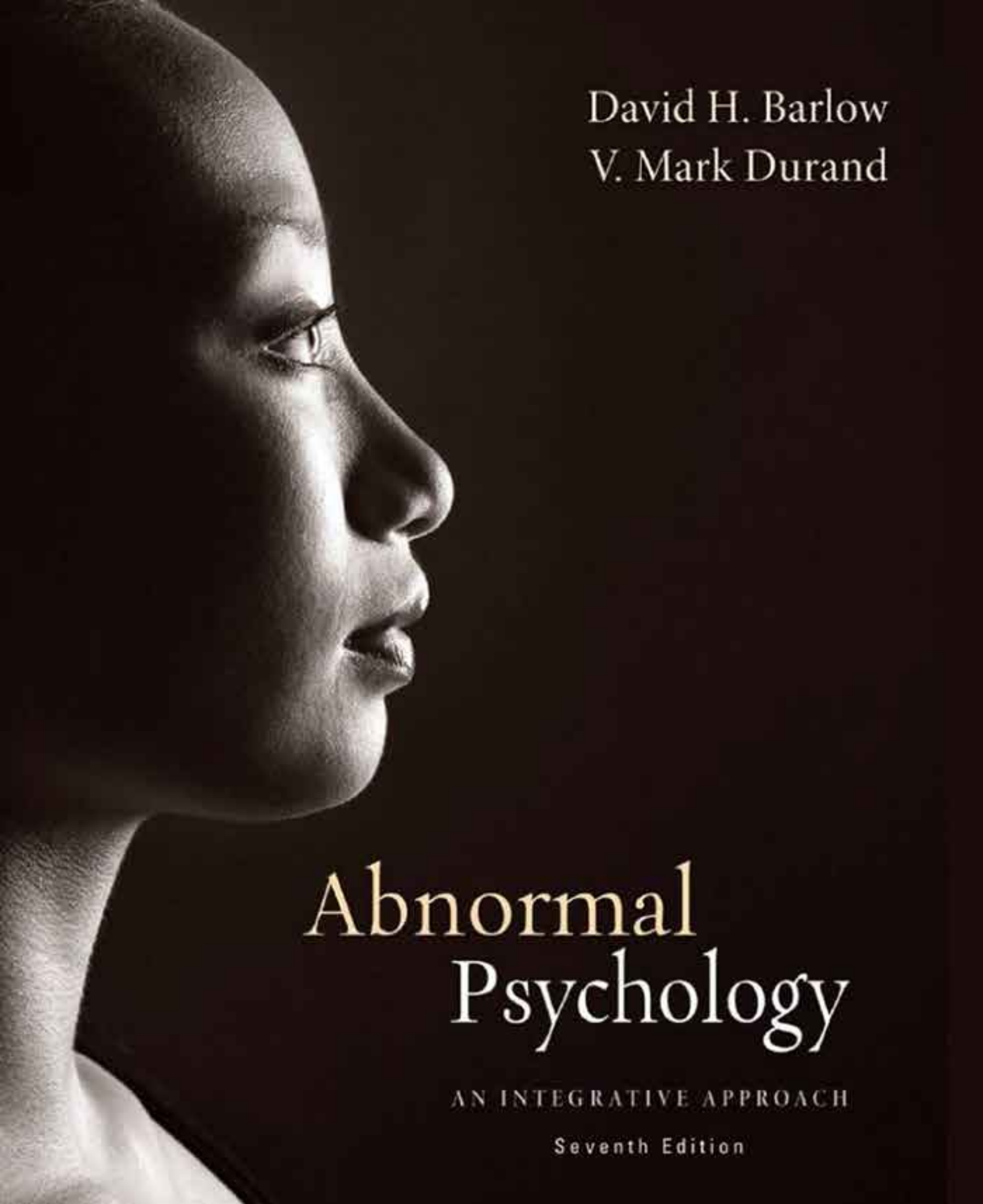

David H. Barlow
V. Mark Durand

Abnormal Psychology

AN INTEGRATIVE APPROACH

Seventh Edition

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David H. Barlow

BOSTON UNIVERSITY

V. Mark Durand

UNIVERSITY OF SOUTH FLORIDA–ST. PETERSBURG

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I dedicate this book to my mother,
Doris Elinor Barlow-Lanigan,
for her multidimensional influence
across my life span.

D. H. B.

To Wendy and Jonathan, whose
patience, understanding, and love
provided me the opportunity to
complete such an ambitious project.

V. M. D.

About the Authors


David H. Barlow

David H. Barlow is an internationally recognized pioneer and leader in clinical psychology. A professor of psychology and psychiatry at Boston University, Dr. Barlow is Founder and Director Emeritus of the Center for Anxiety and Related Disorders, one of the largest research clinics of its kind in the world. From 1996 to 2004, he directed the clinical psychology programs at Boston University. From 1979 to 1996, he was distinguished professor at the University at Albany–State University of New York. From 1975 to 1979, he was professor of psychiatry and psychology at Brown University, where he also founded the clinical psychology internship program. From 1969 to 1975, he was professor of psychiatry at the University of Mississippi, where he founded the Medical School psychology residency program. Dr. Barlow received his B.A. from the University of Notre Dame, his M.A. from Boston College, and his Ph.D. from the University of Vermont.

A fellow of every major psychological association, Dr. Barlow has received many awards in honor of his excellence in scholarship, including the National Institute of Mental Health Merit Award for his long-term contributions to the clinical research effort; the Distinguished Scientist Award for applications of psychology from the American Psychological Association; and the James McKeen Cattell Fellow Award from the Association for Psychological Science honoring individuals for their lifetime of significant intellectual achievements in applied psychological research. Other awards include the Distinguished Scientist Award from the Society of Clinical Psychology of the American Psychological Association and a certificate of appreciation from the APA section on the clinical psychology of women for "outstanding commitment to the advancement of women in psychology." In 2004, he received the C. Charles Burlingame Award from the Institute of Living and was awarded an Honorary Doctorate of Humane Letters degree from the Massachusetts School of Professional Psychology. He also received career contribution awards from the Massachusetts, Connecticut, and California Psychological Associations, and, in 2000, was named Honorary Visiting Professor at the Chinese People's Liberation Army General Hospital and Postgraduate Medical School in Beijing, China. In addition, the annual Grand Rounds in Clinical Psychology at Brown University was named in his honor, and he was awarded the first graduate alumni scholar award at the University of Vermont. During the 1997–1998 academic year, he was Fritz Redlich Fellow at the Center for Advanced Study in the Behavioral Sciences in Menlo Park, California. His research has been continually funded by the National Institute of Mental Health for over 40 years.

Dr. Barlow has edited three journals, has served on the editorial boards of more than 20 different journals, and is currently editor in chief of the "Treatments That Work" series for Oxford University Press.

He has published more than 500 scholarly articles and written more than 65 books and clinical manuals, including *Anxiety and Its Disorders,* 2nd edition, Guilford Press; *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual,* 5th edition, Guilford Press; *Single-Case Experimental Designs: Strategies for Studying Behavior Change,* 3rd edition, Allyn & Bacon (with Matthew Nock and Michael Hersen); *The Scientist–Practitioner: Research and Accountability in the Age of Managed Care,* 2nd edition, Allyn & Bacon (with Steve Hayes and Rosemary Nelson-Gray); *Mastery of Your Anxiety and Panic,* Oxford University Press (with Michelle Craske); and more recently *The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders* with the Unified Team at BU. The book and manuals have been translated into more than 20 languages, including Arabic, Chinese, and Russian.

Dr. Barlow was one of three psychologists on the task force that was responsible for reviewing the work of more than 1,000 mental health professionals who participated in the creation of *DSM-IV,* and he continued on as an Advisor to the *DSM-5* Task Force. He also chaired the APA Task Force on Psychological Intervention Guidelines, which created a template for clinical practice guidelines. His current research program focuses on the nature and treatment of anxiety and related emotional disorders.

At leisure he plays golf, skis, and retreats to his home in Nantucket, where he loves to write, walk on the beach, and visit with his island friends.

V. Mark Durand

V. Mark Durand is known worldwide as an authority in the area of autism spectrum disorder. He is a professor of psychology at the University of South Florida–St. Petersburg, where he was the founding Dean of Arts & Sciences and Vice Chancellor for Academic Affairs. Dr. Durand is a fellow of the American Psychological Association. He has received more than $4 million in federal funding since the beginning of his career to study the nature, assessment, and treatment of behavior problems in children with disabilities. Before moving to Florida, he served in a variety of leadership positions at the University at Albany, including associate director for clinical training for the doctoral psychology program from 1987 to 1990, chair of the psychology department from 1995 to 1998, and interim dean of Arts and Sciences from 2001 to 2002. There he established the Center for Autism and Related Disabilities at the University at Albany, SUNY. He received his B.A., M.A., and Ph.D.—all in psychology—at the State University of New York–Stony Brook.

Dr. Durand was awarded the University Award for Excellence in Teaching at SUNY–Albany in 1991 and was given the Chancellor's Award for Excellence in Research and Creative Scholarship at the University of South Florida–St. Petersburg in 2007. He was named a 2014 Princeton Lecture Series Fellow for his body of work in the field of autism spectrum disorder. Dr. Durand is currently a member of the Professional Advisory Board for the Autism Society of America and is on the board of directors of the International Association of Positive Behavioral Support. He is co-editor of the *Journal of Positive Behavior Interventions*, serves on a number of editorial boards, and has more than 125 publications on functional communication, educational programming, and behavior therapy. His books include *Severe Behavior Problems: A Functional Communication Training Approach*; *Sleep Better! A Guide to Improving Sleep for Children with Special Needs; Helping Parents with Challenging Children: Positive Family Intervention;* the multiple national award winning *Optimistic Parenting: Hope and Help for You and Your Challenging Child;* and most recently *Autism Spectrum Disorder: A Clinical Guide for General Practitioners.*

Dr. Durand developed a unique treatment for severe behavior problems that is currently mandated by states across the country and is used worldwide. He also developed an assessment tool that is used internationally and has been translated into more than 15 languages. Most recently he developed an innovative approach to help families work with their challenging child (Optimistic Parenting), which was validated in a 5-year clinical trial. He has been consulted by the departments of education in numerous states and by the U.S. Departments of Justice and Education. His current research program includes the study of prevention models and treatments for such serious problems as self-injurious behavior.

In his leisure time, he enjoys long-distance running and has completed three marathons.

Brief Contents

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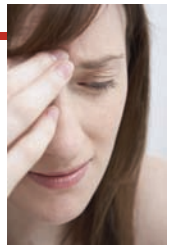
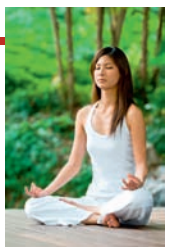




Preface

Science is a constantly evolving field, but every now and then something groundbreaking occurs that alters our way of thinking. For example, evolutionary biologists, who long assumed that the process of evolution was gradual, suddenly had to adjust to evidence that says evolution happens in fits and starts in response to such cataclysmic environmental events as meteor impacts. Similarly, geology has been revolutionized by the discovery of plate tectonics.

Until recently, the science of psychopathology had been compartmentalized, with psychopathologists examining the separate effects of psychological, biological, and social influences. This approach is still reflected in popular media accounts that describe, for example, a newly discovered gene, a biological dysfunction (chemical imbalance), or early childhood experiences as a "cause" of a psychological disorder. This way of thinking still dominates discussions of causality and treatment in some psychology textbooks: "The psychoanalytic views of this disorder are . . . ," "the biological views are . . . ," and, often in a separate chapter, "psychoanalytic treatment approaches for this disorder are . . . ," "cognitive behavioral treatment approaches are . . . ," or "biological treatment approaches are . . ."

In the first edition of this text, we tried to do something very different. We thought the field had advanced to the point that it was ready for an integrative approach in which the intricate interactions of biological, psychological, and social factors are explicated in as clear and convincing a manner as possible. Recent explosive advances in knowledge confirm this approach as the only viable way of understanding psychopathology. To take just two examples, Chapter 2 contains a description of a study demonstrating that stressful life events can lead to depression but that not everyone shows this response. Rather, stress is more likely to cause depression in individuals who already carry a particular gene that influences serotonin at the brain synapses. Similarly, Chapter 9 describes how the pain of social rejection activates the same neural mechanisms in the brain as physical pain. In addition, the entire section on genetics has been rewritten to highlight the new emphasis on gene–environment interaction, along with recent thinking from leading behavioral geneticists that the goal of basing the classification of psychological disorders on the firm foundation of genetics is fundamentally flawed. Descriptions of the emerging field of epigenetics, or the influence of the environment on gene expression, is also woven into the chapter, along with new studies on the seeming ability of extreme environments to largely override the effects of genetic contributions. Studies elucidating the mechanisms of epigenetics or specifically how environmental events influence gene expression are described.

These results confirm the integrative approach in this book: psychological disorders cannot be explained by genetic or environmental factors alone but rather arise from their interaction. We now understand that psychological and social factors directly affect neurotransmitter function and even genetic expression. Similarly, we cannot study behavioral, cognitive, or emotional processes without appreciating the contribution of biological and social factors to psychological and psychopathological expression. Instead of compartmentalizing psychopathology, we use a more accessible approach that accurately reflects the current state of our clinical science.

As colleagues, you are aware that we understand some disorders better than others. But we hope you will share our excitement in conveying to students both what we currently know about the causes and treatments of psychopathology and how far we have yet to go in understanding these complex interactions.

Integrative Approach

As noted earlier, the first edition of *Abnormal Psychology* pioneered a new generation of abnormal psychology textbooks, which offer an integrative and multidimensional perspective. (We acknowledge such one-dimensional approaches as biological, psychosocial, and supernatural as historic trends.) We include substantial current evidence of the reciprocal influences of biology and behavior and of psychological and social influences on biology. Our examples hold students' attention; for example, we discuss genetic contributions to divorce, the effects of early social and behavioral experience on later brain function and structure, new information on the relation of social networks to the common cold, and new data on psychosocial treatments for cancer. We note that in the phenomenon of implicit memory and blind sight, which may have parallels in dissociative experiences, psychological science verifies the existence of the unconscious (although it does not much resemble the seething caldron of conflicts envisioned by Freud). We present new evidence confirming the effects of psychological treatments on neurotransmitter flow and brain function. We acknowledge the often-neglected area of emotion theory for its rich contributions to psychopathology (e.g., the effects of anger on cardiovascular disease). We weave scientific findings from the study of emotions together with behavioral, biological, cognitive, and social discoveries to create an integrated tapestry of psychopathology.

Life-Span Developmental Influences

No modern view of abnormal psychology can ignore the importance of life-span developmental factors in the manifestation and treatment of psychopathology. Studies highlighting developmental windows for the influence of the environment on gene expression are explained. Accordingly, although we include a Neurodevelopmental Disorders chapter (Chapter 14), we consider the importance of development throughout the text; we discuss childhood and geriatric anxiety, for example, in the context of the

Anxiety, Trauma- and Stressor-Related, and Obsessive-Compulsive and Related Disorders chapter. This system of organization, which is for the most part consistent with *DSM-5*, helps students appreciate the need to study each disorder from childhood through adulthood and old age. We note findings on developmental considerations in separate sections of each disorder chapter and, as appropriate, discuss how specific developmental factors affect causation and treatment.

Scientist–Practitioner Approach

We go to some lengths to explain why the scientist–practitioner approach to psychopathology is both practical and ideal. Like most of our colleagues, we view this as something more than simple awareness of how scientific findings apply to psychopathology. We show how every clinician contributes to general scientific knowledge through astute and systematic clinical observations, functional analyses of individual case studies, and systematic observations of series of cases in clinical settings. For example, we explain how information on dissociative phenomena provided by early psychoanalytic theorists remains relevant today. We also describe the formal methods used by scientist–practitioners, showing how abstract research designs are actually implemented in research programs.

Clinical Cases of Real People

We have enriched the book with authentic clinical histories to illustrate scientific findings on the causes and treatment of psychopathology. We have both run active clinics for years, so 95% of the cases are from our own files, and they provide a fascinating frame of reference for the findings we describe. The beginnings of most chapters include a case description, and most of the discussion of the latest theory and research is related to these very human cases.

Disorders in Detail

We cover the major psychological disorders in 11 chapters, focusing on three broad categories: clinical description, causal factors, and treatment and outcomes. We pay considerable attention to case studies and *DSM-5* criteria, and we include statistical data, such as prevalence and incidence rates, sex ratio, age of onset, and the general course or pattern for the disorder as a whole. Since one of us (DHB) was an appointed Advisor to the *DMS-5* task force, we are able to include the reasons for changes as well as the changes themselves. Throughout, we explore how biological, psychological, and social dimensions may interact to cause a particular disorder. Finally, by covering treatment and outcomes within the context of specific disorders, we provide a realistic sense of clinical practice.

Treatment

One of the best received innovations in the first six editions was our discussing treatments in the same chapter as the disorders themselves instead of in a separate chapter, an approach that is supported by the development of specific psychosocial and pharmacological treatment procedures for specific disorders. We have retained this integrative format and have improved upon it, and we include treatment procedures in the key terms and glossary.

Legal and Ethical Issues

In our closing chapter, we integrate many of the approaches and themes that have been discussed throughout the text. We include case studies of people who have been involved directly with many legal and ethical issues and with the delivery of mental health services. We also provide a historical context for current perspectives so students will understand the effects of social and cultural influences on legal and ethical issues.

Diversity

Issues of culture and gender are integral to the study of psychopathology. Throughout the text we describe current thinking about which aspects of the disorders are culturally specific and which are universal, and about the strong and sometimes puzzling effects of gender roles. For instance, we discuss the current information on such topics as the gender imbalance in depression, how panic disorders are expressed differently in various Asian cultures, the ethnic differences in eating disorders, treatment of schizophrenia across cultures, and the diagnostic differences of attention deficit/hyperactivity disorder (ADHD) in boys and girls. Clearly, our field will grow in depth and detail as these subjects and others become standard research topics. For example, why do some disorders overwhelmingly affect females and others appear predominantly in males? And why does this apportionment sometimes change from one culture to another? In answering questions like these, we adhere closely to science, emphasizing that gender and culture are each one dimension among several that constitute psychopathology.

New to This Edition

A Thorough Update

This exciting field moves at a rapid pace, and we take particular pride in how our book reflects the most recent developments. Therefore, once again, every chapter has been carefully revised to reflect the latest research studies on psychological disorders. Hundreds of new references from 2011 to 2013 (and some still "in press") appear for the first time in this edition, and some of the information they contain stuns the imagination. Nonessential material has been eliminated, some new headings have been added, and *DSM-5* criteria are included in their entirety as tables in the appropriate disorder chapters.

Anxiety, Trauma- and Stressor-Related, and Obsessive-Compulsive and Related Disorders (Chapter 5), Mood Disorders and Suicide (Chapter 7), Eating and Sleep–Wake Disorders (Chapter 8), Physical Disorders and Health Psychology (Chapter 9), Substance-Related, Addictive, and Impulse-Control Disorders (Chapter 11), Schizophrenia Spectrum and Other Psychotic Disorders (Chapter 13), and Neurodevelopmental Disorders (Chapter 14) have been the most heavily revised to reflect new research, but all chapters have been significantly updated and freshened.

Chapter 1, Abnormal Behavior in Historical Context, features updated nomenclature to reflect new titles in *DSM-5,* updated descriptions of research on defense mechanisms, and fuller and

deeper descriptions of the historical development of psychodynamic and psychoanalytic approaches.

Chapter 2, An Integrative Approach to Psychopathology, includes an updated discussion of developments in the study of genes and behavior with a focus on gene–environment interaction; new data illustrating the gene–environment correlation model; updated information in the quickly developing area of genetics was added; new studies illustrating the psychosocial influence on brain structure and function in general and on neurotransmitter systems specifically; new studies illustrating psychosocial influences on the development of brain structure and function; updated, revised, and refreshed sections on behavioral and cognitive science including new studies illustrating the influence of positive psychology on physical health and longevity; new studies supporting the strong influence of emotions, specifically anger, on cardiovascular health; new studies illustrating the influence of gender on the presentation and treatment of psychopathology; a variety of powerful new studies confirming strong social effects on health and behavior; and new studies confirming the puzzling "drift" phenomenon resulting in a higher prevalence of schizophrenia among individuals living in urban areas.

Chapter 3, Clinical Assessment and Diagnosis, now presents references to "intellectual disability" instead of "mental retardation" to be consistent with *DSM-5* and changes within the field; a new discussion about how information from the MMPI-2—although informative—does not necessarily change how clients are treated and may not improve their outcomes (Lima et al., 2005); a description of the organization and structure of *DSM-5* along with major changes from *DSM-IV*; a description of methods to coordinate the development of *DSM-5* with the forthcoming ICD 11; and a description of likely directions of research as we begin to head toward *DSM-6*.

In Chapter 4, Research Methods, a new example of how behavioral scientists develop research hypotheses is presented, as well as a new cautionary discussion of the Virginia Tech massacre in the section on case study method, and a new example of longitudinal designs which look at how the use of spanking predicts later behavior problems in children (Gershoff, Lansford, Sexton, Davis-Kean, & Sameroff, 2012).

Chapter 5, now titled "Anxiety, Trauma- and Stressor-Related, and Obsessive-Compulsive and Related Disorders," was reorganized according to the three major groups of disorders: anxiety disorders, trauma- and stressor-related disorders, and obsessive-compulsive and related disorders. Two new disorders (separation anxiety disorder and selective mutism) are presented, and the Trauma and Stressor-Related Disorders section includes not only posttraumatic stress disorder and acute stress disorder but also adjustment disorder and attachment disorders. The final new grouping, Obsessive-Compulsive and Related Disorders, includes not only obsessive-compulsive disorder but also body dysmorphic disorder, hoarding disorder, and finally trichotillomania (hair pulling disorder) and excoriation (skin picking disorder). Other revisions to Chapter 5 include the following:

- Updated descriptions of the nature of anxiety, fear, and panic, and an integrated etiological model of anxiety and related disorders;
- Updated information on the relationship of anxiety and related disorders to suicide;
- A description of modifications to types of panic attacks, which has been reduced from 3 to 2 in *DSM-5;*
- Updated generalized anxiety disorder discussion, one of the few disorders incurring no changes in diagnostic criteria in *DSM-5;*
- Updated information on description, etiology, and treatment for specific phobia and social anxiety disorder;
- Updated Obsessive-Compulsive and Related Disorders discussion, including description, statistics, etiology, and treatment for OCD;
- Added discussion of newly repositioned body dysmorphic disorder from the somatoform disorders, as well as the rationale of the *DSM-5* task force for making this change;
- Updated and more detailed description of hoarding disorder, previously thought to be a variation of OCD but now accorded its own status as a separate disorder in *DSM-5;*
- Reorganized discussion of trichotillomania (hair pulling disorder) and excoriation (skin picking disorder), previously located under impulse control disorders in *DSM-IV* but repositioned because of similarities with Obsessive-Compulsive and other Related Disorders in *DSM-5*.

The grouping of disorders in Chapter 6, now titled Somatic Symptom and Related Disorders and Dissociative Disorders, reflects a major overarching change, specifically for somatic symptom disorder, illness anxiety disorder, and psychological factors affecting medical condition. In addition, Chapter 6 now has an update to culturally specific somatic symptom disorders; updated discussions on the causes and treatment of somatic symptom disorders; updated discussion on conversion disorder and its new subtitle "functional neurological symptom disorder"; a full description of the reorganization of dissociative disorders; new discussion of conceptualization of depersonalization disorder, which is now known as depersonalization-derealization disorder, as a condition encompassing both types of dissociative phenomena; new definitions of dissociative amnesia, that now encompasses dissociative fugue states; and updated discussion of dissociative identity disorder (DID), including new information on personality characteristics associated with the development of this disorder and the incorporation of possession states into the definition of this disorder.

Chapter 7, Mood Disorders and Suicide, is fully consistent with *DSM-5* and now includes a full description of mood disorders new to *DSM-5* such as disruptive mood dysregulation disorder and premenstrual dysphoric disorder, a full description of the new emphasis in mood disorders on chronicity, the creation of persistent depressive disorder as a major new classification of mood disorders, and the latest developments in mood disorders and suicide prevention.

Thoroughly rewritten and updated, Chapter 8, Eating and Sleep–Wake Disorders, contains new information on mortality rates in anorexia nervosa; new epidemiological information

on the prevalence of eating disorders in adolescents; new information on the increasing globalization of eating disorders and obesity; updated information on typical patterns of comorbidity accompanying eating disorders; and new and updated research on changes in the incidence of eating disorders among males, racial and ethnic differences on the thin-ideal body image associated with eating disorders, the role of friendship cliques in the etiology of eating disorders, mothers with eating disorders who also restrict food intake by their children, the contribution of parents and family factors in the etiology of eating disorders, biological and genetic contributions to causes of eating disorders, transdiagnostic treatment applicable to all eating disorders, the effects of combining Prozac with CBT in the treatment of eating disorders, racial and ethnic differences in people with binge eating disorder seeking treatment, and the phenomenon of night eating syndrome and its role in the development of obesity.

Realigned coverage of Sleep–Wake Disorders, also in Chapter 8, with new information on sleep in women is now reported—including risk and protective factors, an updated section on narcolepsy to describe new research on the causes of this disorder, and new research on the nature and treatment of nightmares are now included.

In Chapter 9, Physical Disorders and Health Psychology, updated data on the leading causes of death in the United States; a review of the increasing depth of knowledge on the influence of psychological social factors on brain structures and function; new data on the positive effects of reducing depressive symptoms on survival in patients with metastatic breast cancer; an updated review of developments into causes and treatment of chronic pain; updated information eliminating the XMRV virus as a possible cause of chronic fatigue syndrome; and updated review of psychological and behavioral procedures for preventing injuries.

In Chapter 10, Sexual Dysfunctions, Paraphilic Disorders, and Gender Dysphoria, a revised organization of sexual dysfunctions, paraphilic disorders, and gender dysphoria to reflect the fact that both paraphilic disorders and gender dysphoria are separate chapters in *DSM-5,* and gender dysphoria disorder, is, of course, not a sexual disorder but a disorder reflecting incongruence between natal sex and expressed gender, in addition to other major revisions—new data on developmental changes in sexual behavior from age of first intercourse to prevalence and frequency of sexual behavior in old age; new reports contrasting differing attitudes and engagement in sexual activity across cultures even within North America; updated information on the development of sexual orientation; and a thoroughly updated description of gender dysphoria with an emphasis on emerging conceptualizations of gender expression that are on a continuum.

Chapter 10 also includes updated information on contributing factors to gender dysphoria as well as the latest recommendations on treatment options, recommended treatment options (or not to treat) for gender nonconformity in children, a full description of disorders of sex development (formerly called intersexuality), and a thoroughly revamped description of paraphilic disorders to reflect the updated system of classification with a discussion of the controversial change in the name of these disorders from paraphilia to paraphilic disorders.

A thoroughly revised Chapter 11, Substance-Related, Addictive, and Impulse-Control Disorders, features new discussion of how the trend to mix caffeinated energy drinks with alcohol may increase the likelihood of later abuse of alcohol; new research on chronic use of MDMA ("Ecstasy") leading to lasting memory problems (Wagner, Becker, Koester, Gouzoulis-Mayfrank, & Daumann, 2013); and new research on several factors predicting early alcohol use, including when best friends have started drinking, whether family members are at high risk for alcohol dependence, and the presence of behavior problems in these children (Kuperman, et al., 2013).

Chapter 12, Personality Disorders, now features a completely new section on gender differences to reflect newer, more sophisticated analyses of prevalence data, and a new section on criminality and antisocial personality disorder is now revised to better reflect changes in *DSM-5*.

Chapter 13, Schizophrenia Spectrum and Other Psychotic Disorders, presents a new discussion of schizophrenia spectrum disorder and the dropping of subtypes of schizophrenia from *DSM-5;* new research on deficits in emotional prosody comprehension and its role in auditory hallucinations (Alba-Ferrara, Fernyhough, Weis, Mitchell, & Hausmann, 2012); a discussion of a new proposed psychotic disorder suggested in *DSM-5* for further study—Attenuated Psychosis Syndrome; and a new discussion of the use of transcranial magnetic stimulation.

In Chapter 14, "Neurodevelopmental Disorders" are presented, instead of "Pervasive Developmental Disorders," to be consistent with the major changes in *DSM-5*. In addition, Chapter 14 now describes new research to show that gene–environment interaction can lead to later behavior problems in children with ADHD (Thapar, Cooper, Jefferies, & Stergiakouli, 2012; Thapar, et al., 2005); new research on ADHD (and on other disorders) that is finding that in many cases mutations occur that either create extra copies of a gene on one chromosome or result in the deletion of genes (called copy number variants—CNVs) (Elia et al., 2009; Lesch et al., 2010); and new research findings that show a variety of genetic mutations, including de novo disorders (genetic mutations occurring in the sperm or egg or after fertilization), are present in those children with intellectual disability (ID) of previously unknown origin (Rauch et al., 2012).

Chapter 15, now called Neurocognitive Disorders, features descriptions of research assessing brain activity (fMRI) in individuals during active episodes of delirium as well as after these episodes; data from the Einstein Aging study concerning the prevalence of a disorder new in *DSM-5,* mild neurocognitive disorder (Katz et al., 2012); and a new discussion of new neurocognitive disorders (e.g., neurocognitive disorder due to Lewy bodies or prion disease).

And Chapter 16, Mental Health Services: Legal and Ethical Issues, presents a brief, but new, discussion of the recent trend to provide individuals needing emergency treatment with court-ordered assisted outpatient treatment (AOT) to avoid commitment in a mental health facility (Nunley, Nunley, Cutleh, Dentingeh, & McFahland, 2013); a new discussion of a major meta-analysis showing that current risk assessment tools are best at identifying persons at low risk of being

violent but only marginally successful at accurately detecting who will be violent at a later point (Fazel, Singh, Doll, & Grann, 2012); and an updated section on legal rulings on involuntary medication.

New Features

In addition to the changes highlighted earlier, we have added three new features to the seventh edition:

- New *Student Learning Outcomes* at the start of each chapter assist instructors in accurately assessing and mapping questions throughout the chapter. The outcomes are mapped to core American Psychological Association goals and are integrated throughout the instructor resources and testing program.
- In each disorder chapter is a new feature called *DSM Controversies*, which discusses some of the contentious and thorny decisions made in the process of creating *DSM-5*. Examples include the creation of new and sometimes controversial disorders appearing for the first time in *DSM-5,* such as premenstrual dysphoric disorder, binge eating disorder, and disruptive mood dysregulation disorder. Another example is removing the "grief" exclusion criteria for diagnosing major depressive disorder so that someone can be diagnosed with major depression even if the trigger was the death of a loved one. Finally, changing the title of the "paraphilia" chapter to "paraphilic disorders" implies that paraphilic sexual arousal patterns such as pedophilia are not disorders in themselves, but only become disorders if they cause impairment or harm to others.

DSM-IV, DSM-IV-TR, and *DSM-5*

Much has been said about the mix of political and scientific considerations that resulted in *DSM-5*, and naturally we have our own opinions. (DHB had the interesting experience of sitting on the task force for *DSM-IV* and was an Advisor to the *DSM-5* task force.) Psychologists are often concerned about "turf issues" in what has become—for better or worse—the nosological standard in our field, and with good reason: in previous *DSM* editions, scientific findings sometimes gave way to personal opinions. For *DSM-IV* and *DSM-5*, however, most professional biases were left at the door while the task force almost endlessly debated the data. This process produced enough new information to fill every psychopathology journal for a year with integrative reviews, reanalysis of existing databases, and new data from field trials. From a scholarly point of view, the process was both stimulating and exhausting. This book contains highlights of various debates that created the nomenclature, as well as recent updates. For example, in addition to the controversies described above, we summarize and update the data and discussion of premenstrual dysphoric disorder, which was designated a new disorder in *DSM-5,* and mixed anxiety depression, a disorder that did not make it into the final criteria. Students can thus see the process of making diagnoses, as well as the combination of data and inferences that are part of it.

We also discuss the intense continuing debate on categorical and dimensional approaches to classification. We describe some of the compromises the task force made to accommodate data, such as why dimensional approaches to personality disorders did not make it into *DSM-5,* and why the proposal to do so was rejected at the last minute and included in Section III under "Conditions for Further Study" even though almost everyone agrees that these disorders should not be categorical but rather dimensional.

Prevention

Looking into the future of abnormal psychology as a field, it seems our ability to prevent psychological disorders may help the most. Although this has long been a goal of many, we now appear to be at the cusp of a new age in prevention research. Scientists from all over the globe are developing the methodologies and techniques that may at long last provide us with the means to interrupt the debilitating toll of emotional distress caused by the disorders chronicled in this book. We therefore highlight these cutting-edge prevention efforts—such as preventing eating disorders, suicide, and health problems, including HIV and injuries—in appropriate chapters as a means to celebrate these important advancements, as well as to spur on the field to continue this important work.

Retained Features

Visual Summaries

At the end of each disorder chapter is a colorful, two-page visual overview that succinctly summarizes the causes, development, symptoms, and treatment of each disorder covered in the chapter. Our integrative approach is instantly evident in these diagrams, which show the interaction of biological, psychological, and social factors in the etiology and treatment of disorders. The visual summaries will help instructors wrap up discussions, and students will appreciate them as study aids.

Pedagogy

Each chapter contains several Concept Checks, which let students verify their comprehension at regular intervals. Answers are listed at the end of each chapter along with a more detailed Summary; the Key Terms are listed in the order they appear in the text and thus form a sort of outline that students can study.

Teaching and Learning Aids

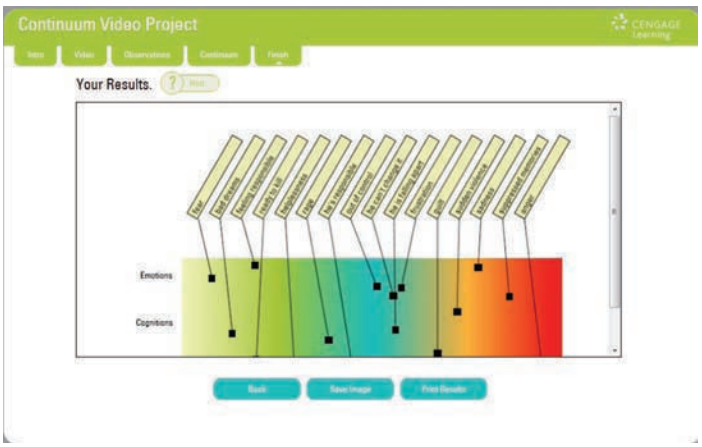
MindTap

MindTap for Barlow and Durand's *Abnormal Psychology: An Integrative Approach* is a highly personalized, fully online learning platform of authoritative content, assignments, and services offering you a tailored presentation of course curriculum created by your instructor. MindTap guides you through the course curriculum via an innovative learning path in which you will complete reading assignments, annotate your readings, complete homework, and engage with quizzes and assessments. MindTap

includes access to the Continuum Video Project and Abnormal Psychology Videos. Go to **cengagebrain.com** to access MindTap.

Continuum Video Project

The Continuum Video Project provides holistic, three-dimensional portraits of individuals dealing with psychopathologies. Videos show clients living their daily lives, interacting with family and friends, and displaying—rather than just describing—their symptoms. Before each video segment, students are asked to make observations about the individual's symptoms, emotions, and behaviors, and then rate them on the spectrum from normal to severe. The Continuum Video Project allows students to "see" the disorder and the person, humanly; the videos also illuminate student understanding that abnormal behavior can be viewed along a continuum.



Videos

More videos are also available in MindTap at **www.cengagebrain.com,** as well as on the DVD, *Abnormal Psychology: Inside/Out,* DVD Volumes 1–4 (ISBN: 9780495032144).

Cognero

Cengage Learning Testing Powered by Cognero is a flexible, online system that allows you to author, edit, and manage test bank content from multiple Cengage Learning solutions, create multiple test versions in an instant, and deliver tests from your LMS, your classroom, or wherever you want. ISBN: 9781285979328

Instructor's Manual

The Online Instructor's Manual contains chapter overviews, learning objectives, lecture outlines with discussion points, key terms, classroom activities, demonstrations, and lecture topics, suggested supplemental reading material, handouts, video resources, and Internet resources. ISBN: 9781285860589

PowerPoints

The Online PowerPoints feature lecture outlines, key figures from the text, and relevant video clips. ISBN: 9781285859101

Titles of Interest

- *DSM-5 Supplement* by Barlow and Durand is a thorough comparison of the changes made in *DSM-5* with the previous criteria and language in *DSM-IV-TR*. Also includes discussion of major controversies resulting from the proposed and realized modifications to the latest diagnostic manual. ISBN: 9781285848181
- *Looking into Abnormal Psychology: Contemporary Readings* by Scott O. Lilienfeld is a fascinating 234-page reader consisting of 40 articles from popular magazines and journals. Each article explores ongoing controversies regarding mental illness and its treatment. ISBN: 0-534-35416-5
- *Casebook in Abnormal Psychology,* 4th edition, by Timothy A. Brown and David H. Barlow, is a comprehensive casebook that reflects the integrative approach, which considers the multiple influences of genetic, biological, familial, and environmental factors into a unified model of causality as well as maintenance and treatment of the disorder. The casebook discusses treatment methods that are the most effective interventions developed for a particular disorder. It also presents three undiagnosed cases in order to give students an appreciation for the complexity of disorders. The cases are strictly teaching/learning exercises, similar to what many instructors use on their examinations. ISBN: 0-495-60438-0

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Finally, you share with us the task of communicating knowledge and discoveries in the exciting field of psychopathology, a challenge that none of us takes lightly. In the spirit of collegiality, we would greatly appreciate your comments on the content and style of this book and recommendations for improving it further.

Reviewers

Creating this book has been both stimulating and exhausting, and we could not have done it without the valuable assistance of colleagues who read one or more chapters and provided extraordinarily perceptive critical comments, corrected errors, pointed to relevant information, and, on occasion, offered new insights that helped us achieve a successful, integrative model of each disorder.

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Abnormal Behavior in Historical Context

Jerry Cooke/Photo Researchers/Science Source

1

CHAPTER OUTLINE

student learning outcomes*

• **Describe key concepts, principles, and overarching themes in psychology**	• Explain why psychology is a science with the primary objectives of describing, understanding, predicting, and controlling behavior and mental processes (APA SLO 5.1b) *(see textbook pages 4–6)* • Use basic psychological terminology, concepts, and theories in psychology to explain behavior and mental processes (APA SLO 5.1a) *(see textbook pages 2–6)*
• **Develop a working knowledge of the content domains of psychology**	• Summarize important aspects of history of psychology, including key figures, central concerns, methods used, and theoretical conflicts (APA SLO 5.2C) *(see textbook pages 7–23)* • Identify key characteristics of major content domains in psychology (e.g., cognition and learning, developmental, biological, and sociocultural) (APA SLO 5.2a) *(see textbook pages 4–5, 12–24)*
• **Use scientific reasoning to interpret behavior**	• See APA SLO 5.1a listed above • Incorporate several appropriate levels of complexity (e.g., cellular, individual, group/system, society/cultural) to explain behavior (APA SLO 1.1C) *(see textbook pages 2–4)*

* Portions of this chapter cover learning outcomes suggested by the American Psychological Association (2012) in their guidelines for the undergraduate psychology major. Chapter coverage of these outcomes is identified above by APA Goal and APA Suggested Learning Outcome (SLO).

Understanding Psychopathology

Today you may have gotten out of bed, had breakfast, gone to class, studied, and, at the end of the day, enjoyed the company of your friends before dropping off to sleep. It probably did not occur to you that many physically healthy people are not able to do some or any of these things. What they have in common is a **psychological disorder**, a psychological dysfunction within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected. Before examining exactly what this means, let's look at one individual's situation.

JUDY... The Girl Who Fainted at the Sight of Blood

Judy, a 16-year-old, was referred to our anxiety disorders clinic after increasing episodes of fainting. About 2 years earlier, in Judy's first biology class, the teacher had shown a movie of a frog dissection to illustrate various points about anatomy.

This was a particularly graphic film, with vivid images of blood, tissue, and muscle. About halfway through, Judy felt a bit lightheaded and left the room. But the images did not leave her. She continued to be bothered by them and occasionally felt slightly queasy. She began to avoid situations in which she might see blood or injury. She stopped looking at magazines that might have gory pictures. She found it difficult to look at raw meat, or even Band-Aids, because they brought the feared images to mind. Eventually, anything her friends or parents said that evoked an image of blood or injury caused Judy to feel lightheaded. It got so bad that if one of her friends exclaimed, "Cut it out!" she felt faint.

Beginning about 6 months before her visit to the clinic, Judy actually fainted when she unavoidably encountered something bloody. Her family physician could find nothing wrong with her, nor could several other physicians. By the time she was referred to our clinic she was fainting 5 to 10 times a week, often in class. Clearly, this was problematic for her and disruptive in school; each time Judy fainted, the other students flocked around her, trying to help, and class was interrupted. Because no one could find anything wrong with her, the principal finally concluded that she was being manipulative and suspended her from school, even though she was an honor student.

Judy was suffering from what we now call *blood–injection–injury phobia*. Her reaction was quite severe, thereby meeting the criteria for **phobia,** a psychological disorder characterized by marked and persistent fear of an object or situation. But many people have similar reactions

(Continued next page)

that are not as severe when they receive an injection or see someone who is injured, whether blood is visible or not. For people who react as severely as Judy, this phobia can be disabling. They may avoid certain careers, such as medicine or nursing, and, if they are so afraid of needles and injections that they avoid them even when they need them, they put their health at risk. ●

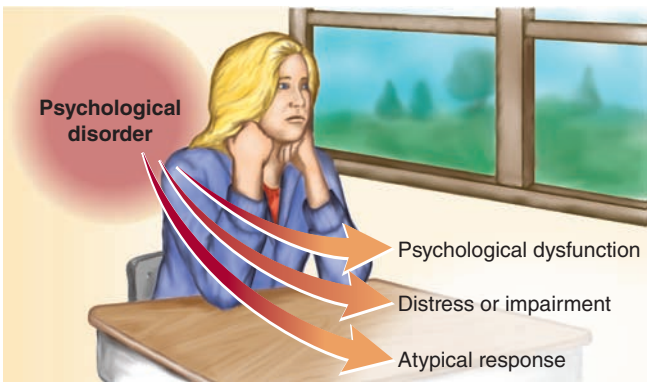
What Is a Psychological Disorder?

Keeping in mind the real-life problems faced by Judy, let's look more closely at the definition of psychological disorder, or **abnormal behavior**: It is a psychological dysfunction within an individual that is associated with distress or impairment in functioning and a response that is not typical or culturally expected (see ● Figure 1.1). On the surface, these three criteria may seem obvious, but they were not easily arrived at and it is worth a moment to explore what they mean. You will see, importantly, that no one criterion has yet been developed that fully defines abnormality.

Psychological Dysfunction

Psychological dysfunction refers to a breakdown in cognitive, emotional, or behavioral functioning. For example, if you are out on a date, it should be fun. But if you experience severe fear all evening and just want to go home, even though there is nothing to be afraid of, and the severe fear happens on every date, your emotions are not functioning properly. However, if all your friends agree that the person who asked you out is unpredictable and dangerous in some way, then it would not be dysfunctional for you to be fearful and avoid the date.

A dysfunction was present for Judy: she fainted at the sight of blood. But many people experience a mild version of this reaction (feeling queasy at the sight of blood) without meeting the criteria for the disorder, so knowing where to draw the line between normal and abnormal dysfunction is often difficult. For this reason, these problems are often considered to be on a continuum or a dimension rather than to be categories that are either present or absent (McNally, 2011; Stein, Phillips, Bolton, Fulford, Sadler, & Kendler, 2010; Widiger & Crego, 2013). This, too, is a reason why just having a dysfunction is not enough to meet the criteria for a psychological disorder.



● **FIGURE 1.1** The criteria defining a psychological disorder.

Personal Distress or Impairment

That the behavior must be associated with distress to be classified as abnormal adds an important component and seems clear: the criterion is satisfied if the individual is extremely upset. We can certainly say that Judy was distressed and even suffered with her phobia. But remember, by itself this criterion does not define abnormal behavior. It is often quite normal to be distressed—for example, if someone close to you dies. The human condition is such that suffering and distress are very much part of life. This is not likely to change. Furthermore, for some disorders, by definition, suffering and distress are absent. Consider the person who feels extremely elated and may act impulsively as part of a manic episode. As you will see in Chapter 7, one of the major difficulties with this problem is that some people enjoy the manic state so much they are reluctant to begin treatment or stay long in treatment. Thus, defining psychological disorder by distress alone doesn't work, although the concept of distress contributes to a good definition.

The concept of *impairment* is useful, although not entirely satisfactory. For example, many people consider themselves shy or lazy. This doesn't mean that they're abnormal. But if you are so shy that you find it impossible to date or even interact with people and you make every attempt to avoid interactions even though you would like to have friends, then your social functioning is impaired.

Judy was clearly impaired by her phobia, but many people with similar, less severe reactions are not impaired. This difference

▲ Distress and suffering are a natural part of life and do not in themselves constitute a psychological disorder.

again illustrates the important point that most psychological disorders are simply extreme expressions of otherwise normal emotions, behaviors, and cognitive processes.

Atypical or Not Culturally Expected

Finally, the criterion that the response be *atypical* or *not culturally expected* is important but also insufficient to determine abnormality by itself. At times, something is considered abnormal because it occurs infrequently; it deviates from the average. The greater the deviation, the more abnormal it is. You might say that someone is abnormally short or abnormally tall, meaning that the person's height deviates substantially from average, but this obviously isn't a definition of disorder. Many people are far from the average in their behavior, but few would be considered disordered. We might call them talented or eccentric. Many artists, movie stars, and athletes fall in this category. For example, it's not normal to plan to have blood spurt from your clothes, but when Lady Gaga did this while performing it only enhanced her celebrity. The late novelist J. D. Salinger, who wrote *The Catcher in the Rye,* retreated to a small town in New Hampshire and refused to see any outsiders for years, but he continued to write. Some male rock singers wear heavy makeup on stage. These people are well paid and seem to enjoy their careers. In most cases, the more productive you are in the eyes of society, the more eccentricities society will tolerate. Therefore, "deviating from the average" doesn't work well as a definition for abnormal behavior.

Another view is that your behavior is abnormal if you are violating social norms, even if a number of people are sympathetic to your point of view. This definition is useful in considering important cultural differences in psychological disorders. For example, to enter a trance state and believe you are possessed reflects a psychological disorder in most Western cultures but not in many other societies, where the behavior is accepted and expected (see Chapter 6). (A cultural perspective is an important point of reference throughout this book.) An informative example of this view is provided by Robert Sapolsky (2002), the prominent neuroscientist who, during his studies, worked closely with the Masai people in East Africa. One day, Sapolsky's Masai friend Rhoda asked him to bring his vehicle as quickly as possible to the Masai village where a woman had been acting aggressively and had been hearing voices. The woman had actually killed a goat with her own hands. Sapolsky and several Masai were able to subdue her and transport her to a local health center. Realizing that this was an opportunity to learn more of the Masai's view of psychological disorders, Sapolsky had the following discussion:

> "So, Rhoda," I began laconically, "what do you suppose was wrong with that woman?"
>
> She looked at me as if I was mad.
>
> "She is crazy."
>
> "But how can you tell?"
>
> "She's crazy. Can't you just see from how she acts?"
>
> "But how do you decide that she is crazy? What did she do?"
>
> "She killed that goat."
>
> "Oh," I said with anthropological detachment, "but Masai kill goats all the time."
>
> She looked at me as if I were an idiot. "Only the men kill goats," she said.
>
> "Well, how else do you know that she is crazy?"
>
> "She hears voices."
>
> Again, I made a pain of myself. "Oh, but the Masai hear voices sometimes." (At ceremonies before long cattle drives, the Masai trance-dance and claim to hear voices.) And in one sentence, Rhoda summed up half of what anyone needs to know about cross-cultural psychiatry.
>
> "But she hears voices at the wrong time." (p. 138)

A social standard of *normal* has been misused, however. Consider, for example, the practice of committing political dissidents to mental institutions because they protest the policies of their government, which was common in Iraq before the fall of Saddam Hussein and now occurs in Iran. Although such dissident behavior clearly violated social norms, it should not alone be cause for commitment.

Jerome Wakefield (1999, 2009), in a thoughtful analysis of the matter, uses the shorthand definition of harmful dysfunction. A related concept that is also useful is to determine whether the behavior is out of the individual's control (something the person doesn't want to do) (Widiger & Crego, 2013; Widiger & Sankis, 2000). Variants of these approaches are most often used in current diagnostic practice, as outlined in the fifth edition of the *Diagnostic and Statistical Manual* (American Psychiatric Association,

Christopher Polk/Getty Images

▲ We accept extreme behaviors by entertainers, such as Lady Gaga, that would not be tolerated in other members of our society.

2013), which contains the current listing of criteria for psychological disorders (Stein et al., 2010). These approaches guide our thinking in this book.

An Accepted Definition

In conclusion, it is difficult to define "normal" and "abnormal" (Lilienfeld & Marino, 1995, 1999)—and the debate continues (Houts, 2001; McNally, 2011; Stein et al., 2010; Spitzer, 1999; Wakefield, 2003, 2009). The most widely accepted definition used in *DSM-5* describes behavioral, psychological, or biological dysfunctions that are unexpected in their cultural context and associated with present distress and impairment in functioning, or increased risk of suffering, death, pain, or impairment. This definition can be useful across cultures and subcultures if we pay careful attention to what is functional or dysfunctional (or out of control) in a given society. But it is never easy to decide what represents dysfunction, and some scholars have argued persuasively that the health professions will never be able to satisfactorily define *disease* or *disorder* (see, for example, Lilienfeld & Marino, 1995, 1999; McNally, 2011; Stein et al., 2010). The best we may be able to do is to consider how the apparent disease or disorder matches a "typical" profile of a disorder—for example, major depression or schizophrenia—when most or all symptoms that experts would agree are part of the disorder are present. We call this typical profile a *prototype,* and, as described in Chapter 3, the diagnostic criteria from *DSM-IV-TR* as well as the emerging criteria for *DSM-5* found throughout this book are all prototypes. This means that the patient may have only some features or symptoms of the disorder (a minimum number) and still meet criteria for the disorder because his or her set of symptoms is close to the prototype. But one of the differences between *DSM-IV* and *DSM-5* is the addition of dimensional estimates of the severity of specific disorders in *DSM-5* (American Psychiatric Association, 2013; Regier et al., 2009; Helzer et al. 2008). Thus, for the anxiety disorders for example, the intensity and frequency of anxiety within a given disorder such as panic disorder is rated on a 0 to 4 scale where a rating of 1 would indicate mild or occasional symptoms and a rating of 4 would indicate continual and severe symptoms (Beesdo-Baum et al., 2012; LeBeau et al., 2012). These concepts are described more fully in Chapter 3, where the diagnosis of psychological disorders is discussed.

For a final challenge, take the problem of defining abnormal behavior a step further and consider this: What if Judy passed out so often that after a while neither her classmates nor her teachers even noticed because she regained consciousness quickly? Furthermore, what if Judy continued to get good grades? Would fainting all the time at the mere thought of blood be a disorder? Would it be impairing? Dysfunctional? Distressing? What do you think?

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▲ Some religious behaviors may seem unusual to us but are culturally or individually appropriate.

The Science of Psychopathology

Psychopathology is the scientific study of psychological disorders. Within this field are specially trained professionals, including clinical and counseling psychologists, psychiatrists, psychiatric social workers, and psychiatric nurses, as well as marriage and family therapists and mental health counselors. *Clinical psychologists* and *counseling psychologists* receive the Ph.D. degree (or sometimes an Ed.D., doctor of education, or Psy.D., doctor of psychology) and follow a course of graduate-level study lasting approximately 5 years, which prepares them to conduct research into the causes and treatment of psychological disorders and to diagnose, assess, and treat these disorders. Although there is a great deal of overlap, counseling psychologists tend to study and treat adjustment and vocational issues encountered by relatively healthy individuals, and clinical psychologists usually concentrate on more severe psychological disorders. Also, programs in professional schools of psychology, where the degree is often a Psy.D., focus on clinical training and de-emphasize or eliminate research training. In contrast, Ph.D. programs in universities integrate clinical and research training. Psychologists with other specialty training, such as experimental and social psychologists, concentrate on investigating the basic determinants of behavior but do not assess or treat psychological disorders.

Psychiatrists first earn an M.D. degree in medical school and then specialize in psychiatry during residency training that lasts 3 to 4 years. Psychiatrists also investigate the nature and causes of psychological disorders, often from a biological point of view; make diagnoses; and offer treatments. Many psychiatrists emphasize drugs or other biological treatments, although most use psychosocial treatments as well.

Psychiatric social workers typically earn a master's degree in social work as they develop expertise in collecting information relevant to the social and family situation of the individual with a psychological disorder. Social workers also treat disorders, often concentrating on family problems associated with them. *Psychiatric nurses* have advanced degrees, such as a master's or even a Ph.D., and specialize in the care and treatment of patients with psychological disorders, usually in hospitals as part of a treatment team.

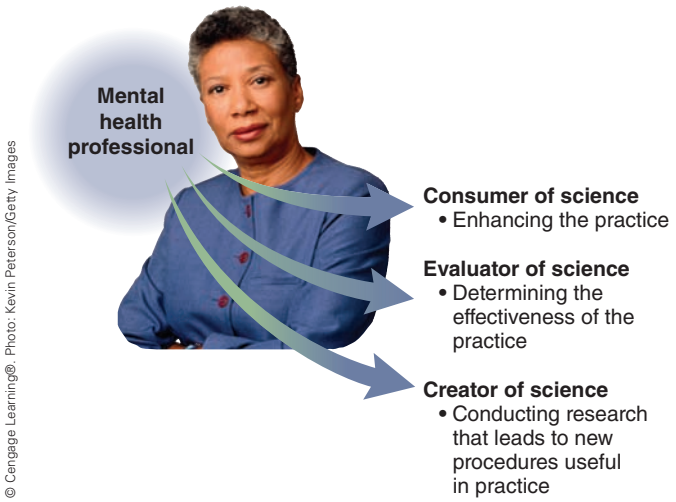
Finally, *marriage and family therapists* and *mental health counselors* typically spend 1–2 years earning a master's degree and are employed to provide clinical services by hospitals or clinics, usually under the supervision of a doctoral-level clinician.

The Scientist-Practitioner

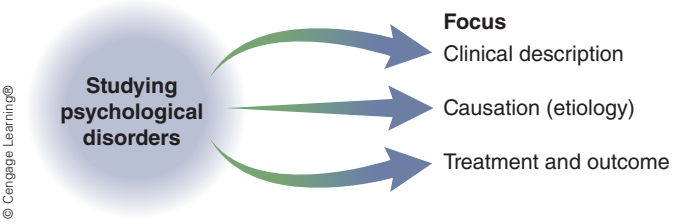
The most important development in the recent history of psychopathology is the adoption of scientific methods to learn more about the nature of psychological disorders, their causes, and their treatment. Many mental health professionals take a scientific approach to their clinical work and therefore are called **scientist-practitioners** (Barlow, Hayes, & Nelson, 1984; Hayes, Barlow, & Nelson-Gray, 1999). Mental health practitioners may function as scientist-practitioners in one or more of three ways (see ● Figure 1.2). First, they may keep up with the latest scientific developments in their field and therefore use the most current diagnostic and treatment procedures. In this sense, they are consumers of the science of psychopathology to the advantage of their patients. Second, scientist-practitioners evaluate their own assessments or treatment procedures to see whether they work. They are accountable not only to their patients but also to the government agencies and insurance companies that pay for the treatments, so they must demonstrate clearly that their treatments work. Third, scientist-practitioners might conduct research, often in clinics or hospitals, that produces new information about disorders or their treatment, thus becoming immune to the fads that plague our field, often at the expense of patients and their families. For example, new "miracle cures" for psychological disorders that are reported several times a year in popular media would not be used by a scientist-practitioner if there were no sound scientific data showing that they work. Such data flow from research that attempts three basic things: to describe psychological disorders, to determine their causes, and to treat them (see ● Figure 1.3). These three categories compose an organizational structure that recurs throughout this book and that is formally evident in the discussions of specific disorders beginning in Chapter 5. A general overview of them now will give you a clearer perspective on our efforts to understand abnormality.

Clinical Description

In hospitals and clinics, we often say that a patient "presents" with a specific problem or set of problems or we discuss the **presenting problem**. *Presents* is a traditional shorthand way of indicating why the person came to the clinic. Describing Judy's presenting



● **FIGURE 1.2** Functioning as a scientist-practitioner.



● **FIGURE 1.3** Three major categories make up the study and discussion of psychological disorders.

problem is the first step in determining her **clinical description**, which represents the unique combination of behaviors, thoughts, and feelings that make up a specific disorder. The word *clinical* refers both to the types of problems or disorders that you would find in a clinic or hospital and to the activities connected with assessment and treatment. Throughout this text are excerpts from many more individual cases, most of them from our personal files.

Clearly, one important function of the clinical description is to specify what makes the disorder different from normal behavior or from other disorders. Statistical data may also be relevant.

For example, how many people in the population as a whole have the disorder? This figure is called the **prevalence** of the disorder. Statistics on how many new cases occur during a given period, such as a year, represent the **incidence** of the disorder. Other statistics include the *sex ratio*—that is, what percentage of males and females have the disorder—and the typical age of onset, which often differs from one disorder to another.

In addition to having different symptoms, age of onset, and possibly a different sex ratio and prevalence, most disorders follow a somewhat individual pattern, or **course.** For example, some disorders, such as schizophrenia (see Chapter 13), follow a *chronic course,* meaning that they tend to last a long time, sometimes a lifetime. Other disorders, like mood disorders (see Chapter 7), follow an *episodic course,* in that the individual is likely to recover within a few months only to suffer a recurrence of the disorder at a later time. This pattern may repeat throughout a person's life. Still other disorders may have a *time-limited course,* meaning the disorder will improve without treatment in a relatively short period.

Closely related to differences in course of disorders are differences in onset. Some disorders have an *acute onset,* meaning that they begin suddenly; others develop gradually over an extended period, which is sometimes called an *insidious onset.* It is important to know the typical course of a disorder so that we can know what to expect in the future and how best to deal with the problem. This is an important part of the clinical description. For example, if someone is suffering from a mild disorder with acute onset that we know is time limited, we might advise the individual not to bother with expensive treatment because the problem will be over soon enough, like a common cold. If the disorder is likely to last a long time (become chronic), however, the individual might want to seek treatment and take other appropriate steps. The anticipated course of a disorder is called the **prognosis**. So we might say, "the prognosis is good," meaning the individual will probably recover, or "the prognosis is guarded," meaning the probable outcome doesn't look good.

The patient's age may be an important part of the clinical description. A specific psychological disorder occurring in childhood may present differently from the same disorder in adulthood or old age. Children experiencing severe anxiety and panic often assume that they are physically ill because they have difficulty understanding that there is nothing physically wrong. Because their thoughts and feelings are different from those experienced by adults with anxiety and panic, children are often misdiagnosed and treated for a medical disorder.

We call the study of changes in behavior over time *developmental psychology,* and we refer to the study of changes in abnormal behavior as *developmental psychopathology.* When you think of developmental psychology, you probably picture researchers studying the behavior of children. We change throughout our lives, however, and so researchers also study development in adolescents, adults, and older adults. Study of abnormal behavior across the entire age span is referred to as *life-span developmental psychopathology.* The field is relatively new but expanding rapidly.

Causation, Treatment, and Etiology Outcomes

Etiology, or the study of origins, has to do with why a disorder begins (what causes it) and includes biological, psychological, and social dimensions. Because the etiology of psychological disorders is so important to this field, we devote an entire chapter (Chapter 2) to it.

Treatment, also, is often important to the study of psychological disorders. If a new drug or psychosocial treatment is successful in treating a disorder, it may give us some hints about the nature of the disorder and its causes. For example, if a drug with a specific known effect within the nervous system alleviates a certain psychological disorder, we know that something in that part of the nervous system might either be causing the disorder or helping maintain it. Similarly, if a psychological treatment designed to help clients regain a sense of control over their lives is effective with a certain disorder, a diminished sense of control may be an important psychological component of the disorder itself.

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▲ Children experience panic and anxiety differently from adults, so their reactions may be mistaken for symptoms of physical illness.

As you will see in the next chapter, psychopathology is rarely simple. This is because the *effect* does not necessarily imply the *cause.* To use a common example, you might take an aspirin to relieve a tension headache you developed during a grueling day of taking exams. If you then feel better, that does not mean that the headache was caused by a lack of aspirin. Nevertheless, many people seek treatment for psychological disorders, and treatment can provide interesting hints about the nature of the disorder.

In the past, textbooks emphasized treatment approaches in a general sense, with little attention to the disorder being treated. For example, a mental health professional might be thoroughly trained in a single theoretical approach, such as psychoanalysis or behavior therapy (both described later in the chapter), and then use that approach on every disorder. More recently, as our science has advanced, we have developed specific effective treatments that do not always adhere neatly to one theoretical approach or another but that have grown out of a deeper understanding of the disorder in question. For this reason, there are no separate chapters in this book on such types of treatment approaches as psychodynamic, cognitive behavioral, or humanistic. Rather, the latest and most effective drug and psychosocial treatments (nonmedical treatments that focus on psychological, social, and cultural factors) are described in the context of specific disorders in keeping with our integrative multidimensional perspective.

We now survey many early attempts to describe and treat abnormal behavior and to comprehend its causes, which will give you a better perspective on current approaches. In Chapter 2, we examine exciting contemporary views of causation and treatment. In Chapter 3, we discuss efforts to describe, or classify, abnormal behavior. In Chapter 4, we review research methods—our systematic efforts to discover the truths underlying description, cause, and treatment that allow us to function as scientist-practitioners. In Chapters 5 through 15, we examine specific disorders; our discussion is organized in each case in the now familiar triad of description, cause, and treatment. Finally, in Chapter 16 we examine legal, professional, and ethical issues relevant to psychological disorders and their treatment today. With that overview in mind, let us turn to the past.

Historical Conceptions of Abnormal Behavior

For thousands of years, humans have tried to explain and control problematic behavior. But our efforts always derive from the theories or models of behavior popular at the time. The purpose of these models is to explain why someone is "acting like that." Three major models that have guided us date back to the beginnings of civilization.

Humans have always supposed that agents outside our bodies and environment influence our behavior, thinking, and emotions. These agents—which might be divinities, demons, spirits, or other phenomena such as magnetic fields or the moon or the

stars—are the driving forces behind the *supernatural model.* In addition, since the era of ancient Greece, the mind has often been called the *soul* or the *psyche* and considered separate from the body. Although many have thought that the mind can influence the body and, in turn, the body can influence the mind, most philosophers looked for causes of abnormal behavior in one or the other. This split gave rise to two traditions of thought about abnormal behavior, summarized as the *biological model* and the *psychological model.* These three models—the supernatural, the biological, and the psychological—are very old but continue to be used today.

Concept Check 1.1

Part A

Write the letter for any or all of the following definitions of abnormality in the blanks: (a) societal norm violation, (b) impairment in functioning, (c) dysfunction, and (d) distress.

1. Miguel recently began feeling sad and lonely. Although still able to function at work and fulfill other responsibilities, he finds himself feeling down much of the time and he worries about what is happening to him. Which of the definitions of abnormality apply to Miguel's situation? _____
2. Three weeks ago, Jane, a 35-year-old business executive, stopped showering, refused to leave her apartment, and started watching television talk shows. Threats of being fired have failed to bring Jane back to reality, and she continues to spend her days staring blankly at the television screen. Which of the definitions seems to describe Jane's behavior? _____

Part B

Match the following words that are used in clinical descriptions with their corresponding examples: (a) presenting problem, (b) prevalence, (c) incidence, (d) prognosis, (e) course, and (f) etiology.

3. Maria should recover quickly with no intervention necessary. Without treatment, John will deteriorate rapidly. _____
4. Three new cases of bulimia have been reported in this county during the past month and only one in the next county. _____
5. Elizabeth visited the campus mental health center because of her increasing feelings of guilt and anxiety. _____
6. Biological, psychological, and social influences all contribute to a variety of disorders. _____
7. The pattern a disorder follows can be chronic, time limited, or episodic. _____
8. How many people in the population as a whole suffer from obsessive-compulsive disorder? _____

The Supernatural Tradition

For much of our recorded history, deviant behavior has been considered a reflection of the battle between good and evil. When confronted with unexplainable, irrational behavior and by suffering and upheaval, people have perceived evil. In fact, in the Great Persian Empire from 900 to 600 B.C., all physical and mental disorders were considered the work of the devil (Millon, 2004). Barbara Tuchman, a noted historian, chronicled the second half of the 14th century, a particularly difficult time for humanity, in *A Distant Mirror* (1978). She ably captures the conflicting tides of opinion on the origins and treatment of insanity during that bleak and tumultuous period.

Demons and Witches

One strong current of opinion put the causes and treatment of psychological disorders squarely in the realm of the supernatural. During the last quarter of the 14th century, religious and lay authorities supported these popular superstitions and society as a whole began to believe more strongly in the existence and power of demons and witches. The Catholic Church had split, and a second center, complete with a pope, emerged in the south of France to compete with Rome. In reaction to this schism, the Roman Church fought back against the evil in the world that it believed must have been behind this heresy.

People increasingly turned to magic and sorcery to solve their problems. During these turbulent times, the bizarre behavior of people afflicted with psychological disorders was seen as the work of the devil and witches. It followed that individuals possessed by evil spirits were probably responsible for any misfortune experienced by people in the local community, which inspired drastic action against the possessed. Treatments included **exorcism**, in which various religious rituals were performed in an effort to rid the victim of evil spirits. Other approaches included shaving the pattern of a cross in the hair of the victim's head and securing sufferers to a wall near the front of a church so that they might benefit from hearing Mass.

The conviction that sorcery and witches are causes of madness and other evils continued into the 15th century, and evil continued to be blamed for unexplainable behavior, even after the founding of the United States, as evidenced by the Salem, Massachusetts, witch trials in the late 17th century.

Stress and Melancholy

An equally strong opinion, even during this period, reflected the enlightened view that insanity was a natural phenomenon, caused by mental or emotional stress, and that it was curable (Alexander & Selesnick, 1966; Maher & Maher, 1985a). Mental depression and anxiety were recognized as illnesses (Kemp, 1990; Schoeneman, 1977), although symptoms such as despair and lethargy were often identified by the church with the sin of *acedia,* or sloth (Tuchman, 1978). Common treatments were rest, sleep, and a healthy and happy environment. Other treatments included baths, ointments, and various potions. Indeed, during the 14th and 15th centuries, people with insanity, along with those with physical deformities or disabilities, were often moved from house to house in medieval villages as neighbors

▲ During the Middle Ages, individuals with psychological disorders were sometimes thought to be possessed by evil spirits and exorcisms were attempted through rituals.

took turns caring for them. We now know that this medieval practice of keeping people who have psychological disturbances in their own community is beneficial (see Chapter 13). (We return to this subject when we discuss biological and psychological models later in this chapter.)

In the 14th century, one of the chief advisers to the king of France, a bishop and philosopher named Nicholas Oresme, also suggested that the disease of melancholy (depression) was the source of some bizarre behavior, rather than demons. Oresme pointed out that much of the evidence for the existence of sorcery and witchcraft, particularly among those considered insane, was obtained from people who were tortured and who, quite understandably, confessed to anything.

These conflicting crosscurrents of natural and supernatural explanations for mental disorders are represented more or less strongly in various historical works, depending on the sources consulted by historians. Some assumed that demonic influences were the predominant explanations of abnormal behavior during the Middle Ages (for example, Zilboorg & Henry, 1941); others believed that the supernatural had little or no influence. As we see in the handling of the severe psychological disorder experienced by late-14th-century King Charles VI of France, both influences were strong, sometimes alternating in the treatment of the same case.

CHARLES VI... The Mad King

In the summer of 1392, King Charles VI of France was under a great deal of stress, partly because of the division of the Catholic Church. As he rode with his army to the province of Brittany, a nearby aide dropped his lance with a loud clatter and the king, thinking he was under attack, turned on his own army, killing several prominent knights before being subdued from behind. The army immediately marched back to Paris. The king's lieutenants and advisers concluded that he was mad.

During the following years, at his worst the king hid in a corner of his castle believing he was made of glass or roamed the corridors howling like a wolf. At other times he couldn't remember who or what he was. He became fearful and enraged whenever he saw his own royal coat of arms and would try to destroy it if it was brought near him.

The people of Paris were devastated by their leader's apparent madness. Some thought it reflected God's anger, because the king failed to take up arms to end the schism in the Catholic Church; others thought it was God's warning against taking up arms; and still others thought it was divine punishment for heavy taxes (a conclusion some people might make today). But most thought the king's madness was caused by sorcery, a belief strengthened by a great drought that dried up the ponds and rivers, causing cattle to die of thirst. Merchants claimed their worst losses in 20 years.

Naturally, the king was given the best care available at the time. The most famous healer in the land was a 92-year-old physician whose treatment program included moving the king to one of his residences in the country where the air was thought to be the cleanest in the land. The physician prescribed rest, relaxation, and recreation. After some time, the king seemed to recover. The physician recommended that the king not be burdened with the responsibilities of running the kingdom, claiming that if he had few worries or irritations, his mind would gradually strengthen and further improve.

Unfortunately, the physician died and the insanity of King Charles VI returned more seriously than before. This time, however, he came under the influence of the conflicting crosscurrent of supernatural causation. "An unkempt evil-eyed charlatan and pseudo-mystic named Arnaut Guilhem was allowed to treat Charles on his claim of possessing a book given by God to Adam by means of which man could overcome all affliction resulting from original sin" (Tuchman, 1978, p. 514). Guilhem insisted that the king's malady was caused by sorcery, but his treatments failed to bring about a cure.

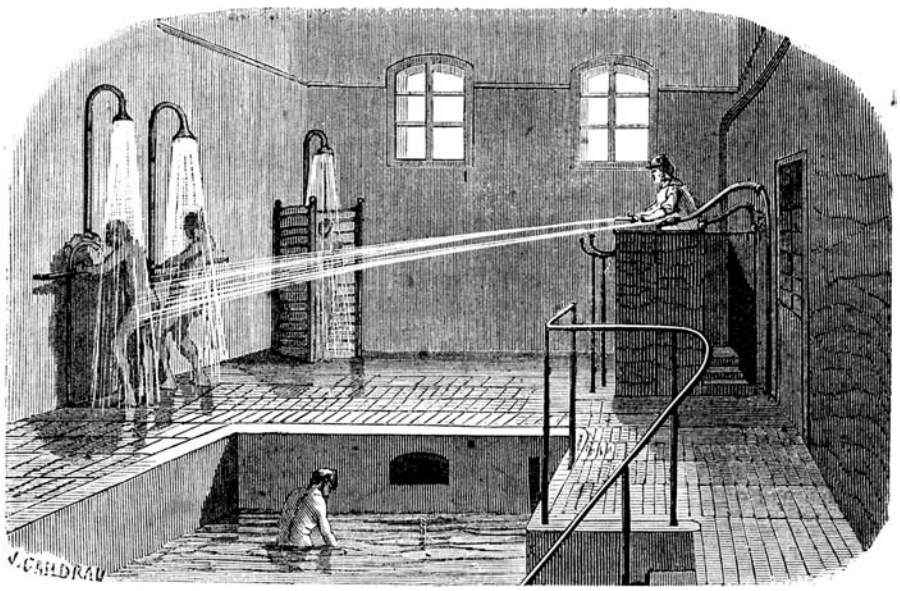
A variety of remedies and rituals of all kinds were tried, but none worked. High-ranking officials and doctors of the university called for the "sorcerers" to be discovered and punished. "On one occasion, two Augustinian friars, after getting no results from magic incantations and a liquid made from powdered pearls, proposed to cut incisions in the king's head. When this was not allowed by the king's council, the friars accused those who opposed their recommendation of sorcery" (Tuchman, 1978, p. 514). Even the king himself, during his lucid moments, came to believe that the source of madness was evil and sorcery. "In the name of Jesus Christ," he cried, weeping in his agony, "if there is any one of you who is an accomplice to this evil I suffer, I beg him to torture me no longer but let me die!" (Tuchman, 1978, p. 515). ●

Treatments for Possession

With a perceived connection between evil deeds and sin on the one hand and psychological disorders on the other, it is logical to conclude that the sufferer is largely responsible for the disorder, which might well be a punishment for evil deeds. Does this sound familiar? The acquired immune deficiency syndrome (AIDS) epidemic was associated with a similar belief among some people, particularly in the late 1980s and early 1990s. Because the human immunodeficiency virus (HIV) is, in Western societies, most prevalent among individuals with homosexual orientation, many people believed it was a divine punishment for what they considered immoral behavior. This view became less common as the AIDS virus spread to other segments of the population, yet it persists.

Possession, however, is not always connected with sin but may be seen as involuntary and the possessed individual as blameless. Furthermore, exorcisms at least have the virtue of being relatively painless. Interestingly, they sometimes work, as do other forms of faith healing, for reasons we explore in subsequent chapters. But what if they did not? In the Middle Ages, if exorcism failed, some authorities thought that steps were necessary to make the body uninhabitable by evil spirits, and many people were subjected to confinement, beatings, and other forms of torture (Kemp, 1990).

Somewhere along the way, a creative "therapist" decided that hanging people over a pit full of poisonous snakes might scare the evil spirits right out of their bodies (to say nothing of terrifying the people themselves). Strangely, this approach sometimes worked; that is, the most disturbed, oddly behaving individuals would suddenly come to their senses and experience relief from their symptoms, if only temporarily. Naturally, this was reinforcing to the therapist, so snake pits were built in many institutions. Many other treatments based on the hypothesized therapeutic element of shock were developed, including dunkings in ice-cold water.



▲ In hydrotherapy, patients were shocked back to their senses by applications of ice-cold water.

Mass Hysteria

Another fascinating phenomenon is characterized by large-scale outbreaks of bizarre behavior. To this day, these episodes puzzle historians and mental health practitioners. During the Middle Ages, they lent support to the notion of possession by the devil. In Europe, whole groups of people were simultaneously compelled to run out in the streets, dance, shout, rave, and jump around in patterns as if they were at a particularly wild party late at night (still called a *rave* today, but with music). This behavior was known by several names, including Saint Vitus's Dance and tarantism. It is most interesting that many people behaved in this strange way at once. In an attempt to explain the inexplicable, several reasons were offered in addition to possession. One reasonable guess was reaction to insect bites. Another possibility was what we now call *mass hysteria.* Consider the following example.

Modern Mass Hysteria

One Friday afternoon an alarm sounded over the public address system of a community hospital calling all physicians to the emergency room immediately. Arriving from a local school in a fleet of ambulances were 17 students and 4 teachers who reported dizziness, headache, nausea, and stomach pains. Some were vomiting; most were hyperventilating.

All the students and teachers had been in four classrooms, two on each side of the hallway. The incident began when a 14-year-old girl reported a funny smell that seemed to be coming from a vent. She fell to the floor, crying and complaining that her stomach hurt and her eyes stung. Soon, many of the students and most of the teachers in the four adjoining classrooms, who could see and hear what was happening, experienced similar symptoms. Of 86 susceptible people (82 students and 4 teachers in the four classrooms), 21 patients (17 students and 4 teachers) experienced symptoms severe enough to be evaluated at the hospital. Inspection of the school building by public health authorities revealed no apparent cause for the reactions, and physical examinations by teams of physicians revealed no physical abnormalities. All the patients were sent home and quickly recovered (Rockney & Lemke, 1992).

Mass hysteria may simply demonstrate the phenomenon of *emotion contagion,* in which the experience of an emotion seems to spread to those around us (Hatfield, Cacioppo, & Rapson, 1994; Wang, 2006). If someone nearby becomes frightened or sad, chances are that for the moment you also will feel fear or sadness. When this kind of experience escalates into full-blown panic, whole communities are affected (Barlow, 2002). People are also suggestible when they are in states of high emotion. Therefore, if one person identifies a "cause" of the problem, others will probably assume that their own reactions have the same source. In popular language, this shared response is sometimes referred to as *mob psychology.*