***CHAPTER 1***

***INTRODUCTION AND***

***HISTORICAL OVERVIEW***

**INTRODUCTION TO THE DSM-5**

This Instructor’s Manual provides instructors with a comprehensive overview of material contained in the text. Each chapter of the Instructor’s Manual contains a chapter synopsis, a review of the learning goals and key terms, a series of Lecture Launchers, a compilation of Discussion Stimulators, and a list of relevant instructional films. Additionally, the manual contains criteria for disorders contained in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) as well as diagnostic criteria for disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5). Material from both editions of the DSM has been included in order to help give instructors relevant background information with the goal of enriching classroom instruction.

**Development Process**

The DSM-5 was developed over a 14-year timespan. It began in 1999 with an initial planning conference held by the American Psychiatric Association (APA) and the National Institute of Mental Health (NIMH), and was ultimately published in May 2013.

Between 2000 and 2002, initial investigatory groups were assembled to begin the revision process. The groups were comprised of international experts in the areas of psychiatry, psychology, social work, pediatrics, psychiatric nursing, gerontology, neurology, and epidemiology. The expert groups included both clinicians and researchers. All participants were volunteers; none were paid.

Between 2004 and 2007 the APA, the World Health Organization (WHO), the World Psychiatric Association (WPA), and the American Psychiatric Institute for Research and Education (APIRE) sponsored 13 international conferences to discuss the DSM-5 revisions. A series of monographs were subsequently published documenting each of the conference proceedings.

In 2006, the Chair of the DSM-5 Revision Task Force was named: David J. Kupfer, M.D. Kupfer is the Chair of the Department of Psychiatry at the University of Pittsburgh’s School of Medicine. He was made responsible for coordinating the efforts not only of the Task Force but of the 13 Work Groups, and upcoming field trials. His Vice Chair was Darryl A. Regier, M.D., M.P.H. Regier is APIRE’s Executive Director and the Director of APA’s Research Division. (Note that Regier helped coordinate the aforementioned 13 international conferences, so he was well versed in the proposed revisions.)

Between 2007 and 2008 Kupfer and Regier nominated the 13 Work Group Chairs, who then in turn nominated other experts to join their groups. All nominations were debated and subsequently approved or denied by the APA’s Board of Trustees. In total, over 160 experts were eventually approved as Work Group members.

From 2008 to 2010 the Work Group Chairs announced the likely DSM-5 diagnostic criteria on the website <http://www.DSM5.org>. Through this website professionals and the general public were permitted to post comments about the proposed criteria. Over 8,000 comments were submitted during this initial comment period. Every comment was catalogued and reviewed by the Work Groups.

Between 2010 and 2011 initial Field Trials were conducted in 11 well-respected medical centers nationwide and in a wide variety of local clinics and clinicians’ offices. Throughout this two-year period, approximately 3,500 clients were evaluated using the proposed DSM-5 criteria.

In 2011 the Work Groups released revised criteria on the website, and once again, opened a discussion board to accept comments from professionals and laypeople. This time, more than 2,000 comments were catalogued and reviewed.

In 2012 the diagnostic criteria were revised again, based on the Field Trial results, and the final version of the DSM-5 was presented to APA’s Board of Trustees. The Trustees, in turn, formed a Scientific Review Committee and a Clinical Public Health Committee to review all the recommendations. The results were then presented to the APA members for their feedback and approval.

Last, APA’s Executive Committee of the Board of Trustees gave their final approval in December, 2012 and the final version of the DSM-5 was published in May, 2013. (Information from APA.org, 2013.)

**Primary Changes in the DSM-5**

There are a number of major changes from DSM-IV-TR to today’s DSM-5. The first of these changes is that the five-axis system of diagnosis has been narrowed down to two primary categories, which are then assessed along a continuum of severity. In addition, culture now plays a central role in the diagnostic process, rather than being an afterthought. These changes are discussed in detail in Chapter 3. Moreover, there is no separate chapter for childhood disorders. Each diagnostic category includes information that might apply to children*—*it is organized chronologically.

Several of the criteria for disorders have been revised (e.g., Bipolar Disorder and Major Depressive Disorder); some disorders have been reclassified (e.g., Substance Use Disorders, Obsessive-Compulsive Disorder); some have been eliminated altogether (e.g., substance dependence and Asperger’s Syndrome); and a handful have been added (e.g., Hoarding Disorder and Excoriation Disorder). Each of these changes is outlined in the following topical chapters, along with several others. (Information from APA.org, 2013.)

**CHAPTER SYNOPSIS**

The study of **psychopathology** is a search for the reasons why people behave, think, and feel in unexpected, sometimes odd, and possibly self-defeating ways. The focus of this book will be on the description, causes, and treatments of a number of different mental disorders. It is important to note at the outset that the personal impact of our subject matter requires us to make a conscious, determined effort to remain objective. **Stigma** remains a central problem in the field of psychopathology. Stigma has four components that involve the labels for mental illness and their uses.

1. **Distinguishing label is applied.**

2. **Label refers to undesirable attributes.**

3. **People with the label are seen as different.**

4. **People with the label are discriminated against.**

Even the use of everyday language terms such as *crazy* or *schizo* can contribute to the stigmatization of the mentally ill. The Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act was signed into law in 2008, with rules regarding the implementation of the law being put into place in early 2010. This was a major advance in securing the same levels of insurance coverage for mental illnesses as for other illnesses. Many frontiers of discrimination persist.

**Defining Mental Disorder**

A number of different definitions of **mental disorder** have been offered, but none can entirely account for the full range of disorders. The DSM-IV-TR definition, as well as the DSM-5 definition, includes a variety of important characteristics.

1. **Personal Distress**: Whether or not a behavior causes personal distress can be a characteristic of mental disorder. But not all behavior that we consider to be part of mental disorders causes distress.

2. **Disability**: Behaviors that cause a disability or are unexpected can be considered part of mental disorder. But again, some behaviors do not cause disability, nor are they unexpected.

3. **Dysfunction:** The behavior impairs a person’s functioning at work, home, school, and/or in social situations. Like the other definitions, however, it cannot fully account for what we study in psychopathology.

4. **Violation of Social Norms**: Behavior that violates social norms can also be considered part of a mental disorder. However, not all such behavior is considered part of a mental disorder, and some behaviors that are part of mental disorders do not necessarily violate social norms.

Taken together, each definition of mental disorder has something helpful to offer in the study of psychopathology. The **DSM-IV-TR and DSM-5** definitions include all of these characteristics.

**History of Psychopathology**

Since the beginning of scientific inquiry into mental illness, supernatural, biological, and psychological points of view have vied for attention. Early concepts of mental illness included **demonology** (possession by demons) but also **biological** approaches as evidenced by the ideas of **Hippocrates,** who believed that mental illness was caused by a disturbance of the humors—for example, that melancholy or depression was caused by excessive amounts of sticky thick black bile and that schizophrenia arose from too much cold mucus. During the **Dark Ages**, some people with mental illness were cared for in monasteries, but many simply roamed the countryside. Some were persecuted as **witches**, but this was relatively rare. (Later analyses indicated that many of the people accused of being witches were not mentally ill.) Treatments for people with mental illness have changed over time, though not always for the better. **Exorcisms** did not do much good. Treatments in **asylums** could also be cruel and unhelpful, but pioneering work by **Pinel**, **Dix**, and others made asylums more humane places for treatment, ushering in an era known for **moral treatment**. Unfortunately, their good ideas did not last, as the mental hospitals became overcrowded and understaffed.

**The Evolution of Contemporary Thought**

Early systems of **classifying mental disorders** led to a reemergence of the **biological perspective** in the eighteenth and nineteenth centuries. Developments outside the field of psychopathology, such as the **germ theory** of disease and the discovery of the cause of **general paresis** via **syphilis**, illustrated how the brain and behavior were linked. Early investigations into the **genetics** of mental illness led to a tragic emphasis on eugenics and the enforced sterilization of many thousands of people with mental illness. Such biological approaches to treatment as induced insulin coma, **electroconvulsive therapy (ECT)**, and **lobotomy** eventually gave way to drug treatments.

**Psychological approaches** to psychopathology evolved from **Mesmer’s** manipulation of “animal magnetism” to treat hysteria (late eighteenth century) through **Charcot’s** interest in psychological aspects of hysteria and **Breuer’s** conceptualization of the **cathartic method** in his treatment of **Anna O.** (late nineteenth century) and culminated in **Freud’s** psychodynamic theories and treatment techniques (early twentieth century). Freud’s theory posited a three-part **psyche** made up of the **id, ego,** and **superego**. He further emphasized stages of **psychosexual development** and the importance of **unconscious processes**, such as **repression** and **defense mechanisms,** with the suggestion that people can **fixate** at an early stage, and that all of this is traceable to early-childhood conflicts. Therapeutic interventions based on psychodynamic theory (**psychoanalytic therapy**) make use of techniques such as **free association** and the analysis of **transference** in attempting to overcome repressions so that patients can confront and understand their conflicts and find healthier ways of dealing with them.

**Jung** and **Adler** took Freud’s basic ideas in a variety of different directions. Those who developed ego analysis maintained that the ego has energies of its own that are just as important as id energies and that it is important to focus on a person’s current living situation as well as his or her social interactions. Freud’s theorizing, though often criticized, introduced a number of concepts that are still discussed today, including defense mechanisms and the importance of the early environment in the development of psychological problems.

**Behaviorism** began its ascendancy in the 1920s and continues to be an important part of various psychotherapies. John **Watson** built on the work of Ivan **Pavlov** in showing how some behaviors can be conditioned, with the **conditioned stimulus**, or **CS**, coming to elicit the **conditioned response**, or **CR**, via its repeated pairing with an **unconditioned stimulus** (**UCS**). B.F. **Skinner**, building on the work of Edward **Thorndike**, emphasized the contingencies associated with behavior, showing how **positive** and **negative reinforcement** could **shape** behavior. Research on **modeling** helped to explain how people can learn even when no obvious reinforcers are present. Early **behavior therapy** techniques included **systematic desensitization, aversion therapy**, and **modeling**. Behaviorism did not account for emotions and thoughts and consequently, **cognitive approaches** became prominent in the 1960s. Cognitive therapy was developed based on the ideas that people not only behave, but they also think and feel. Cognitive therapies focus on changing maladaptive thoughts so that they will act differently and feel better.

**The Mental Health Professions**

There are a number of different mental health professions, including **clinical and counseling psychologist (PhD, PsyD), psychiatrist (MD), psychiatric nurse (RN, LPN), social worker (MSW),** and **marriage and family therapist (MFT, Ph.D.)**. Each involves different training programs of different lengths and with different emphasis on research, psychological assessment, psychotherapy, and psychopharmacology.

**LEARNING GOALS**

1. Be able to explain the meaning of stigma as it applies to people with mental disorders.
2. Be able to describe and compare different definitions of mental disorder.
3. Be able to explain how the causes and treatments of mental disorders have changed over the course of history.
4. Be able to describe the historical forces that have helped to shape our

current view of mental disorders, including biological, psychodynamic, and behavioral views.

1. Be able to describe the different mental health professions, including the

training involved and the expertise developed.

**KEY TERMS**

anal stage, analytical psychology, asylums, aversive conditioning, behaviorism, behavior therapy, cathartic method, classical conditioning, clinical psychologist, collective unconscious, conditioned response (CR), conditioned stimulus (CS), counseling psychologist, defense mechanism, demonology, ego, ego analysis, electroconvulsive therapy (ECT), exorcism, extinction, fixation, free association, general paresis, genital stage, harmful dysfunction, id, individual psychology, interpretation, latency period, law of effect, libido, marriage and family therapist, mental disorder, modeling, moral treatment, negative reinforcement, operant conditioning, oral stage, phallic stage, pleasure principle, positive reinforcement, psyche, psychiatric nurse, psychiatrist, psychoactive medications, psychoanalysis, psychodynamic theory, psychopathology, psychotherapy, reality principle, repression, shaping, social worker, stigma, superego, systematic desensitization, transference, unconditioned response (UCR), unconditioned stimulus (UCS), unconscious

**LECTURE LAUNCHERS**

**1. Careers in Mental Health**

Many students enroll in Abnormal Psychology classes because of an interest in entering the field or a curiosity about abnormal behavior. An interesting class discussion could focus on a more detailed review of the various mental health professions. Each profession can be listed on the board and compared on various dimensions, such as years of training required, difficulty of acceptance into training programs, criteria for acceptance (courses, grades, national exams, outside activities), focus of academic training, and career possibilities. Students are also likely to be interested in comparisons such as opinions that each profession holds of each other, interprofessional conflicts, lines of authority and power structure, salaries (the $125+ hourly rate amazes most students), and similar “insider” information.

Current topics of interest in the mental health field might be discussed, such as:

1. Should clinical psychologists be allowed “admitting privileges” at psychiatric hospitals?

2. Which professionals should be eligible to receive Medicare payments for their services?

3. Should professionals other than psychiatrists be allowed to prescribe psychotropic medications? (see **Discussion Stimulator**)

4. Should training of clinical psychologists focus on clinical or research training, or both?

5. How are career goals affected by managed care?

An article in *American Psychologist* (Purdy, J.E., Reinehr, R.C., & Swarx, J.D., 1989, *44*, 960-961) reported on results of a survey of 106 graduate programs in experimental, clinical, and counseling psychology regarding their admissions criteria. Students might be interested in hearing the conclusions:

The ideal graduate school applicant has a high GRE combined score, strong letters of recommendation, some research experience, and a high overall GPA, with particularly high grades for the final two years. For applicants for a clinical or counseling program, previous clinical experience is desirable. Undergraduate coursework would include statistics, experimental methods, and at least some laboratory experience (p. 961).

Since the publication of this article by Purdy, Reinehr and Swarx, later studies have confirmed their conclusions. See for example the article in the *American Psychologist* (Norcross, John C., Kohout, Jessica L., Wichersky, Marlene. 2005, *60*(9), pp. 959-975.

**2. HANDOUT: Hypnosis**

Because of its central role in the development of psychogenic theories of psychopathology, hypnosis is worth considering in more detail. A good place to start is with the question *what exactly is hypnosis*? Given how often psychologists and psychiatrists use the term, it is sobering to realize how much controversy there is about its nature. Hilgard (1979) suggests the following characteristics:

1. **Increased suggestibility**. Hypnotized subjects seem much more open to suggestions from the hypnotist than they would be in a waking state.

2. **Enhanced imagery and imagination**. Hypnotized subjects are able to imagine vividly the sensory experiences suggested to them and also report that they are able to retrieve images, sometimes from childhood, with great clarity.

3. **Disinclination to plan**. The hypnotized subject loses initiative and instead looks to the hypnotist as a source of direction. Indeed, many hypnotized subjects become annoyed when asked to do some planning on their own.

4. **Reduction in reality testing**. Many hypnotized subjects readily accept all kinds of perceptual distortions that they would not tolerate when awake. Thus hypnotized subjects may accept suggestions that an animal is talking to them or that someone is present in the room when no one is actually there. The logic that operates during a hypnotic trance, allowing a person to perceive the world in a way remarkably different from how he or she regards it when awake, has been called “trance logic” (Orne, 1959).

These are what many mental health workers regard as characteristics of hypnotized subjects. As in all aspects of human behavior, not all people manifest all these characteristics in the same way, and it is indeed possible for subjects who otherwise appear to be deeply hypnotized not to give all these noticeable indications at any one time. An excellent review of the characteristics and therapeutic processes can be found in Varga, K.J, Emese Kekecs, Z., *Psychology of Consciousness: Theory, Research, and Practice*, *1*(3), 2014. pp. 308-319.

Our historical review mentions Mesmer’s therapy for hysterical disabilities and subsequent work by Charcot, Janet, and Breuer. During the same period of time, surgeons were “mesmerizing” patients to block pain. For example, in 1842 a British physician, W.S. Ward, amputated the leg of a patient after hypnotizing him. Apparently the patient felt nothing during what would otherwise have been an excruciatingly painful operation. In 1849 a mesmeric infirmary was opened in London. Hundreds of apparently painless operations were performed while the patients were in hypnotic trances. In the same decade, however, ether was proved to produce insensibility to pain. The term *anesthesia* had heretofore been applied to the numbness felt in hysterical states and paralysis. Oliver Wendell Holmes is credited with suggesting that it be applied to the effects of this new agent and others like it, and that the agents be called anesthetics. The availability of these chemicals for surgical operations discontinued the use of hypnosis as an alleviator of pain.

The person who coined the modern term *hypnotism* is usually considered to be James Braid (1795-1860), a British physician who was also hypnotizing people to reduce pain. However, unlike Mesmer, Braid did not break with his profession, describing what happened in terms that were more consistent with the *Zeitgeist*. He characterized the trance as a “nervous sleep,” from which came the name “neurohypnology,” later shortened to hypnotism. Braid rejected the mystical orientation of Mesmer and yet continued to experiment with the phenomenon as he saw it. He sought a physiological cause and felt he had found one in his discovery that trances could be readily induced by having people stare at a bright object located somewhat above the line of vision. The object was placed in front of a person in such a way that the levator muscles of the eyelids had to be strained in order to keep it in view. Braid suggested that the muscles were markedly affected by having them remain fixed in this position for a given period of time and that somehow this led to nervous sleep or hypnosis. He therefore placed the cause of the sleep inside the subject rather than external to him, as Mesmer had suggested with his concept of animal magnetism. In this way he was able to perform many public demonstrations without incurring the disapproval of his medical colleagues.

As already indicated, the discovery of drugs for anesthesia discouraged the use of hypnosis in medicine. While drugs are clearly more reliable, they are more dangerous than hypnotic inductions. In clinical work many practitioners have employed hypnotic procedures for psychotherapeutic purposes, especially during World War II. From the Gulf War to the present conflicts in the Middle East, veterans have had hypnosis made available to them for the treatment of a variety of issues: bodily pain, terror, physical illness, addictions and guilt. To relieve the combat exhaustion of frightened and sleepless soldiers, doctors hypnotized them and encouraged them to relive traumatic events in the imagination.

The scientific study of hypnosis had to await the development of relatively objective measures in the 1950s. Perhaps it was the principal device developed at Stanford University by Weitzenhoffer and Hilgard (1959) called the Stanford Hypnotic Susceptibility Scale and based on the 1938 scale by Friedlander and Sarbin. In the application of this scale, or scales, the subject is hypnotized and then asked to undertake a series of tasks. For example, the hypnotist may suggest to a subject that his right hand is so heavy that it is doubtful whether he can raise it. Then the hypnotist will ask the subject to try to lift the heavy hand, even though he probably will not be able to do so. The hypnotist oversees the degree to which the subject can or cannot raise the hand and gives a plus or minus score. After the subject has been observed at a number of tasks, he is given a score ranging from zero to twelve, and this score is regarded as a measure of how deeply hypnotized he is.

Most of these scales, however, do not measure the more subjective aspects of hypnosis. For example, many hypnotized subjects, even though they have not been specifically told that it may happen, experience sensations such as floating or spinning. Many hypnotists consider such subjective experiences at least as important as the more observable performances tapped by the various scales. As we might expect, this divergence of interests contributes to the controversy within the field, with the more clinically oriented hypnotists rejecting the validity of such scales. Instead, they content themselves with reports of their subjective reactions.

*References:*

Hilgard, E.R. (1979). The Stanford hypnotic susceptibility scales as related to other measures of hypnotic responsiveness. *American Journal of Clinical Hypnosis, 21*, 68-83.

Orne, M.T. (1959). The nature of hypnosis: Artifact and essence. *Journal of Abnormal and* *Social Psychology, 58,* 277-299.

Weitzenhoffer, A.M. & Hilgard, E.R. (1959). *Stanford hypnotic susceptibility scale, Forms A* *and B.* Palo Alto, CA: Consulting Psychologists Press.

**3. Law and Lunacy in the Middle Ages**

As discussed in the text, Neugebauer (1979, “Medieval and early modern theories of mental illness” *Archives of General Psychiatry, 36,* 477-483) reviewed English legal documents dating back to the 13th century, at a time when the Crown assumed the right and responsibility for caring for the property and person of the mentally disabled. Contrary to the popular view that demonology was the primary explanation for mental illness, Neugebauer found only one reference to demonological possession in all the cases he examined. Two groups of incompetents were distinguished: idiots, or natural fools, and lunatics. These terms seem to roughly correspond to our terms “mentally retarded” and “insane.” For instance, a 16th century source defined idiot as:

“he that is a fool natural from his birth and knows not how to account or number 20 pence, nor cannot name his father or mother, nor of what age himself is, or such like easy and common matters; so that it appears he has no manner of understanding or reason, nor government of himself, what is for his profit or disprofit. “

Commonsense explanations were offered for the person's disturbed state. Consider the following cases: In July, 1490, John Fitzwilliam was said to be mentally disabled starting when he was “gravely ill.” In 1502, John Norwick “lost his reason owing to a long and incurable infirmity” and on September 18, 1291, a jury declared Bartholomew de Sadewill mentally deranged and attributed that condition to “a blow received on the head.” Robert Barry's insanity was, in 1366, thought to have been “induced by fear of his father.” Similarly, a 1568 hearing found James Benok to have been “afflicted by reason of a fright on 20 Oct. 1556 and has so continued from that time to the present.”

Interested students might also want to read the following:

*'Unfortunate folk': Essays on mental health treatment, 1863-1992,* 2001, Barbara Brookes (Ed.). Dunedin, New Zealand: University of Otago Press.

*The invisible plague: The rise of mental illness from 1750 to the present.* Torrey, E. Fuller and Miller, J. (2001). New Brunswick: Rutgers University Press.

**4. Hysteria vs. Malingering and the Views of Thomas Szasz**

At this point in the course, a discussion of the problems of diagnosis and classification and the historical roots of the concept of mental illness could be presented. Thomas Szasz covers this topic in *The Myth of Mental Illness* (1961, New York: Harper and Bros.). Szasz reviews Charcot’s influence on psychiatry and on the public’s view of mental disorders. Before Charcot's time, hysteria was considered to be a form of malingering (faking real physical illness), and such counterfeiters were treated with anger and hostility by physicians who resented the deception. After Charcot had lent his expertise and authority to the problem of hysteria, it was elevated to the status of “illness.” Szasz asserts that this shift has led to the present-day classification of all human conduct as falling within the purview of mental illness.

How did this shift take place? Szasz suggests that Charcot’s goal was to get hypnosis and hysteria accepted by the medical profession as respectable phenomena, worthy of study; further, he asserts that rather than use logical analysis or scientific investigation to understand hysteria, Charcot simply changed the rules of classification so that “malingering” became “illness.” Given that the new illness could nevertheless be considered counterfeit in the sense that it mimics a physiological dysfunction, medicine acquired the responsibility of distinguishing not only real from imitated physical illness, but conscious from unconscious faking. If the sufferer counterfeits unknowingly, he is not a malingerer, but a hysteric. While this change in label may have been humane in the sense that such sufferers were no longer shunned by physicians, Szasz argues that it has obscured our understanding both of true organic neurological disorders and of problems in living that may only look like physical disorders. Further confusion arises when, as is the case today, conscious malingering itself is seen as a form of mental illness; Szasz quotes Bleuler: “Those who simulate insanity with some cleverness are nearly all psychopaths and some are actually insane. Demonstration of simulation, therefore, does not at all prove that the patient is mentally sound and responsible for his actions” (p. 48).

Discussion might focus on the following questions:

1. What are the consequences of labeling a phenomenon an “illness?”

2. How does such a label obscure or clarify that which it describes?

3. Should psychiatry be considered a branch of medicine?

4. What is the value of distinguishing “conscious” from “unconscious” malingering?

5. Would it be considered malingering if organically based symptoms are exaggerated by psychological factors?

6. How can such a distinction be made?

7. If hysteria had continued to be seen as simple malingering, would the psychogenic hypothesis of psychopathology have been advanced?

**5. Asylums in Modern Times**

The text summarizes some recent work by Whitaker (2002) concerning asylums in modern times. Another significant contribution to this area is Burton Blatt’s work exposing the condition of institutions for the mentally retarded as recently as the late 1970s. In *Exodus from* *Pandemonium* (1970, Boston: Allyn & Bacon), Blatt documents institutional care of the mentally retarded. Discussion might be sparked by reading the following quotes from Blatt’s book, asking students to guess the year (or century!) they describe:

The children's dormitories depressed me the most. Here, cribs were placed – as in the other dormitories – side by side and head to head. Very young children, one and two years of age, were lying in cribs without any contact with any adult, without playthings, without apparent stimulation. In one dormitory that had over 100 infants and was connected to nine other dormitories that totaled 1,000 infants, I experienced my deepest sadness. As I entered, I heard a muffled sound emanating from the “blind” side of a doorway. A young child was calling, “Come, come play with me. Touch me (p. 18).

 . . I found two young women in one cell, lying nude in the corner, their feces smeared on the walls, ceiling, and floor – two bodies huddled in the darkness, on a bare terrazzo floor . . . On the next floor was a girl who has been in a solitary cell for five years, never leaving – not for food or toileting or sleep. This cell – this concrete and tile cubicle, without furniture or mattress or washstand, is one human being’s total universe” (pp. 72-73).

The words describe institutions visited by Blatt in the 1960s.

*Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Goffman, E., 1961, Chicago: Aldine Publishing Company) offers a sociological perspective on life in institutions, researched during the 1950s. In the essay “On the Characteristics of Total Institutions,” Goffman discusses institutional life (with a particular focus on mental institutions) from the point of view of both the “inmates” and the staff. Discussion might focus on the loss of identity, personal possessions, meaningful work, and control over personal needs (asking permission to go to the bathroom, use the telephone, spend money, mail letters) that characterizes institutional life, as well as the perspective of the staff who must reconcile patients’ self-destructive behavior and the resulting need for measures which curtail their rights, incompatible standards for different patients (e.g., if the gates are left open for those patients with “town privileges,” patients who could otherwise have enjoyed the use of the grounds might have to be kept in locked wards), and the conflict between humane treatment and institutional efficiency (e.g., collective clothing is depersonalizing, yet much more efficient to clean and keep track of than personally owned clothing). Students might be encouraged to think about ways that institutional life could be improved, as well as whether it is possible to effect true reform without abandoning the institutional system altogether (foreshadowing the discussion of de-institutionalization in Chapter 18).

For those students who believe that our current enlightened recognition of the problem of institutionalization is sufficient to alleviate the conditions in institutions, it can be pointed out that the following quote first appeared in the *Journal of Mental Science* in 1856:

Asylums . . . might justly be called manufactories of chronic insanity. If a case recovers, and few indeed are those that do recover within their walls, it is certainly the result of fortuitous circumstances, and not of any special treatment applied to it (Aldridge, p. 1979, *British Journal of Psychiatry, 134,* p. 333).

Awareness and outrage, while starting points, seem to be insufficient motivators for change in institutional care when viewed from an historical perspective.

A classic experiment by David Rosenhan and colleagues between 1969 and 1972 demonstrated that it was difficult to distinguish sane from insane in hospitals. An expanded interview can be seen at:

<https://search.yahoo.com/search;_ylt=A0SO8wTrREBUsXQAAJ9XNyoA;_ylc=X1MDMjc2NjY3OQRfcgMyBGZyA3lmcC10LTkwMS1zBGdwcmlkAzB2NzJHenEuUURldlNoZnhSc0hHbkEEbl9yc2x0AzAEbl9zdWdnAzAEb3JpZ2luA3NlYXJjaC55YWhvby5jb20EcG9zAzAEcHFzdHIDBHBxc3RybAMEcXN0cmwDNDMEcXVlcnkDZGF2aWQgcm9zZW5oYW4ncyBleHBlcmltZW50IHZpZGVvIGludGVydmlldwR0X3N0bXADMTQxMzQ5ODE5Ng--?p=david+rosenhan%27s+experiment+video+interview&fr2=sb-top-search&fr=yfp-t-901-s&fp=1>

or watch Rosenhan talking about his experience by going to the *Discovering Psychology* video series at this link: <http://www.learner.org/resources/series138.html>

number 21 on Psychopathology and the 7-minute mark.

They were admitted to psychiatric hospitals claiming they heard voices saying “empty, dull, thud” and then after admission claimed that they felt fine and had not more hallucinations. The ensuing experience was described by Rosenhan as dehumanizing. This is an excellent discussion starter.

**6. Setting the Record Straight**

Skinner’s death in August of 1990 rekindled both recognition of his accomplishments in psychology and renewed criticism of his views. Many of his critics are journalists in the popular press who are both confused and inflamed by his social views as espoused in Walden Two and Beyond Freedom and Dignity. Since many of your students may have read one of these books (or, more likely, formed an opinion of Skinner without having read his books), discussion of some of the points raised by Dinsmoor in “Setting the record straight: The social views of Skinner” (1992, *American Psychologist, 47*, 1454-1463) may be helpful. The following points are especially illuminating:

1. While many misinterpreted Skinner as a totalitarian, interested only in controlling the behavior of humans, he may more accurately be seen as a libertarian. His point is that humans are already being controlled by their governments and other social institutions, and the important issue to address is what form that control should best take. One of Skinner's primary concerns, then, was to criticize the use of aversive control, or punishment, as oppressive and ineffective.

2. Dinsmoor believes that Skinner may have been too confident that what is reinforcing is also good for the person whose behavior is being reinforced; thus, he may have underestimated the possibility that positive reinforcement could be used for selfish purposes.

Your students might be encouraged to discuss the nature of control present in our society, and ways in which control could be altered. What utopian societies would result from the ideas of writers in other psychological paradigms?

A second discussion may be about the “air-crib” or “heir conditioner” and Deborah Skinner Buzan. Some claim that her father, B.F. Skinner, confined her to this device, rather than putting her into a regular crib, as some sort of research project.

**DISCUSSION STIMULATORS**

**1. Prescription Privileges for Psychologists**

As mentioned in the text, controversy has emerged in recent years over whether or not psychologists should be allowed to prescribe psychotropic drugs. Several recent articles discuss the pros and cons of such a change and might provoke interesting class discussions. For example, Brentar and McNamara (1991, “The right to prescribe medication: Considerations for professional psychology,” *Professional Psychology: Research and Practice, 22*, 179-187) present arguments in favor of prescription privileges for psychologists as well as impediments to such change. They argue that in rural areas in particular, there are too few psychiatrists to meet the communities' needs for psychotropic medications. Thus, such drugs are usually prescribed by general practitioners who have little or no psychiatric training (and may, in fact, already look to psychologists for help or consultation). In addition, it has been argued that prescription privileges will reduce health care costs since psychologists generally charge significantly less than psychiatrists.

Impediments to changes in the prescription laws include 1) A recent study by Crabtree in 2012 found strong objections from physicians (Dissertation Abstracts International: Section B: The Sciences and Engineering, Vol 73(6-B). p. 3934. Publisher: ProQuest Information & Learning [Dissertation]), 2) psychologists’ theoretical foundation (some are concerned that prescription privileges would lead to a situation where “biological explanations of mental illnesses may be accepted without fully examining psychological determinants” [p. 182]), 3) the need to develop new psychopharmacological training programs for psychologists, 4) necessary changes in licensing laws and procedures for psychologists, and 5) increased malpractice liability for psychologists who wish to prescribe medication.

In “Prescription privileges for psychologists: The case against,” DeNelsky (1991, *Professional Psychology: Research and Practice*, 22, 188-193) raises the concern that prescription privileges would make psychology more a medical specialty than a predominantly behavioral field; he notes that psychiatry moved away from psychotherapy as it began to rely more on psychoactive medications. Students might be asked to read DeNelsky’s article with attention to the paradigmatic issues raised by consideration of such a major change in the role of psychologists. For example, DeNelsky discusses both the usefulness of non-biological interventions for conditions with a biological basis and the idea promoted by other writers that avoiding prescription privileges is a way of returning to the outdated notion of mind-body dualism.

A recent study examined the attitudes of psychology graduate students toward prescription privileges (Luschner, Corbin, Bernat, Calhoun, and McNair, 2002, *Journal of Clinical Psychology, 58*, 783-792). The findings indicated no consensus among graduate students regarding prescription privileges. One concern expressed in this study was that the course work needed to prepare for prescription privileges would considerably lengthen the time required to complete graduate training. Some of the possible issues mentioned in this study include difficulties with the medical profession, how to determine the best training method, increased malpractice insurance costs, whether psychologists could prescribe adequately, and the need for the field of clinical psychology to remain competitive.

In a special issue of the *Journal of Clinical Psychology* (2002, Vol. 58), some of the issues central to this debate were summarized by Helby: 1) The need of mental health care professionals to provide managed care and to collaborate more directly with primary care providers; 2) Whether prescription privileges represents an ongoing move to “medicalize” the field of psychology; 3) How training for prescription privileges will impact the entire graduate curriculum; 4) The cost of obtaining prescription privileges; 5) The impact of privileges on collaboration with physicians; and 6) Policy differences within the professional organizations toward prescription privileges.

**2. Is It Really Abnormal?**

The text discusses four “characteristics” of mental disorder: disability, distress, violation of social norms, and dysfunction. Discussion might focus on how each of these definitions could be misused. Examples: In a repressive society that values neighbors spying on neighbors, could those who do not spy on their neighbors be classified as having a mental disorder? The text discusses personal distress as another characteristic of mental disorder. In the above example, it is not difficult to imagine that one could become distressed either as an individual who spies on neighbors or as the spied-upon neighbor. Would either case be within the realm of abnormal psychology? In addition, some forms of mental disorder are more distressing to others than to the individual who presents for therapy. For example, children may be brought to a therapist because their behavior is distressing to the parents. How do we know that it is the child’s behavior that is abnormal rather than the parents’ lack of parenting skills?

**3. Pre-Post Assessment of Students’ Views of Mental Disorder**

Name

(circle one:) PRE or POST

1) How would you define “mental illness”?

2) Where do you think “mental illness” comes from? Is the root of mental disorder primarily physical/organic, early childhood experiences, current environmental forces, or some other factor?

3) How do you think mentally disturbed people should be treated? What treatment approach(es) do you think work best?

4) What do you hope to learn from this course? (Or, if post-course, what have you learned that is most valuable?)

**4. Are you satisfied with the current classification system for mental disorders?**

Have students generate a list of behaviors they consider “odd” or “abnormal.” Then have them discuss whether each behavior meets the criteria for being a mental disorder. Are there behaviors that *are* concerning that don’t meet the criteria for being a mental disorder? Are there behaviors that *are not* concerning that do meet the criteria for being a mental disorder? Facilitate a class discussion that includes the student’s reactions to the classification system.

**INSTRUCTIONAL FILMS**

(A list of film distributors can be found at the end of this manual.)

1. *The Mind, No. 1* − *Search for Mind* (PBS/ALS, 60 min, color video, 1988)

Explores ways that science has looked into the mind throughout history, from psychoanalysis to neuroscience.

2. *Hurry Tomorrow* (Richard Cohen Films, b&w, 1975)

A documentary filmed in a Los Angeles psychiatric hospital that depicts the attitudes of staff and the treatment of patients. The film also illustrates how individuals struggle to maintain their dignity in what the film maker described as “a dehumanized environment.”

3. *King of Hearts* (color film, MGM, 1966)

This classic film stars Alan Bates as an English soldier sent to scout out a

German-occupied French village, abandoned by all but members of the local insane asylum. The film focuses on what happens when these residents occupy the town. An excellent and humorous portrayal of normal and abnormal behavior.

4. *Back from Madness: The Struggle for Sanity* (FHS, 53 min, color, #BVL6299)

“This program provides a view of the world of insanity that few ever see, following four psychiatric patients for one to two years, from the time they arrive at Harvard’s Massachusetts General Hospital, and contextualizing their present-day treatments with rare archival footage demonstrating how their conditions were treated in the past. On one level, the program examines what psychiatric treatment is like today at one of the world's most famous hospitals. Beyond this, the program is about the patients themselves, and the inner strength required of them as they search for some relief from the severe mental illnesses they are coping with: schizophrenia, manic-depression, obsessive-compulsive disorder, and suicidal depression. Caution: graphic images contained in this program may be objectionable to certain viewers. An HBO production.”

5. *Mistreating the Mentally Ill* (FHS, 56 min, color, #BVL5069)

“There are 250 million seriously mentally ill people the world over and no society – rich or poor – has devised a humane system of care. This program focuses on the U.S., Japan, India, and Egypt, examining how each culture sees mental illness and treats the less accepted members of society. In general, Japan locks its patients up for long periods in predominantly for-profit institutions where they are often subject to brutal treatment; the U.S., with the best of intentions, casts many of its mentally ill out on the streets or into vast shelters with little hope of receiving care; India treats less than 10%of those who need care, with occasional oases of good community care contrasting with examples of inhumane conditions in psychiatric hospitals; while in Egypt, rural traditions that tolerate the mentally ill are being submerged in industrialization, and one of Cairo's largest private mental hospitals is run as a business by the president of the World Federation of Mental Health. The program concludes that the problem is not merely shortage of funds, but the indifference of society to the mentally ill.”

6. *Committed in Error: The Mental Health System Gone Mad*. (FHS, 52 min, #BVL3997). “This is the story of a man who spent 66 years incarcerated and forgotten in mental health institutions, although there was never anything wrong with him. This particular story takes place in Britain, but it could as easily have happened in the U.S. – people put away because they were hard of hearing, or their family didn’t want them – people whose lives were destroyed because the system went tragically wrong.”

7. *Bellevue: Inside Out* (FHS, 76 min., #BVL11870)

“New York City's Bellevue Hospital has a renowned psychiatric emergency center that treats 7,000 men and women annually. This gritty program takes a daunting look at the daily operation of the center by focusing on a handful of people as they struggle with their illnesses. The entire experience is presented, from arrests of the criminally insane and admissions of new patients to long-term treatment and therapy groups. In addition to working with mental disorders, doctors and nurses also confront drug and alcohol addiction in an environment where 50 percent of their patients have substance abuse problems. An HBO production.”

*8. How Mad Are You?* (BBC Horizon, 108 min, color, video, 2008)

“Around one in four people in the UK has been diagnosed with mental illness at some point in their lives. For many, simply being called "mentally ill" is a heavy burden, as it can bring profound social stigma, leaving some patients outcast all their lives. This two-part special for Horizon confronts this stigma and probes the fine line between mental illness and sanity. It asks: how mad are you? The programme features 10 volunteers; half have psychiatric disorders, the other half don’t − but who is who? Over five days, the group takes part in a life-changing experience as they are put through a series of challenges − from performing stand-up comedy to mucking out cows − to see who copes best with the tests put before them.” The events are designed to explore the character traits of mental illness and ask whether the symptoms might be within all of us. Horizon asks if you can tell who is who, and considers where the line between sanity and madness lies.