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THE PERSONAL ALLURE OF A BEHAVIORAL SCIENCE

Psychology is a hybrid subject. With its basic concepts and theories rooted in ancient religions and philosophy, its branches reaching into experimental biology, physiology, pharmacology, anthropology, sociology, and even biography, psychology's theories and data are diverse, inconsistent, and at times contradictory. Attempts to produce an integrated comprehensive theory remain elusive. In its place we find an array of mini-theories tied to specific subareas of the field (e.g., cognitive, developmental, physiological, or social psychology). Although we remain intrigued, compelled to search for answers to the riddle of ourselves and others, we can often feel more than a bit overwhelmed by the task.

Nowhere is this truer than in the subdiscipline of abnormal psychology. Its topics directly affect our quality of life both as individuals and as a society, sometimes even in life-and-death ways. Multiple professions draw on and in turn influence our view of abnormal psychology (e.g., psychology, psychiatry, social work, counseling, nursing, special education). Within and across

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these professions, competing theories, treatments, and public policy positions vie for dominance. Increasingly there are consumer advocacy or self-help groups that offer an alternative to professional services, often motivated by a deep disappointment with services that had been received. Alcoholics Anonymous, Survivors of Psychiatry (A. J. Joseph, 2013), the recovery movement for persons with "serious mental illness" (Roe & Davidson, 2008), and the Son-Rise Program (Kaufman, 1995) for parents and their autistic children all claim insights and knowledge ignored by the mainstream mental health professions.

As one examines the subdiscipline of abnormal psychology, one stark division is striking: the struggle between clinical research scientists and clinical practitioners over the right to claim expert knowledge in the field. This schism in the field is often referred to as the *scientist–practitioner gap* (Stricker & Trierweiler, 2006), though Saltzman and Norcross (1990) may have more aptly described the situation as the "therapy wars." Both sides of this division have their own theories, kinds of data, research methods, professional literature, networks, and associations. Sometimes they collaborate, but more often than not they operate in parallel universes, except in competing for research funding, tenure positions in academic departments, contracts from employers, reimbursements from insurance companies for their services, and publishing outlets for their writings (Sternberg, 2005).

In seeking legitimacy for our psychological expertise and knowledge, we psychologists rarely acknowledge our own humanity even when it is revealed by our professional conflicts and rivalries. We are reluctant to acknowledge in ourselves the same irrational forces that we attempt to explain in our research populations or that we attempt to treat in our clinical and counseling practices. But to understand anxiety, interpersonal conflict, perfectionism, paranoia, dependency, narcissism, and so forth, we must start with ourselves.

Honest self-examination has its roots in philosophy (the Delphic oracle of ancient Greece who admonished all who would enter her temple to "First, know thyself"), the Catholic confessional (Saint Augustine of Hippo's autobiographical Confessions c. 400 AD), and pastoral counseling (Boston's Emmanuel movement c. 1905). It was adopted by the founder of psychoanalysis, Sigmund Freud (1920/1966), in his method of "free association" and later amplified in humanistic psychology's (Jourard, 1964; Rogers, 1951) focus on self-awareness and self-disclosure. Contemporary interest in Buddhist mindfulness practices in cognitive–behavior therapies reflects a similar orientation, requiring us to be accepting of all of our thoughts, images, feelings, and memories (Hayes, Follette, & Linehan, 2004). Granted, each of these traditions has many institutional differences and varied practices and traditions, but they share a core component: The individual must pay attention to, and become responsible for, his or her inner experience.

In understanding ourselves, where we come from, and where we are heading, we acquire self-knowledge that ultimately allows us to both live well and effectively be of assistance to others. This self-understanding is our touchstone for the practical validity of psychological knowledge. It is a capacity that resides within each of us. In a discipline in which clinical theories often disagree and research results often conflict, we have no choice but to return to our own self-understanding. In working with others, it permits us to ask: When have I come closest to experiencing the kind of pain or exhibiting the kind of extreme behavior that I am seeing in this person? What else was going on in my life when I felt or acted this way? What helped me to move through that time into a better place?

In this way we build an empathetic understanding of those around us, and we begin to experience firsthand the renowned 20th-century American psychiatrist Harry Stack Sullivan's (1968) well-known dictum: We "are much more simply human than otherwise" (p. 32). No matter how strange, bizarre, or seemingly inhuman another person's actions are, we should regard such an individual as first a fellow human being and not, for example, as a "bipolar disorder," "psychotic schizophrenic," "oppositional defiant child," or "borderline personality." When we label and categorize people in this manner, we subtly but radically shift our focus from a person who is like us when we are overwhelmed, to an overwhelming person to be around—a slippery slope on the road to nonpersonhood.

A lack of openness to self-awareness inhibits not only our ability to progress as a discipline but also our ability to be helpful to others. When we believe that our technical expertise and professionalism are the only critical elements in providing beneficial treatment, we risk devaluing the self-respect and autonomy of the person who is suffering. No matter how many helpful services or treatments we decide to offer such a person to "fix" the problem, this help often comes at a heavy price—a loss of control and responsibility on the client's part for his or her own life.

NAMING THE DISCIPLINE

The topic of study before us is psychological suffering. On the face of it, this appears straightforward, yet the divisions in the discipline affect everything in our field, even the most basic question of how to label and define the subject matter to be studied. When this topic is taught in medical or nursing settings, psychological suffering is most often referred to as *psychiatric* or *mental* disorder (connoting that these are parallel to physical and medical disorders). At psychoanalytic training institutes a similar course would be entitled *Psychopathology*, a term that combines the ancient Greek terms *psyche*

and *pathos* to describe the suffering of the mind, spirit, or soul. This suggests a discipline that is the psychological equivalent of the study of pathology in medicine—*pathology* being the study of the anatomical and physiological basis of disease. Some medical schools and psychology graduate programs retained the term *psychopathology*, despite no longer teaching a psychoanalytic approach. Terms that were once considered technical or medical, such as *mental illness* or *emotional disturbance*, are no longer considered so, although they are still widely used in everyday language and may be incorporated into various legislative acts or legal rulings.

Nor does the confusing terminology stop there. Harry Stack Sullivan (1953/1968) preferred the more normalizing term *problems in living* to either *psychiatric disorders* or *psychopathology*. With the rise of behaviorism in clinical psychology (in the 1960s), departments renamed their courses and textbooks "Abnormal Behavior" or "Behavior Disorders" and focused on inappropriate, unproductive, or irrational behaviors, in so doing making overt the field's focus on enforcing social expectations and norms. Therefore, as a trained psychologist who teaches a course called Abnormal Psychology, I will refer to this area of study by that name, while keeping the imperfections and potentially pejorative connotations of the term in mind.

In truth, the field of abnormal psychology is as diverse and divisive as our Western societies. *Abnormal psychology*, *psychopathology*, *psychiatric disorders*, and *problems in living* are overlapping terms and phrases referring to a key cornerstone in the knowledge base of the various mental health professions (psychology, counseling, social work, psychiatry, psychiatric nursing, and rehabilitation counseling). Every institution and person within society has a considerable stake in how we conceptualize and then act toward or on the individuals and groups whose actions fall under the purview of this field of study, however it is termed. The psychological or psychiatric diagnoses and treatments that emerge out of these fields of study have an impact on how we as individuals or institutions respond when a person violates social norms and expectations. After all, the successful functioning of our society depends on an effective response and resolution of the kinds of psychological suffering and problems in living studied in abnormal psychology.

It is in courses with such titles that future consumers, practitioners, and researchers learn how to think about the nature and meaning of psychological suffering, what questions are important and reasonable to ask, and what the criteria are for deciding what constitutes a good answer. It is only after these fundamental questions are answered that we can attempt to answer the key questions as to what causes this suffering and what can be done to ameliorate it. The effects of this area of study are felt broadly throughout society in families, schools, hospitals, nursing homes, health care clinics, mental health and college counseling centers, courts and prisons, mental health professions,

health insurance and pharmaceutical companies, government agencies, the military, and even at times our religious institutions.

I have gradually come to see the subject matter of abnormal psychology not as a study of the various states of mind that disrupt the peaceful states of mind that usually prevail but rather as a study of how we all come to terms with the pervasive aspects of human suffering, particularly that form of human suffering that seems self-inflicted or self-perpetuating. This psychological suffering is multifaceted, including the rational and irrational anxiety and guilt, self-condemnation, hopelessness, helplessness, self-harm, rage, confusion, and paranoia that we are all prone to when life circumstances are sufficiently hostile or horrible. We cannot expect our students to take this difficult journey toward greater self-understanding alone.

MY STORY I: SEEKING THE AUTHORITY OF SCIENCE

When I entered graduate school to become a clinical psychologist over 40 years ago, I was eager to learn the emerging behavioral science answers to the age-old problems that medicine and religion had too often failed to solve. Nor was my interest merely professional or theoretical (as it almost never is for those who study clinical aspects of psychology); I hoped that the answers to certain mysteries from my own life would also be somehow magically revealed once I added scientific theories and data to my own more philosophical perspective. For example, I wondered why in our extended family that four of the five adult males of my parents' generation (whom I knew quite well) were quite successful in their chosen careers, yet seemed troubled in their personal lives. One was a binge drinker, another experienced periodic incapacitating depression, a third had a clandestine affair leading to divorce, and a fourth emotionally and physically abused his wife. The fifth male was always friendly and upbeat and seemed a devoted husband and father. Yet he engaged in underhanded business practices that harmed the career prospects of another member of the group, and they became estranged for many years.

The women in these partnerships fared only somewhat better, though they were all devoted mothers, and several had professional careers. However, one was prone to bouts of depression and withdrawal, a second was obese and died relatively young of heart failure, a third, the subject of the abuse, was chronically depressed and eventually made a serious suicide attempt. Of course, much of this was kept secret beyond each nuclear family, but by the time I left for college, all of these family secrets were more generally known throughout the extended family.

As a child, many of these people were my role models, even my heroes. The reality of what I would learn about the family's dynamics and secrets left

me somewhat stunned and confused as a young adult. Yet nothing of these revelations that emerged over time would top the information I was given on a warm spring day in my junior year of high school. My father suggested we go for a ride in the car to have a talk. Because this was not something he had ever suggested before, I anxiously agreed. As it turned out, the purpose of the talk was to provide me with a bit of family history that he and my mother now thought I was old enough to hear, namely, the circumstances of my maternal grandfather's death. I knew he had died when my mother was in grade school and that she had taken it very hard and did not like to talk about it. So I must have learned early not to ask questions, because that is all that I knew of him.

The circumstances were the following. My maternal grandfather was from a large family of Russian–Jewish extraction. After immigrating to the United States in the early 1900s, the family, led by my great-grandfather, had been remarkably successful in the business community. At the height of the Great Depression, his son, my grandfather, had continued to live the high life, well beyond his means. But then, one day, his loans from a major banking institution in the Northeast came due. To avoid bankruptcy, he walked out of a meeting where he had tried and failed to receive an extension on the loan payment due, and shot himself in front of the bank. As an insurance salesman, the only asset he had remaining was his own life insurance policy, which in those days did not exclude payment in the event of suicide. My mother, walking home from school, encountered a newsboy standing on the street corner hawking papers: "Read all about it: Local businessman shoots himself in front of bank." She arrived home to learn that the newsboy was referring to her father and that he was dead. Being Jewish, the family regarded suicide as the most venal of sins, and they were deeply disgraced; they therefore never discussed him or what he had done. My parents apparently thought that I needed to know this to protect myself should I ever be taunted by peers concerning my family's shameful past. At least, that is what my father said. Of course, no one in the community ever taunted me about my grandfather's death or even mentioned his name. The purpose of this conversation remains almost as much of a mystery as my grandfather's life.

These discoveries and revelations about the members of my family in my middle and late teens were not the only mysteries to be solved. I struggled to find a meaningful role for myself in a society that seemed to be coming apart at the seams: the political assassinations of President Kennedy, and 5 years later his brother Robert Kennedy and Martin Luther King Jr.; a seemingly senseless war in Vietnam to which hundreds of thousands of my peers were being sent as draftees (and I might have been too); close friends becoming heroin addicts and psychiatric patients, some of whom seemed to become robotic creatures thanks to the medications their doctors prescribed them. Turning away from increasingly dangerous involvement in the politics of

protest, I immersed myself in graduate study in philosophy and then clinical psychology.

By the time I entered graduate school in clinical psychology I had convinced myself that I could separate my own doubts about who I was from the political divisions within the country and from the study of psychological disorders and their treatment. I believed I could do this because that is what every graduate program brochure in the research-oriented field of clinical psychology stated—that the science of clinical psychology was a rational enterprise that progressed only when behavioral scientists put aside all personal, moral, or political values and relied on their powers of empirical observation, rationality, and quantitative analysis (i.e., the scientific method). I was instructed that personal feelings, relationships, and moral and political values were part of one's private life, not a part of the science of psychology.

It was only when my first marriage began to unravel in graduate school and I sought psychotherapy at the University Counseling Center that I began to examine my own family experience. In so doing, I recognized the importance of my grandfather's suicide in my own inner turmoil and conflicted relationships with romantic partners. The event and the secrecy surrounding it were key missing pieces in the puzzle of my mother. My mother's veneration of her mother (our Nana) who had survived the blow of her husband's suicide and worked day and night to support her three children now seemed reasonable rather than exaggerated. I also came to understand my mother's idolization of her older brother's substantial success in business, her willingness to overlook the sometimes questionable methods he used toward that end, and her fear that everyone she loved was likely to die suddenly and tragically without warning. (It took me until my late 20s before I realized that I had internalized the very same fear and that it was not simply an inevitable part of being human to have such a belief.) Though I obviously had never met my grandfather, once I was told how he had died, I could begin to also imagine his life, and my mother's, while he lived. I felt a sense of connection to him and his family that I had never had before. The extended family problems that had both contributed to and been exacerbated by his suicide were not thereby solved, but my mother made more sense to me, and I felt more compassion for her and, as a result, also for myself. It is only in Hollywood movies that insight and self-understanding arrive in a single momentous flash (often after a brilliant therapist's interpretation). In life and real psychotherapy, self-understanding is achieved as the result of hard work, with uneven progress, often interrupted by periods of backsliding or regression (Horney, 1942/2013).

Over the years of working clinically with individuals, couples, and families as a psychologist and teaching abnormal psychology to a broad cross section of college and graduate students, I also came to realize that few, if any, families

exist without their own mysteries and heartaches. Most families have their secrets (Farberow, 1963), and even when the secrets become known to other family members, we protect our own from public ridicule, humiliation, and at times, even legal prosecution by holding those secrets within the family. As my career evolved, I came to see that most of my colleagues and undergraduate and graduate students were similarly burdened by family mysteries and secrets.

MY STORY II: PERSONAL MEANING VERSUS SCIENTIFIC EXPLANATION

My experience as a client at the University Counseling Center was fundamentally life-altering. I had been fortunate to have access to a psychologist who was a supportive, nonjudgmental, patient listener who offered insightful observations on my emotional life and interpersonal relationships. He had been trained by a student of Carl Rogers, at the time the leader of humanistic psychology in the United States, and had also been strongly influenced by the interpersonal theory of H.S. Sullivan. However, as a graduate student in a research-oriented clinical psychology doctoral program, I was unsettled by the experience, self-awareness, and new understanding of interpersonal relationships and how I was affected by them. The longer I was in psychotherapy at the counseling center, the more confusing my role as a graduate student became. Hardly any of the clinical psychology course work examined any of the psychotherapeutic processes I was experiencing as a client. In fact, subjective feelings, memories of important or even traumatic events, and perceptions of significant relationships were all described as outside the purview of a psychological science, to be left to the musings of poets, artists, and philosophers. To say this was to imply that these topics were not about "real" objective features of our world, but rather shadowy phenomena that our minds deceived us into thinking were of importance in explaining our actions and behaviors. Consequently, in class discussions in which the research literature on the process and/or outcome of psychotherapy was discussed (e.g., Bergin & Garfield, 1971; Eysenck, 1952), no one was permitted to discuss their own personal life experiences in psychotherapy or whether they felt they had benefitted. Yet, by the end of the second year of graduate school, most of the graduate students in my class of eight doctoral students had sought assistance from the counseling center, and even the most scientific among us freely shared our amazement at the positive impact it was having on reducing our intense stress and anxiety that had surfaced in graduate school.

The irony of the situation was not lost on us. Several of us had a sense that we might not be able to survive the highly competitive graduate clinical

research doctoral program (which 2 years previously we had fought so hard to enter) without the support we were receiving from the counseling center. Yet the faculty of that research program denied in their teaching that our experience in psychotherapy was any more beneficial than the mere passage of time. So we in essence led an intellectual double life, going to our therapy sessions, excitedly talking with one another about our growing self-awareness, and attending classes on how to do research on clinical treatment in which we progressed toward our doctoral degree.

REFLECTION ON CONFLICTING EXPERIENCES

We felt the tension between these two roles (psychotherapy client and research trainee in clinical psychology) intensely, but we did not yet understand it intellectually. At the time, we graduate students simply thought that the clinical practitioners and the clinical research scientists on the faculty just did not like each other much as individuals. We mistook an institutional, professional, and theoretical conflict for a personal one. It was only after years of reflection, literature reviews, and philosophical analysis, along with the emergence of the professional schools movement in clinical psychology (the PsyD or Vail model; Peterson, 1976), that I began to make sense of what had created this tension. I eventually discovered a legitimate, serious, scholarly literature of clinical and counseling psychology that has been excluded from consideration in our graduate programs on the grounds that it was not sufficiently scientific.

Here I briefly identify this literature and many of its most published theorists and researchers. I do this in a more detailed manner than is customary in an introductory chapter because many readers may be skeptical of the claim that there is a rigorous scholarly literature in abnormal psychology that challenges the mainstream view of establishing the knowledge base through strictly empirical and experimental methods. Many of the works cited in this review receive more in-depth discussion in later chapters of the book.

The Survival of Humanistic Psychology

One of my first discoveries was that Carl Rogers's work on what he came to call a *person-centered approach* to clinical and counseling practice, although less prominent in mainstream psychology after the 1970s, remained alive and well in the Society of Counseling Psychology (Division 17 of the American Psychological Association [APA]) and the Society for Humanistic Psychology (Division 32 of the APA) and related organizations (e.g., Bohart & Watson, 2011; Elliot, Greenberg, & Lietaer, 2004; Gendlin, 1996; McLeod, 2010;

O'Hara, 1997; Prouty, 2003; Schneider, Bugental, & Pierson, 2001; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006; J. C. Watson, Goldman, & Greenberg, 2011). Many of these investigators and practitioners incorporated other humanistic–existential or Gestalt therapy approaches into their work. Although he was not a student of Rogers, Joseph Rychlak (1981) was a leader in both humanistic and philosophical psychology, at the same time incorporating cognitive and psychodynamic elements into his work and remaining committed to experimental investigations of purposeful behavior, what he referred to as *teleosponsivity*. He also coined the terms *intraspective* and *extraspective*, which are useful in directing our attention to the fundamental difference between theories and methods that study our interior, introspective, subjective experience of living—the *intraspective* orientation—and theories and methods that study people by observing their behavioral, physical, and physiological responses to the environment—the *extraspective* orientation.

The Harvard Department of Social Relations Life History Approach

The Harvard Department of Social Relations was created in the hopes of integrating experimental psychology with psychoanalysis, anthropology, and sociology. These were all departments or traditions that claimed insights into the human mind and behavior. Gordon Allport (1937), who had written the first American textbook on personality, and Henry Murray (1943), who had established the Harvard Psychological Clinic and created the Thematic Apperception Test, left the Harvard Psychology Department to join this new department after conflict with the psychology department experimentalists (namely, B.F. Skinner). This group produced an impressive body of work on personality development, narrative research, and abnormal psychology (White, 1992), and that tradition has been continued by Runyan (1982), McAdams (2006), Josselson and Lieblich (1993), and Messer (1986). Others in this tradition who may not identify with its more psychoanalytic aspects but who resonate with the critical importance of systematic case study research in clinical and counseling psychology include Hoshamond (1992), Fishman (1999), Dattilio, Edwards, and Fishman (2010), Edwards (1998), Eells (2007), and McLeod (2010).

Theoretical and Philosophical Psychology

The life history and narrative approach to abnormal psychology described above has received strong support from philosophically oriented psychologists as well. This literature critically examines the philosophy of science that justifies the current mainstream approach to psychology, finding it better suited to the physical sciences than to the study of the human mind and behavior.

This group may be roughly divided into groups by philosophical orientation. Gergen (1985) inspired many social constructionist critiques of the objectivity of science (e.g., Christopher, 2006; Christopher, Wendt, Marecek, & Goodman, 2014; Cushman, 1996; Kirschner, 1996).

A second group has been inspired by European philosophical hermeneutics, which insists that all linguistic terms, including psychological terms, require interpretation of meanings and therefore are not purely objective in a scientific sense. This group includes Freeman (1997); Martin and Sugarman (2000); Polkinghorne (2004); Richardson, Fowers, and Guignon (1999); Sass and Parnas (2003); Slife, Reber, and Richardson (2005); and Sugarman (2005). A third group, influenced by Anglo-American philosophy in their critique of the logical foundations of psychological science, includes Robinson (1995, 2008); Harré (1998); Held (1995, 2007); Osbeck, Nersessian, Malone, and Newstetter (2011). A fourth group, Howard (1986); R. B. Miller (2004); Tjeltveit (1999, 2006); and Woolfolk (1998) is focused on epistemological and ethical issues that are inherent in psychological judgments and therefore differentiate psychological science from the physical sciences.

Although not always in agreement with one another, these authors in philosophical and theoretical psychology critique an exclusively quantitative/experimental approach to psychological theory and research and invite the inclusion of personal meaning, intention, purpose, moral and ethical values, and agency implicit in human behavior as proper subjects for scholarly investigation. Although one may disagree with the conclusions drawn in this body of work, one cannot question that it represents a serious body of scholarship on the question of the nature of psychology as a discipline and the legitimate grounds for knowledge claims in the realm of clinical practice.

Psychoanalytic Psychology

Many of the academic psychologists drafted into the U.S. Armed Forces during World War II were given on-the-job training in psychoanalytic crisis intervention to assist psychiatrists in the care of soldiers who were psychologically traumatized by combat (Herman, 1995). After the war there was a growing interest in psychoanalysis among academic psychologists, especially in metropolitan areas that were home to psychoanalytic training institutes (New York, Philadelphia, Boston, Chicago, Los Angeles, and San Francisco). Eventually a lawsuit sponsored by the APA forced the institutes to allow doctoral psychologists upon graduation to receive training and certification as psychoanalysts. Given the usual disparagement of psychoanalytic theory and research in the mainstream psychological literature during the 20th century, students are often quite surprised to learn that Division 39 (Psychoanalysis) of the APA is one of the largest divisions, with about 2,600 members.

(Division 12, the Society of Clinical Psychology, represents the mainstream scientific view and has a membership of about 3,200; http://www.apa.org/secure/reporting/comparison-report.aspx).

Psychoanalysis has developed through its international organizations into an impressive network of journals, publishers, training institutes, and practitioners that includes psychiatrists (MDs), psychologists, social workers, and psychiatric nurses. Many psychologists have made important contributions to this literature (e.g., Della Selva, 1996; Eagle, 1989; Fonagy, 2010; Karon, 2004; Karon & VandenBos, 1981; McWilliams, 2011; Messer, 1986, 2013; Mitchell, 1988; Safran, 2012; D. K. Silverman, 2005; L. H. Silverman & Lachmann, 1985; Stolorow, Brandchaft, & Atwood, 1987; Wachtel, 1997).

Phenomenological Psychology

A fifth tradition that honors the exploration of subjective personal experience in academic psychology is often identified with the Departments of Psychology at Duquesne University, the University of Dallas, West Georgia State University, and Seattle University. Developed by Amedeo Giorgi and colleagues from the philosophical phenomenology of Husserl, the 19th-century German philosopher who laid the groundwork for the emergence of existentialism, phenomenological psychology proposes the systematic investigation of the lived experience of human beings through the careful description of psychological states in first-person accounts (e.g., Aanstoos, 2012; Arons, 1993; Burston & Frie, 2006; Churchill, 2006; Fischer, 2000; Giorgi, 2010; Keen, 1970; Valle, 1998; Wertz, 1986; Wertz et al., 2011).

Community and Critical Psychology

A sixth area outside the mainstream Boulder-model clinical psychology comprises those in abnormal and clinical psychology who wish to work in the community in primary prevention or community organization and who thereby encounter resistance from, and conflict with, established political and economic forces (e.g., A. G. Levine & Levine, 2014; M. Levine, Perkins, & Perkins, 2005). Some have also called this *critical psychology* or *critical psychiatry* because of its reliance on Marxist or socialist analysis of the forces at play in the community when working with underserved populations and minorities. These psychologists look at the social, economic, and political implications of psychological practices and whether psychology is a force of social change or a force preserving the status quo (e.g., Fox, 1993; Hare-Mustin, 2004; Hare-Mustin & Marecek, 1988; Laing, 1959; Marecek & Hare-Mustin, 2009; Prilleltensky,1989; Prilleltensky, Prilleltensky, & Voorhees, 2009; Teo, 2009). Recent work by the investigative journalist Robert Whitaker (2005,

2011) has raised similar questions about the politics of mental health in the United States and its control by the powerful guild interest of the American Psychiatric Association, major pharmaceutical companies, and social-economic elites.

MY STORY III: GRADUATE TRAINING IN BEHAVIORAL CLINICAL PSYCHOLOGY

Of course, I had not entered graduate study to undergo psychotherapy or question its philosophy of science but to learn to be a behavioral scientist/psychologist able to unlock the mysteries of the human mind and thereby provide a service that might reduce the amount of human misery in the world, including my own. In my initial enthusiasm, I immersed myself in the study of physiological psychology, advanced statistics, classical and contemporary learning theory, applied behavioral analysis, and behavior therapy. I scoured the professional literature for case studies revealing how these principles were actually applied in the real world of clinical practice, and marveled at the reports of success with cases that had been previously considered incurable. I was chastened a bit in my enthusiasm by the former chair of the psychology department, J. P. Chaplin, who advised our first-year graduate seminar to always take advantage of any new "miracle" treatment in psychology or psychiatry during the early years of its development—before it lost its effectiveness. That comment, the only one from a department faculty member that implied any skepticism about the behavioral approach we were learning, proved prophetic, and I would find that it applied equally well to other therapeutic fads I would encounter over the ensuing decades.

Over the 5 years I was in graduate school my enthusiasm for behavioral science as a solution to the personal and family problems of humankind waxed and waned. The advantages I personally observed were many and remain with me to do this day:

- Behavioral approaches (Skinner, 1953; Ullmann & Krasner, 1965) placed primary emphasis on how the environment controlled behavior, and so changing behavior was done by changing the environment, not just trying to change the person who was disturbing, or was disturbed in, that environment.
- Unlike many more abstract theories in clinical psychology (particularly psychoanalysis), behavioral theory was clear and straightforward. With some serious work, it could be learned readily by graduate students over a period of 2 or 3 years. When psychology students then taught parents, teachers, caseworkers,

prison guards, and hospital attendants the basic principles of behavioral management, the information was greeted with enthusiasm. It seemed to work.

- On a personal level, I built reinforcement and behavior shaping into my own study schedule, and found it quite useful. Instead of attempting to study in 5 and 6 hour blocks during the day or night (a goal I frequently failed to reach), I would begin by giving myself a reward or reinforcement (a 10-minute study break with a snack) after 2 hours of studying, gradually lengthening the time required to receive the reinforcement to 3 and 4 hours.
- In the consulting room, working with individual clients/patients, Jacobson's (1976) progressive muscle relaxation exercises were often immediately helpful in lessening the subjective anxiety I encountered in many of my early cases. I used these exercises myself, as well, and in about three weeks began to feel a reduction in the anxiety symptoms I had experienced periodically since I was 13 years of age.
- Although the theory of behavioral psychology rejected the medical model of psychiatric treatment involving brain-altering chemicals or electroconvulsive therapy, behaviorists tended to resemble physicians in their relationship with the patient/client. The psychologist, like the physician, was taking responsibility for fixing the problem using scientific theories and prescribing behavior change techniques rather than medication and deserved therefore the same kind of respect and remuneration from patients and society at large. In short, behavioral psychologists could feel like "real doctors," without having gone to medical school.

However, there were problematic areas that I also personally observed:

- Although in theory any learned behavior can be unlearned, given the power to completely control a person's environment, it was rare even in institutional settings for the psychologist to have such power. Even when environmental changes did produce the desired behavioral effect, the behavior often did not generalize to other settings.
- Working with children required reinforcement programs at both home and school, and overstressed parents and teachers frequently found the behavior modification techniques too complicated to implement, even though they understood the principles and wished they were organized enough in their own lives to make them work. Positive, sometimes even almost

miraculous, results were often followed by setbacks, even in the main environment where the reinforcement system was implemented.

- Contingencies of reinforcement would over time lose effectiveness, causing an increase in the problem behavior, or the individual would substitute a new problem behavior for the old one (referred to by psychoanalysts as *symptom substitution*).
- Although progressive muscle relaxation was useful, the systematic desensitization procedures that used it to decondition anxiety responses to specific stimuli in the environment often proved unwieldy and ineffective. The psychologist Arnold Lazarus (1976), who developed the technique with the psychiatrist Joseph Wolpe in South Africa (Wolpe, 1969), found that a majority of the patients they had treated developed symptom substitution. This ultimately led Lazarus to offer an alternative to behavior therapy that was broadly eclectic.
- Although it felt quite good to be seen as the "expert" according to the medical model, there was a subtle but ultimately quite profound impact on the therapeutic relationship that was disturbing to me. The amount of control and direction applied to the session by the behavior therapist produced a tendency toward either resistance (to authority) or passivity in one's clients.

I had sincerely hoped that I would come to understand the research methods of psychology through my graduate degree in clinical psychology. I wanted to understand not only what behavioral techniques worked in the clinic but also how the evidence for their effectiveness was established. I threw myself wholeheartedly into becoming a "scientist–practitioner." I participated in three community-based research projects evaluating methods to reduce recidivism using psychoeducational methods in persons arrested for DUI, to decrease absenteeism and acting out at a middle school using a (Skinnerian) token system, and to identify the behavioral characteristics of children at high risk of later symptoms of schizophrenia (funded by the National Institute of Mental Health).

Although the process was invaluable in terms of understanding the difference between research as an idealized process and the reality of everyday complications when doing research in the community, it was also disturbing in a manner that paralleled the classroom discussions we were having with regard to research on the lack of effectiveness of psychotherapy. The research protocols all called for very scripted (i.e., "controlled") interactions with the research participants. For studies like these to have internal validity, they must be designed to provide standardized interactions with the research

participants both in terms of clinical assessment and treatment. We did not get to know the people as we would have if we were simply providing a clinical service, but instead we got to know them by observing and measuring their behaviors with formal standardized instruments or by providing them with a previously designed clinical intervention that was the same for all members of the treatment group. We were not to interact with the participants in any other ways or in individualized ways.

I worried that the data we generated reflected the responses of human beings when they were treated like faceless numbers by researchers devoid of much of their humanity as a result of following these scripted protocols. The resulting knowledge reflected how human beings behaved when they were not treated as human beings. Considering that about half of a graduate student's time in clinical psychology was devoted to such research, one wondered whether it was time well spent.

MY STORY IV: UNSPOKEN FAMILY AND PROFESSIONAL TENSIONS

I had been practicing and teaching courses related to clinical practice for about 20 years when I came to understand another critical family influence that had affected my career. My father was a pharmacist and had served in the navy in World War II as a pharmacist's mate on an aircraft carrier. His ship was scheduled for the invasion of Japan that was cancelled after the dropping of atomic bombs on Hiroshima and Nagasaki. The sailors on the ship were encouraged to go ashore after the Japanese surrender to view the carnage, and he did. For many years after, he would on occasion scream out in his sleep when dreaming of his wartime experiences. He returned to civilian life to go into business as a part owner of a neighborhood pharmacy. He had been trained in pharmacy in an era when most pharmaceuticals were available without prescription and the trusted local pharmacist was a person who people in the neighborhood went to asking for relief from their various symptoms. Essentially, he was trained to prescribe medication, in many ways on a par with a physician in that regard. Yet he was frustrated that he could not afford to attend medical school and had to settle for a pharmacy degree. Consequently, he freely offered advice to anyone who asked, and his customers usually returned with thanks for his assistance. He was a strong believer in the value of medications that altered mood states and thought nothing of giving his children pills to help them sleep or calm down for an exam. He also freely took them himself and was a stone wall when it came to discussing difficult life experiences such as the war or his childhood. I had a sense that military service in a combat zone was a living nightmare, but only from what was not said.

My mother, however, was a trained social worker who strongly believed in the model of casework in which one tried to understand the social and psychological reasons for a person's behavior and then attempted to talk the situation through to a resolution. If there was a problem in the family, she wanted to try to talk it through as well (except, of course, if it was something she was too frightened to talk about, such as her father's suicide).

The tension in our home because of these competing approaches was palpable, but I never really understood where it originated. In retrospect, it seems now that the fact that my mother turned to me to talk about her concerns, fears, and dark moods when my father was out of the house working 60-hour weeks, or in the home but too exhausted or irritable from work to have much to give, must have upset him. Did my willingness to converse on such topics with her seem like an indictment of his unavailability, inadvertently pointing out his inadequacy, or did it just seem to him an incredible waste of time? I will never know. Regardless, it dawned on me some 40 years later as I was expounding in class one day on the tension in psychology between the medical model in psychiatry and the psychosocial model in clinical psychology that I had been living with that tension my entire life. Little wonder that it was something about which I was passionate, and remain so.

Indeed, for me, the question of whether medications should be the primary treatment for most psychological problems is one of both great social and personal importance. While I was in graduate school, and for the first 10 years after I received my doctorate, I hewed to the mainstream view that relatively mild and moderate psychiatric problems with anxiety, depression, and personality traits such as defiance of authority, shyness, or impulsivity should be dealt with by psychosocial interventions conducted by psychologists, counselors, and social workers. The more severe problems involving psychosis, profound depression, or a complete inability to function in society should be treated by psychiatrists with medication and hospitalization. I did not question that division of labor, nor the pharmaceutical research that supported it, nor the psychological textbooks and journals that published or cited such drug research. There was a kind of peaceful coexistence between psychology and psychiatry in those days. We were not truly brethren in arms, but we were no worse than friendly adversaries, arguing about whether the occasional case was moderate or severe. Generally, I avoided this potential conflict, as I had the one between my social worker mother and pharmacist father.

It was not until the mid-1980s when fluoxetine (Prozac) was introduced that all that began to change, and psychiatry and the pharmaceutical companies began a strategy to redefine all psychological dysfunctions as "biochemical imbalances in the brain" that could be fine-tuned with medications (Kramer, 1993). This research claimed to be based on new evidence that the

neurotransmitter serotonin was a bigger culprit in the cause of anxiety and depression than had been thought when the earlier generation of antidepressant medications had been developed. Those medications were presumed to alter both norepinephrine and serotonin levels in the brain. Although they were slow to work and produced many side effects that made some patients discontinue use, many found relief from Prozac, a selective serotonin reuptake inhibitor (SSRI) that often produced a reduction in anxiety that was almost immediate, with minimal immediate unpleasant side effects. It was seen as a miracle drug because it helped mild to moderate symptoms of depression, as well as more serious cases, and patients liked how they felt on the drug much more than on the old-style antidepressants.

However, I was skeptical of such claims on two counts. First, I was seeing that individuals in therapy who were switched to an SSRI antidepressant seemed to quickly lose interest in working on the problems in their relationships that had been the focus of psychotherapy. When I would ask about those interpersonal difficulties, clients would usually respond that nothing had changed in their life, but with the medication it just did not seem to bother them anymore that, for example, their spouse had lost interest in a sexual relationship with them or that their business was heading toward bankruptcy. In other words, they reacted in much the same way people do when abusing drugs. Their life circumstances had not improved; they just seemed oblivious to their problems. In fact, in some instances, clients came into therapy sessions clearly giddy, giggling, and quite intoxicated and reported they had been feeling and acting this way since they started their SSRI. As it turned out, this was another new therapy that was best to receive during its early stages of introduction into the culture. The early claim that 70% of the patients receiving SSRI medications had positive outcomes was exaggerated, and the negative side effects, including significant weight gain and loss of sexual desire, were underestimated (Healy, 2009; Kirsch & Sapirstein, 1998).

In my years at the community mental health center I had not been impressed with the antipsychotic medications in use, which were typically a cocktail of medications for psychosis and depression, with significant side effects. My clients taking them were not able to make much use of the therapeutic relationship. I would later learn that my observations were not unique and that even some psychiatrists had begun to object to the widespread use of high doses of phenothiazine medications (the "antipsychotics") and the greater than reported risk of a disfiguring neurological disorder, tardive dyskinesia, the effects of which could be more socially disabling than psychosis (Cohen, 2010).

The former editor of the prestigious *New England Journal of Medicine*, Professor Marcia Angel of the Harvard School of Public Health, in an unprecedented fashion suggested that an entire generation of scientific findings on

psychotropic medications should be discarded as contaminated by the financial interests of the pharmaceutical companies and the psychiatrists whom they employed (Angel, 2005). These companies and their paid psychiatric researchers, she suggested, manipulated the process of conducting randomized clinical trials on antidepressants, antipsychotics, and antianxiety medications through data suppression, selective assignment of patients to treatment or control groups, selective dosing of treatment and control groups, selective use of outcome measures to highlight improvement and hide treatment failures, underreporting of serious side effects, and outright research fraud (Angel, 2005). Prestigious medical school professors were paid large sums of money to have their names inserted into research papers submitted to major prestigious medical and psychiatric journals as lead authors on studies they had neither designed nor executed. This has been generally acknowledged as an accurate critique, and a number of major medical journals (including *The Lancet* and *The New England Journal of Medicine*) have taken steps to insist that authors indicate any financial relationships they have with the companies that manufacture the drugs evaluated in their studies. However, it is unclear how well these new policies are being, or even can be, enforced.

Robert Whitaker's (2005, 2011) investigative journalism gives a clear account of the contemporary history of attempts by the leadership of the American Psychiatric Association to corner the market on the treatment of mental disorders by emphasizing in the diagnostic criteria of mental disorders in the third and fourth editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) those symptoms that improve from drug treatments. In so doing, they contributed to the manipulation of psychiatric research findings and publications by many major pharmaceutical companies to guarantee acceptance of their products. As a result, the number of Americans on antidepressant and antipsychotic medications has skyrocketed, as have the profits of these companies.

The discipline of abnormal psychology is truly as fascinating as most of us expected it to be when we took our first course. Yet, it is currently a field of study in which research on the primary treatment approach (psychoactive medications) is seriously discredited and in which its primary diagnostic system (the *DSM–5*; American Psychiatric Association, 2013) has been rejected by not only over 40,000 psychologists and mental health professionals worldwide (see http://dsm5-reform.com/the-coalition/) but also by the head of research at the National Institute of Mental Health, the U.S. government's primary research center on psychological disorders, Dr. Thomas Insell, who described the *DSM* as scientifically invalid (Horgan, 2013). This is obviously a field undergoing massive upheaval. How does one learn in the face of such confusion?

A PRAGMATIC APPROACH TO ABNORMAL PSYCHOLOGY

In the face of theoretical confusion, professional rivalries, and debates over what constitutes adequate validation of treatment techniques, a return to the philosophy of pragmatism that guided America's first academic psychologist, William James (1907/1975), is an excellent place to start. Pragmatism tells us to put the most trust in the concepts and theories that lead to positive practical outcomes in the real world, as judged by the people most directly affected by those ideas. We are to regard as valid those concepts and theories that produce a tangible difference in our everyday world (Fishman, 1999). Pragmatism is a philosophical approach that favors the judgments of everyday people, not the societal experts. It is much like the democratic approach to choosing a leader or laws to govern a people. Democracy assumes that the people most affected by a leader or laws ought to make these choices, not the people who are at a distance and cannot observe the consequences of the choice. Pragmatism asserts that we find the truth by looking at the impact that ideas and theories have on our everyday existence.

By the same token, the people most affected by our theories of abnormal psychology and clinical practice are the consumers and direct service providers, and they should be considered the best judges of what is good practice. Neither democratic governments nor pragmatic approaches to professional and practical knowledge are perfect methods of choosing who or what to believe; it is only that all other alternatives are worse.

The ideas (theories) that lead us to act in ways that further our practical goals in the world are what we should hold as true. Those ideas resulting in undermining our goals are to be rejected as false. This approach draws our attention to two critical concepts: (a) the practical and (b) goals. Our *goals* are those states of affairs in the world we prefer, value, and think are good for us. The *practical* is about the day-to-day business of living our lives. The beauty of this theory is that no one needs an electron microscope, a $5 million research grant, or supercomputer to tell whether a theory of psychotherapy, or a therapy based on such a theory, is actually making a practical difference in one's ability to accomplish one's own goals. It may take some self-awareness, honesty, careful thought, feedback from significant others, and time, but in the end we are not dependent on any multinational research team, corporation, professional organization, or government agency to answer the question, Is what I am doing working? Am I closer to reaching my goals in how I wish to live my life now than I was before I tried this new approach? Pragmatism encourages the pursuit of local knowledge first and the building of broader generalizations based on actual experience in different locales, rather than on assertions of universal principles of clinical practice (Fishman, 1999).

The concept of "what works" is clearly value-laden, just as *mental health* and *illness* are more implicitly value-laden terms (Fowers, 2005; Miller, 1983, 2004; Tjeltveit, 1999). Pragmatism calls on us to openly acknowledge how moral and ethical values play a part in what we consider "good" or "best practices" to be. A great deal of human suffering that has resulted from dangerous mental health treatments (e.g., frontal lobotomy, eugenic sterilizations, electroconvulsive therapy, antipsychotic medications, aversive conditioning of autistic children) might have been avoided if the technicians, psychologists, and psychiatrists administering these treatments had considered what they were doing within the context of the basic moral framework of humanity, rather than as a scientific treatment (R. Whitaker, 2005).

A pragmatic approach to building a knowledge base in clinical and abnormal psychology is similar to Schön's (1987) generalized model of professional knowledge acquisition that he named "reflective practice," and its origins lie not only in pragmatists of the early 20th century such as William James and John Dewey (Menand, 2001) but also extend back at least 2,400 years to the *Ethics* of Aristotle (McKeon, 1941), who spoke of the difference between theoretical knowledge and *practical wisdom*—knowing what to do and how to do it to accomplish a real-world task or solve a real-world problem. We must not only know how to do things but also have moral values that guide us in knowing whether to do what we know how to do.

Clinical decision making in all of the health professions is a form of practical wisdom (Toulmin, 2003). It requires cognitive information about the nature of a problem, technical skill in how to intervene in a helpful manner, and moral values to guide us in what outcomes of treatment are truly helpful as opposed to expedient or simply profitable to the practitioner. If any of these three components are missing, then practical action fails to be practical wisdom and fails the standard of a pragmatic intervention. Whatever else such a clinical intervention might be—theoretically grounded, spiritually inspired, or empirically validated—it fails to be pragmatic.

A pragmatic approach depends heavily on a community of practitioners sharing their experiences, building a common knowledge base, and refining their theories and practices through reflection on the outcomes of their efforts. This work is best documented through case study research (Fishman, 1999, 2013). This will come as quite a shock to those who have taken even an introductory research methods course in psychology and who have learned that case studies are permitted in the early stages of exploring an area of research (the context of discovery) but not in the later stages where causal scientific claims are being tested (the context of justification). Fishman (1999, 2013) has effectively refuted that argument, though his position is often ignored in the scientific journals. Much of this argument pivots on the usefulness of thinking of human actions as caused in the same sense that

chemical or physical reactions are caused. Fishman argued that all human actions in the real world are context-dependent and influenced by multiple, often nonreplicable factors. Consequently, careful comprehensive case studies, often including quantitative measures, are preferable to using methods of empirical validation with control groups and rigid predesigned methods.

In this volume, I follow in the pragmatic tradition of James and Fishman and present abnormal psychology through the knowledge base of clinical practice (clinical case studies) supplemented by empirical survey research related to epidemiology and the functioning of the mental health system, as well as some literature reviews on etiological factors and treatment outcomes.

THE CASE OF PETER: A PRESSURED AND TWISTED BRAIN?

How we think about mental illness and treatment makes an enormous difference in outcome, but unless one has extensive experience in clinical work or personal experience as a consumer, it is hard to see how theories could make that much difference. To illustrate this, the case of Peter is presented. First, the case is described as it would be traditionally in a medical or psychiatric setting leading to a diagnosis and treatment plan. In the retelling I describe Peter as he emerged as a person in psychotherapy. To protect confidentiality, no real names are used and any details of the case that might reasonably be thought to lead to a reader discovering "Peter's" identity have been altered in such a way as to preserve the psychological and social integrity of the case.

Peter in Psychiatric Treatment

Peter is a 21-year-old Caucasian male who dropped out of college after one semester at age 18 years. He recently returned home after 3 years living and working in Texas, where he held positions of increasing responsibility in an environmental lab. He has been living with his parents for 9 months, becoming increasingly reclusive and noncommunicative. He had been fired from several low-paying jobs since his return to the area. His mother brought him to the interview because she is worried about the way he has become withdrawn and noncommunicative. Peter rarely leaves his bedroom, sleeps all day, and spends evenings and nights either watching television or surfing the Internet. He rarely interacts or talks with anyone in the household or with visitors to the house, even relatives he has known his whole life. He does minimal chores when asked.

Several months ago his mother took him to a psychiatrist who diagnosed him with bipolar disorder and placed him on medications usually used

to treat depression and thought disorder (psychosis). These included lithium (lithium carbonate, 1,500 mg/day) and olanzapine (5 mg/day). The psychiatrist also referred him to work with a counselor in his office on a weekly basis. Peter discontinued both after a few months. He said the medication slowed his racing thoughts, but he did not "feel like himself" on the drugs and preferred a more natural approach. He is asking for an evaluation as to whether he should resume the medication.

In the first interview, he reported these events and experiences in a halting and disjointed manner and was difficult to follow. He repeatedly checked with the interviewer to see what the interviewer was thinking and seemed wary and defensive, as if expecting to be deemed odd or strange. His speech was peppered with neologisms, and his sentences trailed off into incomplete thoughts. When prompted, he would finish a thought that he had left hanging. He complained that his head seemed pressured and his brain strained or twisted in his skull. He was unable to explain what this meant exactly or what other physical symptoms in his head or neck were associated with this brain state.

Peter reported no motivation to return to the world of work, though he expressed awareness that this was not the way a 21-year-old person should be living. In discussing his life in Texas the year before returning east, he indicated that he had been feeling unusually good during that period. He deeply regrets now that he did not stay. He had been eating healthfully, exercising a good deal in preparation for participation in a half-marathon, and generally thriving. This is the period that his previous psychiatrist saw as indication of a manic prologue to his current depression. Peter described himself as having gone overboard in trying to lose weight and get into shape; he did not know how to sustain this, so he left for home.

When asked the source of his problems, he attributes much of his troubles to his astrological sign or to his inborn introverted personality. Peter's previous psychiatrist told him he had a chemical imbalance in his brain that he will have to learn to live with the rest of his life and that medications would help control the effects of the imbalance.

Peter reports that he has two siblings, a brother 2 years older and a sister 5 years younger. They are both doing well in school and socially. He believes he is the only sibling "not making it." His parents have been married for 30 years and are both hard-working members of the business community who are presently quite successful, though there have been some tough financial times in the past. They have health insurance that covers his treatment. There is no known psychiatric history in the family, though he does not know much about his mother's extended family and describes them as rather "sketchy."

Given Peter's recent history, the psychiatrist reiterated the message he had received from his previous psychiatrist and strongly urged Peter to go back on medication to treat his biochemical imbalance. He pointed out that the side effects he had experienced were common and that they could try a new atypical antipsychotic medication that tended to have fewer side effects than his previous one. Because he had not benefitted from counseling, the psychiatrist suggested that he need not resume that aspect of his treatment so long as he was taking his medications.

Peter in Psychotherapy

My first contact with Peter was over the telephone in a call initiated by his mother, Kathy. She had called to ask for an appointment for Peter, briefly describing him as needing help because he had taken himself off his medication for bipolar disorder and was becoming a recluse, sleeping in his bedroom all day and staying up all night watching television or browsing the Internet. I was struck by the way she talked about him as though he were a young adolescent, despite the fact that he was 21 years of age. One indication of this was the fact that she was prepared to end our telephone discussion without having him talk with me. I have a general policy that I will not make an appointment for someone to come for an initial visit for psychotherapy unless I have a preliminary phone discussion with the person in question, so I asked to speak with Peter, and though he was entirely passive in our discussion of what his mother said, he did not resist the idea of making an appointment, saying, "I guess I have nothing to lose." Peter was faithful in keeping his appointments, though he did on occasion oversleep and arrive late. During the initial sessions he spoke haltingly, often in incomplete sentences, occasionally creating neologisms by combining two words with related meanings into one. His clearest and most lengthy comments were those expressing a great deal of self-loathing for messing up his life, especially about leaving Texas to return to the East.

He could not explain why he had so impulsively left a good job in a city he enjoyed living in to come back without a job or a plan to get one. He wondered whether the psychiatrist who had prescribed the mood stabilizer and antipsychotic medication might have been incorrect to interpret Peter's decision to leave as a sign of mania. Most every session in the first few months ended with a question of whether I thought he would be better off on medication. I took this to mean he wondered whether we were wasting our time, and I reassured him that I thought we were on the right path and that psychotherapy was a slow and at times painful process. I assured him that if he wished to return to the psychiatrist for medication I would support that decision, though it was not something I would have initiated. I further explained

that when we make impulsive decisions—like the one he made to leave Texas—there usually is a reason, even if it is not known at the time. By carefully reviewing in therapy the weeks and months preceding his departure, I assured him it was likely we would find out what he was thinking and feeling that led to that decision.

As we proceeded, Peter revealed that he found his mother both overinvolved and controlling and at other times quite distant and emotionally needy. His father, with whom he identified, was described as "like me, introverted and noncommunicative." Dad worked long days, coming home for meals, but rarely conversing with anyone while home. His brother was 2 years older than Peter and led a charmed existence as prince of the family, successful in everything he touched, except relationships with women. His younger sister, 5 years younger than Peter, was the family princess. She was in high school and partying all the time with college boys who were living life in the fast lane. Peter did not use the terms *prince* and *princess* in describing his siblings, but everything he said pointed to those characterizations and what must have been his anger as the lost child in the middle.

Peter struggled in school from the second grade onward, except for in sports, in which he was a great success, though always in his brother's shadow. By eighth grade he was drinking with his brother's friends, and he reported that high school was a blur of alcohol and pot punctuated by athletic success. His teachers seemed to have passed him to keep him playing athletics, despite the fact that he was stoned for many classes and rarely did more than the bare minimum of homework. He went to a college renowned for its athletics, but withdrew after one semester, which he again spent inebriated.

None of these features of his life history were stated directly, and it often took several sessions for bits and pieces of each storyline to emerge. I listened, encouraged self-exploration, and offered mildly interpretive summaries of what I heard ("Seems like your brother and sister can do no wrong in your parents' eyes—that would have upset me growing up as their brother."). He felt disloyal to his family when he said anything negative about anyone but himself. Over the succeeding 6 months the following family context for Peter's "bipolar disorder" emerged.

- Throughout his childhood there had been periods of financial feast and famine as his parents' various investments succeeded wildly or failed miserably.
- In either instance, neither parent was in the house on weekdays before 7:00 p.m. and the children were cared for by a succession of sitters, older cousins, and so forth. When they did arrive home, Mom was irritable and explosive and Dad was withdrawn and uninvolved.

- A few months before he left Texas he had spent time with his parents on a vacation and had been convinced they were headed for a divorce, though they never discussed this with him or the other members of the family.
- His mother had over the phone belittled his career plans in Texas and informed him that if his sister did not straighten out she would be sent to the state institution for delinquent adolescents.
- He had felt guilty being happy in Texas when everyone back home seemed so miserable. He thought he had no right to be happy if they were not.
- He thought now that he had figured out how to be a happy and successful person, he could return to his family and teach them how to live healthy and happy lives, especially his younger sister, who he feared was headed for disaster.
- He was a great admirer of the Dalai Lama and other political activists for their efforts toward social justice and peace, and he felt his family would not approve of such political ideas.

Peter had been taught an intense form of family loyalty in which one was never permitted to question family values or the actions of one's elders, no matter how harmful those actions were to the children. Everyone was supposed to have the same opinions, feelings, and lifestyle or risk being written off as not worthy of membership in the family. Although he seemed to be a lost soul, hiding out from the world in his bedroom, he actually knew what he liked, what kind of life was fulfilling for him, and what made him a happy person. He was trapped in his belief that he only deserved to live that life if his family would join him, and they would have no part of it. But he had never told them why he had really come home or how he felt about their cavalier rejection of his suggestions for a healthier and happier lifestyle. Faced with ostracism and rejection and feeling to blame for his own errors in judgment, he withdrew from the family.

Not unlike his spiritual and political heroes, he was now imprisoned in an act of resistance to the power politics of his family. I shared this interpretation with him in a number of forms, complimenting him on his generosity of spirit, courage in tackling the unspoken issues in the family, perceptiveness, and so forth. I encouraged him to take ownership of his future and not to leave it in the hands of the rest of the family to decide. We began talking about his need to get a job so that he could move out of the house and be on his own again.

As with all discussions with Peter since the first phone call, he tackled new challenges by a mixture of avoidance and then decisive action. He began

to work for his mother around the house doing odd jobs and was beginning to check the classified section of the local paper for a different job when he seemed to hit a wall. For several weeks we were just stuck, and then toward the end of one of these lackluster sessions, Peter commented:

> I guess I had better tell you something I promised my brother that I would. I don't know how to say this except just to say it—my father asked my mother for a divorce yesterday, and the poor woman is completely devastated.

This was the clearest and most emotionally open statement he had made about his family situation in the 9 months I had worked with him. He was fully present for the final 15 minutes of the session. His thinking and communication were sharp and quick. He was able to be angry without feeling shame or reticence.

Over the next 6 months, there was a cascade of revelations about the psychological family context in which Peter's problems were imbedded. These were issues that Peter had known about but had never considered relevant to his own difficulties functioning in the world. His father seemed oblivious to the impact his decision to leave was having on the rest of the family, and his mother began drinking heavily alone in her bedroom at night (as she had done periodically in the past). His older brother competed openly with Peter to be Mom's savior and belittled and humiliated Peter whenever Peter threatened his preeminence as prince of the family. His younger sister ended up in drug rehabilitation after nearly losing her life. Other revelations of equally meaningful family secrets cannot be revealed without jeopardizing confidentiality.

As each aspect of the family's pain and conflict emerged, Peter grew stronger and more independent. He found a job in the community and then went back to college, first part-time and then full-time, earning excellent grades. Two years into the therapy he decided to transfer to an out-of-state university, and our work together ended. There was still work to be done, but Peter had emerged from his period of withdrawal and hopelessness and was making a life for himself more independent of his family's conception of who he had to be.

Reflections on Peter's Case

The section of the case study entitled "Peter in Psychiatric Treatment" is based on Peter's report of his prior contacts with a psychiatrist and supplemented by my own experience working with the psychiatrists who practice in my locale and how they tend to discuss their treatment. The description is largely in terms of an *extraspective* account—what Peter said and did during

the interview. The theory of the case is physiological or biomedical, presenting Peter with a biological account of why it feels to him that his brain is broken. There is a biochemical imbalance in his brain that is causing his problems, and the medication he will be given will directly alter the biochemicals in his brain, presumably to rebalance them. Peter's brain is described by him and to him in terms that are objectified: "This is what your brain is doing," not "This is what you are doing." Peter's life history to the extent that it is reported (depending on the psychiatrist, the interview would have been between 30 and 40 minutes) is used to provide evidence that his behavior fits a pattern of a diagnosis of bipolar disorder. Because he fits that pattern and that pattern is presumed to be due to a genetic or biochemical process in the brain that is no longer normal (imbalanced), then the treatment with brain altering medications is seen as logical and appropriate. The psychiatrist presents to Peter an explanation of his problem behaviors (impulsive decision making, social withdrawal, incoherent communications) as determined by his brain state and not as something he can control or alter without medication. He is a passive victim in his own life story, and the psychiatrist is a heroic figure who can act logically and rationally to put Peter's life in order.

In the account of the psychotherapy I actually did with Peter (altered only to preserve confidentiality), I approach Peter with the benefit of considerable clinical experience. I had settled on a style of practice that was a combination of humanistic values emphasizing the encouragement of autonomy and personal freedom, a psychodynamic understanding of the importance of early childhood influences that may be unconscious, and the importance of understanding a client's family system. I had learned that it was imperative to provide my clients with both the support they needed to become the person they wanted to be and with sufficient self-understanding so that clients would begin to make sense to themselves and understand why they engaged in the self-defeating actions that sabotaged their own growth. For that understanding I had come to rely on interpersonal and object relations theory as captured in the works of Fromm-Reichmann (1950), Malan (1995), and Karon and VandenBos (1981).

I was generally skeptical of the benefit of psychotropic medications except in circumstances in which no other psychotherapy had been found to be helpful, or in emergencies to return a person's sleep cycle to some semblance of normality or calm an extremely agitated individual. In these emergency situations I expected that medication would not be needed for more than a week or two once the effect of psychotherapy was evident. At the time I worked with Peter there was a great deal of experimental psychopharmacological research supporting the use of medications with bipolar disorder accompanied by thought disorder as the treatment of choice, but for the reasons described earlier, I was not all that convinced of the validity of that research (Kaplan & Sadock, 1989).

I saw Peter as a 21-year-old young man who had been in intense psychological pain and suffering for a year or more and whose pain was an exacerbation of an internal sense of frustration and desperation that he felt for most of his life. He was raised by parents who themselves had difficult lives, who struggled to find financial stability, and whose personal relationship was greatly strained. He was not the only child of this marriage in trouble, but the only one they were willing to acknowledge to the rest of the world as in trouble. Peter had never really participated in his own education, having had some mild learning difficulties in the elementary grades and having engaged in extensive substance abuse from middle school on. He had many good qualities—compassion for others in the family, a sense of loyalty to his parents, an insightful understanding of other people's motivations—that he kept well hidden. He knew he was not living anywhere near his potential, and I sensed in speaking with him even the first hour that he had a vast amount of untapped potential as a human being. I believe he felt my awareness of who he might become and was willing to trust me to help him bring out his inner self. He had submerged his identity his entire life to keep his older brother from being threatened and to keep his parents from feeling burdened by a second child. He resisted asserting his own agency in the world and taking responsibility for himself rather than the other people he cared about who might be threatened by his taking up more of the oxygen in the house. It was a slow and at times frustrating process for both of us but more than worth the effort in the end.

THE WAY FORWARD

In discussing the various aspects of abnormal psychology in the chapters to follow, I pay close attention to how the pragmatic aspects of the psychodynamic, humanistic–existential, and family systems approaches can inform a viable alternative to the dominant bio–cognitive–behavioral view of psychopathology. In focusing on literatures that can offer both short-term symptom relief as well as the possibility of life-transforming psychological treatment, I do not intend to denigrate or disparage bio–behavioral treatments that offer relatively brief contact with providers and relatively quick symptom relief, although they are, generally speaking, less concerned with life-transforming effectiveness.