular school shootings, a society rife with political and racial divisions, and—to top it all off—the lengthy COVID-19 pandemic. That’s a lot to handle! Psychologist Karla Vermeulen (2021), who researches this age group, refers to them as “Generation Disaster.” She argues that the historical circumstances they faced while growing up have shaped their psychological development. Vermeulen (2021) points out that in 2017 (before the COVID-19 pandemic exacerbated things), nearly 9 million Americans ages 18 to 25 were coping with some type of mental distress or substance use issue—a huge number of young people!

What sorts of things do members of “Generation Disaster” tell us about their life experiences? A sampling of relevant first-hand accounts from Vermeulen (2021) offers insights into their psychology. A male born in 2000 complained that his generation is too often misconstrued as lazy, when in fact they are merely struggling: “We are not lazy—we live in a scary and hard time” (p. 108). Building on this, one of his peers contended that the current generation of college students has had to face continual anxiety over things prior generations did not, like terrorism and school shootings:

Things like terrorist attacks and school shootings are extremely real and extremely possible to happen to us I hear kids talk about how when they are bored in class sometimes they think about what they would do if a school shooter came into the building. I don’t think that is something my parents ever thought about. And I think it really has an effect on our mental health. (p. 77)

Also affecting Generation Disaster’s mental health is a sense that prior generations have decimated the environment and are bequeathing the mess to them: “Climate change does worry me and impact my daily life I have had nightmares about it and I try not to read any of the apocalyptic articles because I don’t want to stress myself out” (p. 152). This sentiment was echoed by a female born in 1999 who lamented that “a big part of the challenges of younger generations is having to deal with the greed and mistakes of the previous generations not thinking or caring about the future” (p. 119). But Generation Disaster’s difficulties do not end there. Beyond the horrors of terrorism, school shootings, and climate change, many of them feel that the fast-paced interconnected world they reside in has only amplified their distress: “With access to the Internet, and having been raised throughout this mess, I feel hyperconnected and hypersensitive to what the world holds” (p. 112). A trans man born in 1993 perhaps summed it up best:

My generation is exhausted. We overwork, overstress, and abuse substances to cope. We can’t afford therapy no matter how much we all need it We are saddled with debt and half the time aren’t sure when our next real meal will be Our country is dying and has been dying You have to be born rich to survive at this point and it’s going to kill us all. (p. 181)

In reflecting on the challenges of Generation Disaster, Vermeulen concludes that “today’s emerging adults are indeed demonstrably more anxious, depressed, and addicted than current older groups” but it is unclear “whether these rates reflect an increase in distress over previous cohorts moving through this same stage or if this is a developmental rite of passage that all groups go through as they move into adulthood” (p. 109). Although the psychological issues of Generation Disaster cannot be directly attributed to the grievous events they have endured (because correlation doesn’t prove causation), advocates of sociocultural perspectives are likely to maintain that these events have played an important role in their increased levels of anxiety, depression, and mental distress. Do you agree or disagree?

Are you a member of Generation Disaster? If so, what has your experience been? Has the era you were raised in contributed to whatever mental distress you and your peers have faced? If so, what—if anything—can or should be done about it?



Photo 1.3 People in the United States born between 1990 and 2001 have lived through a lot—including the 9/11 attacks, rampant school shootings, and the COVID-19 pandemic. Some call them “Generation Disaster.”

Yoav Aziz/Unsplash.

“Abnormal Psychology”

Until recently, psychopathology and mental distress were referred to as **abnormal psychology**. This phrase is still sometimes used. It might even be the name of the course in which you are reading this book. However, many consider abnormal psychology a problematic term due to its negative associations—which is why the *Journal of Abnormal Psychology* changed its name to the *Journal of Psychopathology and Clinical Science*. As the editors explained, “human diversity is too broad to be contained—or constrained—by the metaphor of abnormality” (MacDonald et al., 2021, p. 2). Ironically, “abnormal psychology” has become pejorative for the very reason the phrase has also been

Abnormal psychology: Alternative name for the study of psychopathology and mental distress that is increasingly considered pejorative.

useful. Calling something abnormal makes judgments about it explicit in a way that using the terms psychopathology and mental distress does not. Although it is critical to acknowledge the negative connotations that the word “abnormal” carries, considering common criteria of “abnormality” can help students clarify their judgments about psychopathology and mental distress. So, let’s turn to those criteria next.

1.3 Common Criteria of “Abnormality”

Common criteria of “abnormality”:

Statistical deviation, violation of social norms and values, behavior that disturbs others, harmfulness to self or others, emotional suffering, and misperception of reality; used to make judgments of “abnormality.”

It may be becoming apparent that psychopathology and mental distress do not come readily labeled and identified for all to see. People use **common criteria of “abnormality”** to distinguish them. Though many of these criteria have overlapping elements, each is important on its own. None are necessary and sufficient, but all are useful. As you read about them, consider previously introduced concepts like psychopathology, deviance, and social oppression. How do criteria for “abnormality” help us judge when mental distress is expectable, socially deviant, or triggered by an internal dysfunction?

Statistical Deviation

Statistical deviation identifies abnormality by comparing people to statistical norms. For example, most of us live with other people, not by ourselves. Anyone who does live alone is, statistically speaking, abnormal. Of course, just because something is statistically deviant doesn’t necessarily mean it’s pathological. For instance, only a small percentage of people earn doctoral degrees. This makes doing so statistically abnormal, but few would argue that holding a doctorate is a sign of psychopathology! The “Controversial Question” feature offers another example of the uncertain link between statistical deviation and disorder.

Controversial Question: Is Shortness a Disorder?



In 2003, an advisory panel for the Food and Drug Administration in the United States recommended genetically engineered human growth hormone be approved for use in otherwise healthy children (mostly boys) identified as being idiopathically short. *Idiopathic* illnesses are ones that arise unexpectedly without a known cause. Although these very short children were at the bottom of the normal growth curve, they showed no hormonal deficiencies (Angier, 2003). The FDA approved the advisory panel’s recommendation and now growth hormone can be prescribed for children diagnosed with *idiopathic short stature (ISS)* (P. Cohen, Rogol, et al., 2008; Inzaghi et al., 2019; M. Morrison, 2015). The rationale for this? American men under the average height of 5’ 9” are more likely to drop out of school, drink excessively, date sporadically, get sick, or experience depression (Angier, 2003). In other words, short men develop psychosocial problems more often than their taller friends—although whether they are at risk for more serious psychopathology remains unclear (P. Cohen, Rogol, et al., 2008).

Consider shortness in relation to the common criteria of “abnormality” discussed in this chapter. A case for shortness as abnormal, even pathological, can be made using four of the criteria: statistical deviance, violation of social norms and values, internal dysfunction, and emotional suffering:

- Shortness is *statistically deviant*. Only a small percentage of men are under the 5’ 3” height targeted by the FDA.
 - Shortness *violates social norms* requiring men to be imposing and strong. This perhaps explains why short men earn less money, date less often, and have a lot less luck getting elected to higher office (in U.S. presidential elections, for example, the shorter candidate usually loses).
 - Shortness is due to an *internal dysfunction*. Due to hormonal dysfunctions, what some medical specialists call a “growth failure” occurs.
 - Shortness is associated with *emotional suffering*. As mentioned above, short men drink more, date less, get sick, and feel depressed more often than tall men.
- Of course, the criteria used to discern shortness as “abnormal” can also be challenged.
- *Statistical deviance* is not always viewed negatively. LeBron James’ extreme height is statistically deviant but is generally credited as helping make him a spectacular basketball player. Singer Bruno Mars is quite short but is often considered a sex symbol.
 - *Social norms and values* change. Sometimes they are foolish or shallow. In the past, social norms led people to see many things as pathological that today we do not. For instance, enslaved people in the United States who ran away from their masters were once diagnosed as suffering from a disorder called *drapetomania* (Cartwright, 1851).

- The idea of shortness as *internal dysfunction* can be challenged, especially given the FDA's recommendation that short boys with no discernible growth hormone deficiency be medicated to cure their shortness. If there is no discernible hormone deficiency, what is the internal dysfunction? Maybe it's not that short people necessarily have an internal dysfunction, but rather that in Western cultures "short stature itself is often regarded as an inherently undesirable state" (M. Morrison, 2015, p. 310).

Almost everyone has something about their looks they don't like. How much emotional suffering must one experience about being short before it becomes a problem? Regardless of your opinion, the example of shortness highlights something fascinating, namely that almost anything can be talked about in a way that makes it seem functional or dysfunctional. Criteria for "abnormality" can help us in thinking about what we consider normal or pathological, but these criteria can never resolve the issue once and for all.

Author disclaimer: I'm 5' 3" tall. Check out this online list of short statured men (all better known than I am) who may or may not have suffered from idiopathic shortness: <http://shortguycentral.com/gallery.php>. For more general information and support for short people, see <http://www.supportfortheshort.org>.

Critical Thinking Questions

1. Using the criteria for "abnormality" discussed in this chapter, do you believe that idiopathic short stature is a disorder? Why or why not?
2. Choose another physical difference between people besides shortness and apply the criteria for "abnormality" to it. Using the criteria as a guide, do you see this difference as a disorder or as normal human variation? Explain.

Statistical deviation is pertinent to prevalence and incidence estimates that tell us about the frequency of mental disorders. **Prevalence** refers to the percentage of people in the population currently believed to have a specific disorder, while **incidence** is the number of new cases reported over a specified period (N. Pearce, 2012). Prevalence and incidence rates make clear that mental disorders are statistically deviant. For example, the lifetime prevalence rate of schizophrenia has been reported to be between 0.3 and 0.7 percent of people (American Psychiatric Association, 2022; N. Pearce, 2012). Its annual incidence rate has been estimated to be anywhere between 14 and 42 out of every 100,000 people (Esan et al., 2012; J. J. McGrath, 2005). This means that a little less than 1 percent of the world's population is thought to have schizophrenia and that 14 to 42 people out of 100,000 are expected to develop it in any given year. While statistical deviance alone does not guarantee something will be identified as "abnormal," the things that mental health professionals consider disordered are statistically atypical.

Prevalence: Percentage of people in the population believed to currently suffer from a specific mental disorder.

Incidence: The number of new cases of a mental disorder that are diagnosed within a specified period.

Violation of Social Norms and Values

Sara and Brian

Sara and Brian seek marriage counseling because their marriage is on the rocks. Brian was raised in a family where feelings were rarely discussed. Conflict was considered unpleasant, and people's differences were usually ignored or minimized to maintain congenial relationships. Sara, by comparison, grew up in a home where people freely expressed emotions; even negative feelings were readily communicated, often with a great deal of yelling and screaming. As each blames the other for their marital problems, it quickly becomes clear to their marriage counselor that Sara and Brian's different family norms and values lead them to see each other as abnormal.

"Something's definitely wrong with him," Sara says of Brian. "He doesn't seem to have feelings. That's not normal unless he's a robot!"

"It's not me, Doc," Brian retorts. "Sara's just out of control, always yelling or crying or getting upset. Last week she got so mad that she threw a stapler across the room at me. It's like she's a crazy person!"

Sara and Brian's assessments of one another demonstrate how *violation of social norms and values* play into judgments of abnormality. Different people have different ideas about how others should behave, what is socially appropriate, and what is morally acceptable. Even though violation of social norms seems readily applicable to socially deviant behavior, we often infer internal pathology in those who consistently violate values we hold dear. Perhaps this is because across families

and cultures, varied social norms and values influence what people deem out of the ordinary. Not surprisingly, this means that what mental health professionals consider pathological is often controversial—and can change over time.

Sexuality is one of the most obvious areas where we see this. Medical experts once considered masturbation and other forms of non-procreative sex clear indicators or causes of psychopathology (Bullough, 2002). The eighteenth-century Swiss physician S. A. D. Tissot (1728–1797) labeled those who masturbate as having a mental disorder called *onanism*, which he defined as “all non-procreative sex” (Bullough, 2002). He described the dangers of those suffering from it:

Onanism ... led to (1) cloudiness of ideas and sometimes even madness; (2) decay of bodily powers, resulting in coughs, fevers, and consumption; (3) acute pains in the head, rheumatic pains, and an aching numbness; (4) pimples on the face, suppurating blisters on the nose, breast, and thighs, and painful itchings; (5) eventual weakening of the power of generation as indicated by impotence, premature ejaculation, gonorrhea, priapism, and tumors in the bladder; and (6) disordering of the intestines, resulting in constipation, hemorrhoids, and so forth. (Bullough, 2002, p. 29)

While Tissot’s eighteenth-century ideas about masturbation strike most people today as outdated, social norms continue to change, often rapidly. Until 1973, the DSM considered homosexuality to be a mental disorder (Drescher, 2012; A. V. Horwitz, 2021). However, as homosexuality became more socially accepted, people began to question its deviant status and eventually the American Psychiatric Association stopped classifying it as a disorder (Drescher, 2012; A. V. Horwitz, 2021). Importantly, even when social norms change, it doesn’t mean that everyone agrees. Though the American Psychiatric Association (1998, 2000b) and American Psychological Association (2012) reject homosexuality as a mental disorder and cite extensive research that therapies to convert homosexuals into heterosexuals are ineffective and damaging, a small number of rogue mental health professionals stubbornly (and controversially) insist that homosexuality is pathological and can be successfully treated (Higbee et al., 2022; Morrow & Beckstead, 2004). Social norms and values are one way to determine what is “abnormal,” but conflict always remains because people and cultures differ in what they see as acceptable and appropriate.

An important question to ask is whether at least some social norms and values are universal. Do certain values cut across all people and cultures—such as taboos against murder and incest? Some people maintain that while many social values are relative to time, place, and culture, at least some norms are universal. Does this mean that certain forms of psychopathology and mental distress are problematic regardless of when and where they occur? Are social values and norms about them always culturally relative or at least sometimes universal?

Behavior that Disturbs Others

Behavior that disturbs others is often judged abnormal. For example, people riding in elevators usually face toward the doors. Next time you get on an elevator, see what happens when you face away from the doors and toward those riding with you. Your fellow passengers may consider your actions strange, and a significant number of them may feel uncomfortable. Behavior that disturbs others often violates social norms and values, too. Creating a scene in a restaurant, loitering on a street corner while talking to oneself, dressing in atypical fashion, and expressing emotions generally considered inappropriate to a situation (e.g., laughing during a funeral) violate social norms and, consequently, tend to disturb others.

Our responses to people differ depending on how we interpret why they engage in disturbing or disruptive behavior. When we conclude that such behavior is a product of mental disorder, we often excuse it. In this line of thought, mentally disordered people are suffering from internal psychopathology and cannot be accountable for their disturbing behavior. A contrary line of thinking holds that those engaging in disturbing behavior freely choose it, thus they are responsible for the consequences of their conduct. The “illness versus responsibility” debate occurs prominently in the legal arena because the legal system generally presumes that people are responsible for behaving in ways consistent with social norms and laws, whereas the mental health system contradicts this by arguing that sometimes disturbing or illegal behavior is a byproduct of mental illness. More on this when we discuss competency to stand trial and the insanity defense in Chapter 16.

Another difficult question arises: When someone else's behavior disturbs us, does this tell us more about us or them? For instance, protesters who engage in civil disobedience may disturb us by disrupting our routines and forcing us to examine issues we would rather ignore. However, this does not make them mentally disordered.

Harmfulness to Self or Others

Sue repeatedly cuts her arms with a razor blade. Jorge gambles away his life savings. Miwa overdoses on painkillers. Gerald abuses his wife. These are examples of behavior that appears maladaptive or causes *harmfulness to self or others*. Harmful behavior is often implicitly assumed to indicate psychopathology. So, we might diagnose Sue as suffering from borderline personality disorder (see Chapter 12), Jorge as having gambling disorder (see Chapter 11), Miwa as experiencing major depressive disorder (see Chapter 5), and Gerald as having intermittent explosive disorder (see Chapter 13). Of course, there are also many cases in which harmful behavior might not be attributed to mental disorder. For example, Bill smokes cigarettes, Goran never puts on sunscreen, Isabella skydives, Cai drives fast on the freeway, and Gina likes to rock climb without safety gear. In these cases, there is clearly potential harm to self or others. However, are these people suffering from psychopathology?

Harmfulness to self or others as an indicator of pathology seems most clear in situations where there is agreement that the potential harm in a behavior outweighs any possible benefits. In psychology, this often applies to circumstances where people are an imminent threat to themselves or others—such as in attempted suicide, assault and battery, or attempted murder. Consistent with this, most mental disorders explicitly include criteria indicating that impaired social, occupational, or other functioning is required before a disorder can be diagnosed (American Psychiatric Association, 2022). That is, people's symptoms must harm or interfere with their lives. Harm to self or others is important in judgments about pathology and distress, even though people often disagree about what constitutes harm or how much is necessary.

Emotional Suffering

Excessive *emotional suffering* and unhappiness are often judged abnormal. Consistently appearing depressed, anxious, angry, or ambivalent is both socially deviant and often thought to imply internal pathology. As with other criteria, however, agreeing on how much emotional suffering is pathological can prove challenging. Most of us would concur that a suicidally depressed person is suffering, but what about less extreme instances? For example, is feeling emotionally down for an extended period psychopathological if it does not significantly affect work or relationships? Further, do the reasons why someone is suffering matter?

Neil and Sharon

Consider Neil, a successful businessman and husband who suddenly and inexplicably becomes extremely depressed. There appear to be no specific environmental triggers for Neil's sadness and only after he is briefly hospitalized and medicated does he begin to feel better. Neil is suffering, but for no apparent reason—which leads him and his doctors to view his suffering as due to an internal dysfunction rather than life circumstances.

Compare Neil with Sharon, a middle-aged woman who feels extremely depressed, anxious, and angry after her 19-year-old son is killed while serving in the military. Sharon clearly is experiencing emotional suffering, but does having a good reason for it make it an understandable reaction to terrible life circumstances rather than a sign of mental disorder? Or is any extreme emotional suffering, even in response to difficult life events, a form of psychopathology?

It is easy to see emotional suffering as a form of mental distress but less clear when it rises to the level of psychopathology. This begs two important questions. First, how do we decide what constitutes a good reason for suffering? Second, how much suffering is appropriate? Can we be confident in a case like Neil's that there is no reason for his suffering, as opposed to simply not being able to find the reason? When and how does suffering indicate psychopathology?

Misperception of Reality

When Burt tells us that the CIA is monitoring his actions via microchips secretly embedded in his brain, we are likely to feel he has lost touch with reality and therefore suffers from psychopathology of some kind. *Misperception of reality* is often attributed to faulty perceptions and interpretations. Those who misperceive reality are usually considered to be irrational or suffering from some sort of perceptual defect (Dryden & Ellis, 2001). The ability to accurately perceive reality is commonly considered a critical component of psychological well-being. Conceptually, as with some of the other criteria we have been reviewing, misperception of reality is most useful in extreme cases. After all, few would question that Burt's perceptions do not match what is going on around him. But what about other situations in which people's perceptions of reality conflict? Assessing reality misperception helps us make judgments about psychopathology and distress—especially in cases where someone's perceptions diverge extensively from most everyone else's. However, there is often disagreement about such determinations and who has the authority to make them.

Sara and Brian

In the marriage counseling of Sara and Brian, Sara insists that her mother-in-law is “out to get her” by putting her down and manipulating Brian to spend more time with her than Sara. Brian sees no evidence of this, arguing that his mother only wants what is best for him and Sara. Whose perceptions of reality are correct? If we could determine this, would it matter? Is the person whose perceptions are less correct more psychologically disturbed? Finally, who is the ultimate authority on reality? Is it Sara, Brian, Brian's mother, their therapist, or someone else altogether?

Biological

perspectives: Attribute mental distress to illnesses that afflict people.

Psychological

perspectives: Attribute mental distress to psychological conflicts involving problematic thoughts, feelings, and behaviors.

Sociocultural

perspectives: Attribute mental distress to social causes (e.g., socioeconomic conditions, cultural influences, and social oppression).

Trepanation: Prehistoric treatment of abnormal behavior in which holes were drilled in the skull to free evil spirits; also called *trephination*.

Demonological

perspective: Views abnormal behavior as due to possession by evil spirits; also called the *supernatural perspective*.

1.4 Three Contrasting Perspectives

The contrasting perspectives on psychopathology and mental distress reviewed in this book are divided into three types. **Biological perspectives** emphasize malfunctioning physiology and focus on mental illnesses as medical conditions that afflict people. **Psychological perspectives**, by contrast, conceptualize psychopathology in psychological terms as involving problematic thoughts, feelings, and behaviors. Finally, **sociocultural perspectives** attribute mental distress to social causes, with factors like socioeconomic conditions, cultural influences, and social oppression as the root causes of people's emotional upset. Your task is to master these perspectives and figure out what you agree or disagree with about each as you develop your own personal perspective.

HISTORICAL PERSPECTIVES

1.5 From Stone Age to Greek and Roman Perspectives

Stone Age Perspectives

Disagreement about mental distress and what to do about it is not new. Humans have tried to understand “madness” since the beginning of recorded history (R. Porter, 2002). The first evidence of people trying to manage it goes back to the Stone Age. Prehistoric skulls from around the world show evidence of **trepanation** (also called *trephination*), a process by which holes were drilled in them (Sturges, 2013). Historians often view trepanation as evidence of the **demonological perspective** (also called the *supernatural perspective*), which attributes psychopathology to possession by evil spirits (Vadermeersch, 1994). From a demonological perspective, drilling a hole in the skull allowed possessing spirits to escape (R. Porter, 2002). At the same time, trepanation has also been viewed as an early biological approach (Millon, 2004; Sturges, 2013). After all, drilling a hole in the skull constitutes a biological intervention. Trepanning was used for many centuries. There is evidence of it during the Greek and Roman periods, the Middle Ages, and the Renaissance (Dreher, 2013; Missori et al., 2015; J. Weber & Czarnetzki, 2001).

Greek and Roman Perspectives

Hippocrates' (Mostly) Biological Perspective

The Greek physician Hippocrates (460–367 BCE) is considered the founder of a scientific approach to medicine and neurology (Breitenfeld et al., 2014). Many of his views about mental distress therefore reflect an early biological perspective (J. R. Matthews & Matthews, 2013; Millon, 2004). Hippocrates believed that the world was made of four substances: earth, air, fire, and water. These elements were characterized by heat, cold, moisture, and dryness, which through a variety of factors (including the weather, heredity, and diet) combined inside each person to form four **bodily humors**: *black bile* (combining cold and dryness), *yellow bile* (combining hot and dryness), *phlegm* (combining cold and moisture), and *blood* (combining heat and moisture) (J. R. Matthews & Matthews, 2013). Hippocrates maintained that psychopathology resulted when these bodily humors were out of balance. His effort to categorize types of madness based on bodily humor imbalances anticipates later attempts at diagnostic classification (Millon, 2004). In keeping with his rejection of supernatural explanations in favor of biological humors, many of Hippocrates' recommended treatments were medicinal. Peppermint leaves were used to relieve depression, the herb St. John's wort was used to ward off evil spirits, and peony was worn around the neck to prevent epilepsy (J. R. Matthews & Matthews, 2013).

Bodily humors: Four biological substances identified by the Ancient Greeks and long considered important in understanding mental distress; the four humors were *black bile*, *yellow bile*, *phlegm*, and *blood*.

Hysteria and the Wandering Womb

Hippocrates' view of **hysteria**—a malady involving numerous psychological and physical symptoms that the Greeks diagnosed exclusively in women—also reflects a biological viewpoint in that he attributed it to a woman's uterus detaching from its natural location and wandering around her body (Ng, 1999; Palis et al., 1985; C. Tasca et al., 2012). This explanation—the **wandering womb theory**—seems silly today, but it represents an early effort to understand psychological distress in biological (rather than supernatural) terms. Many sociocultural theorists see hysteria as a sexist term. They argue that women from Hippocrates' days onward have often been unfairly diagnosed as hysterical (C. Tasca et al., 2012; Ussher, 2013).

Hysteria: A malady involving numerous psychological and physical symptoms that the ancient Greeks diagnosed exclusively in women.

Wandering womb theory: The ancient Greek physician Hippocrates' biological theory that attributed hysteria to a woman's uterus detaching from its natural location and wandering around her body.

Socrates, Plato, and Aristotle

Whereas Hippocrates saw psychopathology as stemming primarily from brain processes, the philosopher Socrates (470–399 BCE) and his student Plato (429–347 BCE) focused less on the brain and more on the soul. Their perspectives incorporate supernatural and biological elements, as well as psychological ones. Socrates believed that when human passions run amok, emotional distress results. His famous plea, "Know thyself," makes it clear that introspective self-knowledge is the key to overcoming our passions (Millon, 2004). Plato offered a similarly psychological perspective, arguing that psychopathology originates when there is a problem in the part of the soul that controls reason (J. R. Matthews & Matthews, 2013). Interestingly, he distinguished madness instilled by the Gods (which is desirable because it endows us with special abilities, such as being able to predict the future) from madness caused by disease (which isn't desirable and requires treatment) (J. R. Matthews & Matthews, 2013).

Plato's student Aristotle (384–322 BCE) adopted a more naturalistic perspective like Hippocrates, but he saw the heart rather than the brain as the central organ responsible for mental functioning. Aristotle influenced modern cognitive-behavioral therapy (CBT) (defined in Chapter 2 and revisited throughout the book). His emphasis on using reason and logic to overcome emotional difficulties has a cognitive flavor (J. R. Matthews & Matthews, 2013), while his view of learning as the association of ideas anticipated classical conditioning (described in Chapter 2), in which learning results from repeatedly pairing stimuli so that they become associated with one another.

1.6 Perspectives during the Middle Ages

Avicenna's Biological Perspective and Early Hospitals

Avicenna

The Middle Ages roughly cover the period from the fall of the Western Roman Empire in 476 CE to Columbus' arrival in North America in 1492 (Papiasvili & Mayers, 2013). The Greeks' scientific perspective flourished most fully in the Islamic Middle East, where the bodily humors

theory maintained influence (Millon, 2004; Papiasvili & Mayers, 2013; R. Porter, 2002). The Islamic philosopher and physician Avicenna (980–1037 CE) described mania, melancholia, insomnia, and hallucinations (Papiasvili & Mayers, 2013). He adopted Hippocrates’ biological perspective, hypothesizing that the middle part of the brain is responsible for intellectual dysfunction and the frontal areas control reason and common sense (Millon, 2004). Avicenna also noted a relationship between emotional states and health (Millon, 2004).

Early Hospitals

Hospitals were established in Baghdad, Cairo, Damascus, and Aleppo between the eighth and thirteenth centuries and provided services to those considered mad (Papiasvili & Mayers, 2013). During this period, various psychological and biological treatments were developed. For instance, Cairo’s Mansuri Hospital employed something that resembles today’s *bibliotherapy*: Patients were encouraged to read books and discuss their emotional reactions in groups. Other techniques common in the era included hydrotherapy, music, and activities (Papiasvili & Mayers, 2013).

Demonological Perspectives in Europe

In Christian Europe during much of the Middle Ages, Hippocrates’ biological perspective held less sway than in the Islamic Middle East. Theological approaches dominated, increasing the influence of demonological explanations. Christian theology saw madness as a moral struggle (Papiasvili & Mayers, 2013). Strategies for overcoming it often involved punishment for sinful behavior. Fasting, prayer, and various types of exorcism to expel the devil were employed. Many of those deemed possessed were labeled as witches. Two monks, Heinrich Kramer (1430–1505) and Jacob Sprenger (~1435–1495), authored the *Malleus Maleficarum* (also known as the *Hammer of Witches*), a book in which they systematically examined witchcraft and demonic possession (Elkins, 2016; H. Kramer et al., 1486/2021; Papiasvili & Mayers, 2013; R. Porter, 2002). This book served as an early “diagnostic manual” but from a demonological perspective.

Malleus Maleficarum:

Popular book during the Middle Ages that examined witchcraft and demonic possession; reflected a demonological perspective.

The Influence of Cultural Context: Dancing Mania

Some of the syndromes identified during the Middle Ages strike us as strange today. For instance, *dancing mania* was a form of “mass madness” in which people felt an unstoppable urge to dance. For instance,

dozens of mediaeval authors recount the terrible compulsion to dance that, in 1374, swept across western Germany, the Low Countries, and northeastern France. Chronicles agree that thousands of people danced in agony for days or weeks, screaming of terrible visions and imploring priests and monks to save their souls On a far larger scale was the outbreak that struck the city of Strasbourg in 1518, consuming as many as 400 people. One chronicle states that it claimed, for a brief period at least, about 15 lives a day as men, women, and children danced in the punishing summer heat. (J. Waller, 2009, p. 624)

Dancing mania illustrates the idea that how people express “madness” is at least partly determined by historical context and culture (J. Waller, 2009).

1.7 Renaissance Perspectives

The Renaissance as One of Europe’s Most “Psychically Disturbed” Periods

The Renaissance in Europe, which lasted roughly from the late 1400s until the early 1700s, is considered a period of intense scientific and artistic achievement. However, the changes it brought resulted in substantial social upheaval. Consequently, some historians have argued that the Renaissance was one of Europe’s most “psychically disturbed” periods, with *melancholia* (or *melancholy*, an early and somewhat more inclusive term for what today we might call depression) the condition warranting the most attention (Dreher, 2013). Long-established and new explanations of mental distress flourished, including those that attributed it to “the influence of the moon, the stars,

weather, earwigs in the head, and an imbalanced life involving excessive or insufficient drink, diet, sleep, exercise, passions, and humors, along with witchcraft and the devil himself” (Dreher, 2013, p. 36). Treatments were as varied as the explanations: whipping, chaining, bloodletting, laxatives, exorcisms, herbal medicines, diets of various sorts, and even near-drowning were all employed as remedies for madness (Dreher, 2013).

Early Asylums in Europe

Geel

The Church often took on caring for “mad” people, providing them food and shelter. One of the best-known examples of humane religious treatment occurred in Geel, Belgium, where rumors circulated of miraculous cures of madness (Aring, 1974; J. L. Goldstein & Godemont, 2003). Pilgrims from all over Europe descended on the town to receive nine days of religious treatment. At the request of the church canons, area residents housed pilgrims before and after their treatments. To this day, Geel continues to offer community support services for those diagnosed with mental disorders—although no longer under the auspices of the Church (Aring, 1974; J. L. Goldstein & Godemont, 2003).

Bedlam

Not all Renaissance treatments for madness were as pleasant as Geel. *Asylums* for housing mad persons began to appear throughout Europe. Despite being founded to treat madness, these institutions usually wound up serving more of a custodial function for vagrants, criminals, the sick, people without housing, and those who today likely would be identified as psychotic or demented (Shorter, 1997). One of the more notorious asylums was Bethlehem Hospital in London. Begun as a Church institution, Bethlehem was acquired by the city of London in 1547. During the Renaissance and into the 1700s and 1800s, it was known for its deplorable conditions. Treatments included cold baths, bloodletting, and rotating patients in chairs for hours at a time (often resulting in vomiting) (Devlin, 2014; Elkins, 2016). Many patients were kept in chains and displayed to sightseers visiting the gallery (J. C. Harris, 2003). In 1733, the artist William Hogarth famously portrayed these horrific conditions as part of his work, *A Rake’s Progress* (J. Andrews, 2007a; J. C. Harris, 2003). Over time the hospital’s nickname, “Bedlam,” became synonymous with “a scene or state of wild uproar and confusion” (Dictionary.com, n.d.-a). Interestingly a modern version of the institution, now called Bethlehem Royal Hospital, remains an active psychiatric hospital, albeit in a different location and minus the notoriety.

1.8 Perspectives during the Eighteenth and Nineteenth Centuries

Moral Therapy

Alienists and the Development of Moral Therapy

Historical accounts of eighteenth- and nineteenth-century approaches to mental distress often focus on several interrelated themes: efforts toward more humane care, the development of biological and psychological perspectives, and the increasing reliance on asylums. In the late 1700s and early 1800s, the first psychiatrists (called *alienists* back then because they worked with people experiencing “mental alienation”) began to see the asylum as critical to effective treatment (R. Porter, 2002). They generally viewed psychopathology in biological terms, but many of their interventions had a psychological flavor. These interventions often involved talking to inmates about their difficulties and providing them a structured schedule and mild discipline within the asylum. Even though they hypothesized about biological causes of psychopathology, these alienists were simultaneously contributing to the development of **moral therapy**, an early version of psychotherapy with a clear psychological bent—especially compared with more biological perspectives (Elkins, 2016; R. Porter, 2002). Moral therapy did away with physical coercion. Early alienists—most famously Philippe Pinel (1745–1826) in France—began viewing the asylum as a place where gentler treatment would allow for more effective therapy. Unchained inmates became “part of a supportive social environment” in which they were treated kindly while being asked to participate in activities

Moral therapy: An early treatment for mental distress in which providing a warm and nurturing environment was used to help people overcome madness.

(such as group discussions, chores/work, art, music, reading, and writing) that were “designed to enhance their physical, mental, and emotional well-being” (Elkins, 2016, p. 79).

The York Retreat

The traditional asylum was not the only setting where moral therapy blossomed. Independently of Pinel and the other European asylum administrators, the English Quaker William Tuke (1732–1822) developed a version of moral therapy at the *York Retreat* that grew less from a biological perspective and more from a religious one—although it intermingled both (Charland, 2007). Tuke was not a doctor, and the York Retreat was a very different kind of asylum—one that emphasized Quaker values (such as benevolence, charity, discipline, self-restraint, and temperance) more than medicine (Charland, 2007; Elkins, 2016). As Tuke himself wrote, “medicine, as yet, possesses very inadequate means to relieve the most grievous of human diseases” (Tuke, as cited in Charland, 2007, p. 66). Moral treatment spread throughout Europe and the United States. Unlike larger, more traditional institutions, asylums providing Tuke’s version of moral therapy were typically small, rarely restrained patients, allowed them to wear their own clothes, and tried to foster a family-like atmosphere (J. Andrews, 2007b; “Moral Treatment in America’s Lunatic Asylums,” 1976). They also encouraged patient participation in activities such as arts and crafts, carpentry, domestic tasks, and farming—all consistent with the Quaker emphasis on living a healthy and meaningful life (Charland, 2007).

Critics of Moral Therapy

Historians generally view moral treatment as a benevolent movement that treated patients kindly and was a clear improvement upon previous practices (Bockoven, 1972; Charland, 2007; Elkins, 2016). However, in its day moral treatment did have its critics. Members of the Alleged Lunatics’ Friends Society, a group concerned with the rights of those deemed mad, attacked moral treatment “as an imposition of society’s values on the individual”; they “expressed suspicion of the tranquility so frequently admired by the Commissioners in asylums,” suggesting that “patients were first crushed, ‘and then discharged to live a milk sop existence in society’” (Hervey, 1986, pp. 253–254). The issue of whether involuntary hospital treatment is an act of kindness or oppression isn’t unique to thinking about moral treatment. It remains something we struggle with to this day (see Chapter 16). Nineteenth-century critics notwithstanding, historians still tend to conclude that “moral treatment was a new and more humane way of working with the insane” (Elkins, 2016, p. 84).

Why Did Moral Therapy Decline?

The reasons for the decline of moral therapy in the second half of the nineteenth century have been hotly debated. Some historians argue that the movement spread too quickly. They contend that, in addition to uninspired leadership after its founders passed on (Bockoven, 1972), the moral treatment movement led to the rapid proliferation of asylums, resulting in overcrowding and staff shortages. Consequently, asylums became unable to offer the personalized attention moral treatment required. This problem was compounded in the United States, where immigration produced a more diverse population and the prejudices of those running the asylums interfered with the provision of compassionate care (Bockoven, 1972). Other historians assert that moral treatment failed because it simply wasn’t effective. In this interpretation, many patients required more stringent, medically based treatments than moral treatment provided. This contradicts historians who argue that moral treatment was highly successful (Bockoven, 1972)—so successful that physicians turned against it because it showed how lay people could cure madness better than doctors could (Elkins, 2016). In this analysis, moral therapy disappeared because medical doctors reasserted their authority and instituted a more strictly medical model that restored them as the ultimate authorities on mental illness and its treatment (Elkins, 2016; Vatne & Holmes, 2006).

Larger Asylums and Their Reform

Moral treatment all but disappeared in the latter 1800s and was replaced by custodial care—warehousing patients for long periods of time without providing much in the way of treatment. As asylums became larger and more custodial in nature, the focus shifted from best treatments to a more

basic question: How do we ensure inmates have adequate basic living conditions? Thus, the latter 1800s focused on reforming oppressive conditions in asylums and other institutions such as jails. The most famous asylum reformer was Massachusetts school teacher Dorothea Lynde Dix (1802–1887), who for forty years investigated, reported on, and tried to improve the settings where mad people were housed (T. J. Brown, 1998; Gollaher, 1995; Millon, 2004; Parry, 2006). In a petition she brought before the Massachusetts Legislature in 1843, Dix (1843/2006, p. 622) forcefully made her case: “I proceed, Gentlemen, briefly to call your attention to the present state of Insane Persons confined within this Commonwealth, in cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods, and lashed into obedience!” Through her advocacy efforts in both the United States and Europe, over thirty mental hospitals were founded or expanded during the latter half of the nineteenth century (Parry, 2006; Viney & Bartsch, 1984). Though Dix was a heroic social advocate whose forty-year crusade to build mental hospitals to house and care for the mentally ill marked a humane historical turning point, some historians blame her for the rise of large, state-sponsored mental institutions that warehoused the mentally ill without providing sufficient treatment (Bockoven, 1972).

1.9 Perspectives in the Twentieth and Twenty-first Centuries

Early Twentieth-century Mental Hospitals

The first half of the twentieth century saw an expansion in the size of mental hospitals in the United States and Europe—partly because collectively housing patients in hospitals was viewed as most efficient and effective, but also because families and communities welcomed having hospitals relieve their burden of care (M. Knapp et al., 2011). In the United States, for instance, over 400,000 mental patients were institutionalized by 1940, mainly in large state psychiatric hospitals (Grob, 1994). Patients were often housed for long periods of time with little treatment provided. Funding was lacking, staff shortages were common, and the physical conditions of the hospitals were deteriorating (Grob, 1994).

Of the treatments employed, some don’t hold up well to historical scrutiny, though they were used because they sometimes worked and few alternatives were available (Lieberman, 2015). Controversial twentieth-century treatments include malarial therapy, convulsion therapy, and psychosurgery. *Malarial therapy* was rooted in the assumption that a high fever improves symptoms of psychopathology; thus, patients were injected with the malaria virus as a treatment for their ills (Elkins, 2016; Lieberman, 2015). *Convulsion therapy* was used to treat schizophrenia; epileptic-like convulsions were induced by injecting patients with insulin (*insulin coma therapy*) or administering electric shocks to their brains (*electroconvulsive therapy* [ECT]) (Endler, 1988; R. M. Kaplan, 2013; Lieberman, 2015; Shorter, 1997). Lastly, *psychosurgery* (brain surgery for mental disorders) severed connections between the prefrontal lobes and other parts of the brain; this was known as **lobotomy** (J. Johnson, 2014; Swayze, 1995). Except for ECT, these treatments are rarely (if ever) used anymore. Many of them are revisited in future chapters (e.g., when we discuss psychosis in Chapter 4).

Lobotomy: Historical form of psychosurgery used mainly for schizophrenia in which the prefrontal cortex was surgically disconnected from the rest of the brain; also called a *leucotomy*.

Antipsychiatry and Desinstitutionalization

Antipsychiatry

The second half of the twentieth century saw the birth of an **antipsychiatry** movement that challenged the hegemony of biological perspectives. R. D. Laing (1927–1989) and Thomas Szasz (1920–2012) are two figures associated with this movement. Laing (1965, 1967) challenged the idea that “mental illness” is best explained in biological terms. He saw “madness” as a meaningful and important response to oppressive life circumstances and believed people should be provided an opportunity to delve into the meaning of their mental distress instead of simply being prescribed drugs to remove their symptoms.

Similarly, Szasz (1974) argued that biological perspectives conflate mind and body. He claimed that *minds*, which are non-physical, can’t be biologically diseased; only *brains* can be physically sick. This explains why the notion of a brain tumor makes sense but a mind tumor doesn’t. Minds can’t get tumors because minds aren’t physical things! Therefore, in Szasz’s view, the concept of “mental illness” (illnesses of the mind) makes no sense—logic that, interestingly, also applies to the term mental distress. Despite rejecting the label “antipsychiatrist,” Szasz spent his career

Antipsychiatry: Movement that challenged the medical model of psychiatry, arguing that mental illnesses are better viewed as everyday problems in living.