Perspectives on Abnormal Psychology

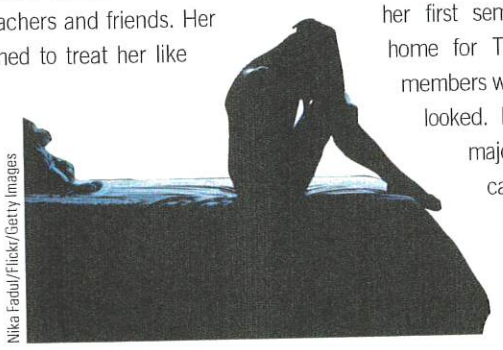
Special Features

C / Mariella

case

Mariella, a 19-year-old college freshman, has been repeatedly asking herself, "What's going on?" and "What should I do?" Something was not right. Mariella was outgoing, bright, and cheery in high school but was now fatigued, blue, and pessimistic in college. She was starting her second semester and thought the tough college adjustment period her friends and family talked about should be over by now. Were her feelings of fatigue and discontent just a temporary "funk," or was something seriously wrong?

Mariella's fatigue and discontent began early in her first semester and worsened toward finals week. She enrolled in five courses and was soon overwhelmed by extensive reading assignments, large classes, and fast-approaching deadlines. She struggled to finish her work, often seemed isolated from others, and felt unimportant in the huge academic setting. Mariella believed no one cared whether she was in class, and she longed for days in high school when she interacted with a close-knit group of teachers and friends. Her college professors seemed to treat her like a number and not a student, and her classmates always seemed to be rushing about with little time to talk.



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Mariella was an "A" student in high school but was now struggling to get Cs in her college classes. She had great trouble concentrating on what she read, which led to low test scores. Mariella did talk to her friends and family members back home about her troubles, but no one truly understood what she was going through. Instead, they thought Mariella was experiencing simple, normal homesickness that would soon end.

Mariella began spending more time alone as her first semester approached mid-November. She often slept, watched television, listened to music, and went online. She no longer found much enjoyment doing things that used to appeal to her, such as going to the movies and playing the guitar. Mariella declined invitations from others to go out, and her roommate noticed that Mariella seemed sad and lonely. Unfortunately, no one took the time to ask Mariella if something serious might be wrong.

Mariella also lost significant weight her first semester. When she went home for Thanksgiving, her family members were surprised at how she looked. Mariella had noticed no major change except for occasional hunger, but in fact she had lost 10 pounds from her 120-pound frame. Unfortunately, she received flattering comments on how she looked, so the larger problem of her sad mood went undetected. Her concentration and eating problems continued when she returned to school to finish her first semester, and Mariella struggled to finish her final examinations and receive passing grades.

Mariella was happy to return home for the winter break and hoped her feelings of fatigue and discontent were simply related to school. Unfortunately, she remained sad, did not regain lost weight from the previous semester, and continued to sleep much of the day. She dreaded returning to school but felt pressure from others to do so. Mariella became quite despondent when she returned to school in mid-January. She knew something would have to change to endure this second semester, but she felt confused and unsure. Once again she was asking, "What's going on?" and "What should I do?"

What Do You Think?

1. Why do you think Mariella feels the way she does?
2. What should Mariella do? What would you do if in her situation?
3. Which aspects of Mariella's story concern you most?
4. Do you know people who have had similar experiences? What did they do?
5. What should Mariella's friends and family do to help?

Introduction

If Mariella had lived centuries ago, demonic possession might have been a common explanation for her problems. Scientists and mental health professionals today, however, focus on a person's biology, environment, and other factors to help people like Mariella. Scientists and mental health professionals develop perspectives or **models**—ways of looking at things—to piece together why someone like Mariella has problems.

Perspectives or models are systematic ways of viewing and explaining what we see in the world. When you try to explain high prices for an item, you might think about the economic model of *supply and demand* to conclude everyone wants the item but supplies are limited. Or if a friend of yours is sick, you might think about the disease model of *germ theory* to ask whether she was around a sick person or if she ate spoiled food. Mental health professionals use models to help explain unusual behavior or mental disorders in people like Mariella. Five main models to explain mental disorders are described in this chapter:

- The *biological model* focuses on genetics, neurotransmitters, brain changes, and other physical factors.
- The *psychodynamic model* focuses on internal personality characteristics.
- The *humanistic model* focuses on personal growth, choice, and responsibility.
- The *cognitive-behavioral model* focuses on specific thoughts and learning experiences.
- The *sociocultural model* focuses on external environmental events and includes the family systems perspective.

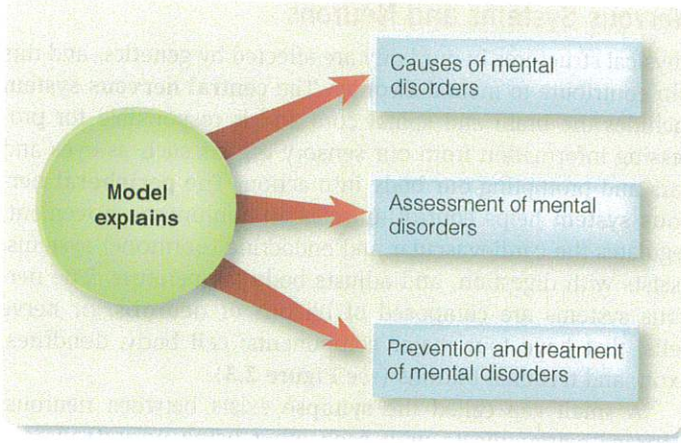


FIGURE 2.1 THE USE OF MODELS. Models or perspectives affect the way we think about causes of mental disorder, our methods of assessment, and our methods of prevention and treatment.

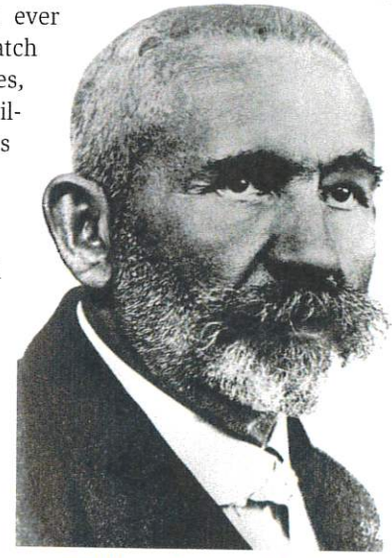
These models dominate the mental health profession today and influence the way we think about, assess, and treat mental disorders (see **Figure 2.1**). Each model has strengths and weaknesses, but each provides mental health professionals with ways of understanding what is happening to someone like Mariella. In this chapter, we show how each model could be used to explain Mariella's problems and help her. Many mental health professionals also integrate these models to study and explain mental disorders.

The Biological Model

The **biological model** rests on the assumption that mental states, emotions, and behaviors arise from brain function and other physical processes. This model has been in use for centuries and is stronger than ever today. Read a newspaper or magazine, watch television, or go online—countless articles, documentaries, and advertisements are available about medications and other substances to treat mental conditions. Some drug or herb always seems available to cure depression, anxiety, or sexual dysfunction. Despite the incessant advertising, however, the biological model of mental disorder, including the use of medications, is supported by scientific research that links genetics, neurochemistry, and brain changes to various psychological problems.

The biological model of mental disorder was pioneered by *Emil Kraepelin* (1856–1926), who noticed various **syndromes** or clusters of symptoms in people. Mariella had a cluster of symptoms that included concentration problems, oversleeping, sadness, and weight loss. Her symptoms are commonly described within the syndrome of *depression* (Chapter 7). Kraepelin believed, as do many psychiatrists and other mental health professionals today, that syndromes and symptoms have biological causes. Kraepelin proposed two major types of mental disorders, each with different biological causes: *dementia praecox* (similar to schizophrenia, discussed in Chapter 12) and *manic-depressive psychosis* (similar to bipolar disorder, discussed in Chapter 7).

Kraepelin also believed syndromes to be separate from one another, like mumps and measles, and that each syndrome has unique causes, symptoms, and outcomes. In Mariella's case, her symptom of sadness seemed partly caused by her separation from home and led to outcomes such as poor grades. Kraepelin and many psychiatrists also believe each syndrome has its own biological cause. A psychiatrist may feel Mariella's sadness was caused by depression that ran in her family (genetics), by a chemical (neurotransmitter) imbalance, or by some brain change. We discuss these biological causes next.



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Emil Kraepelin is considered by many to be the father of psychiatric classification and a key contributor to the biological model.

Genetics

Do you think Mariella's sadness may have been present as well in some of her family members? Many mental disorders such as depression do seem to run in families. Genetic material may be involved when symptoms of a mental disorder are passed from parents to children. Genetic material refers to molecular "codes" contained in the nucleus of every human cell (Ahuja, 2014). *Genes* are the smallest units of inheritance that carry information about how a person will appear and behave. Genes carry information about hair and eye color, weight and height, and even vulnerability to diseases such as lung cancer or mental disorders such as depression. Human genes are located on 46 *chromosomes* or threadlike structures arranged in 23 pairs. A person's chromosomes come half from the biological mother and half from the biological father.

The genetic composition of a person is known as a **genotype** and is fixed at birth. Genotypes produce characteristics such as eye color that do not change over time. An observable characteristic of a person is known as a **phenotype**, which *can* change over time. Observable characteristics can include intelligence, as well as symptoms of a mental disorder such as difficulty concentrating. Phenotypes can change because they result from genetic *and* environmental influences. Your intelligence is partly determined by genetics from your parents but also by the type of education you received as a child. Scientists are interested in knowing which genetic and environmental influences impact the development of emotions, cognitions, and behavior (O'Connor, 2014). This research specialty is known as **behavior genetics**.

Behavior geneticists are interested in the degree to which a mental disorder is

determined by genetics. *Heritability* refers to the amount of variation in a phenotype attributed to genetic factors, often expressed as a number ranging from 0 to 1. Some mental disorders such as anxiety-related disorders have modest heritability, but many major mental disorders have more substantial genetic influences in their development (see **Figure 2.2**). Disorders with particularly high heritability include bipolar disorder and schizophrenia (Pearlson, 2015).

Behavior geneticists also focus on what *specific* genes are inherited and how these genes help produce a mental disorder. Researchers in the field of **molecular genetics** analyze *deoxyribonucleic acid* (DNA)—the molecular basis of genes—to identify associations between specific genes and mental disorders. Molecular genetics is quite challenging for several reasons. First, most mental disorders are influenced by multiple genes, not just one. When you hear a media report that researchers found a gene for Alzheimer's disease, keep in mind they likely found only one of many genes. Second, the same symptoms of a mental disorder may be caused by different genes in different people. Third, it is estimated that there are about 20,000 to 25,000 human protein-coding genes, so finding specific ones related to a certain disorder is like finding a needle in a haystack. Despite these challenges, advances in molecular genetics will likely lead to findings that help scientists determine how and if disorders are genetically distinct from one another. Knowledge of specific genes can also help researchers determine how genes influence physical changes in the body, which we discuss next.

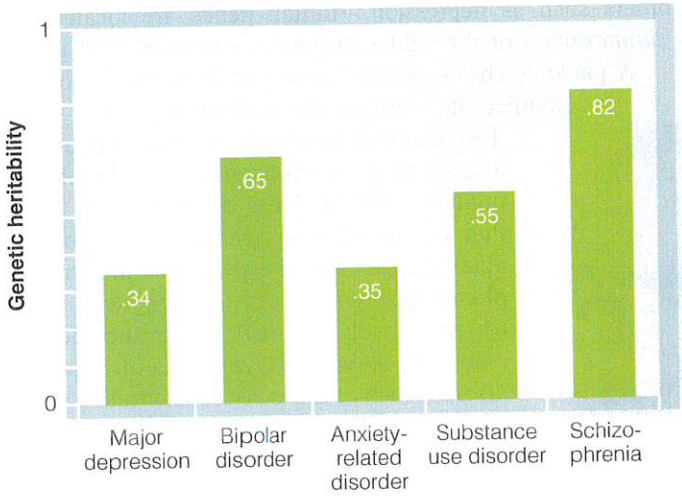


FIGURE 2.2 HERITABILITY OF MAJOR MENTAL DISORDERS. *Adapted from Merikangas, K.R., & Risch, N. (2005). Will the genomics revolution revolutionize psychiatry? In N.C. Andreasen (Ed.),* Research advances in genetics and genomics: Implications for psychiatry *(pp. 37-61). Washington, DC: American Psychiatric Publishing; Kendler, K.S., Chen, X., Dick, D., Maes, H., Gillespie, N., Neale, M.C., & Riley, B. (2012). Recent advances in the genetic epidemiology and molecular genetics of substance use disorders.* Nature Neuroscience, 15, *181-189.*

Nervous Systems and Neurons

Physical structures in our body are affected by genetics, and this can contribute to mental disorder. The **central nervous system** includes the brain and spinal cord and is responsible for processing information from our sensory organs such as eyes and ears and prompting our body into action. The **peripheral nervous system** helps control muscles and voluntary movement, regulates the cardiovascular and endocrine (hormone) systems, assists with digestion, and adjusts body temperature. The nervous systems are composed of billions of **neurons**, or nerve cells, that have four major components: cell body, dendrites, axon, and terminal buttons (see **Figure 2.3**).

A small gap called the **synapse** exists between neurons. Neurons communicate with each other using **neurotransmitters**, or chemical messengers that allow information to cross the synapse. Not all neurotransmitters released into the synapse are used, so an unused neurotransmitter is reabsorbed and recycled in a process called **reuptake**. Medications influence neurotransmitter systems to treat mental disorders. Medications may *block synapses* to decrease neurotransmitter levels or *block reuptake* to increase neurotransmitter levels. People with depression often take drugs such as Prozac or Paxil to increase availability of certain neurotransmitters for improved energy and mood. Six major neurotransmitters are discussed throughout this textbook: serotonin, norepinephrine, dopamine, gamma-aminobutyric acid (GABA), acetylcholine, and glutamate. **Table 2.1** lists functions associated with each.

Brain

The brain is our most complex and important organ and comprises about *86 billion* neurons (Lent, Azevedo, Andrade-Moraes, & Pinto, 2012). The brain consists of two cerebral hemispheres that are mirror images of each other. The *right hemisphere* controls movement for the left side of the body, influences spatial relations and patterns, and affects emotion and intuition. The *left hemisphere* controls movement for the right side of the body, influences analytical thinking, and affects grammar and

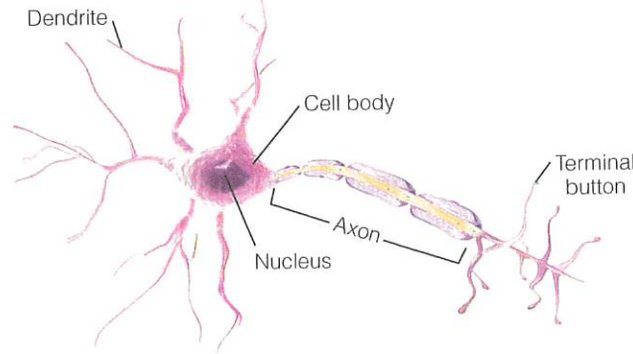


FIGURE 2.3 BASIC PARTS OF A NEURON. *Adapted from Josephine F. Wilson,* Biological foundations of human behavior, *Fig. 2.6, p. 30. Reprinted by permission of the author.*

TABLE 2.1

Major Neurotransmitter Systems Associated with Mental Disorders

Neurotransmitter system	Functions
Serotonin	Processing of information; regulation of mood, behavior, and thought processes
Norepinephrine	Regulation of arousal, mood, behavior, and sleep
Dopamine	Influences novelty-seeking, sociability, pleasure, motivation, coordination, and motor movement
Gamma-aminobutyric acid (GABA)	Regulation of mood, especially anxiety, arousal, and behavior
Acetylcholine	Important in motor behavior, arousal, reward, attention, learning, and memory
Glutamate	Influences learning and memory

vocabulary. The two hemispheres do communicate with each other, however. Complex behaviors such as playing a piano or using language are influenced by both hemispheres.

The **cerebral cortex** covers much of each hemisphere and is largely responsible for consciousness, memory, attention, and other higher-order areas of human functioning. The brain itself is divided into four main lobes (see left side of **Figure 2.4**). The **frontal lobe** is in the front portion of the brain and has many important functions such as movement, planning and organization, inhibiting behavior or responses, and decision making. The frontal lobe is thus a central focus of many mental health researchers. The **parietal lobe** is behind the frontal lobe and is associated with touch. The **temporal lobe** is at the base of the brain and is associated with hearing and memory. The **occipital lobe** is behind the parietal and temporal lobes and is associated with vision.

The brain may also be organized along the *forebrain*, *midbrain*, and *hindbrain*. The forebrain contains the **limbic system** (see right side of Figure 2.4), which regulates emotions and impulses and controls thirst, sex, and aggression. The limbic system is important for several mental disorders and is composed of the hippocampus, cingulate gyrus, septum, and amygdala. Farther down the forebrain, the **basal ganglia** help control posture and motor activity. The **thalamus** and **hypothalamus** are at the crossroads of the forebrain and midbrain and relay information between the forebrain and lower brain areas. The midbrain also contains the *reticular activating system*, which is involved in arousal and stress or tension. The hindbrain includes the *medulla*, *pons*, and *cerebellum*. These structures are involved in breathing, heartbeat, digestion, and motor coordination.

Biological Assessment and Treatment

How can knowledge about genetics, neurotransmitters, and brain changes be used to evaluate and treat people with mental disorders? A biologically oriented mental health professional such as a psychiatrist would first give a diagnostic interview (Chapter 4) to better understand a person's problems. Biologically oriented health professionals also use assessment methods to obtain images of brain structure and functioning. *Magnetic resonance imaging* (MRI) provides high-quality brain images to reveal tumors, blood clots, and other structural abnormalities. **Figure 2.5** (page 28) compares MRI images of a youth with autism to a youth without autism. Other methods for brain imaging are described in Chapter 4.

Biologically oriented mental health professionals decide on treatment once a comprehensive evaluation is complete. Psychiatric medications are commonly used to treat mental disorders by affecting neurotransmitter systems. Medications that decrease *dopamine* generally have antipsychotic effects to ease symptoms of schizophrenia. Medications that increase *norepinephrine* or *serotonin* often have antidepressant effects. Medications that increase *GABA* often have antianxiety effects.

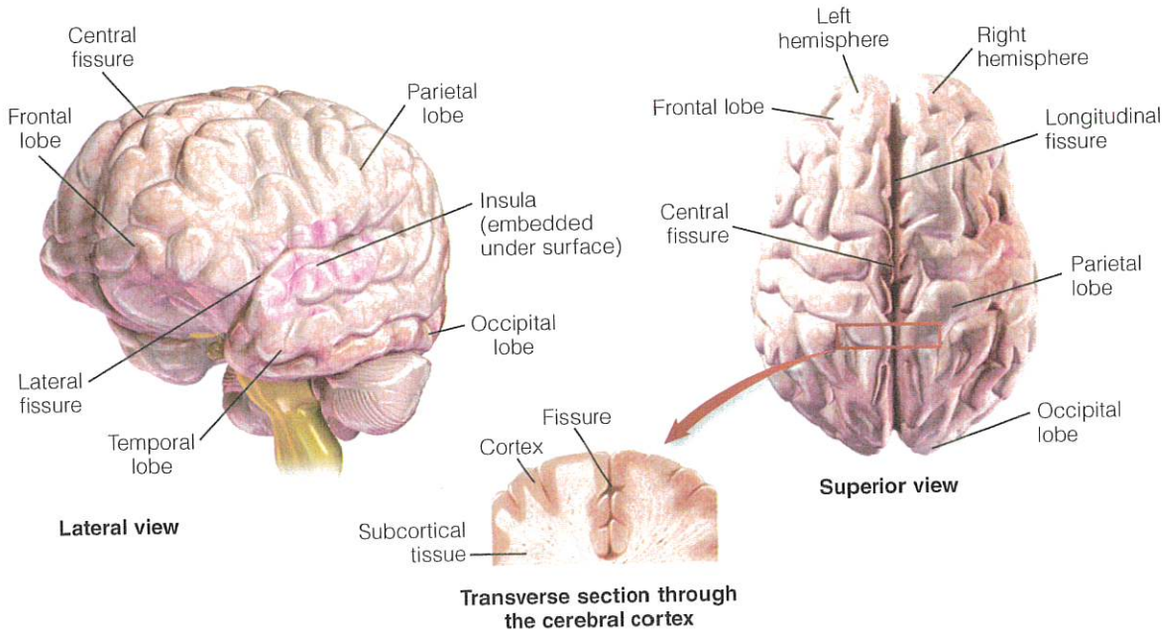
Evaluating the Biological Model

The biological model is respected because genetics, neurotransmitters, and brain areas clearly influence problems such as anxiety (Chapter 5), depression and bipolar disorder (Chapter 7), schizophrenia (Chapter 12), intellectual disability and autism (Chapter 13), and Alzheimer's disease (Chapter 14). Findings from this model have led to better knowledge about which genes are inherited, how neurotransmitter effects and medications can help treat mental disorder, and how brain changes over time lead to abnormal behavior. The biological perspective comprises much of the material in this textbook.

The biological perspective also has some limitations. First, biological factors do not provide a full account of *any* form of mental disorder. Some disorders have substantial genetic contributions, such as schizophrenia or bipolar disorder, but environmental or nonbiological factors are clearly influential as well. An exclusive focus on biological factors would also deny crucial information about cultural, family, stress, and other factors that influence all of us. Second, we do not know yet exactly how biological factors *cause* mental disorder. We can only say biological changes appear to be significant risk factors for mental disorder. Biological risk factors also clearly interact with environmental risk factors, as we discuss throughout this textbook.

Interim Summary

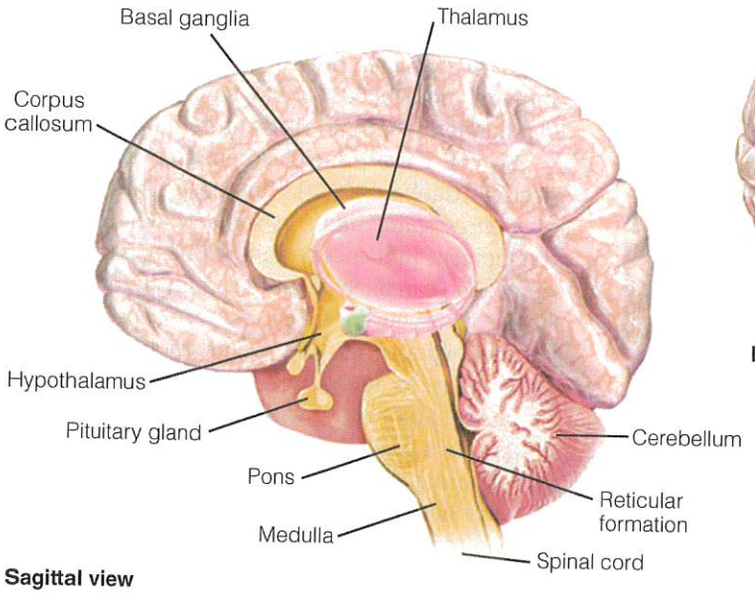
- The biological model assumes that mental states, emotions, and behaviors arise largely from physical processes.



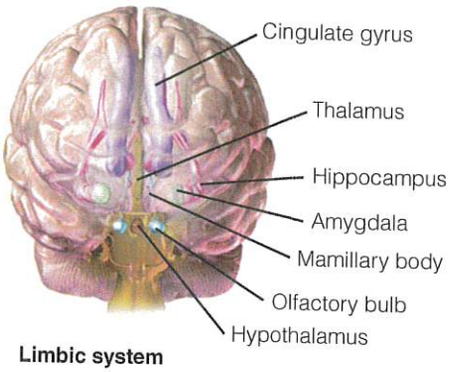
Structure	Location and Description
Central fissure	Deep valley in the cerebral cortex that divides the frontal lobe from the rest of the brain
Cerebellum	Located within the hindbrain; coordinates muscle movement and balance
Cerebral cortex	Outer-most layer of the brain. Covers almost all of each hemisphere of the brain; referred to as the grey matter of the brain (named after its characteristic coloring).
Frontal lobe	Located in the front of the brain (in front of the central fissure). The frontal lobe is the seat of a number of very important functions, including controlling movement, planning, organizing, inhibiting behavior or responses, and decision-making.
Hemisphere (left)	Controls the right half of the body, is typically responsible for analytic thinking, and is responsible for speech
Hemisphere (right)	Controls the left side of the body, is involved in the determination of spatial relations and patterns, and is involved in emotion and intuition
Lateral fissure	Deep valley in the cerebral cortex that is above the temporal lobe
Longitudinal fissure	Deep valley in the cerebral cortex that divides the left and right hemispheres of the brain
Occipital lobe	Located behind the parietal and temporal lobes of the brain; associated with vision
Parietal lobe	Located behind the frontal lobe of the brain and above the lateral fissure; associated with the sensation of touch.
Prefrontal cortex	Controls attention and impulse control; used in problem solving and critical thinking
Subcortical tissue	Brain tissue immediately below the cerebral cortex
Temporal lobe	Located below the lateral fissure of the brain; associated with auditory discrimination.

FIGURE 2.4 MAJOR FEATURES OF THE HUMAN BRAIN.

- A genetic approach to mental disorder focuses on heritability and molecular genetics.
- Neurons are the basic unit of the nervous systems and communicate using chemical messengers or neurotransmitters.
- The brain is composed of billions of neurons, as well as several lobes and other structures important for basic functioning.
- The biological model is important for understanding many components of major mental disorders, but it cannot explain all aspects of the disorders.



Sagittal view



Limbic system

Structure	Location and Description
Amygdala	Structure in the limbic system that is involved in emotion and in aggression
Basal ganglia	Brain structures that control posture, motor activity, and anxiety level
Corpus callosum	A band of nerve fibers that connects the two hemispheres of the brain, allowing for communication between the right and left sides of the brain.
Hindbrain	Most posterior part of the brain; includes the medulla, pons, and cerebellum; these structures are involved in important "automatic" activities of the body like breathing, heartbeat, and digestion. In addition, the cerebellum controls motor coordination.
Hypothalamus	Regulates basic biological needs like hunger, thirst, and body temperature
Hippocampus	Part of the limbic system involved in memory and learning
Limbic system	Regulates emotions and impulses, and is also responsible for basic drives like thirst, sex, and aggression. The limbic system consists of several structures that are implicated in psychological disorders: the hippocampus, cingulate gyrus, septum, and amygdala.
Medulla	Located in the hindbrain; involved in regulating breathing and blood circulation
Pituitary gland	Regulates other endocrine glands and controls growth; sometimes called the "master gland."
Pons	Located in the hindbrain; involved in sleep and arousal
Reticular formation	Internal structures within the midbrain that are involved in arousal and stress or tension
Spinal cord	Transmits information between the brain and the rest of the body; controls simple reflexes
Thalamus	Relay signals to and from the cerebral cortex to other brain structures

FIGURE 2.4—cont'd

Review Questions

1. How might the biological model explain Mariella's problems?
2. Explain the concepts of behavior genetics, heritability, and molecular genetics.
3. Identify some major neurotransmitter systems implicated in mental disorders.
4. What are major structures of the brain, and which ones might be most important for Mariella's condition?
5. What might a biologically oriented mental health professional recommend as treatment for Mariella?

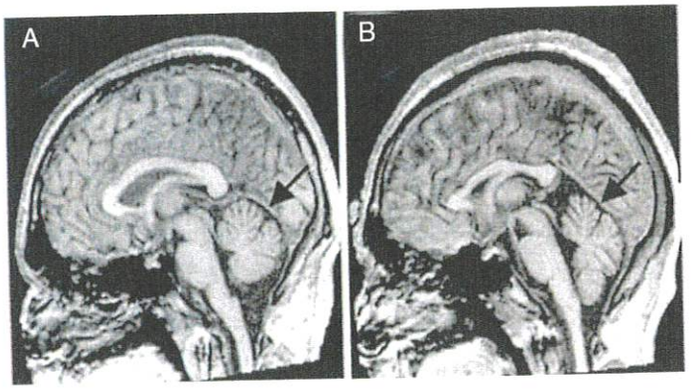


FIGURE 2.5 MRI SCANS FROM THE CEREBELLAR AREAS OF A 16-YEAR-OLD BOY WITH AUTISM (A) AND A 16-YEAR-OLD BOY WITHOUT AUTISM (B). Note the somewhat smaller cerebellar area in the youth with autism, which may contribute to abnormal motor movements and cognitive impairments often seen in people with autism. *From Palmen, J.M.C., van Engeland, H., Hof, P.R., & Schmitz, C. 2004. Neuropathological findings in autism.* Brain, *127, 2572-2583.*

The Psychodynamic Model

The biological model focuses on internal physical structures related to mental disorder. The **psychodynamic model** also focuses on internal structures but mental ones rather than physical. The psychodynamic model comes from *Freudian theory* that assumes mental states and behaviors arise from motives and conflicts within a person. The term *intrapsychic* refers to psychological dynamics that occur within a person's mind, so this term is often used to describe the psychodynamic model. The psychodynamic model represents one of the most sweeping contributions to the mental health field; its influence permeates our culture. Psychodynamically oriented words or phrases such as *ego, unconscious,* and *Freudian slip* have become part of our common vernacular. You may have even come across aspects of Freudian thought in art, literature, films, and textbooks.

Several basic principles comprise the psychodynamic perspective (Gabbard, 2014). One basic principle is that *childhood experiences shape adult personality*. The belief that childhood development influences adult behavior is almost universally accepted. You can likely identify certain childhood experiences that shaped who you are today. You are a product of your biology, youthful experiences, and events happening now. Ignoring any of these factors means we lose much information about your personality and history with others. Imagine if we focused only on Mariella's problems for the past few months—we would lose other information, such as her high school experiences that may influence her current symptoms.

A second key principle of the psychodynamic perspective is that *causes and purposes of human behavior are not always obvious but partly unconscious*. Unconscious means the part of the mind where mental activity occurs but of which a person is unaware. Scientists in disciplines such as neuroscience have found that certain mental and behavioral processes do not appear to be under cognitive control (MacDonald, Naci, MacDonald, & Owen, 2015). The implication is that realms of emotion, cognition, and behavior exist of which we are not consciously aware. These hidden realms of emotion, thought, and behavior may also affect motives that drive us to act in certain ways. This is known as **unconscious motivation**. Healthy behavior is considered behavior for which a person understands the motivation (do you know why you are doing what you are doing?). Unhealthy behavior results when we do not fully understand the

2.1

Focus on

Violence

A More Complex Approach

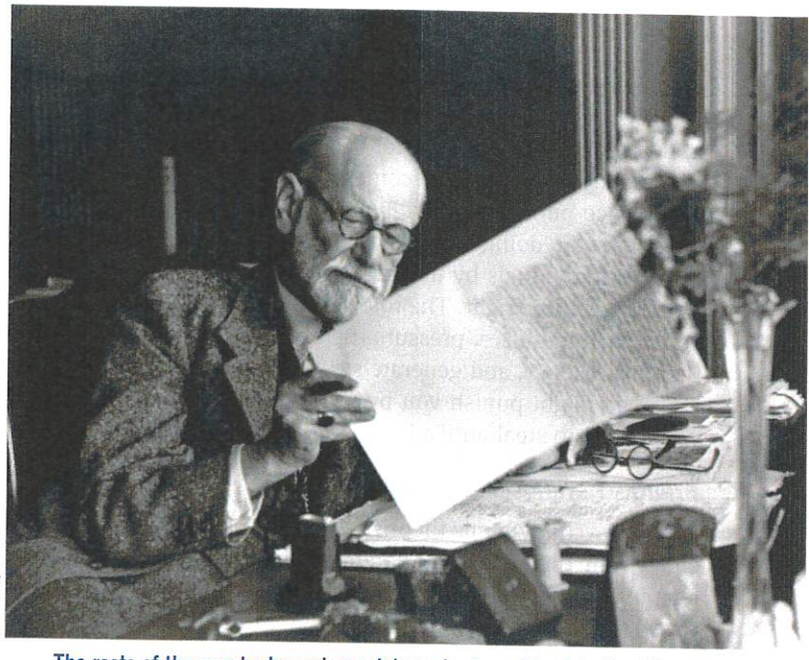
Violence and aggression are complex behaviors that cannot necessarily be explained by single models such as a biological one. Instead, a more complex and developmental approach is often needed. One example is aggression in adolescents with delinquent behavior or conduct disorder (Chapter 13). Some youth have certain biological qualities that may predispose them to conduct problems such as aggression, although not all youth with these qualities necessarily become aggressive. Those who are more likely to become aggressive tend to experience harsh parental discipline, emotional neglect, lack of teaching from parents, and conflicts with aggressive peers. These experiences then interact with academic and social problems, which can lead to association with deviant peers in middle or high school. If parents' supervision declines during this time, then the child may not develop adequate social skills to control anger and aggression. In this scenario, many contributing factors are involved, including biological, psychological, and social factors (Hyde, Shaw, & Hariri, 2013).

A more in-depth approach may be necessary to explain forms of violence in adulthood as well. Intimate partner violence is a significant problem among college students but one that cannot be fully explained just by learning or sociocultural factors. One group of researchers examined college students in dating relationships who recorded daily instances of interpersonal violence and other behaviors. Students were much more likely to engage in physical or psychological interpersonal violence on days they were drinking alcohol, using marijuana, or were more angry, hostile, or irritable (negative affect). The study also revealed that multiple factors can interact in various ways to influence different kinds of violence. For example, number of alcoholic drinks consumed in addition to negative affect was most closely related to physical violence (Shorey, Stuart, Moore, & McNulty, 2014).

unconscious causes of our behavior. The goal of psychodynamic therapy is thus to make the unconscious more conscious.

A third key principle of the psychodynamic perspective is that *people use defense mechanisms to control anxiety or stress.* **Defense mechanisms** are strategies to cope with anxiety or stressors such as conflict with others. Psychodynamic theorists believe most humans can adapt to challenges and stressors by using healthy defense mechanisms. Some people with a mental disorder over-rely on less effective defense mechanisms, or defense mechanisms do not work well for them and they become quite stressed.

A fourth key principle of the psychodynamic model is that *everything we do has meaning and purpose and is goal-directed.* This is known as **psychic determinism**. Mundane and bizarre behavior, dreams, and slips of the tongue all have significant meaning in the psychodynamic model. Behaviors may in fact have different meanings. Think about Mariella's weight loss: Was her behavior motivated by a simple desire to lose weight, or was it a signal to others that she needed help?



Bettmann/Corbis

The roots of the psychodynamic model can be traced back to the life and times of the Viennese physician Sigmund Freud (1856–1939).

Brief Overview of the Psychodynamic Model

We now provide an overview of the major concepts of the psychodynamic model. This includes a description of the structure of the mind, as well as an explanation of psychosexual stages and defense mechanisms.

Structure of the Mind

A major component of the psychodynamic model of personality and mental disorders is *structure of the mind.* According to Freud and other psychodynamic theorists, the mind (and hence personality) is composed of three basic structures in our unconscious: *id, ego,* and *superego* (see **Figure 2.6**). The **id** is the portion of the personality that is present at birth. The purpose of the id is to seek immediate gratification and discharge tension as soon as possible. This process is the **pleasure principle**. The id propels us to meet demands of hunger, thirst, aggression, or sexual or physical pleasure as soon as possible. The id is thus hedonistic and without values, ethics, or logic. Think about a baby who cries when she wants something and does not want to wait for it. Babies, and maybe even some adults you know, have "id-oriented" personalities.

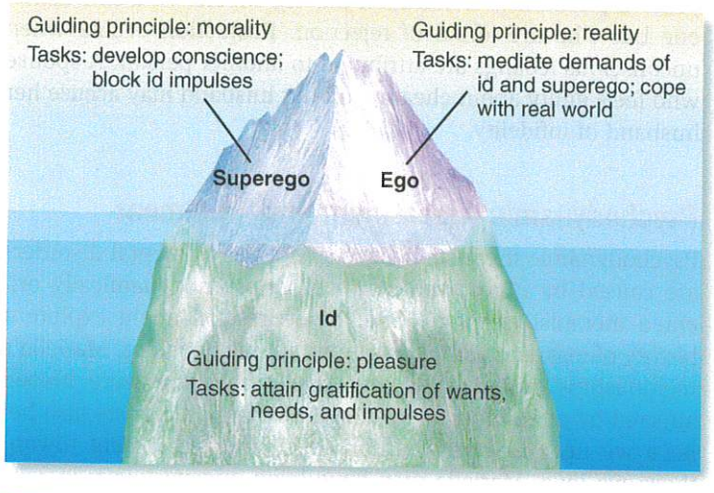


FIGURE 2.6 FREUD'S STRUCTURE OF THE MIND. *Adapted from Rathus,* Psychology: Concepts and Connections, *9th ed., Fig. 11.1, p. 402. Copyright © 2005 Wadsworth, a part of Cengage Learning. Reproduced by permission. www.cengage.com/permissions.*

The id uses a **primary process** form of thinking if gratification is not immediate—this involves manufacturing a fantasy or mental image of whatever lessens the tension. You might want to date someone but are convinced he or she will reject your invitation, so you simply fantasize about being with that person. Or you might think about food when you are hungry. Dreaming is also a form of primary process. Primary processes cannot provide real gratification such as a date or food, however, so we must develop a second personality structure to help us address real-life demands—the ego.

The **ego** is an organized, rational system that uses higher-order thinking processes to obtain gratification. The ego is the executive of the personality and operates along the **reality principle**, or need to delay gratification of impulses to meet environmental demands. If you badly want an iPad, then your id might urge you to steal one. This would land you in trouble, however, so the ego tries to mediate demands of the id and demands of the environment. The ego uses **secondary process** to do this. Secondary process involves learning, perception, memory, planning, judgment, and other higher-order thinking processes to plan a workable strategy. The ego might plan to schedule some overtime shifts at work so you can earn extra money to buy the iPad. The id thus receives what it wants eventually but in a socially acceptable way. A strong ego is often considered by psychodynamic theorists to be the hallmark of mental health.

The third component of the personality is the **superego**. The superego develops in early childhood and represents societal ideals and values conveyed by parents through rewards and punishments. The superego is essentially one's sense of right and wrong. Punished behavior becomes part of one's *conscience,* and rewarded behavior becomes a part of one's *ego ideal.* The conscience punishes individuals by making them feel guilty or worthless for doing something wrong, whereas the ego ideal rewards individuals by making them feel proud and worthy for doing something right. The role of the superego is to block unacceptable id impulses, pressure the ego to pursue morality rather than expediency, and generate strivings toward perfection. Your superego might punish you by using guilt, shame, and worry if you decide to steal an iPad.

Freud's Psychosexual Stages

Not all psychodynamic theorists adhere strictly to Freudian principles, but they do agree childhood is extremely important in shaping a person's character and personality. Freud himself proposed that each person progresses through **psychosexual stages of development**. These stages occur early in life and are marked by *erogenous zones,* or areas of the body through which hedonistic id impulses are expressed. **Table 2.2** provides a description of each stage.

Severe difficulties experienced by a child at a psychosexual stage may be expressed later in life as symptoms of mental disorders. These difficulties are marked by excessive frustration or overindulgence at a psychosexual stage and can result in **fixation**, or delayed psychosexual development. The particular stage at which such frustration or overindulgence is encountered will determine the nature of later symptoms. A child neglected or deprived during the oral stage of development may compensate in adulthood by engaging in excess oral behaviors such as smoking, talkativeness, or drinking too much alcohol. A child overindulged by parents during toilet training in the anal stage may compensate in adulthood by being overly neat or compulsive. A psychodynamic theorist might say Mariella's basic needs of nurturance and safety were unsatisfied during her oral stage of development, and so she remained fixated at this stage. Her depression may thus be a signal to others that she craves social attention and comfort.

TABLE 2.2

Freud's Psychosexual Stages of Development

Stage	Age	Focus
Oral stage	0–6 months	Mouth is the chief means of reaching satisfaction.
Anal stage	6 months–3 years	Attention becomes centered on defecation and urination.
Phallic stage	3–6 years	Sexual organs become the prime source of gratification.
Latency stage	6–12 years	Lack of overt sexual activity or interest.
Genital stage	12 years to adulthood	Mature expression of sexuality.

Defense Mechanisms

The ego experiences *anxiety* when the id urges it to seek impulsive gratification or when the superego imposes shame and guilt. Anxiety is a painful emotion that warns the ego to quell the threat and protect the organism. The ego uses secondary processes of memory, judgment, and learning to solve problems and stave off external threats. But these measures are less useful when internal threats arise from the id or superego. What then? The ego has at its disposal various tactics called defense mechanisms, which are unconscious mental processes used to fend off conflict or anxiety.

We all use defense mechanisms, such as when we claim we did not really want to date someone who just turned down our invitation. Use of defense mechanisms becomes a problem, however, when we use them excessively or when we use a select few defense mechanisms exclusively. If we constantly deny reality and continue to ask out people who are likely to reject us, then we may get depressed. Moderation and variety are important for mental health, including use of defense mechanisms.

Table 2.3 lists many defense mechanisms proposed by psychodynamic theorists. Let's discuss some of the primary ones. **Repression** is a basic ego defense that occurs when a person banishes from consciousness threatening feelings, thoughts, or impulses, like a strong sexual desire for a stranger. **Regression** involves returning to a stage that previously gave a person much gratification—think of a middle-aged man under stress who begins to act as if he were a teenager. **Reaction formation** occurs when an unconscious impulse is consciously expressed by its behavioral opposite. "I love you" is thus expressed as "I hate you," a phenomenon common among tweens who like someone but who are afraid of rejection. **Projection** occurs when unconscious feelings are attributed to another person. A spouse who feels guilty about cheating on her husband may accuse her husband of infidelity.

Psychodynamic Assessment and Treatment

Psychodynamic theorists believe symptoms of mental disorders are caused by unresolved conflicts. A psychodynamically oriented therapist treating Mariella's depression might explore a history of loss, such as loss of important relationships. Mariella's relationships with friends and family at home were indeed affected by attending college. Psychodynamic theorists also believe we unconsciously harbor anger and resentment toward those we love. Mariella may have been unconsciously jealous of, and angry at, her friends and family members who did not move far away and who did not fully appreciate her problems in college. Perhaps she internalized feelings of resentment by directing the feelings toward herself—anger turned inward.

TABLE 2.3

Examples of Defense Mechanisms

Defense mechanism	Description
Denial	Refusing to accept or acknowledge reality
Displacement	Expressing one's unacceptable feelings onto a different object or person than the one that is truly the target of the feelings
Fantasy	Imagining some unattainable desire
Identification	Modeling another person's behavior or preferences to be more like them
Intellectualization	Providing an in-depth intellectual analysis of a traumatic or other situation to distance oneself from its emotional content
Overcompensation	Emphasizing strength in one area to balance a perceived weakness in other area
Projection	Attributing one's own unacceptable motives or impulses to another person
Rationalization	Developing a specific reason for an action, such as justifying why one did not purchase a particular car
Reaction formation	Expressing an unconscious impulse by engaging in its behavioral opposite
Regression	Returning to an earlier psychosexual stage that provided substantial gratification
Repression	Keeping highly threatening sexual or aggressive material from consciousness
Sublimation	Transforming emotions or sexual or aggressive material into more acceptable forms such as dancing or athletic or creative activity
Undoing	Reversing an unacceptable behavior or thought using extreme means

This may have led to symptoms of depression such as low self-esteem and sadness. Mariella's depression may have been caused by this unconscious conflict of emotions.

How does a psychodynamic theorist know what unconscious material exists for a client? A psychodynamic mental health professional often assesses unconscious motivations and conflicts using *projective techniques.* Projective techniques are based on the **projective hypothesis**, or an assumption that people project unconscious needs and conflicts onto ambiguous stimuli such as inkblots. People *impose their own structure* on unstructured stimuli and thus reveal something of themselves. Unconscious material is thus uncovered. In Chapter 4, we discuss two major projective tests used to access unconscious material—the *Rorschach* and the *Thematic Apperception Test* (TAT). However, we present next an overview of projective assessment within the context of Mariella's case.

A psychodynamic theorist might expect a depressed client like Mariella to respond to projective tests in ways that indicate underlying anger and hostility. Such findings would support the psychodynamic explanation of depression as "anger turned inward" in response to loss. Mariella might be given an inkblot from the Rorschach and asked, "What might this be?" or asked to develop a story about characters depicted in the TAT. Mariella could reveal unconscious material about herself because she must impose some structure, organization, and interpretation onto ambiguous materials. She may respond to an inkblot by saying it represents "two bears fighting with each other" or develop a story from a TAT card about a woman who is mad at a friend. A psychodynamic theorist might conclude from these responses that Mariella is "projecting" her anger and hostility onto the neutral stimulus of an inkblot or TAT card. This "projected" anger and hostility is considered to be unconscious material.

Psychodynamic theorists also use other techniques to access unconscious material. **Free association** means asking a client to say whatever comes to mind during the session, without exercising censorship or restraint. This is not easy (try it) because the client must stop censoring or screening thoughts that may seem ridiculous, aggressive, embarrassing, or sexual. A psychodynamic therapist is looking for slips of the tongue, or Freudian slips, that reveal quick glimpses of unconscious material. Mariella could be speaking during free association and "accidentally" say she has always resented her mother for pushing her to do things outside the home.

A related technique is **dream analysis.** Dreams are thought to reveal unconscious material because ego defenses are lowered during sleep. The **manifest content** of a dream is what actually happens during the dream. The manifest content of a dream may be, for example, that the dreamer is confronted with two large, delicious-looking ice cream cones. The **latent content** of a dream, however, is its symbolic or unconscious meaning. Dreaming about ice cream cones may symbolically represent a longing to return to the mother's breast.

How might psychodynamic theorists use information from projective tests, free association, and dreams to treat Mariella? A key goal of psychodynamic treatment is to help clients gain *insight* into their current problems. **Insight** means understanding the unconscious determinants of irrational emotions, thoughts, or behaviors that create problems or distress. The need for defense mechanisms and psychological symptoms should disappear once these unconscious reasons are fully confronted and understood. A psychodynamic theorist believes Mariella can improve by understanding the true, underlying reasons for her depression, including feelings of anger turned inward.

Psychodynamic theorists interpret past experiences and information from projective assessments to help accomplish insight. **Interpretation** is a cornerstone of psychodynamic therapy and the method by which unconscious meanings of emotions, thoughts, and behavior are revealed. A mental health professional will "translate" for a client what may be causing current symptoms involving emotions, thoughts, or behaviors. Significant

insight or behavioral change rarely comes from a single interpretation but rather a slow process in which meaning behind certain emotions, thoughts, and behaviors is repeatedly identified in one context after another. A psychodynamic therapist might point out Mariella's various child, adolescent, and adult experiences, as well as projective assessment responses to illustrate a history of becoming angry with others but bottling up such anger and becoming depressed. Certain dreams and Freudian slips would be instructive as well.

A client's behavior with a therapist can also illuminate the unconscious and reveal conflicts with others. **Transference** is a key phenomenon in psychodynamic therapy that occurs when a client reacts to a therapist as if the latter is an important figure from childhood. Positive and negative feelings can be transferred. Conflicts and problems that originated in childhood are thus reinstated in the therapy room. Mariella might one day yell at her therapist to reflect anger toward her mother.

Client–therapist interactions provide important clues about the nature of a client's problems but are also an opportunity for the therapist to carefully and supportively interpret transference in an immediate and vital situation. A client will, ideally, then recognize the irrational nature and origins of transference feelings and cope with these in more rational ways. The client can begin to control such reactions in real-world settings and to use them as a basis for further interpretation and analysis.

Evaluating the Psychodynamic Model

As mentioned, the most influential principle of the psychodynamic perspective may be that childhood experiences greatly affect adult functioning. The influence of this principle can be seen in popular media as well as in psychology and psychiatry. Think about how we value the health, welfare, and education of children. We also emphasize the negative consequences of child maltreatment, poor parenting, and inadequate education. Children are not little adults who can roll with the punches or easily avoid the stress of a dysfunctional family or dangerous home or neighborhood. Psychodynamic theory has certainly helped us focus on providing better environments for our children. The psychodynamic theory of defense mechanisms also makes intuitive sense. Many of us use defenses to ward off anxiety and cope with psychological threats in our environment.

A strict view of the psychodynamic perspective does reveal some limitations, however. Perhaps the biggest weakness is that little empirical support exists for many of the major propositions and techniques of the perspective. Psychodynamic theory was mostly formed from anecdotal evidence, and many concepts such as the id are abstract and difficult to measure. If we cannot measure an important variable reliably and with confidence, then its usefulness is questionable. Psychodynamic theorists were accused for many years of being "antiscientific" because they accepted Freud's propositions as simple truth. This stance, predictably, divides people into believers and nonbelievers. Believers thought empirical research was unnecessary, and nonbelievers saw no point to empirically testing the theory. Psychodynamic theory has thus lost much of its broad, mainstream appeal, but a short-term therapy approach based on the theory remains popular among some mental health professionals (Driessen et al., 2015).

Interim Summary

- The psychodynamic model rests on the assumption that mental states and behaviors arise from unconscious motives and intrapsychic conflicts.
- Two major assumptions of this perspective are psychic determinism and unconscious motivation.
- According to psychodynamic theorists, the id, ego, and superego comprise the mind.
- Psychosexual stages are developmental stages that influence personality and abnormal behavior.
- We use defense mechanisms to cope with life demands and intrapsychic conflict.
- Problems occur when we use defense mechanisms exclusively or excessively.
- Strengths of the psychodynamic perspective include defense mechanisms and an emphasis on how childhood experiences influence adult personality.
- A major weakness of the psychodynamic perspective is the relative lack of research support for its major assumptions.

Review Questions

1. How might the psychodynamic model explain Mariella's problems?
2. How might a psychodynamically oriented therapist assess and treat Mariella?
3. Describe the following features of the psychodynamic perspective and how they can help us understand Mariella's symptoms: psychic determinism, unconscious motivation, structure of the mind, psychosexual stages, defense mechanisms.
4. Review the list of defense mechanisms in Table 2.3. Which have you used, and which do you use the most?
5. What are strengths and limitations of the psychodynamic perspective?

The Humanistic Model

Biological and psychodynamic perspectives focus primarily on internal factors such as genetics and unconscious conflicts. Some theorists have reacted to these models with disdain because the models do not emphasize personal growth, free will, or responsibility. Biological and psychodynamic theorists concentrate heavily on how factors such as genetics and unconscious conflicts automatically shape human behavior. Other theorists, however, focus more on how people can make choices that influence their environment and how they can take responsibility for their actions.

One group of theorists that emphasize human growth, choice, and responsibility adopt a **humanistic model** of psychology.

2.2

Focus on

Law and Ethics

Dangerousness and Commitment

Determining whether someone is dangerous to oneself or others is extremely difficult. Behaviors such as suspiciousness, excitability, uncooperativeness, and tension are not good predictors of dangerousness. Making the task more difficult is that a large majority of people with mental disorders are *not* dangerous (Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014). A psychologist's ability to predict dangerous behavior may be better in the short term than the long term, although errors still occur. Some variables may help predict dangerousness, including psychopathy (Chapter 10), school and work maladjustment, excessive substance use, violent criminal history, early age of onset of violent behaviors, injury to victims, and psychotic symptoms (Chapter 12) (Bonta, Blais, & Wilson, 2014; Parry, 2013).

The issue of predicting dangerousness relates to committing someone to a mental hospital against his will. The conflict between individual rights to be free versus societal rights to be protected from dangerous people has been an issue for centuries. Detaining and separating people perceived as dangerous to the general population has become an accepted practice. **Civil commitment** refers to involuntary hospitalization of people at serious risk of harming themselves or others or people who cannot care for themselves (Slate, Buffington-Vollum, & Johnson, 2013). Commitment in this regard can occur on an *emergency* basis for a few days or more *formally* for extended periods by court order.

Criminal commitment refers to involuntary hospitalization of people charged with a crime. A person may be hospitalized to determine her competency to stand trial or after acquittal by reason of insanity. **Competency to stand trial** refers to whether a person can participate meaningfully in his own defense and can understand and appreciate the legal process. Such competency is often questioned for people who commit crimes while experiencing intellectual disability, psychotic disorders, dementia, or substance use problems (Greene & Heilbrun, 2014).

Insanity is a legal term that refers to mental incapacity at the time of a crime, perhaps because a person did not understand right from wrong or because the person was unable to control personal actions at the time of the crime. A person judged to be insane is not held criminally responsible for an act but may be committed as a dangerous person, sometimes for extensive periods of time. The insanity defense has always been controversial, but very few defendants (about 1 percent) actually use this defense. This may be complicated, however, by the number of people with intellectual disability in the criminal justice system (Sakdalan & Egan, 2014).

The humanistic model was developed in the 1950s and retains some relevance today. A main assumption of the humanistic model is that people are naturally good and strive for personal growth and fulfillment. Humanistic theorists believe we seek to be creative and meaningful in our lives and that, when thwarted in this goal, become alienated from others and possibly develop a mental disorder. A second key assumption of the model is that humans have choices and are responsible for their own fates. A person with a mental disorder may thus enhance his recovery by taking greater responsibility for his actions.

Humanistic theorists adopt a **phenomenological approach**, which is an assumption that one's behavior is determined by perceptions of herself and others. Humanistic theorists believe in a subjective human experience that includes individual awareness of how we behave in the context of our environment and other people. To fully understand another person, therefore, you must see the world as he sees it and not as you see it. We all have different views of the world that affect our behavior. Humanistic theory was shaped greatly by the works of Abraham Maslow, Carl Rogers, and Rollo May. We explore these theorists next to expand on our discussion of the humanistic model.

Abraham Maslow

Abraham Maslow (1908–1970) believed humans have basic and higher-order needs they strive to satisfy during their lifetime (see **Figure 2.7**). The most basic needs are physiological and include air, food, water, sex, sleep, and other factors that promote *homeostasis*, or maintenance of the body's internal environment. We feel anxious or irritable when these needs are not met but feel a sense of well-being when the needs are met and when we have achieved homeostasis. These needs must be largely fulfilled before a person can meet other needs. *Safety needs* include shelter, basic health, employment, and family and financial security. *Love and belongingness needs* include intimacy with others and close friendships—a strong social support network. *Esteem needs* include confidence in oneself, self-esteem, achievement at work or another important area, and respect from others. These needs are thought to apply to everyone and have even been adapted to the care of intensive care and dying patients (Jackson et al., 2014).

The highest level of need is **self-actualization**, defined as striving to be the best one can be. Maslow believed humans naturally strive to learn as much as they can about their environment, seek beauty and absorb nature, create, feel close to others, and accomplish as much as possible. Self-actualized people are also thought to be moral beings who understand reality and can view things objectively. Pursuit of self-actualization normally occurs after other basic needs have been met, although some people may value other needs such as respect from others more highly than self-actualization.

Maslow believed healthy people are motivated toward self-actualization and become mature in accepting others, solving problems, seeking autonomy, and developing deep-seated

- Abraham Maslow outlined a series of human needs; the highest level is self-actualization, or pursuit of one's full potential.
- Carl Rogers developed client-centered therapy, which focuses on unconditional positive regard, or complete acceptance of a client, and empathy.
- Rollo May's existential approach emphasized authenticity, or how closely one adheres to one's personality, as well as anxiety about alienation from others.
- The humanistic perspective relies on qualitative assessment of an individual's perceptions of himself and the world as well as nondirective therapy.
- Strengths of the humanistic perspective include its emphasis on personal responsibility for recovery and process variables important for treatment.
- Weaknesses of the humanistic perspective include relative lack of research support and poor utility for certain groups of people.

Review Questions

1. How might the humanistic model explain Mariella's problems?
2. How might a client-centered therapist assess and treat Mariella?
3. Describe the following features of the humanistic perspective and how they can help us understand Mariella's symptoms: phenomenological approach, self-actualization, conditional positive regard, authenticity.
4. What are strengths and limitations of the humanistic perspective?

The Cognitive-Behavioral Model

The psychodynamic and humanistic perspectives we have covered so far focus specifically on internal variables, lack empirical support, or seem not to apply well to many people with a mental disorder. Another perspective of mental disorders focuses on external as well as internal factors, has good empirical support, and is relevant to many people with a mental disorder. The *behavioral perspective* focuses on external acts and the *cognitive perspective* focuses on internal thoughts. Some theorists discuss these perspectives separately, but many contemporary researchers and therapists understand the limitations of working within just one model. Many mental health professionals now combine these perspectives into a singular *cognitive-behavioral model.* We discuss these perspectives next and then note how combining the two provides a good explanation for mental disorders and treatment.

Behavioral Perspective

The **behavioral perspective** developed in reaction to psychodynamic theory that dominated psychology in the early 20th century. Many psychologists were concerned that variables such as id and unconscious were difficult to measure and not important to mental health outcomes. The behavioral perspective instead focuses on environmental stimuli and behavioral responses—variables that can be directly observed and measured. The behavioral perspective is based on the assumption that all behavior—normal or abnormal—is learned. The behavioral model dominated psychology in the mid-20th century because learning principles received much empirical support and applied to many topics of psychological research. Treatment approaches from a behavioral perspective were also found to be quite effective for many problems such as anxiety disorders and intellectual disability. The behavioral perspective is based heavily on a learning approach, so a discussion of key learning principles is important.

Learning Principles

Two key learning principles are critical to the behavioral perspective: classical conditioning and operant conditioning. *Classical conditioning* essentially refers to learning by association and was studied initially by *Ivan Pavlov* (1849–1936), a Russian physiologist. Pavlov was interested in the digestive system but made some interesting observations during his experiments with dogs. Pavlov gave meat powder repeatedly to dogs to produce salivation, and he found the dogs often salivated *beforehand,* such as when hearing approaching footsteps! Pavlov was intrigued and explored the nature of this reaction. He rang a bell immediately before a dog received meat powder. This was repeated several times and resulted in dogs salivating after the bell but *before* the meat powder. The dogs learned to salivate to a stimulus, in this case a ringing bell that should not by itself cause salivation. The dogs had learned by association: the bell meant food.

This important experiment led ultimately to **classical conditioning** theory ("conditioning" means learning). Learning occurs when a *conditioned stimulus* (CS; bell) is paired with an *unconditioned stimulus* (UCS; meat powder) so future presentations of the CS (bell) result in a conditioned response (CR; salivation). Classical conditioning theory also suggests that problems such as trauma-based disorders might develop because classical conditioning once took place. Posttraumatic stress disorder (Chapter 5) involves avoiding situations or people that remind someone of a traumatic experience. Rape victims with this disorder often avoid certain parts of a city associated with the assault, or may feel anxious when they see someone who reminds them of their attacker. These behavioral and emotional reactions might be understood via classical conditioning: a location or physical feature (CS) was paired with an assault (UCS), and now the CS produces the classically conditioned response (CR) of intense fear and avoidance (see **Figure 2.8**).

Operant conditioning is based on the principle that behavior followed by positive or pleasurable consequences will likely be repeated, but behavior followed by negative consequences, such as punishment, will not likely be repeated (McSweeney & Murphy, 2014). Reinforcement is thus an important aspect of operant conditioning. **Positive reinforcement** involves giving a

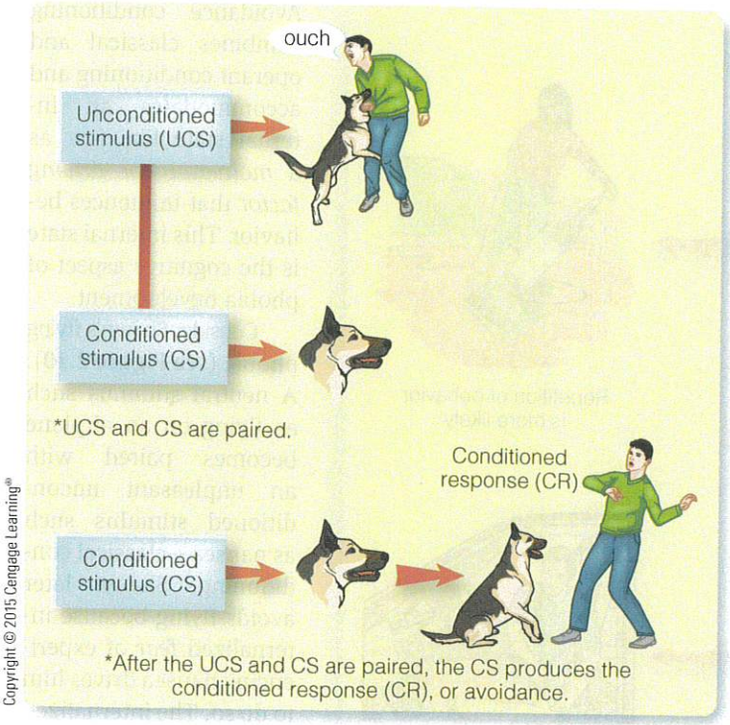


FIGURE 2.8 PRINCIPLES OF CLASSICAL CONDITIONING.

pleasant event or consequence after a behavior. A child praised or rewarded for cleaning his room is likely to repeat the behavior in the future. Positive reinforcement can also maintain maladaptive behavior, as when someone with depression receives sympathy from others or when parents allow a child to miss school and play video games.

Negative reinforcement involves removing an aversive event following a behavior, which also increases the future likelihood of the behavior. Why do you wear deodorant? You likely do not do so for all the wonderful compliments you get during the day but rather to avoid negative comments about body odor! Negative reinforcement can also explain why some fears are maintained over time. Someone afraid of spiders may avoid closets because spiders like to live in dark places. Such avoidance is reinforced because spiders are not encountered and so the aversive event of fear is removed. Such avoidance is also likely to continue in the future (see **Figure 2.9**).

Behavior can also be "shaped" through reinforcement. Students might shape a professor's teaching style by rewarding more interesting lectures. Students might provide strong reinforcement by maintaining eye contact, asking questions, or saying, "That is really interesting!" when a professor provides multiple examples or case illustrations. You can see where this is headed. When students reinforce successive approximations of this lively lecture style, they have the power to make the class more engaging, fresh, and interesting. If you try this on your professors, please do not let them know the source of the idea, and please do not keep them completely under your control!

Cognitive Perspective

The **cognitive perspective** arose from the behavioral perspective because people often behave in ways that have little to do with reinforcement. How did Tony develop an intense fear of heights when he never had a traumatic experience involving heights? An understanding of thoughts, perceptions, and emotions may better account for Tony's fear and avoidance. Not everything can be explained by simple principles of classical and operant conditioning. The cognitive perspective instead suggests that emotions and behavior are influenced by how we perceive and think about our present and past experiences. Learning principles help comprise the behavioral perspective, but other principles comprise the cognitive perspective. These are discussed next.

Cognitive Principles

Each of us actively processes and interprets our experiences. Such processing and interpretation is influenced by **cognitive schemas**, or beliefs or expectations that represent a network of accumulated knowledge. We go into many situations with some expectation of what may happen. Think about the unwritten script that occurs when you enter a restaurant. You wait to be seated, place your order, eat, pay, and leave. If a restaurant conducted this script in a different order, you might be a little confused. Our schemas or expectations about events affect our behavior and emotional experiences. College students told they are drinking a beverage with alcohol—when in fact they are drinking a nonalcoholic beverage—often report feeling intoxicated. They talk loudly or become silly as though they are intoxicated. Their *expectancies* of what they are like when intoxicated influence their behavior, even when not drinking alcohol!

Cognitive distortions are another important principle of the cognitive perspective and refer to irrational, inaccurate thoughts people have about environmental events. Aaron Beck's cognitive theory (Beck & Haigh, 2014) holds that mental disorder may result if one has negative views of oneself ("I'm not good at anything"), other people in the world ("No one cares about anyone except himself"), and the future ("Things will never get easier for me").

Cognitive distortions often come in the form of *arbitrary inference*, which means reaching a conclusion based on little evidence. A professor may see that 2 out of 50 students fell asleep during one lecture and assume she is a bad teacher. The professor ignored the greater evidence that most people did pay attention and instead focused on the two who did not. As professors, we also see students who agonize over one or two mistakes at the expense of seeing the greater value of their examination or project.

Another common cognitive distortion is *personalization*, or erroneously blaming oneself for events. If a coworker refused to speak to you one day, you might personalize the event by wondering what offense you committed. You are ignoring other, more reasonable explanations for what happened—perhaps your coworker just had a fight with her spouse or was worried about a sick child. Cognitive distortions are common to many mental disorders such as anxiety, depressive, eating, and sexual disorders. Indeed, we discuss them throughout this textbook.

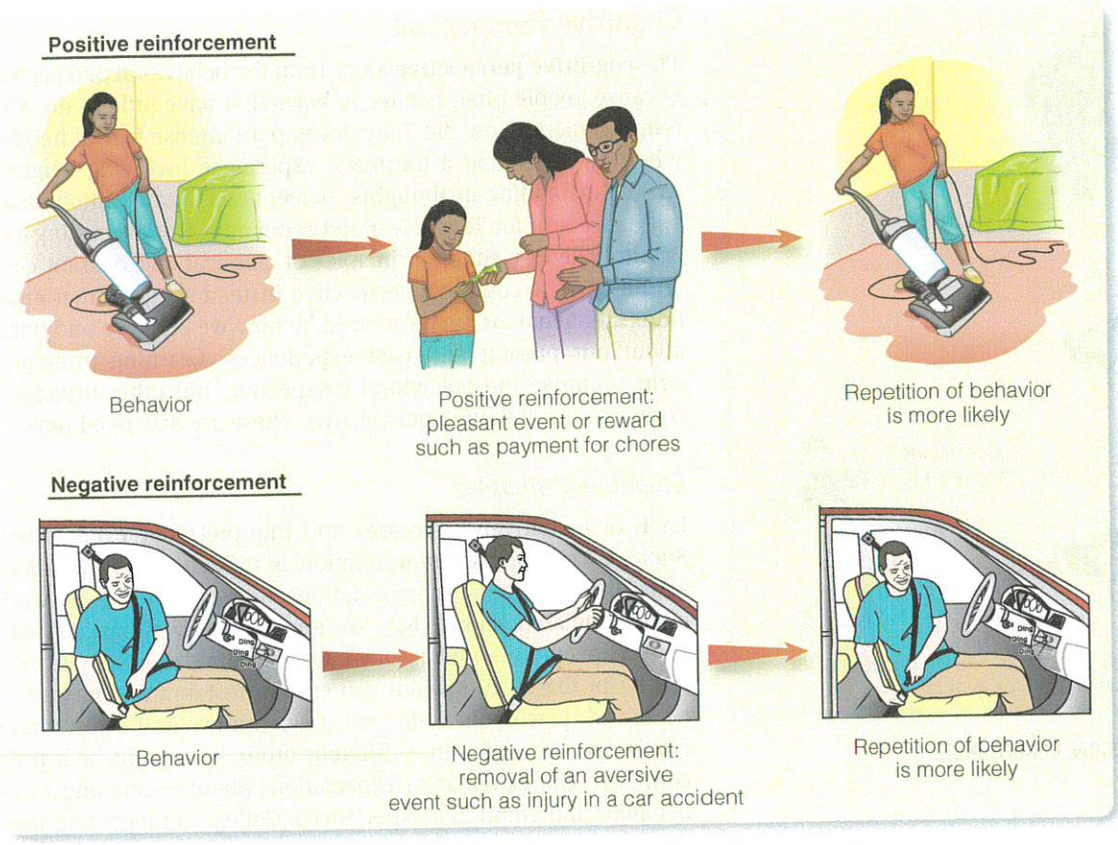


FIGURE 2.9 PRINCIPLES OF OPERANT CONDITIONING.

A Cognitive-Behavioral Model

The cognitive perspective highlights the idea that information processing and learning are *active*, not passive, processes. Contemporary psychologists have generally combined behavioral and cognitive approaches into a *cognitive-behavioral model*. This model rests on the assumption that learning principles *and* cognitions interact to influence a person's behavior. This assumption is evident when considering **modeling**, which refers to learning by observing and imitating others. People often learn by watching others, such as when they watch others operate a piece of machinery or use drugs. We process this information, judge how good someone is modeling the behavior, and decide to practice the behavior ourselves. Modeling, also known as *vicarious conditioning*, implies that cognitive mechanisms such as thoughts, beliefs, or perceptions influence learning. A combined cognitive-behavioral perspective helps explain why certain behaviors are learned through observation and not simple reinforcement.

Learning principles and cognitions also interact to help explain specific disorders. Many people are afraid of airplanes even though airplanes are not typically dangerous or threatening. Classical and operant conditioning may help explain why fear in these situations is maintained, but why do people *start* avoiding harmless objects or situations in the first place? People who avoid a harmless stimulus internalized something that *now motivates or drives subsequent avoidance behavior*. A type of learning called **avoidance conditioning** is thus often proposed. Avoidance conditioning combines classical and operant conditioning and accommodates an internal state like fear as a *motivating or driving factor* that influences behavior. This internal state is the cognitive aspect of phobia development.

Consider Shawn's flying phobia (see **Figure 2.10**). A neutral stimulus such as flying on an airplane becomes paired with an unpleasant unconditioned stimulus such as nausea—classical conditioning. Shawn later avoids flying because internalized *fear* of experiencing nausea drives him to do so. The internalized state that drives Shawn's future avoidance could not be explained by simple classical or operant conditioning. The internalized state or cognitive component instead provides a more complete account of why Shawn's phobia continued over time.

Contemporary models of mental disorders often include a combination of learning principles and cognitive influences such as expectancies and motivations. Substantial research also supports the idea that cognitive schemas and distortions influence forms of mental disorder. The combination of behavioral/learning and cognitive principles has also led to many important assessment and treatment strategies, some of which are discussed next.

Cognitive-Behavioral Assessment and Treatment

Behavior therapy represented a novel way of treating mental disorders when introduced in the 1950s and initially included treatments based on principles of classical and operant conditioning. The scope of behavior therapy has since expanded to include other forms of treatment such as cognitive therapy (Beck & Dozois, 2014). Many mental health professionals today endorse a cognitive-behavioral orientation that recognizes the importance of classical and operant conditioning as well as cognitive theories of mental disorders.

A key assessment approach within the cognitive-behavioral perspective is **functional analysis**. Functional analysis refers to evaluating antecedents and consequences of behavior, or what preceded and followed certain behaviors. This is often done by observing a person. A mental health professional might note that Mariella's depressive symptoms were preceded by

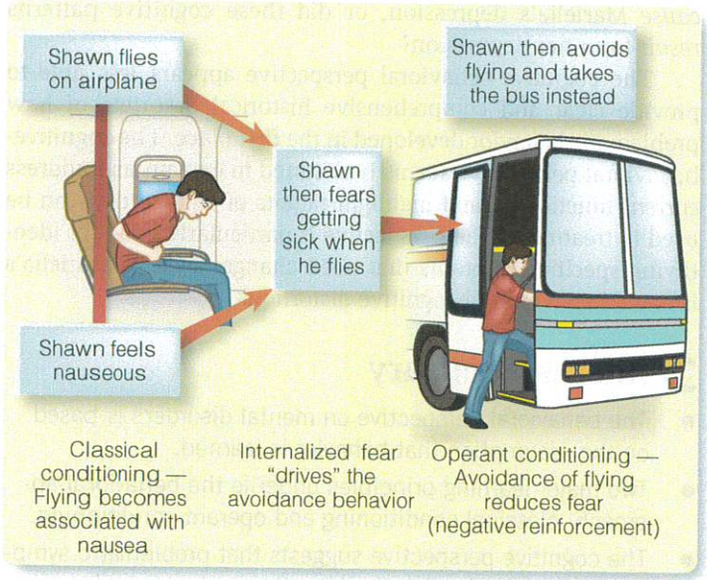


FIGURE 2.10 AVOIDANT CONDITIONING. Shawn is conditioned to avoid flying.

school-based stressors and loneliness and followed by rewards such as greater attention from family members and friends.

Cognitive variables must also be considered during assessment. Mariella may have certain cognitive distortions, such as believing her troubles in school were related to lack of ability, that others did not care about her, and that things would not improve in the future. Her symptoms may have been at least partly caused by these kinds of cognitive schemas or beliefs that are linked to depression. A therapist would assess for these cognitive processes as well during a functional analysis.

How might a cognitive-behavioral therapist treat Mariella's symptoms? **Cognitive-behavioral therapy** refers to a large collection of treatment techniques to change patterns of thinking and behaving that contribute to a person's problems. These techniques have much empirical support and are among the most effective forms of therapy. Cognitive-behavioral therapy has been shown to be equal or superior to alternative psychological or psychopharmacological treatments for adults and youth (Hofmann, 2013; Nathan & Gorman, 2015).

Aaron Beck has been a pioneer in developing cognitive-behavioral treatments for various clinical problems. His model uses cognitive *and* behavioral techniques to modify problematic thinking patterns. Under this model, the following techniques might be used to treat Mariella's depression:

1. Scheduling activities to counteract her inactivity and her focus on depressive feelings. Mariella might be given "homework assignments" to go to the movies with friends or play the guitar before others.
2. Mariella might be asked to imagine successive steps leading to completion of an important task, such as attending an exercise class, so potential barriers or impediments can be identified, anticipated, and addressed. This is called *cognitive rehearsal.*
3. Mariella might engage in assertiveness training and role-playing to improve her social and conversational skills.
4. Mariella might be asked to identify thoughts such as "I can't do anything right" that occur before or during feelings of depression.
5. The reality or accuracy of Mariella's thoughts might be examined by gently challenging their validity ("So you don't think there is *anything* you can do right?").
6. Mariella might be taught to avoid personalizing events for which she is not to blame. She may be shown that her classmates' busy behaviors reflect their own hectic lives and not attempts to rebuff Mariella.
7. Mariella could be helped to find alternative solutions to her problems instead of giving up.

A common therapeutic technique from this perspective is **cognitive restructuring**, or helping someone think more realistically in a given situation. How might cognitive restructuring help Mariella? Recall that Mariella was distancing herself from family, friends, and enjoyable activities. She felt her friends did not understand her or care about her. A therapist using cognitive restructuring might help Mariella see the situation more realistically. The therapist might help her understand her friends are not avoiding her, but rather she is avoiding them. Mariella is not giving her friends the opportunity to support and care for her because Mariella is isolating herself. A therapist using cognitive restructuring will be quite direct with Mariella, using discussions and making arguments that Mariella is viewing her situation irrationally. Irrational beliefs such as "My friends don't care about me" are unfounded and lead to depression. The therapist may also try to teach Mariella to "modify her internal sentences." Mariella might be taught when feeling depressed to pause and ask herself what her immediate thoughts are. The therapist would then ask Mariella to objectively evaluate these thoughts and make corrections. The therapist might thus have her imagine particular problem situations and ask her to think more realistically in these situations.

Other cognitive-behavioral techniques are used to treat mental disorders as well. **Systematic desensitization** is an approach used to treat fear-related concerns. A client is first taught to relax, typically via progressive muscle relaxation techniques. The therapist and client then construct a hierarchy of situations or objects related to the feared stimulus. Items at the bottom of the hierarchy arouse fear at low levels; for a person afraid of dogs, for example, this might mean watching a dog in a film. More fear-provoking items are further along the hierarchy. Contact with an actual feared situation, such as petting a dog, is at the top of the hierarchy. Clients reach a state of relaxation and progressively encounter each object or situation on the hierarchy. If a client becomes too fearful, the procedure is halted so the client can once again become relaxed. Progression along the hierarchy is then restarted. A person is thus desensitized to the previously feared stimulus or situation. From a classical conditioning perspective, the client has learned to respond to a previously feared stimulus with relaxation instead of excessive arousal.

A key element of systematic desensitization is **exposure treatment**, which involves directly confronting a feared stimulus. This can be done gradually or, in the case of *flooding*, the client does not relax in advance but is instead exposed immediately to a feared stimulus. Exposure treatment can be done by having clients imagine the presence of a feared stimulus or by facing the feared stimulus or situation in real life. Clients are understandably fearful in these situations, but if they continue to stay in the presence of the stimulus, fear diminishes. A nonfearful response becomes associated with a previously feared stimulus or situation through repeated exposure sessions.

Systematic desensitization and exposure treatment are based on classical conditioning, but other behavior therapy techniques are based on operant conditioning, which emphasizes reinforcement. A relatively simple application is when a mental health professional stops reinforcing a problematic behavior and reinforces more adaptive and acceptable behavior. Or a therapist might help parents manage consequences for their children to increase positive behavior such as completing homework and decrease negative behavior such as aggression.

Operant conditioning principles are also apparent in token economies to modify behaviors of institutionalized populations such as people with intellectual disability or schizophrenia. A **token economy** is a reinforcement system for certain behaviors in which tokens or points are given for positive behaviors and exchanged later for tangible rewards. Someone with schizophrenia on an inpatient hospital unit may earn points for positive behaviors such as attending group therapy sessions and showering. These points could later be exchanged for privileges such as day passes from the hospital. Token economies are also used to improve social and academic skills and other behaviors in children.

Evaluating the Cognitive-Behavioral Model

The cognitive-behavioral perspective has contributed greatly to our understanding and treatment of mental disorders. The behavioral approach and its emphasis on learning principles revolutionized the study and treatment of mental disorders following psychodynamic theory. The model has been broadened to include thought processes, expectancies, and other internal states. A combined cognitive-behavioral model is among the most influential for conceptualizing the development and maintenance of problematic behavior. The perspective also offers a broad array of treatment choices for many mental disorders. These cognitive-behavioral treatments often have been shown to be effective and efficient, often requiring fewer than 20 sessions.

Limitations of the cognitive-behavioral model should be noted, however. Most problematic might be the model's concept of how mental disorders first develop. Many cognitive-behavior theorists reduce complex behaviors such as depression to simple learning history or cognitive schemas, but this does not seem plausible. Many biological, personality, and social factors also contribute to depression and other disorders. The "chicken and egg" problem is also relevant to cognitive-behaviorism: Did problematic thoughts, beliefs, or expectancies *cause* Mariella's depression, or did these cognitive patterns *result* from her depression?

The cognitive-behavioral perspective appears less able to provide clear and comprehensive historical accounts of how problematic behavior developed in the first place. The cognitive-behavioral perspective seems best suited to explain and address *current* functioning and highlight targets of change that can be used in treatment. The perspective is particularly good for identifying specific symptoms that need change, such as Mariella's isolated behavior and cognitive distortions.

Interim Summary

- The behavioral perspective on mental disorders is based on the assumption that behavior is learned.
- Two major learning principles underlie the behavioral approach: classical conditioning and operant conditioning.
- The cognitive perspective suggests that problematic symptoms and behavior develop from the way we perceive and think about our present and past experiences.
- Key principles of the cognitive perspective include schemas and cognitive distortions.
- Behavioral and cognitive perspectives have been combined to form the cognitive-behavioral model.
- Major cognitive-behavioral treatment approaches include cognitive restructuring, systematic desensitization, exposure, and token economy.
- Strengths of a cognitive-behavioral model include its broad array of effective treatments.
- A major limitation of the cognitive-behavioral model is its poor account of how mental problems originally develop.

Review Questions

1. How might the cognitive-behavioral model explain Mariella's problems?
2. What treatments might a cognitive-behavioral therapist use to treat Mariella's problems?
3. Describe the following learning principles and how they might help us understand Mariella's symptoms: classical conditioning, operant conditioning, modeling.
4. What are strengths and limitations of a cognitive-behavioral perspective on mental disorders?

The Sociocultural Model

The models of mental disorder we have discussed so far in this chapter—biological, psychodynamic, humanistic, and cognitive-behavioral—focus primarily on individuals and their personal characteristics. We do not live in a vacuum, however—many outside factors affect how we feel, think, and behave. Biological, psychodynamic, humanistic, and cognitive-behavioral perspectives do acknowledge some environmental role in psychological problems. The **sociocultural perspective** differs from these models in

2.3

Focus on

Gender

A More Complex Approach

Different models are useful for understanding symptoms, causes, and treatment of mental disorder. The use of a single model to describe a mental disorder can be a problem, however, when gender differences arise. For example, a well-established finding is that female and male children experience similar rates of depression but female adults experience depression at twice the rate of male adults. To explain this finding using just a psychodynamic or cognitive-behavioral model would be difficult. Instead, researchers generally develop integrative models to help explain gender differences. Some have proposed models that focus on negative life events as well as biological, cognitive, and emotional factors (Auerbach, Ho, & Kim, 2014; Xia & Yao, 2015). For example, a girl may experience sexual maltreatment as a child, develop a negative cognitive style, experience increased biological arousal, and display emotional difficulties into adulthood that include depression. These factors may pertain more to girls than boys, which may help explain gender differences in adult depression.

Another problem that differs by gender is excessive alcohol use, which is much more common in males than females by late adolescence. Single models such as the humanistic or sociocultural perspective cannot fully account for this difference. Instead, an integrative model may be best. Early in life, certain biological and psychological factors that predispose alcohol use appear to be similar for boys and girls. During adolescence, however, some important changes may take place. Boys may become more impulsive and sensation seeking, experience later brain maturation, and be more sensitive to peer influences than girls (Kuhn, 2015). These factors may predispose boys to disruptive drinking more than girls.

its greater emphasis on environmental factors; its core assumption is that outside influences play a *major* role in creating a person's psychological problems. The sociocultural perspective focuses on influences that social institutions and other people have on a person's mental health.

Many sociocultural factors potentially influence the development, symptom expression, assessment, and treatment of mental disorders. We highlight here several prominent examples of sociocultural influences on mental health. This is not an exhaustive list, but these examples best highlight this perspective and current areas of investigation. We begin with more global influences, such as culture and gender and neighborhoods, and finish with a topic closer to home—family.

Culture

Culture refers to the unique behavior and lifestyle shared by a group of people. Culture is composed of viewpoints, beliefs, values, and preferences that are evident in rituals, food, customs, laws, art, music, and religion. Culture is not innate but external, learned, and transmitted to others. Culture is not the same as **ethnicity**, which refers to clusters of people who share cultural traits and who use those traits to distinguish themselves from others. Culture is also different from **race**, which refers to a category typically based on physical characteristics (Ferraro & Andreatta, 2014).

One difference between ethnicity and race is that ethnic groups identify themselves as such. The concept of race, however, evolved from early attempts to categorize people based on physical characteristics such as skin color, hair texture, and facial features. However, analyses of genetic material (DNA) actually reveal more differences *within* racial groups than *between* racial groups (Berg, Tymoczko, Gatto, & Stryer, 2015). This reinforces the idea that race is not biologically based but rather socially defined. Culture includes but is not limited to concepts of ethnicity and race, and culture is learned from others and passed on to succeeding generations.

Culture can contribute to mental disorder in several ways. First, culture might serve as a distant but *direct cause* of mental disorders. Culturally shared beliefs and ideas can lead to particular forms of stress that, in turn, lead to specific forms of problems called **cultural syndromes** (American Psychiatric Association [APA], 2013). *Dhat syndrome,* for example, is an anxiety-related belief observed in Indian men that one is "losing" semen through nocturnal emissions, masturbation, or urination. The cultural belief driving the fear is that excessive semen loss results in illness (Udina, Foulon, Valdes, Bhattacharyya, & Martin-Santos, 2013).

Culture can help cause mental disorder but can also *influence the way individuals cope with stressful situations*. Two examples are amok and family suicide (Hagan, Podlogar, & Joiner, 2015). *Amok* is a condition in South Asian and Pacific Islander cultures in which a person attacks and tries to kill others. Cultures in which this condition is observed are often characterized by passivity and nonconfrontation, so amok is seen as a failure to cope with extreme stress. The English phrase "running amok" is derived from this condition (although its meaning is not literal!). *Family suicide* is sometimes observed in Japanese culture when parents and children commit suicide together. This act may be preceded by financial debt or a disgraceful event that causes extreme stress. Family suicide is seen as a coping response, albeit a maladaptive one, because cultural values discourage living disgracefully after a shameful event.

Culture can also influence mental disorders by *shaping the content of symptoms.* Examples include anthrophobia and brain fag. *Anthrophobia,* a phobia of interpersonal relations, is observed in Japanese culture and involves fears of one's body

imagenavi/AGE Fotostock

Culture can influence such problems as anthrophobia.

TABLE 2.4

How Does Culture Contribute to Mental Disorders?

Method	Examples
Direct cause: culturally shared belief leads to stress, and then to symptoms of mental disorder	Dhat syndrome
Influences the way individuals cope with stress	Amok Family suicide
Shapes the content of the symptoms or the symptoms themselves	Anthrophobia Brain fag Dissociative identity disorder Anorexia nervosa

odor, flushing or blushing, and eye contact. These symptoms reflect the culture's hypersensitivity to being looked at or looking at others as well as concern about how one's own behavior is viewed by others. *Brain fag* involves symptoms of intellectual and visual impairment and other body complaints in Nigerian and Ugandan cultures. This condition develops during periods of intensive reading and study, such as before an academic examination, and appears influenced by a culture that promotes family-oriented education. This places intense pressure on a student to be academically successful for the family's sake (Tseng & Zhong, 2012).

Disorders found primarily in Western societies also contain unique symptoms and features. *Multiple personality disorder*, now termed *dissociative identity disorder* (APA, 2013), is one example. Someone with this disorder may not report being "possessed" by animals or spirits (as is the case in other cultures) but reports being possessed by other selves or personalities that control his behavior. Culture thus influences the possession source: in non-Western cultures possession may be by animals or spirits, but in Western cultures, possession may be by other personalities (Tseng & Zhong, 2012).

Anorexia nervosa (Chapter 8) involves excessive concern about being overweight and severe weight loss that threatens one's health. This condition is often observed in American and European cultures but is relatively absent in Samoa and the Pacific Islands where food is scarce or where being overweight is considered attractive. A sociocultural theory stipulates that anorexia nervosa is more prevalent in food-abundant societies that stress an "ideal body" as thin (Fitzsimmons-Craft et al., 2014). Culture thus affects the development of psychological problems in various ways (see **Table 2.4**).

Gender

Mental disorders affect men and women, but some problems seem more common in one gender than the other. Men are more likely to have antisocial personality and substance use disorder, but women are more likely to have anxiety-related and depressive disorders (APA, 2013). Gender differences may be explained by differences in biology, gender identity, socialization, and social situations in which women and men find themselves (Aneshensel, Phelan, & Bierman, 2013). Biological differences in sex hormones may help explain why more men than women have sexual disorders (Chapter 11).

Gender identity refers to one's awareness of being male or female or perceived degree of masculinity or femininity. Gender identity is influenced by parenting style and interactions with others and can be related to mental disorder. People who are androgynous in their personality, as opposed to strictly masculine or feminine, tend to have fewer symptoms of eating disorders (Strother, Lemberg, Stanford, & Turberville, 2012).

Men are also less likely to find themselves in certain situations compared with women, especially as victims of domestic violence and sexual assault. This may help explain why men have fewer anxiety-related disorders than women (Chapter 5). Our *expectations of men and of women*, or socialization differences, also play a role in developing symptoms of mental disorders. We generally expect men to be less emotionally expressive. Men who are anxious and depressed may thus be more likely to use alcohol and other drugs to self-medicate their symptoms, whereas women may be more likely to talk to friends or see a therapist.

Gender differences are most evident for depression, where women have much higher rates than men, and social support seems to be a key factor. Women generally have more social support than men with respect to number of close relationships and level of intimacy of these relationships. If social support suffers, however, women may be more susceptible to depression because they rely more on social support for their well-being (Kendler & Gardner, 2014). Recall that Mariella's separation from family members and friends near home was related to her sadness.

Women may be more likely than men to respond to stress by "tending-and-befriending" (Bodenmann et al., 2015). Women

Millennium Images/SuperStock

According to a sociocultural model, anorexia nervosa may be a condition that occurs more in food-abundant societies that stress a thin ideal.

often respond to stress by nurturing and protecting offspring (tend) and by affiliating with others to reduce risk of harm (befriend). Doing so may have an evolutionary component. When a threat existed, quieting offspring and blending into the environment was adaptive because one was not seen as a threat. Affiliating with a social group following a threat also increased the chance one would be protected. This tending and befriending pattern has also been linked to neurobiological systems that characterize attachment to others and caregiving, and these are specific to women. This theory and related findings illustrate that understanding gender differences can help us explain mental disorders and develop treatments. Mariella could volunteer to help others to help reduce her social isolation and depression.

Neighborhoods and Communities

Another influence on our mental well-being is our surrounding neighborhoods and communities. Several neighborhood characteristics are associated with poorer mental health (Poole, Higgo, & Robinson, 2014). First, neighborhoods with high rates of poverty, turnover among residents, and families headed by single parents often have high rates of juvenile delinquency and childhood maltreatment. Second, people in neighborhoods characterized by physical (abandoned buildings, vandalism) and social (public drunkenness, gangs, disruptive neighbors) decline often have substantial anxiety, depression, and physical complaints. Third, neighborhoods characterized by noise, crowding, and pollution are often associated with high rates of depression, aggression, and childhood behavior problems.

Why do certain neighborhood characteristics relate to poor mental health? A common theme appears to be stress (Senn, Walsh, & Carey, 2014). Certain neighborhoods generate many stressful life events. People from these neighborhoods also have few resources to handle these stressors, so their ability to cope is taxed. Individual differences exist, however, with respect to how able and how well one can cope with such stressors. Some people are "resilient" to such stressors, and psychologists have focused more on features and mechanisms of this resilience. Knowledge about resilience can help psychologists prevent negative mental health outcomes even for people who live under adverse conditions. We discuss resilience in more detail in Chapter 3 within the context of risk and prevention.

Family

Many theorists believe that positive family relationships decrease risk for psychological problems but that family conflict can increase risk. A **family systems perspective** assumes that each family has its own rules and organizational structure, or hierarchy of authority and decision making. When family members keep this organization and obey the rules, a sense of homeostasis or stability is created. Dysfunctional families, however, experience problems and distress because the structure and rules are not optimal (Zvara et al., 2014). Some problematic family relationships and environmental variables are discussed next.

Problematic Family Relationships

Inflexible families are overly rigid and do not adapt well to changes within or outside the family. This can lead to substantial conflict, especially as a child reaches adolescence and wants more independence. *Enmeshed* families are characterized by family members who are overly involved in the private lives of other family members—everything is everyone's business. This can lead to overdependence of family members on one another and feelings of being controlled by others. A family systems theory of anorexia nervosa suggests some individuals try to regain control over their lives by refusing to eat in reaction to parents' excessive involvement and control.

Disengaged families are characterized by family members who operate independently of one another with little parental supervision. This family structure might predispose children to develop conduct problems or get into legal trouble. Families can also be characterized by *triangular relationships,* or situations in which parents avoid talking to each other or addressing marital conflicts by keeping their children involved in all conversations and activities.

Problematic Family Environment

Family environment refers to features or dimensions of family functioning. One feature of family environment is *family affect,* or the degree to which a family is cohesive, organized, and free of conflict. Another feature is *family activity,* or the degree to which families engage in cultural, recreational, and religious activities together. *Family control* is the degree to which a family is

rigid or flexible when adapting to new situations or challenges (Goldenberg & Goldenberg, 2013).

Family environment does seem to influence the mental health of individual family members. For example, **expressed emotion** is the degree to which family interactions are marked by emotional overinvolvement, hostility, and criticism. A parent in a family with high expressed emotion might say to his son: "You never get out of the house. You are never going to amount to anything if you keep it up." Communications like this, although perhaps intended to motivate the son, likely lead to stress and negative feelings of self-worth. People with schizophrenia living in families with high expressed emotion, especially criticism, are at greater risk for relapse compared with people living in families with low expressed emotion (Cechnicki, Bielanska, Hanuszkiewicz, & Daren, 2013). Interventions have thus been developed to help family members understand how their actions can negatively affect someone who has, or who is at risk for, a mental disorder.

Sociocultural Assessment and Treatment

Socioculturalists believe psychological problems largely develop because of the impact of social institutions and other people. What sociocultural factors may have affected Mariella, who was Latina? Mariella's culture is typically *collectivist*, meaning less emphasis on the self and more emphasis on interdependence with others such as friends and family members. Social support is thus likely quite important for Mariella, and her isolation at school may have influenced her sadness and pessimism. The importance of Mariella's academic achievement from a cultural and family perspective is also important to consider. Mariella may have experienced intense pressure to do well at college, which in turn led to added stress. Her family's dismissive reaction to her depressive symptoms when she was home for Thanksgiving may have led to further pessimism and self-criticism as well.

Mariella's identity as a Latina may have influenced her college experience. Latinas, compared with their male counterparts, may be more passive and less competitive. Mariella may have been experiencing some ambivalence about pursuing advanced academic training given her gender as well. Overall, many potential cultural, gender role, and familial issues may have influenced the development and maintenance of Mariella's depressive symptoms.

Clinicians should thus conduct a thorough assessment of an individual's culture. A cultural assessment does not simply include race but also a person's self-defined ethnicity, sources of social support, affiliations and interactions with social institutions, and larger worldview factors such as religious preference. A person's gender role within a cultural context as well as important neighborhood and community factors should also be assessed. A thorough evaluation of family structure, dynamics, and environment is necessary for understanding a person's mental health as well.

Sociocultural assessment methods are less advanced than those of other models of mental disorder. Measures are available for social stressors, social support, and family environment, but few measures are available for features of culture, gender role, and neighborhood or community variables. A mental health professional, therefore, may be limited to using an unstructured interview when conducting these assessments. (Unstructured interviews are problematic assessment tools; we discuss this in Chapter 4.)

Treatment from a sociocultural perspective focuses on addressing a person's difficulties at global and individual levels. Globally, sociocultural interventions focus on decreasing or preventing stress created for people through sexism, racism, or age or religious discrimination. Consider discrimination based on race or ethnicity, which places additional burden and stress on people and may lead to economic hardship and limited resources for education, health care, and employment. People who experience discrimination because of lack of economic resources are also likely to live in stressful neighborhoods or communities—neighborhoods with high rates of unemployment, poverty, crime, and substance use problems. Unremitting stress from these circumstances can have a significant negative impact on a person's mental health. Racial and ethnic disparities also exist with respect to access to physical and mental health care (Le Cook et al., 2014).

A comprehensive program is clearly needed to address the influence of racial and ethnic discrimination on mental health and access to services. This would include programs to make community members aware of the discrimination, public policy and laws to prevent such discrimination, and efforts to decrease disparities in employment, housing, and economic well-being.

Treatment from a sociocultural perspective also focuses on addressing a person's difficulties at *individual* levels. *Family therapy* or *couples therapy*—in which multiple family members meet with a therapist at the same time—are used by various kinds of mental health professionals (Goldenberg & Goldenberg, 2013). These therapies allow for better assessment of a family's problems and provide the opportunity to intervene with all members. Many family and couples therapists directly coach individuals on what to say to other family members and provide feedback about their interactions.

Family and couples therapists also identify and fix problems in communication. Therapists emphasize that nothing is wrong with the family or dyad itself but instead focus on particular relationship issues or communication patterns. One family member might be exhibiting more emotional distress or behavioral problems than others, but this is thought to reflect problems within a family or couple. All family members must thus engage in treatment and change the way they interact with other family members.

Evaluating the Sociocultural Model

The sociocultural perspective has much strength for understanding mental disorders. First, the perspective highlights the importance of social influences on emotions, cognitions, and behaviors. Humans are indeed social beings and so our mental health is clearly influenced by people and institutions around

us. Second, the sociocultural perspective provides a good understanding of different sources of stress that have an impact on a person and how that person copes with stress. Sources of stress may occur at global and individual levels. Finally, the sociocultural perspective emphasizes the critical role that family members have in influencing mental health.

Limitations of the sociocultural model should be noted, however. First, evidence linking social, cultural, or environmental factors to mental health is largely correlational. Whether these factors *cause* symptoms of mental disorders is unclear. Second, we do not yet know why people exposed to adverse influences have various outcomes: Some will develop various psychological problems, and some will not. Why does one child living in a poor neighborhood and raised by a dysfunctional family become delinquent but another becomes depressed? Why does one child with abusive parents commit suicide but his sibling succeeds in college with few psychological effects? The sociocultural perspective has great strength, but its account of how psychological problems develop remains incomplete.

Pamela Moore/Getty Images

Family therapy is a commonly used treatment in the sociocultural model of mental disorder.

Interim Summary

- A sociocultural perspective focuses on how other people, social institutions, and social forces influence a person's mental health.
- Culture is the unique behavior and lifestyle shared by a group of people.
- Gender differences, including our expectations of men and of women, may help instigate certain mental disorders.
- Demographic, physical, and stressful aspects of neighborhoods and communities are associated with changes in mental health.
- Family structure and functioning, as well as maltreatment and expressed emotion, can impact the psychological well-being of individuals.
- A strength of the sociocultural perspective is its focus on social and environmental factors and family on mental health.
- A limitation of the sociocultural perspective is the lack of evidence that adverse environments cause mental disorders.

Review Questions

1. How can the sociocultural model explain Mariella's problems?
2. Describe what is meant by "culture." How might culture influence the development of Mariella's problems?
3. Discuss how gender roles may influence Mariella's mental health.
4. What aspects of neighborhoods and communities are associated with stress and mental health?
5. How might family structure, functioning, and environment be associated with Mariella's problems?
6. What socioculturally based treatment might a mental health professional use to help Mariella?
7. What are strengths and limitations of the sociocultural perspective?

2.1 / An Integrative Psychologist: Dr. John C. Norcross

Dr. John C. Norcross

In the early days of psychotherapy, an ideological cold war reigned as clinicians were separated into rival schools—biological, psychodynamic, cognitive-behavioral, humanistic, sociocultural, and so on. Clinicians traditionally operated from within their own theoretical frameworks, often to the point of being blind to alternative conceptualizations and potentially superior treatments.

As the field of psychotherapy has matured, integration has emerged as a clinical reality and the most popular approach. Clinicians now acknowledge the inadequacies of any one theoretical school and the potential value of many perspectives. Rival therapy systems are increasingly viewed not as adversaries but as partners; not as contradictory but as complementary.

My practice and research is devoted to *integration:* a dissatisfaction with single-school approaches and a concomitant desire to look across school boundaries to see how patients can benefit from other ways of conducting treatment. The goal is to enhance the effectiveness and applicability of psychotherapy by tailoring it to the singular needs of each client. Clients frequently require an eclectic mix or hybrid of different perspectives.

Applying identical treatments to all patients is now recognized as inappropriate and probably unethical. Imagine if a physician delivered the same treatment—say, neurosurgery or an antibiotic—to every single patient and disorder. Different folks require different strokes. That's the mandate for integration.

How do we select treatment methods and relationship stances that fit? On the basis of research evidence, clinical experience, and patient preferences. A client who denies the existence of an obvious problem (the precontemplation stage), for example, will profit from a different relationship and treatment than a client who is committed to changing her behavior right now (the action stage). Or a client who seeks more insight into the early childhood antecedents of a problem, for another example, will probably secure better results in psychodynamic therapy than one who seeks psychoactive medication (biological therapy) or specific skills in restructuring thoughts

TABLE 2.5

Perspectives to Explain Mental Disorder

Biological
Mental disorder is related to brain or neurochemical changes or genetics.
Psychodynamic
Mental disorder is related to internal mental structures and childhood experiences.
Humanistic
Mental disorder is related to choices people make in their environment and how satisfied they are with their real self.
Cognitive-Behavioral
Mental disorder is a learned behavior and is influenced by how people perceive and think about their environment.
Sociocultural
Mental disorder is related to outside influences such as social institutions or family members.
Biopsychosocial
Mental disorder is related to a variety of biological, individual, and social environmental risk factors that interact with one another.

personal narrative

(cognitive therapy). And a client who responds negatively to external guidance and direct advice (high reactance) will surely require a different treatment than one who enjoys them (low reactance). Decades of research can now direct us in making better marriages between some treatments and certain disorders and client characteristics.

The integrative psychotherapist leads by following the client. An empathic therapist works toward an optimal relationship that enhances collaboration and results in treatment success. That optimal relationship is determined by both patient preferences and the therapist's knowledge of the client's personality and preferences. If a client frequently resists, for example, then the therapist considers whether she is pushing something that the client finds incompatible (preferences), or the client is not ready to make changes (stage of change), or is uncomfortable with a directive style (reactance).

Integration refers typically to the synthesis of diverse systems of psychotherapy, but we need not stop there. We can combine therapy formats—individual, couples, family, and group. We frequently integrate medication and psychotherapy, also known as combined treatment. Integration gets us beyond either/or to both/and.

In practice, integrative psychologists are committed to the synthesis of practically all effective, ethical change methods. These include integrating self-help and psychotherapy, integrating Western and Eastern perspectives, integrating social advocacy with psychotherapy, integrating spirituality into psychotherapy, and so on. When asked about my doctrine, I reply with the words of the Buddha: "anything that can help to alleviate human suffering."

As a university professor teaching abnormal psychology and clinical psychology, I find that my students naturally favor integration. Theoretical purity, they remind me, is for textbooks, not people. And as a clinical psychologist in part-time independent practice, I find my clients overwhelmingly require an integrative or eclectic approach. Rigid therapy, they teach me, is bad therapy.

Integrative therapy brings evidence-based flexibility and empathic responsiveness to each clinical encounter. Integrative therapy offers the research evidence and clinician flexibility to meet the unique needs of individual patients and their unique contexts. For these reasons, integration will assuredly be a therapeutic mainstay of the 21st century. Come join us!

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Final Comments

You might wonder which major perspective of abnormal behavior is the best one, especially when each one provides such a different view of mental disorder (**Table 2.5**). Each perspective has its own strengths and limitations and none provides a complete and comprehensive account of all psychological problems. Many mental health professionals thus adopt the notion of a *biopsychosocial model* to mental disorder. A biopsychosocial model stipulates that mental disorder can be attributed to many biological (e.g., genetic, brain changes), psychological (thought, emotional changes), and social (family, societal) variables. These variables work in tandem to produce healthy or unhealthy behavior.

In Chapter 3, we present a general theoretical model, the *diathesis-stress model,* that resembles the biopsychosocial model and addresses the issue of how mental health problems develop. This model incorporates notions of *diathesis,* or predisposition or vulnerability to mental disorder, and *stress,* which can be environmental, interpersonal, or psychological. This model, because of its flexible, wide-ranging definition of diathesis and stress, can accommodate the five perspectives covered in this chapter as well as combinations of these perspectives. The diathesis-stress model is perhaps the best way to think about mental health issues. Chapter 3 begins with a detailed description of this model and its implications for studying, treating, and preventing psychological problems.

Key Terms

models 22
biological model 23
syndromes 23
genotype 23
phenotype 23
behavior genetics 23
molecular genetics 24
central nervous system 24
peripheral nervous system 24
neurons 24
synapse 24
neurotransmitters 24
reuptake 24
cerebral cortex 25
frontal lobe 25
parietal lobe 25
temporal lobe 25
occipital lobe 25
limbic system 25
basal ganglia 25
thalamus 25

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