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Understanding Mental Disorders

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Personality and Abnormal Psychology

How do we define personality? To endeavor to do so is to get at the very root of psychology, namely, who a person really is, what makes a person tick, and why. Popular meanings of personality generally fall into one of two categories: the social skills and the salient impression one leaves on others. Closely linked to the study of personality is the study of abnormal behavior, or mental illness, a concern of philosophers since ancient times. When we speak of mental illness, we are speaking not only of the gross distortions in reality as characterized by illnesses such as schizophrenia, but also of the less severe difficulties that many people encounter dealing with everyday life.

This chapter will cover psychodynamic, behaviorist, type/trait, and phenomenological theories of personality and abnormal psychology, as well as some of the corresponding approaches of psychotherapy. Using the DSM-IV classification system, we will review some of the major categories of psychopathology: disorders first diagnosed in infancy, childhood, or adolescence; schizophrenic disorders; mood disorders; somatoform disorders; dissociative disorders; eating disorders; and personality disorders. (Mental retardation is discussed in the chapter on developmental psychology, and deliriums and dementias are discussed in the physiological psychology chapter.)

HISTORICAL PERSPECTIVE

William Sheldon's early theory of personality defined physical/biological variables that he related to human behaviors. He characterized people by body type, relating body type (somatotypes) to personality type. He used the terms **endomorph**, **mesomorph**, and **ectomorph** to characterize body types that were soft and spherical; hard, muscular, and rectangular; and thin, fragile and lightly muscled, respectively.

Early theories of abnormal behavior were similarly strange by today's standards: Abnormal behavior was seen as evidence of demonic possession or even witchcraft. However, beginning with the Renaissance, this view began to lose favor.

Some historians of psychology, most notably **E. G. Boring**, have suggested that the development of psychology is due not primarily to the efforts of great people, but to *Zeitgeist*, or the changing spirit of the times. Beginning with **Edward Titchener's method of introspection**, which formed the system of psychology called **structuralism**, a half dozen or so other major systems of psychology have developed over psychology's history, perhaps due to *Zeitgeist*: **functionalism**, **behaviorism**, **gestalt psychology**, **cognitive psychology**, **psychoanalysis**, and **humanism**.

Sigmund Freud's (1856–1939) theory of personality was the first comprehensive theory on personality and abnormal psychology. Most of Freud's predecessors emphasized consciousness and the power of reason in human behavior. Based upon his experience treating neurosis, Freud reversed this thinking and opened up a whole new perspective on personality. He

pioneered the psychoanalytic system of thought in psychology. His theory will be covered in detail in this chapter.

Humanism developed as a system in the mid-20th century. It arose in opposition to both psychoanalysis and behaviorism. Humanistic psychology opposed the pessimism of the psychoanalytic perspective and the robotic concepts of behaviorism. Humanists believe in the notion of free will and the idea that people should be considered as wholes rather than in terms of stimuli and responses (behaviorism) or instincts (psychoanalysis). Important humanists include **Abraham Maslow** (1908–1970) and **Carl Rogers** (1902–1987). More information on these theorists is presented in this chapter.

Treatment options for people with mental illness have improved tremendously over time. Beginning in the 1500s, asylums were created to care for the mentally ill, where patients were treated like animals. Cells were dark dungeons with no provisions for heat in the winter. Hands and feet were chained and patients slept on straw rather than beds. They were kept shackled to the wall and were forced to sit in their own filth.

In 1792, **Philippe Pinel** was placed in charge of an asylum in Paris that was marked by the conditions just described. Pinel, however, believed that people with mental illness should be treated with consideration and kindness. He removed shackles from the patients, allowed them to go outside on hospital grounds, gave them beds to sleep on, and, in general, made sure the patients were treated humanely. As you might imagine, these changes had beneficial effects on the patients. These reforms spread to other asylums.

An important reformer in the United States was **Dorothea Dix**. From 1841 to 1881, she was a zealous advocate of treating the hospitalized mentally ill in a humane way. Her campaign was instrumental in improving the lives of the mentally ill in this country.

Advances were made in the later part of the 19th century in the biomedical understanding of physical and mental disorders. An important development was the discovery of the etiology (cause) of **general paresis**. General paresis was a disorder characterized by delusions of grandeur, mental deterioration, eventual paralysis, and death. It was eventually discovered that general paresis was due to brain deterioration caused by syphilis (which was untreatable until 1909), and that the mental disorder seen in the syndrome was caused by organic brain pathology. The idea that physiological factors could underlie mental disorders was an important advance in our understanding of abnormal psychology.

In 1938, **Cerletti** and **Bini** introduced the use of the electroshock for the artificial production of convulsive seizures in psychiatric patients. They believed that epileptic-like convulsions could cure schizophrenia (they were wrong). The convulsions were so violent that patients were in danger of fracturing vertebrae and other bones.

Between 1935 and 1955, tens of thousands of patients were subjected to **prefrontal lobotomies** to treat schizophrenia. In this surgical treatment, the frontal lobes of the brain were severed from the brain tissue. Unfortunately, this procedure also destroyed parts of the

frontal lobe—the lobe of the brain responsible for most of the traits that make us distinctly human. Lobotomy didn't cure schizophrenia—it just made the patient easier to handle, since, in many cases, the patient became tranquil and showed an absence of feeling.

The introduction of antipsychotic drugs in the 1950s to treat schizophrenia changed the atmosphere in psychiatric hospitals. Surgeons stopped performing lobotomies and using electroshock therapy for schizophrenia as these antipsychotic drugs offered a major breakthrough in treatment modalities, with many formerly “hopeless” patients released from psychiatric hospitals completely.

Finally, in 1883, **Emil Kraepelin** published a textbook in which he noted that some symptoms of mental disorders occurred together regularly enough that the symptom patterns could be considered specific types of mental disorders. He then described these disorders and worked out a scheme of classifying these disorders integrating clinical data. Kraepelin's classification system was effective in summarizing what was known at the time. It was also a precursor to our current classification system, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The fourth edition is referred to as DSM-IV.

THEORIES OF PERSONALITY AND ABNORMAL PSYCHOLOGY AND TREATMENT MODELS

We can categorize theories of personality into four areas: psychodynamic (psychoanalytic), behaviorist, phenomenological, and type and trait. There are great differences between these divisions in how personality is defined and how those theoretical perspectives explain abnormal personality; there are also differences within each division.

Psychodynamic

Sigmund Freud

The theories subsumed under **psychodynamic** or **psychoanalytic theory** postulate the existence of unconscious internal states that motivate the overt actions of individuals and determine personality. Sigmund Freud's model of personality was the structural dynamic model, and involved three major systems: the **id**, **ego**, and **superego**. The **id** is the reservoir of all psychic energy and consists of everything psychological that's present at birth. It functions according to the **pleasure principle**, whose aim is to immediately discharge any energy build-up i.e., relieve tension. The **primary process** is the id's response to frustration operating under the dictum of “obtain satisfaction now, not later.” For example, if a person gets hungry and food is unavailable, it is through the use of the primary process that a memory image of food might alleviate the frustration experienced. The mental image of the object is known as **wish-fulfillment**. However, since the person can't eat his mental image, another system forms.

Since the mental image cannot effectively reduce tension on a permanent basis, the **ego** and its mode of functioning, the **secondary process**, come into play. The ego operates according to the **reality principle**, taking into account objective reality as it guides or inhibits the activity of the id and the id's pleasure principle. The aim of the reality principle is to postpone the pleasure principle until the actual object that will satisfy the need has been discovered or produced. It must be emphasized that while the ego's functioning suspends the workings of the primary process, it does so only in service of the id to pragmatically meet the demands of objective reality. The mutual give and take of ego and secondary process with reality promotes the growth and elaboration of the psychological processes of perception, memory, problem-solving, thinking, and reality testing. The ego can be understood to be the organization of the id; receiving its power from the id, it can never really be independent of the id.

The **superego** is similar to the id in that it too is not directly in touch with reality and strives for the ideal rather than the real. However, it represents the moral branch of personality, striving for perfection. There are two subsystems of the superego: the **conscience** and the **ego-ideal**. Whatever a child's caregivers say is improper and the child is punished for is incorporated into the child's conscience. Whatever they approve of and reward the child for tends to be incorporated into ego-ideal. Ultimately, a system of right or wrong is substituted for the parental punishment—reward.

An **instinct** is an innate psychological representation (wish) of a bodily (biological) excitation (need). Instincts are the propelling aspects of Freud's dynamic theory of personality. Freud listed two general types of instincts: life and death instincts, sometimes called **Eros** and **Thanatos**, respectively. The life instincts serve the purpose of individual survival (hunger, thirst, and sex). The form of energy by which the life instincts perform their work is called **libido**. The death instincts represent an unconscious wish for the ultimate absolute state of quiescence.

The ego's recourse to releasing excessive pressures due to anxiety is referred to as **defense mechanisms**. All defense mechanisms have two common characteristics: 1) they deny, falsify, or distort reality; and 2) they operate unconsciously. There are eight main defense mechanisms: **repression**, **suppression**, **projection**, **reaction formation**, **rationalization**, **regression**, **sublimation**, and **displacement**. **Repression** is the unconscious forgetting of anxiety-producing memories. **Suppression** is a more deliberate, conscious form of forgetting. **Projection** is when a person attributes his forbidden urges to others. For instance the thought, "I hate my uncle," may cause too much anxiety, so it gets turned into "My uncle hates me." In **reaction formation**, a repressed wish is warded off by its diametrical opposite. For example, a young boy who hates his brother and is punished for his hostile acts may turn his feelings into the exact opposite; he now showers his brother with affection. **Rationalization** refers to process of developing a socially acceptable explanation for inappropriate behavior or thoughts. **Regression** refers to a person reverting to an earlier stage of development in response to a traumatic event. **Sublimation** is transforming unacceptable urges into socially acceptable behaviors. In **displacement**, pent-up feelings (often hostility) are discharged on objects and people less dangerous than those objects or people causing the feelings. An example of displacement occurs when someone who is harassed by his boss at work goes home and provokes an argument with his wife.

Carl Jung

Later psychoanalytic theories have given more emphasis to interpersonal, sociological, and cultural influences, while maintaining their link with the psychoanalytic tradition. **Carl Jung** preferred to think of libido as psychic energy in general (not just psychic energy rooted in sexuality). Jung identified the ego as the conscious mind, and he divided the unconscious into two parts: the personal unconscious, similar to Freud's notion of the unconscious, and the **collective unconscious**. The collective unconscious is a powerful system that is shared among all humans and considered to be a residue of the experiences of our early ancestors. It includes images that are a record of common experiences, such as having a mother and a father. These images are the building blocks for the collective unconscious, referred to in Jung's theory as **archetypes**. An archetype is a thought or image that has an emotional element.

Major Jungian archetypes include: the **persona**, the **anima** and **animus**, the **shadow**, and the **self**. The **persona** is a mask that is adopted by a person in response to the demands of social convention. This archetype originates from social interactions in which the assumption of a social role has served a useful purpose to humankind throughout history. The **anima** (feminine) and the **animus** (masculine) help us to understand gender, the feminine behaviors in males, and the masculine behaviors in females. The **shadow** archetype consists of the animal instincts that humans inherited in their evolution from lower forms of life. The shadow archetype is responsible for the appearance in consciousness and behavior of unpleasant and socially reprehensible thoughts, feelings, and actions. The **self** is the person's striving for unity, and is the point of intersection between the collective unconscious and the conscious. Jung symbolized the self as a *mandala*, a Sanskrit word meaning *magic circle*. Jung saw the mandala as the mythic expression of the self, as the reconciler of opposites and as the promoter of harmony.

Jung also had a typology of personality. Jung distinguished two major orientations of personality: **extroversion** and **introversion**. Extroversion is an orientation toward the external, objective world. Introversion is an orientation toward the inner, subjective world. These two opposing orientations are both present in the personality, but ordinarily one of them is dominant. Jung also described four psychological functions: thinking, feeling, sensing, and intuiting. Typically, one of those four functions is more differentiated than the other three. Jung believed that these systems, attitudes, and functions all interact in dynamic ways to form personality.

Alfred Adler

Alfred Adler's theory turned the attention to immediate social imperatives of family and society (social variables) and their effects on unconscious factors. Adler was the originator of the concept of the inferiority complex—that is, the individual's sense of incompleteness, sense of imperfection, physical inferiorities, as well as social disabilities. According to Adler, it is striving toward superiority that drives the personality. This striving enhances the personality when it is socially oriented, that is, when the striving leads to endeavors that benefit all people; when the striving is selfish and not socially oriented, it becomes the root of personality disturbances.

The notions of the **creative self** and the **style of life** were also important to Adler's theory. The creative self is that force by which each individual shapes his or her uniqueness and makes his or her own personality. Style of life represents the manifestation of the creative self and describes a person's unique way of achieving superiority (as opposed to inferiority). The family environment is crucial in molding the person's style of life. (Adler coined the term "lifestyle.")

Another important concept in Adler's theory of personality is **fictional finalism**. This is the notion that an individual is motivated more by his or her expectations of the future than by past experiences. According to Adler, human goals are based on a subjective or fictional estimate of life's values rather than objective data from the past.

Notice the difference between Freud, Jung, and Adler. Whereas Freud's major assumption is that behavior is motivated by inborn instincts and Jung's principal axiom is that a person's conduct is governed by inborn archetypes, Adler assumes that people are primarily motivated by striving for superiority.

Karen Horney

Karen Horney postulated that the neurotic personality is governed by one of ten needs. Each of these needs is directed toward making life and interactions bearable. Examples of these neurotic needs are the need for affection and approval, the need to exploit others, and the need for self-sufficiency and independence. While healthy people have the need for affection and the need for independence, Horney emphasizes that these neurotic needs resemble healthy ones except in four respects: one, they are disproportionate in intensity; two, they are indiscriminate in application; three, they partially disregard reality; and four, they have a tendency to provoke intense anxiety. For instance, someone with a neurotic need for self-sufficiency and independence would go to great extremes to avoid being obligated to someone else in any way. As the central focus of the person's life, it would be a neurotic need and not a healthy one.

Horney's primary concept is that of basic anxiety. This is based on the premise that a child's early perception of the self is important. A sense of helplessness as a child confuses the child, makes the child feel insecure, and produces basic anxiety in the child. To overcome basic anxiety and attain a degree of security, the child uses three strategies in his relationship with others: moving toward people to obtain the good will of people who provide security; moving against people, or fighting them to obtain the upper hand; and moving away, or withdrawing, from people. These three strategies are the general headings under which the ten neurotic needs fall. Healthy people use all three strategies, depending on the situation. However, the highly threatened child will use one of these strategies rigidly and exclusively, and this carries over into adult personality.

Ego Psychologists

A modification and extension of Freud's theory was initiated by his daughter, **Anna Freud**, and was the result of her work in psychotherapy with children. She suggested that

psychoanalytic theory and psychotherapy could profit from more direct investigation of the conscious ego and its relation to the world, to the unconscious, and to the superego. She also augmented our understanding of the ego defense mechanisms. She is usually considered to be the founder of **ego psychology**.

Erik Erickson, another ego psychologist, provided a direct extension of psychoanalysis to the psychosocial realm. He expanded and reworked Sigmund Freud's stages to cover the entire lifespan and in so doing showed how even negative events or conflicts could have positive effects on adult personality. He used this framework to describe the healthy person on his or her own terms and not merely as opposed to the unhealthy individual. A full discussion of Erickson's developmental stages is included in the developmental psychology chapter.

Object Relations

Object-relations theory also falls under the realm of psychodynamic theories of personality. In this context, "object" refers to the symbolic representation of a significant part of the young child's personality. Object-relations theorists look at the creation and development of these internalized objects in young children. Important object-relations theorists include **Melanie Klein**, **D. W. Winnicott**, **Margaret Mahler**, and **Otto Kernberg**.

Psychoanalytic Treatment

Psychoanalysis is probably the best known type of psychotherapy. This therapy was developed by Sigmund Freud and is an intensive, long-term treatment for uncovering repressed memories, motives, and conflicts stemming from problems in psychosexual development. Freud believed that by gaining insight into the repressed material, the energy being utilized to deal with the repressed conflict would be freed up and made available for further development.

Early in the development of psychoanalysis, Freud used **hypnosis** to free repressed thoughts from the patient's unconscious, but he later dropped that method in favor of alternative methods. Freud used **free association**, a technique whereby the client says whatever comes to his or her conscious mind regardless of how personal, painful, or seemingly irrelevant it may appear to be. Through free associations, the analyst and patient together reconstruct the nature of the client's original conflict. Freud also used **dream interpretation**. Freud believed that the defenses are relaxed and the mind is freer to express forbidden wishes and desires during dream states. Therefore, understanding patients' dreams leads to an understanding of their unconscious conflicts. **Resistance**, or an unwillingness or inability to relate to certain thoughts, motives, or experiences, is also a major part of analysis. Such things as forgetting dream material, missing a therapy session, blocking associations, and switching topics rapidly are indications of resistance and subject to analysis. And finally, **transference** involves attributing to the therapist attitudes and feelings that developed in the patient's relations with significant others in the past. It is through transference that the analyst can help recreate the patient's experiences so that the patient has an opportunity to uncover, acknowledge, and understand his or her relationships with others. The therapist too will experience a full array

of emotions toward the patient at various points in the treatment. This is known as **countertransference** and must be understood by the therapist so that it does not impinge on the treatment in a counterproductive way. This is one of the reasons psychoanalysts-in-training undergo psychoanalysis themselves.

Classical psychoanalysis is very expensive and requires a larger commitment of time than most people can make. As a result, there have been many modifications in the treatment. The **neo-Freudian approaches** place much more emphasis on current interpersonal relationships and life situations than on childhood experience and psychosexual development.

Behaviorism

The basic assumption of behavior theory regarding personality development is that behavior is learned as people interact with their environment. Rather than focus on unconscious instincts, the **behaviorist theories of personality** tend to look first and foremost at behavior. **John Dollard** and **Neal Miller** blended some psychoanalytic concepts in a behavioral stimulus-response reinforcement learning theory approach. Dollard and Miller focused on conflicting motives or conflicting tendencies in the development of personality. **B. F. Skinner** considered personality to be a collection of behavior that happens to have been sufficiently reinforced to persist. That is to say, “personality” is the result of behavioral development of an organism. **Albert Bandura** also contends that learning principles are sufficient to account for personality development. The basis of his **social learning theory** is modeling observed behavior. Bandura stressed that learning occurs not only by having one’s own behavior reinforced (as Skinner believes), but also by observing other people’s behaviors being reinforced. This is called **vicarious reinforcement**, or more generally, vicarious learning.

Seligman’s Learned Helplessness Theory of Depression

Martin Seligman conducted classic studies of “learned helplessness” in the 1960s. In these studies, he placed dogs in a cell with relatively high walls. He then administered a shock to the floor of the cell. Initially, the dogs would attempt to jump free of the cell and the shock. Over time, the dogs stopped jumping since they were unable to escape the cell. Later, Seligman replaced the high walls with relatively low walls. Nonetheless, when he administered a shock to the floor of the cell, the dogs did not jump, even though they could have easily escaped the cell if they had attempted to do so. Thus, the dogs had learned to be helpless.

Seligman and others extrapolated this to the realm of human depression and locus of control. Individuals who consistently face difficult situations from which they cannot escape learn to feel powerless to overcome their problems. Over time, this kind of environment can result in learned helplessness, an external locus of control (see the work of Julian Rotter later in this chapter), and depression.

Behavior Therapy

Behaviorists view maladjustment and abnormal behavior as learned through interactions between people and the environment. Individuals learn faulty coping patterns that are maintained by some kind of reinforcement. Although psychoanalysts consider the symptoms to be manifestations of some disorder, behaviorists consider the symptoms to *be* the disorder.

Behavior therapy has proven to be quite successful with certain problems, particularly phobias, impulse control problems, and personal care maintenance for people with mental retardation and hospitalized psychotic patients. We cover different types of behavior therapy in depth in the chapter on learning and ethology.

Cognitive-Behavior Therapy

Over the last few decades, cognitive-behavior therapy, blending cognitive and behavioral approaches, has developed. Essentially, cognitive-behavior therapy tries to change and restructure patient’s distorted and/or irrational thoughts. **Beck’s cognitive therapy for depression** and **Albert Ellis’s rational-emotive therapy (RET)** are two examples. In Beck’s therapy, the client might be asked to write down negative thoughts about himself or herself, figure out why they are unjustified, and come up with more realistic and less destructive cognitions. The basic assumption of Ellis’s RET is that people develop irrational ways of thinking. Therefore, in Ellis’s therapy, the therapist might challenge an irrational belief that the client has, helping him or her to recognize these beliefs and change them to more rational ones.

In contrast to behaviorists, psychoanalysts do not believe that symptom relief is adequate therapy. Because the underlying cause is still there, psychoanalysts suggest that new symptoms will develop to replace the old one. This is called **symptom substitution**. Naturally, behaviorists disagree with this viewpoint.

Humanism

Phenomenological theorists emphasize internal processes rather than overt behavior. Phenomenological psychologists are sometimes called humanistic because they focus on that which distinguishes us from animals. The concepts of phenomenology are similar to those of the existential theorists, since existential psychology employs phenomenological analysis. The Gestalt theory of personality, closely linked to both existential and humanistic theories, has a holistic view of the self.

Kurt Lewin

Kurt Lewin’s field theory puts very little stock in constraints on personalities such as fixed traits, habits, or structures (e.g., id, ego, and superego). Lewin’s theory was heavily influenced by Gestalt psychology. He saw personality as being dynamic and constantly changing. According to Lewin, a personality can be divided up dynamically into ever-changing regions

that he called systems. Under optimal conditions, the regions within the personality are well articulated and function in an integrated fashion. When the person is under tension or an anxiety, however, articulation between various regions is generally diffused. Allport and Rogers's theories (to be discussed later) resemble Lewin's ideas of stressing more current behaviors and thought processes, as opposed to focusing on early developmental factors.

Abraham Maslow

Abraham Maslow, a humanistic theorist, is known for his hierarchy of human motives and for his views on self-actualization. Maslow proposed that needs were organized hierarchically ascending from basic needs to complex psychological needs. People strive for the higher-level needs only when their lower-level needs are met. Maslow's lowest levels of needs are the physiological and safety needs (food, shelter and so on). Next are belongingness and love needs, then esteem, cognitive, and aesthetic needs, and finally, the highest order of need: **self-actualization**, referring to the need to realize one's fullest potential. According to Maslow, most people don't reach self-actualization.

Maslow studied the lives of individuals whom he felt were self-actualizers (e.g., Beethoven, Einstein, George Washington Carver, and Eleanor Roosevelt). He identified several characteristics that these people had in common. These characteristics included a nonhostile sense of humor, originality, creativity, spontaneity, and a need for some privacy. According to Maslow, self-actualized people are more likely than non-self-actualized people to have what he called **peak experiences**: profound and deeply moving experiences in a person's life that have important and lasting effects on the individual.

George Kelly

George Kelly used himself as a model to theorize about human nature, and set aside the traditional concepts of motivation, drive, unconscious emotion, and reinforcement. Kelly hypothesized the notion of the individual as scientist, a person who devises and tests predictions about the behavior of significant people in his or her life. The individual constructs a scheme of anticipation of what others will do, based on his knowledge, perception, and relationships with these other people. The anxious person, rather than being the victim of inner conflicts and dammed-up energy (as in psychodynamic theory), is one who is having difficulty constructing and understanding the variables in his or her environment.

According to Kelly, psychotherapy is a process of insight whereby the individual acquires new constructs that will allow him or her to successfully predict troublesome events. Then, the individual will be able to direct these new constructs into already existing constructs.

Humanist-Existential Therapies

In general, humanist-existential therapies tend to emphasize the process of finding meaning in one's life by making one's own choices. Mental disorders tend to be viewed as stemming from problems of alienation, depersonalization, loneliness, and a lack of a meaningful

existence. Humanistic therapy facilitates exploration into a client's thoughts and feelings. Existential approaches to therapy include empathy toward the client, as well as understanding, affirmation, and positive regard.

Carl Rogers

Carl Rogers identified himself with humanistic psychology, although his personality theory is basically phenomenological. He is most known for his psychotherapy technique known as **client-centered therapy**, **person-centered therapy**, or **nondirective therapy**. Rogers believed that people have the freedom to control their own behavior, and are neither slaves to the unconscious (as the psychoanalysts would suggest), nor subjects of faulty learning (as the behaviorists would suggest). The client is seen as being able to reflect upon his or her problems, make choices, take positive action, and help determine his or her own destiny.

One objective of Rogers's therapy is to help the client become willing and able to be himself or herself and to increase the congruence between what the person thinks he or she should be (the ideal self) and what he or she actually is. A climate of **unconditional positive regard** and understanding is provided to enhance this desired situation.

Victor Frankl

Victor Frankl, a survivor of Nazi concentration camps, is closely identified with the human search for meaning to existence. Mental illness and maladjustment, in Frankl's view, stems from a life of meaninglessness.

Trait/Type Theorists

Type theorists attempt to characterize people according to specific types of personality. **Trait theorists** attempt to ascertain the fundamental dimensions of personality. For our purposes, we will consider them together.

Type A/Type B

One well-known type theory divides personalities into two types: **Type A** and **Type B** personalities. Type A personality is characterized by behavior that tends to be competitive and compulsive. The Type B personality is generally laid-back and relaxed. Not surprisingly, type A personalities are more prone to heart disease than Type B personalities, and are most prevalent among middle- and upper-class men.

Raymond Cattell

Raymond Cattell, a trait theorist, used factor analysis (covered in the chapter on statistics, research methods, and testing) to measure personality in a more comprehensive way, attempting to account for the underlying factors that determine personality. Cattell identified sixteen basic traits, or relatively permanent reaction tendencies in individuals, that constitute the building blocks of personality.

Hans Eysenck

Hans J. Eysenck also used factor analysis to develop a theory of personality. He determined that the broad dimensions of personality were types, which were followed by more specific traits. Hans Eysenck's goal was to use scientific methodology to test Jung's division of **extroversion** and **introversion**. After extensive research, Eysenck distinguished two dimensions in which human personalities differed. One dimension was introversion-extroversion, and the second dimension was emotional stability–neuroticism. Still later, Eysenck added another dimension that indicated **psychoticism**.

Gordon Allport

Gordon Allport, primarily a trait theorist, listed three basic types of traits or dispositions: **cardinal**, **central**, and **secondary**. Cardinal traits are traits around which a person organizes his or her life. For instance, Mother Teresa's cardinal trait may be self-sacrifice. Not everyone develops cardinal traits. Everyone though, has central and secondary traits. Central traits represent major characteristics of the personality that are easy to infer, such as honesty or fatalism. Secondary traits are more personal characteristics that are more limited in occurrence.

A major part of Allport's theory is the concept of **functional autonomy**. Functional autonomy means that a given activity or form of behavior may become an end or goal in itself, regardless of its original reason for existence. A hunter, for example, may have originally hunted in order to obtain food to eat. However, the hunter may continue to hunt even after there is enough food. Allport's theory suggests that the hunter may continue to hunt simply because of the enjoyment: that which began simply as a means to obtain a goal became the goal itself. The theory allows for many types of motives, as well as the uniqueness of motives in any individual.

Allport distinguished between an **idiographic** approach to personality and a **nomothetic** approach to personality (Allport borrowed these terms from the German philosopher Windelband). The idiographic approach to studying personality focuses on individual case studies, while the nomothetic approach focuses on groups of individuals and tries to find the commonalities between individuals. Allport insisted that personality theorists should use the idiographic approach and avoid the nomothetic approach. Allport later substituted the term *morphogenic* for idiographic and the term *dimensional* for nomothetic.

David McClelland

David McClelland identified a personality trait that is referred to as **the need for achievement** (nAch). People who are rated high in nAch tend to be concerned with achievement and have pride in their accomplishments. These individuals avoid high risks (to avoid risk of failing) and low risks (because easy tasks won't generate a sense of achievement). Additionally, they set realistic goals, and do not continue striving toward a goal if success is unlikely.

Herman Witkin

Herman Witkin endeavored to draw a relationship between an individual's personality and his or her perception of the world. Witkin classified people according to their degree of **field-dependence**. At one pole is the capacity to make specific responses to perceived specific stimuli (field-independence). At the other pole is a more diffuse response to a perceived mass of somewhat undifferentiated stimuli (field dependence). For example, people who are highly field-dependent will be more influenced by the opinions of others because they respond in a diffuse manner, not distinguishing separate ideas or even distinguishing their own ideas from those of others.

Julian Rotter

Another important area of personality research is **Julian Rotter's** work on **internal and external locus of control**. People with an internal locus of control tend to believe that they can control their own destiny. Those with an external locus of control tend to believe that outside events and chance control their destiny. Locus of control and self-esteem are related. People who attribute their success to ability (internal locus of control) tend to have higher self-esteem than people who attribute their success to luck or task ease (external locus of control). There is also a relationship between people's attributions of failure and self-esteem. People with high self-esteem tend to attribute their failures to bad luck or task difficulty (external locus of control) while people with low self-esteem tend to attribute their failures to lack of ability (internal locus of control).

Machiavellianism

"**Machiavellian**" is a personality trait that refers to someone who is manipulative and deceitful (from Niccolo Machiavelli's book, *The Prince*). People who score high on Machiavellianism tend to agree with statements such as "most people don't really know what's best for them," "the best way to handle people is to tell them what they want to hear," and "anyone who completely trusts anyone else is asking for trouble." Experiments have shown that people high in Machiavellianism are much more successful manipulators than those low in Machiavellianism.

Androgyny

Sandra Bem's theory on gender identity is related to personality theory. Bem's theory holds that because people can achieve high scores on measures of both masculinity and femininity on personality inventories, then masculinity and femininity must be two separate dimensions. **Androgyny** is defined as the state of being simultaneously very masculine and very feminine.

Mischel's Criticism

The notion of explaining behavior on the basis of personality types or traits has not gone unchallenged. Indeed, the concept of stable personality traits has been seriously challenged by **Walter Mischel**. Mischel believes that human behavior is largely determined by the characteristics of the situation rather than by those of the person.

UNDERSTANDING MENTAL DISORDERS**DSM-IV**

Because there are so many ways in which psychopathology can manifest itself, it is useful to have a classification system for mental disorders. We will be using the system presented in the Fourth Edition of the *Diagnostic and Statistical Manual of Mental Disorders*, known as the **DSM-IV**, published by the American Psychiatric Association in 1994. The DSM-IV is the most widely accepted scheme (in the United States) for the classification of mental disorders. DSM-IV's classification scheme is not based on theories of etiology or treatments of different disorders. Rather, it is based on atheoretical descriptions of symptoms of the various disorders. For example, the DSM-IV doesn't list "neurosis" as a category of mental disorders, since neurosis is a theoretical term that is derived from psychoanalytic theory. (Questions about neurosis and the DSM have appeared on recent GRE Psychology tests.)

The DMS-IV has sixteen major diagnostic classes, some of which will be discussed here. A hallmark of the DSM is its system of **multiaxial assessment**. In this system, clients are assessed on several different domains of information, all of which may help the clinician plan treatment. Five axes are included in the DSM-IV system. On **Axis I**, the clinician is to list the client's clinical disorders with exception of personality disorders and mental retardation. **Axis II** is for personality disorders and mental retardation. **Axis III** is used for recording any medical conditions that are potentially relevant to understanding or treating the client's mental disorder. **Axis IV** is used to indicate any psychosocial or environmental stresses that may influence progression, treatment, or outcome of the disorders from Axis I or Axis II. **Axis V** indicates the clinician's judgment of the client's overall functioning level. This judgment is assessed by using a **Global Assessment of Functioning (GAF)** scale that ranges from 0 to 100.

Disorders First Diagnosed in Infancy, Childhood, or Adolescence

Attention-deficit/hyperactivity disorder (ADD/HD) is characterized by developmentally atypical inattention and/or impulsivity-hyperactivity. Children with this disorder may have very short attention spans and have difficulty staying on task or with organizing tasks. These children are frequently unable to follow instructions or requests and are often unable to stick to activities for extended periods of time. Group situations are particularly difficult for these children. Hyperactivity manifests itself in motor activity such as excessive running or

climbing, fidgeting, and restlessness. Impulsivity is manifested by an inability to delay gratification, impatience, and frequently interrupting others. Although the disorder typically occurs by age three, it is frequently not diagnosed until the child begins school. As many as three to five percent of school children may experience the symptoms of this disorder. The disorder is more prevalent in males than in females. Symptoms usually attenuate during adolescence.

The essential features of **autistic disorder** are lack of responsiveness to others (impairment in social skills), gross impairment in communication skills, and repetitive behaviors. Individuals with the disorder are often inflexibly routinized and stereotyped. Children with autism may not cuddle or make eye contact, and may display little or no facial expression. Impairment in language skills, both receptive and expressive, is often present. Children with this disorder tend to be oversensitive to sensory stimuli such as sound, lights, color, odor, and/or touch. The disorder occurs in about two to five out of 10,000 individuals, and can be chronic. Only a small percentage of these individuals will be able to achieve an autonomous life with adequate social adjustments in adulthood.

Tourette's disorder, a tic disorder, is characterized by multiple motor tics (e.g., eye-blinking, skipping, deep knee bends) and one or more vocal tics (e.g., grunts, barks, sniffs, snorts, coughs, utterance of obscenities). Tics are sudden, recurrent, and stereotyped. The duration of the disorder is lifelong, but periods of remission may occur. Tourette's disorder occurs in approximately four to five individuals out of 10,000.

Schizophrenia and Other Psychotic Disorders

The term **schizophrenia** is a relatively recent term, coined in 1911 by Eugen Bleuler. Before Bleuler, schizophrenia was called *dementia praecox*, a term that has appeared on the GRE Psychology test. Schizophrenia literally means "split mind," since the disorder is characterized by gross distortions of reality and disturbances in the content and form of thought, perception, and affect. Unfortunately, this has led many lay people to confuse schizophrenia with multiple personality disorder (currently known as dissociative identity disorder). By "split mind," Bleuler did not mean that the mind is split into different personalities, but that the mind is split off from reality. Although no single feature need be present to diagnose schizophrenia, a person with schizophrenia may have any or all of the following symptoms: delusions, hallucinations, disorganized thought, inappropriate affect, and catatonic behavior.

Symptoms of schizophrenia are divided into positive and negative types. **Positive symptoms** are behaviors, thoughts, or affects added to normal behavior. Examples include delusions and hallucinations, disorganized speech, and disorganized or catatonic behavior. Positive symptoms are considered by some to be two distinct dimensions, the psychotic dimension (delusions and hallucinations) and the disorganized dimension (disorganized speech and behavior), perhaps with different underlying causes. **Negative symptoms** are those symptoms that involve the absence of normal or desired behavior. An example is flat affect, where the individual's emotional expression is blunted.

Delusions are false beliefs, discordant with reality, that are maintained in spite of strong evidence to the contrary. Common delusions include **delusions of reference**, **persecution**, and **grandeur**. Delusions of reference may involve the belief of an individual that others are talking about him or her. This individual may believe that common elements in the environment are directed at him or her. Delusions of persecution involve the belief that the person is being deliberately interfered with, discriminated against, plotted against, or threatened. Delusions of grandeur involve the belief by the patient that he or she is a remarkable person, such as an inventor, historical figure, or even the Queen of England. Other delusions involve the concept of thought broadcasting, which is the belief that one's thoughts are broadcast directly from one's head to the external world, and thought insertion, the belief that thoughts are inserted in one's head.

Hallucinations are perceptions that are not due to external stimuli but have a compelling sense of reality. Hallucinations can occur in all sensory modalities. The most common form of hallucination is auditory, involving voices that the individual perceives as coming from outside his or her head.

Disorganized thought is characterized by the loosening of associations. This may be exhibited as speech in which ideas shift from one subject to another on unrelated subjects in such a way that a listener would be unable to follow the train of thought. A patient's speech may be so disorganized that it will seem to have no structure—as though it were just words thrown together, incomprehensibly. This is sometimes called *word salad*. In fact, a person with schizophrenia may even invent new words. These new words are called *neologisms*.

A common characteristic of schizophrenia is disturbance of affect, or the expression of emotion. Problems with affect may include **blunting**, in which there is a severe reduction in the intensity of affect expression; **flat affect**, in which there are virtually no signs of affective expression; or **inappropriate affect**, in which the affect is clearly discordant with the content of the individual's speech or ideation. For example, a patient with inappropriate affect may begin to laugh hysterically while describing a parent's death. Interestingly, it has become more difficult to assess the affective aspects of schizophrenia because the antipsychotic medications used in treatment frequently blunt and flatten affect as well.

Catatonic motor behavior refers to various extreme behaviors characteristic of some people with schizophrenia. The patient's spontaneous movement and activity may be greatly reduced or the patient may maintain a rigid posture, refusing to be moved. At the other extreme, catatonic behavior may include useless and bizarre movements not caused by any external stimuli.

Before schizophrenia is diagnosed, a patient often goes through a phase characterized by poor adjustment. This phase is called the **prodromal phase**. The prodromal phase is exemplified by clear evidence of deterioration, social withdrawal, role functioning impairment, peculiar behavior, inappropriate affect, and unusual experiences. This phase is followed by the **active phase** of symptomatic behavior.

If schizophrenia development is slow and insidious it is referred to as **process schizophrenia**, and prognosis for recovery is especially poor. If the onset of symptoms is intense and sudden, it is referred to as **reactive schizophrenia**, and the prognosis for recovery is better.

The DSM-IV divides schizophrenia into five subtypes: **catatonic**, **paranoid**, **disorganized**, **undifferentiated**, and **residual**. Since these are all subtypes of schizophrenia, people with these disorders tend to share the core symptoms; the patient's primary symptom(s) differentiate among the subtypes.

The primary symptom of the **catatonic** type of schizophrenia is a disturbance in motor behavior. Most notably, there is an alternation between extreme withdrawal of behavior (no movement, maintenance of a peculiar position for hours or days) and excitement or excessive movement. The **paranoid** type of schizophrenia is characterized by a preoccupation with one or more delusions or frequent auditory hallucinations. In this subtype there is a relative preservation of cognitive and affective functioning. The **disorganized** type of schizophrenia (formerly called *hebephrenic schizophrenia*) is characterized by flat or inappropriate affect and disorganized speech and behavior. The **undifferentiated** type of schizophrenia is diagnosed when the general criteria for the other categories are not met. The diagnosis of **residual** schizophrenia is used when there has been a previous schizophrenic episode, but positive psychotic symptoms are not currently displayed, although patients may still show disturbances and often negative symptoms.

Despite extensive research, the etiology of schizophrenia remains unclear. The leading biochemical explanation for schizophrenia is the **dopamine hypothesis**. Dopamine, a neurotransmitter, plays an important role in movement and posture in certain brain pathways. (A neurotransmitter is simply a chemical that helps individual neurons communicate with each other; see the chapter on physiological psychology.) The dopamine hypothesis suggests that the delusions, hallucinations and agitation associated with schizophrenia arise from an excess of dopamine activity at certain sites in the brain. A variant of this hypothesis is that the amount of dopamine is normal but that there is an oversensitivity to dopamine in the brain or that there are too many receptors that receive the dopamine. Evidence supporting the dopamine hypothesis comes from the effectiveness of antipsychotic drugs in treating schizophrenia.

The **double-bind hypothesis** of schizophrenia holds that as a child, the person with schizophrenia received contradictory and mutually incompatible messages from his or her primary caregiver (usually the mother). For instance, a mother may tell her child to be more affectionate, yet yell at or punish the child whenever the child approaches her. Torn between these contradictory messages, the child may begin to feel anxious, and these disorganized messages become internalized. From this point, the child begins to see his or her perceptions of reality as unreliable. Although this hypothesis is not widely supported, research has suggested that faulty family communication may play some role in explaining the origins of some forms of schizophrenia.

Mood Disorders

We all have times when we feel sad. Sometimes, we feel very sad, such as when we are grieving. During these periods, we might even say that we are “depressed.” However, this is just part of normal human experience and not a mental disorder. In contrast, mood disorders are severe and persistent.

Major depressive disorder is characterized by at least one major depressive episode. In major depressive disorder, the essential feature is at least a two-week period during which there is a prominent and relatively persistent depressed mood, or loss of interest in all or almost all activities. Other symptoms include appetite disturbances, substantial weight changes, sleep disturbances, decreased energy, feelings of worthlessness or excessive guilt (sometimes delusional), difficulty concentrating or thinking, and thoughts of death or attempts at suicide. In order for major depressive disorder to be diagnosed, these symptoms must cause significant distress and/or impairment in functioning. As many as 15 percent of individuals with this disorder die by suicide.

The **bipolar disorders** (formerly known as manic-depression) are a major type of mood disorder characterized by both depression and mania. Manic episodes are often characterized by an abnormal and persistent elevated mood, accompanied by a decreased need for sleep. There is also flight of ideas and increased self-esteem. Judgment is usually impaired, sexual and other behavioral restraints are lowered, and the individual tends to be impatient with any attempts to restrain his or her behaviors. Manic episodes generally have a rapid onset and a briefer duration than depressive episodes. Bipolar I disorder has these manic episodes, whereas bipolar II disorder has **hypomania**. In contrast to mania, hypomania typically does not significantly impair functioning, nor are there psychotic features, although the individual may be more energetic and optimistic.

Dysthymic and **cyclothymic disorders** don’t quite meet the criteria for major depressive and bipolar disorders, respectively, but essentially are characterized by similar, less severe symptoms.

Many etiologies have been proposed for mood disorders, ranging from genetics to sociocultural factors. The first explanation we will cover revolves around neurotransmitters. Recall from earlier in this chapter that neurotransmitters are chemicals that help individual neurons communicate with each other. Neurotransmitters that have been implicated in mood disorders include **norepinephrine** and **serotonin**. These two are often linked together into what is called the monoamine theory of depression, or sometimes the **catecholamine theory of depression**. These theories hold that too much norepinephrine and serotonin leads to mania, while too little leads to depression. Although more recent research has shown that it is not necessarily that simple, you should be aware of this theory for the GRE Psychology test.

Anxiety Disorders

There are more than ten disorders listed in the *anxiety disorders* portion of the DSM-IV. One type of anxiety disorder is a **phobia**. A phobia is simply an irrational fear of something that results in a compelling desire to avoid it. Most of the phobias that you are probably familiar with are what DSM-IV calls **specific phobias**. A specific phobia is one in which anxiety is produced by a specific object or situation. Claustrophobia is an irrational fear of closed places; acrophobia is an irrational fear of heights; cynophobia is an irrational fear of dogs; and so on. A more complicated kind of phobia is **agoraphobia**, or a fear of being in open places or in situations where escape might be difficult. Agoraphobics tend to be uncomfortable going outside their homes alone. **Social phobia** is characterized by anxiety that is due to social situations. These individuals have persistent fear when exposed to social/performance situations that may result in embarrassment.

Another type of anxiety disorder is **obsessive-compulsive disorder (OCD)**. The disorder is characterized by repeated obsessions (persistent irrational thoughts) that produce tension and/or compulsions (irrational and repetitive impulses to perform certain acts) that cause significant impairment in a person’s life. Loosely speaking, obsessions are thoughts and compulsions are behaviors. For instance, a person might obsess about dirt and compulsively wash his or her hands (to neutralize the anxiety produced by the obsession).

Somatoform Disorders

In general, **somatoform disorders** involve the presence of physical symptoms that suggest a medical condition but which are not fully explained by a medical condition. The afflicted person with somatoform disorder is not faking, but really believes that he or she has a medical condition. Examples include **conversion disorders** and **hypochondriasis**. A **conversion disorder** is characterized by unexplained symptoms affecting voluntary motor or sensory functions. Examples include paralysis when there is no neurological damage or even blindness when there is no evidence of damage to the visual system or brain. Incidentally, conversion disorder used to be referred to as *hysteria*. In **hypochondriasis**, the person is preoccupied with fears that he or she has a serious disease. These fears are based on a misinterpretation of one or more bodily signs or symptoms. These fears continue even after complete medical exams have proven that the person doesn’t have the disease he or she claims to have.

Dissociative Disorders

In dissociative disorders, the person avoids stress by dissociating, or escaping from his or her identity. The person otherwise still has an intact sense of reality. Examples of dissociative disorders include **dissociative amnesia**, **dissociative fugue**, **dissociative identity disorder** (formerly multiple personality disorder), and **depersonalization disorder**.

Dissociative amnesia is characterized by an inability to recall past experience. The qualifier “dissociative” simply means that the amnesia is not due to a neurological disorder.

Dissociative fugue involves amnesia that accompanies a sudden, unexpected move away from one's home or location of usual daily activities. A person in a fugue state is confused about his or her identity and may even assume a new identity.

In **dissociative identity disorder** (formerly multiple personality disorder) there are two or more personalities that recurrently take control of a person's behavior. This disorder results when the components of identity fail to integrate. Two of the most famous cases that appear in the media are Sybil, who had 15 separate personalities, and Truddi Chase, who had 92 separate personalities. In most cases, the patients have suffered severe physical and/or sexual abuse as young children. After much therapy, the personalities can usually be integrated into one.

In **depersonalization disorder**, the person feels detached, like an outside observer of his or her mental processes and/or behavior. However, even during these times, the person still has an intact sense of reality.

Eating Disorders

Anorexia nervosa is characterized by a refusal to maintain a minimal normal body weight. The person with anorexia nervosa also has a distorted body image, and believes that he or she is overweight even when emaciated. In females, amenorrhea (the cessation of menstruation) is usually present. More than 90 percent of cases are female and 10 percent of hospitalized cases result in death due to starvation, suicide, or electrolyte imbalance.

Bulimia nervosa involves binge-eating accompanied by excessive attempts to compensate for it by purging, fasting, or excessive exercising. In bulimia nervosa, unlike anorexia nervosa, the individual tends to maintain a minimally normal body weight. At least 90 percent of cases are female.

Personality Disorders

A personality disorder is a pattern of behavior that is inflexible and maladaptive, causing distress and/or impaired functioning in at least two of the following: cognition, emotions, interpersonal functioning, or impulse control. The DSM-IV lists ten personality disorders; we will cover four of the most common: **schizoid**, **narcissistic**, **borderline**, and **antisocial**. Passive-aggressive personality disorder has been deleted from the DSM-IV Classification of Personality Disorders. However, it is listed in the "Other Conditions That May Be a Focus of Clinical Attention" section of the DSM-IV.

Schizoid personality disorder is a pervasive pattern of detachment from social relationships and a restricted range of emotional expression. People with this disorder show little desire for social interactions; have few, if any, close friends; and have poor social skills. It should be noted that schizoid personality disorder is *not* the same as schizophrenia.

In **narcissistic personality disorder** there is a grandiose sense of self-importance or uniqueness, preoccupation with fantasies of success, an exhibitionistic need for constant admiration and attention, and characteristic disturbances in interpersonal relationships such as feelings of entitlement. As used in everyday language, narcissism refers to those who like themselves too much. However, people with narcissistic personality disorder have very fragile self-esteem and are constantly concerned with how others are viewing them. There may be marked feelings of rage, inferiority, shame, humiliation, or emptiness when these individuals are not viewed favorably by others.

People with **borderline personality disorder** show behavior that has features of both personality disorders and some of the more severe psychological disorders. In borderline personality disorder, there is pervasive instability in interpersonal behavior, mood, and self-image. Interpersonal relationships are often intense and unstable. There may be a profound identity disturbance manifested by uncertainty about self-image, sexual identity, long-term goals, or values. There is often intense fear of abandonment. Suicide attempts and self-mutilation (cutting or burning) are common.

Antisocial personality disorder has previously been referred to as psychopathic disorder and sociopathic disorder. The essential feature of the disorder is a pattern of disregard for, and violation of, the rights of others. This is evidenced by repeated illegal acts, deceitfulness, aggressiveness, and/or a lack of remorse for said actions. Serial killers who show no guilt for their actions, imposters, and many career criminals have this disorder.

DIATHESIS-STRESS MODEL

Psychologists are not interested in just describing the various types of mental disorders; they're also interested in why these disorders occur. The **diathesis-stress** model is a framework that can be used to examine the causes of mental disorders. A *diathesis* is a predisposition toward developing a specific mental disorder. It could be a genetic or anatomic abnormality, or a biochemical disorder that predisposes an individual to mental illness. Excessive stress operating on a person with a predisposition (diathesis) may lead to the development of the specific mental disorder. According to this model, an individual whose brain is oversensitive to dopamine and who also experiences excessive stress may be likely to develop schizophrenia. The diathesis-stress model reminds us that causal factors at the biological and psychological levels interact with each other.

PRIMARY PREVENTION

Efforts to seek out and eradicate conditions that foster mental illness and to establish the conditions that foster mental health are called **primary prevention**. Examples include increasing access to good prenatal and postnatal care, providing training in psychosocial skills to those who need it, promoting opportunities for education, and training parents in child-raising skills. Primary prevention is proactive, not reactive. It seeks to stop mental illness before it occurs rather than treating the illness after it occurs.

BEING LABELED “MENTALLY ILL”

David Rosenhan (1973) studied whether or not it was possible to be judged sane if you are in an “insane place” (a psychiatric hospital). Rosenhan and seven other “sane” people were admitted into different psychiatric hospitals by reporting auditory hallucinations. Each of these pseudopatients was diagnosed to have either paranoid schizophrenia or bipolar disorder and each was admitted. Once admitted, they acted normally in every way. Yet, because they had already been labeled as mentally ill, even normal activities were interpreted by the staff as evidence of mental illness. For instance, when they discussed their situation in a rational way with members of the staff, they were reported to be using the defense mechanism of intellectualization.

The pseudopatients remained in the hospitals an average of three weeks. Not one was identified as sane. In fact, when they were finally released (and they were only able to be released with the help of spouses and friends), the discharge diagnoses were either paranoid schizophrenia or bipolar disorder in remission. Rosenhan concluded that clinicians need to exercise greater care when judging normality and abnormality. Once someone is labeled mentally ill, the label never really goes away. Additionally, this study demonstrated that mental illness could be feigned, as well as misdiagnosed.

Thomas Szasz, an outspoken critic of labeling people “mentally ill,” argues that most of the disorders treated by clinicians are not really illnesses. Rather, they are traits or behaviors that differ from the cultural norm. Szasz argues that labeling people as mentally ill is a way to force them to change and conform to societal norms rather than allowing them to attack the societal causes of their problems. The phrase to associate with Szasz is the name of his most famous book, *The Myth of Mental Illness*.

SYSTEMS OF PSYCHOLOGY: A BRIEF OVERVIEW		
System	Key People	Important Concepts/Goals/Methods
Structuralism	Titchener	Breaks consciousness into elements by using introspection
Functionalism	James, Dewey	Stream of consciousness; studies how mind functions to help people adapt to environment; attacked structuralism
Behaviorism	Watson, Skinner	Psychology as objective study of behavior; attacked mentalism and the use of introspection; attacked structuralism and functionalism
Gestalt	Wertheimer, Köhler, Koffka	Whole is something other than the sum of its parts; attacked structuralism and behaviorism
Cognitive	Chomsky	Behaviorism is not an adequate explanation for human behavior; humans think, believe, are creative
Psychoanalysis	Freud, Jung, Adler	Behavior is a result of unconscious conflicts, repression, defense mechanisms
Humanism	Maslow, Rogers	Looks at people as wholes; humans have free will; psychologists should study mentally healthy people, not just mentally ill/maladjusted ones