THE SOCIAL SCIENCE ENCYCLOPEDIA

Second Edition

Edited by

Adam Kuper and Jessica Kuper

London and New York

schizophrenic disorders, it has been established that a combination of drug and psychological or social treatments is more effective than either used alone. Psychiatric treatment has also been shown to diminish patients' use of medical facilities.

Psychiatry: past and future

Psychiatric illness is not new to modern society. In the Hippocratic writings (400 BC) there are clear descriptions of the major psychiatric disorders. Throughout the centuries psychopathology was described, explained and classified by the great physicians of the time. The degree of sophistication, or lack thereof, paralleled that for medicine in general. There was no autonomous discipline of psychiatry.

The historian George Mora divided modern scientific psychiatry into three overlapping periods. First, from 1800 to 1860, the mental hospital or asylum was the centre of psychiatric activity. It was staffed by a new type of physician, the alienist, totally devoted to the care of mentally ill people. The major accomplishments of this period were the practice of moral therapy, the description and classification of mental disorders, and the study of brain anatomy. Famous names associated with this period are Esquirol, Morel, Kahlbaum, Tuke, Rush and Ray. Second, from 1860 to 1920, the centre of psychiatry moved from the hospital to the university, which could simultaneously treat patients, teach, and do research. The important names of this era include Griesinger, Meynert, Forel, Bleuler, Charcot, Jackson, Kraepelin, A. Meyer and S. Freud. It was Kraepelin who provided a classification of mental disorders that is the intellectual precursor of DSM-III. Meyer developed the psychobiologic approach, trained a whole generation of leaders in American psychiatry and provided the fertile ground for the growth of psychoanalysis in the USA. Third, the period from 1920 to the present has been referred to as the psychiatric explosion. As described earlier, the greatest expansion of knowledge in psychodynamic, sociocultural, biologic and behavioural approaches began in the 1950s.

It is anticipated that by the end of the twentieth century there will be important new developments in psychiatry. These will include greater sophistication in nosology with improved validity for certain diagnostic categories; at the same time there will be philosophical and empirical sophistication in understanding the limitations of the diagnostic or categorical approach to other mental disturbances; significant advances in understanding the biology of mental processes in general and of the depressive and schizophrenic disorders in particular; significant advances in the evaluation of psychologic therapies so that more effective matches can be made between disorder and treatment; significant advances in the integration of biologic, psychodynamic, behavioural and social approaches to the diagnosis and treatment of mental disorders; advances in the integrative efforts between psychiatry and other medical disciplines such as neurology, medicine and paediatrics.

The advances described above will further define psychiatry both as a mental health profession and as a medical speciality.

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See also: DSM-IV; mental disorders; mental health; psychoanalysis; psychopharmacology.

psychoanalysis

Psychoanalysis is a procedure for the treatment of mental and emotional disturbances. Sigmund Freud originated and developed psychoanalysis as a result of his individual researches into the causes of hysteria, one of the common forms of mental illness in Europe in the latter part of the nineteenth century (see Jones 1953).

The unique characteristic of psychoanalysis as a therapy derives from its theory of psychopathology. The central finding of psychoanalysis is that mental and emotional disturbances result from unconscious mental life. Treatment therefore depends upon the ability of the patient, with the help of the analyst, to

reveal unconscious thoughts and feelings. The formula that propelled the psychoanalytic method from its inception ('what is unconscious shall be made conscious') remains vitally significant. The changes that have occurred in the formula have resulted from a broadened and deepened understanding of the nature of unconscious mental life and how it functions developmentally in relation to consciousness and to the environment.

According to Freud's first conception of symptom formation, morbid thought patterns occurred during a dissociated state and were prevented from normal discharge because of the altered states of consciousness. The undischarged tensions produced symptoms. The cure required some method of discharge – an abreaction or mental catharsis. By applying hypnosis, the noxious material could be brought to the surface and discharged through verbal association. This chain of inference, formulated first in collaboration with Joseph Breuer (1842–1925) who described his clinical experience in treating a female patient he named Anna O. (Freud 1955: vol. 2), was dependent upon a quantitative hypothesis concerning unconscious mental life and its relation to conscious states. In this pre-psychoanalytic period of research, excessive excitation and the blockage of discharge were thought to produce pathological effects.

A major shift occurred both in research and in the explanatory theory towards the turn of the century. Freud recognized, largely through his self-analysis but also through careful attention to what his patients told him, that a qualitative factor was as important as the quantitative in the pathological process. The unconscious thoughts and feelings contained sexual content and meaning which was linked to arousal, or in earlier language, the quantity of excitation.

The introduction of the qualitative factor altered the theory of neurosis and the therapeutic procedure and, indeed, the method of research. Instead of managing a procedure designed to discharge quantities of noxious excitation stored within the psyche, the problem shifted to uncovering the meaning of the symptoms, and through association, their roots in the unconscious. Hypnosis no longer served the purpose, since it was imperative that the entire treatment procedure elicit the full participation of the patient. Freud asked his patients to recline on the couch and to say whatever came to mind. This method, called free association, created a contradiction in terms. Freud discovered that it was difficult for the patient to carry out his request. Difficulty in associating did not seem to be a random effect, but along with the symptoms could be understood as an inherent aspect of the patient's manner of thinking and feeling and the particular form and content of the presenting symptoms. Freud visualized the difficulties of free association as *resistance* and as part and parcel of the problem of unconscious content attempting to break through the barriers that guarded conscious mental life.

The research and treatment method, called psychoanalysis, replicated the individual's intrapsychic struggle with the unconscious. Freud's model of neurotic suffering combined both the quantitative and qualitative ideas in the concept of intrapsychic conflict. Symptoms, those alien and debilitating conditions, appear as a result of conflict within the psyche.

According to this model, the terms of neurotic conflict begin with desire; the aim is gratification. The impulse to act, to seek direct gratification of desire, is inhibited by restrictive forces within the psyche. The most familiar type of restriction arises from the individual's moral standards, which render unacceptable the direct gratification of desire. This opposition of the forces of desire and morality produces the debilitating symptoms but in forms that will allow a measure of gratification of desire, however small and costly. Symptoms, resulting from intrapsychic conflict, are the individual's best effort at compromise.

However, as Freud discovered, symptom formation, since it utilizes compromises, follows principles of mental function which apply across a broad spectrum of activity. Therefore, the dynamics of intrapsychic conflict go beyond the pathological and enter into the realm of a general psychology. Normal mental activity such as dreaming, to cite one illustration, follows the same principle as the activity that leads to symptom formation (Freud 1955: vols 4 and 5). A dream is a symptom of mental conflict since it represents a compromise among forces in the unconscious that simultaneously push toward gratification of desire while inhibiting this tendency. The symbolic content of the dream disguises the conflict but also expresses all the terms of the conflict – both desire and prohibition.

This model of intrapsychic conflict underwent a variety of modifications throughout Freud's lifetime. For example, the idea of desire shifted from a dual instinct theory of sex and self-preservation to a dual instinct theory of sex and aggression. Closer attention to the object of desire (in contrast to the aim of discharge) revealed that while its normal pathway was outward towards objects and the environment, it could turn inward, particularly during stressful episodes in the individual's life. But even where desire turned inward, the object remained important in the psychoanalytic theory of conflict because of the observation that the individual retained an internalized image of the object, while seemingly relinquishing it in its real form. Even in the case of the most severe psychological disturbances – psychoses – the individual may appear

uninterested in the object world, but the internal conflict evolves around the representations of these objects both in their beneficent and malevolent forms.

The formalization of the model of conflict led to the structural hypothesis that postulates three parts of the psychic structure: id, superego and ego. The id is the part of the mind that generates desire, both sexual and aggressive impulses. The superego is the agency that involves the conscience (the imperatives of 'thou shalt not') and the ideals (the imperatives that one must achieve in order to feel loved and to experience self-esteem). The ego is the executive apparatus consisting of a variety of functions which together mediate the terms of the conflict between id, superego and, finally, reality.

Several problems arise in the application of the structural hypothesis, indeed, in working with all of these superordinate hypotheses in psychoanalytic theory. The hypothesis, which is part of the metapsychology of psychoanalysis, poses a number of problems in application, both in strict scientific research as well as in clinical work. Some of these problems can be dismissed readily, such as the use of the structural hypothesis as though it referred to 'real' agencies of the mind. The id, superego and ego are abstract concepts, an attempt to organize a theory of conflict. They are not anatomical entities, nor are they especially valuable as a guide to the phenomenology of conflict. But the structural hypothesis and the concepts of id, superego and ego serve a number of intellectual purposes in the theory of psychoanalysis. One example is the concept of resistance, or what prevents unconscious content from direct appearance in conscious images and thoughts. The work of psychoanalysis indicates that the derivatives of unconscious mental life are omnipresent in consciousness, but in such indirect and disguised forms (except in the case of delusional thinking and hallucinations) as to stretch credulity about the idea of unconscious derivatives affecting conscious thinking and activity. The structural hypothesis organizes Freud's observations and conclusions about resistance as a part of unconscious mental life: he posited the need to broaden the term of resistance (from barriers to consciousness) to defence as an unconscious function of the ego to limit the danger that occurs when the pressure to act on impulses becomes great (Freud 1955: vol. 20).

Another problem with the structural hypothesis of psychoanalysis derives from the logical consequences of using this hypothesis to distinguish among and explain the forms and functions of various pathologies. Psychological conflict implies that a psychic structure exists within the individual, so that, for example, moral imperatives no longer depend upon the parents for their force. The individual has a conscience which inflicts some measure of painful anxiety and guilt when unconscious desire seeks gratification.

The classical theory of psychoanalysis presumes that psychic conflict and structure become established during the last stages of infantile development, which is called the Oedipal stage (Freud 1955: vol. 7). In relinquishing incestuous desire, the child of approximately age 5 identifies with the objects and consequently emerges from infancy with a reasonably self-contained psychic structure. The pathologies linked to conflict in psychic structure, the transference neuroses, include hysteria, obsessional neuroses and related character neuroses. These pathologies are called transference neuroses because they do not impair the patient's ability, despite pain and suffering, to establish attachments to objects. However, the attachments are neurotically based in that the patient shifts the incestuous struggle from parents to other people. In the transference neuroses, the relationship to objects is not totally determined by the persistence of neurotic disturbance. For example, a person may be able to function reasonably well with other people except that the person is incapable of sexual intimacy as a result of neurotic inhibition.

Psychoanalytic investigation, especially of the post-Second World War period, has given rise to doubt about some of the formulations of the structural hypothesis and some of its derivatives in the explanation of pathologies. For example, can one clearly differentiate structural conflict from earlier developmental problems which derive from the deficits of infancy? The investigation of borderline conditions (a consequence of developmental deficits) or narcissistic disturbances (the conditions of impaired self-esteem and painful self-awareness), suggest that early internalizations of objects so colour the later identifications as to minimize the effects of psychological structure (see Segal 1964). Critics argue that to treat such patients using classical techniques will prove futile. On the more theoretical plane, the critics also dispute the distinction between transference and narcissistic disturbances because of the importance of object attachments in the latter category of disturbance. Perhaps underlying the controversies within the psychoanalytic profession are more fundamental differences than the suggestion that one or more hypotheses are open to question. After all, any scientific endeavour attempts to disprove hypotheses and to modify the theory as a result of fresh observation and experimentation.

Almost from its inception, psychoanalysis has been the centre of debate in which the contenders, more than disputing particular hypotheses, are engaged in a test of contradictory world-views. As indicated earlier, a tension inherent in psychoanalytic observation and explanation pervades the field. The dialectics of

quantity and quality, of mechanics and meaning, colour the evaluation and practice in the field. The tension extends into more abstract polarities: humanity between science and humanism, tragic and utopian views of humanity, and conservative versus imperialistic visions of the place of psychoanalysis in improving human relations.

Freud cautioned against abandoning points of view implicit in the quantitative and qualitative position in psychoanalysis. While he was an artist in his observation of pathology and mental function – (see, for example, Freud's exquisite narrative of an obsessional illness in his case 'The Rat Man' (Freud 1955: vol. 10)) – Freud never abandoned the theory of instincts and its grounding in biology. From early on, the disputes in psychoanalysis have resulted from attempts to frame the theories of pathology and therapy along a single dimension, what Freud called the error of *pars pro toto*, or substituting the part for the whole. Thus, in contemporary psychoanalysis, the stress on developmental deficits over structural conflict arises in part from a humanistic perspective and leads to the use of therapists not as objects in a transference drama that requires interpretation, but as surrogates who will use their beneficent office to overcome the malevolence of the past, particularly of early infancy. These debates within psychoanalysis have strong intellectual, as well as cultural and philosophical, foundations. Some investigators place psychoanalysis squarely in the midst of interpretive disciplines rather than the natural sciences (Ricoeur 1970). They link psychoanalysis to hermeneutics, linguistics and the humanities as against biology, medicine, psychiatry and the sciences. These debates also have economic and political ramifications concerning what constitutes the psychoanalytic profession and the qualifications of those who seek to enter its practice.

Psychoanalysis began as a medical discipline for the treatment of neurotic disturbances. It continues this therapeutic tradition of classical psychoanalysis in broadened application to the psychoses, borderline and narcissistic conditions through variants of psychoanalytic psychotherapy. As a result of its methods of investigation, its observations and theories, psychoanalysis has become a part of the general culture. The applications of psychoanalysis in literary criticism, history, political and social sciences, law and business are evidence of its infusion into the general culture. Writers, artists and critics, while debating the uses of psychoanalysis beyond the couch, understand the theory and experiment with its applications to the arts. Freud gave birth to a therapy and a theory and, perhaps beyond his intent, to a view of the world and the human condition.

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See also: ego; free association; Freud, Sigmund; id; motivation; Oedipus complex; psychiatry; transference; unconscious.

psycholinguistics *see* Chomsky, Noam; first language acquisition; language; pragmatics

psychological anthropology

Psychological anthropology is an area of anthropological theory concerned with relations between the individual and cultural systems of meaning, value and social practice. The field consists of a wide range of approaches to problems that arise in the intersections of mind, culture and society. It has been shaped particularly by interdisciplinary conversations between anthropology and other fields in the social sciences and humanities (Schwartz *et al.* 1992).

Because of anthropology's traditional focus on culture as shared, collective and public, psychological anthropology's concern with the individual in society has often fostered closer contacts with psychology and psychiatry than with the anthropological mainstream. Historically, psychological anthropology's fieldwork-based approach and emphasis upon naturalistic data aligned it more closely with psychoanalysis than with experimental psychology. However, the turn towards cognitive approaches in academic psychology produced new convergences with anthropology in both cognitive science (e.g. Holland and Quinn 1987) and the emerging area of 'cultural psychology' (Stigler *et al.* 1990).

The antecedents of psychological anthropology may be found in the earlier field of 'culture and personality' which emerged in mid-twentieth-century American anthropology. Associated most prominently with the work of Franz Boas's students Margaret Mead and Ruth Benedict, the field was influenced by an eclectic range of writers in anthropology, psychoanalysis and psychiatry, including Edward Sapir, A. I. Hallowell and Gregory Bateson. The long-term goal of culture and personality researchers was to develop a science of culture capable of identifying causal links between psychological processes and social and cultural forms.