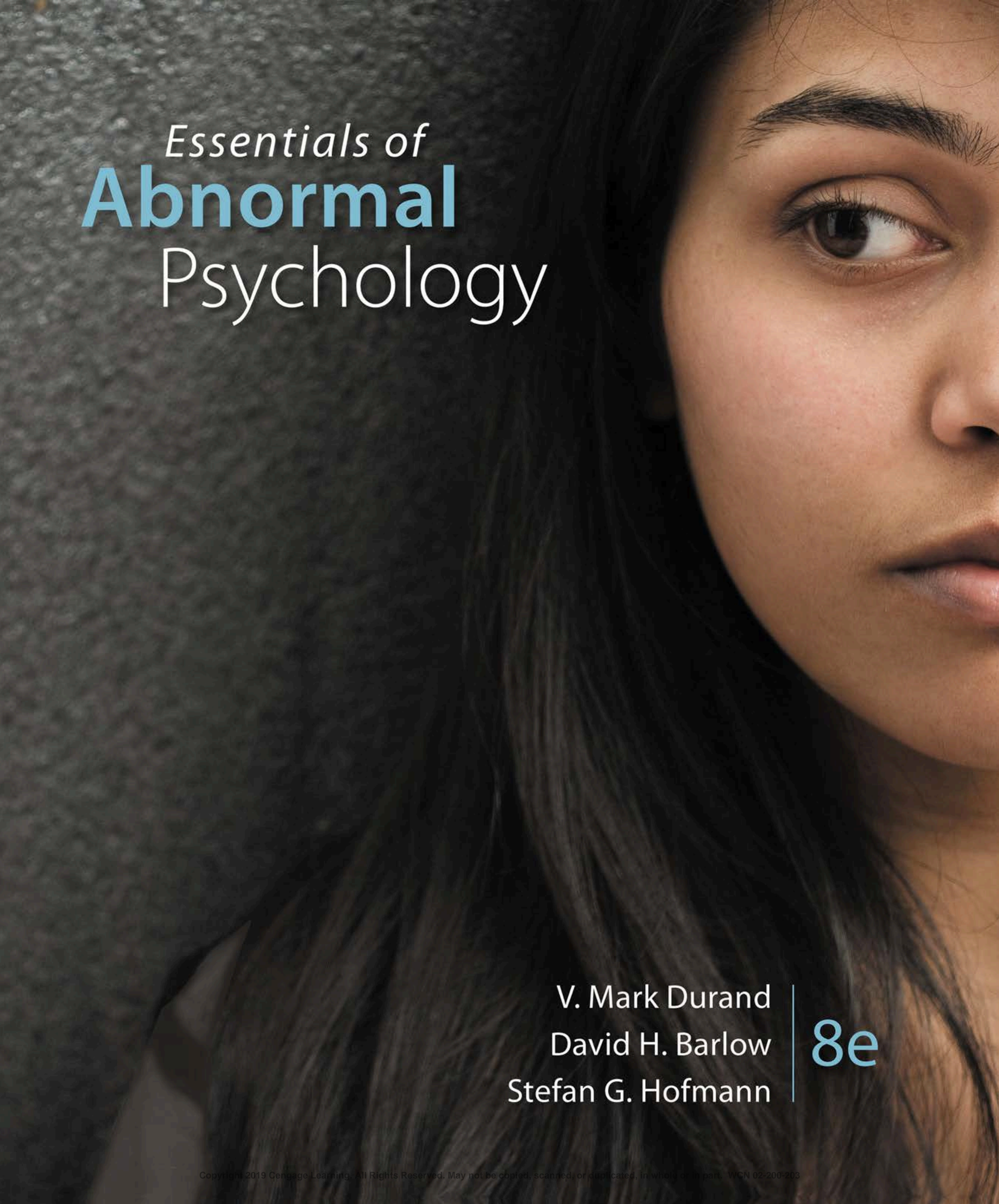

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Essentials of Abnormal Psychology

EIGHTH EDITION

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University of South Florida-St. Petersburg

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Australia • Brazil • Mexico • Singapore • United Kingdom • United States

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

—V. M. D.

To my mother, Doris Elinor Barlow-Lanigan, for her multidimensional influence across my life span.

—D. H. B.

To Benjamin and Lukas for helping me integrate the many dimensions of life.

—S. G. H.

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About the Authors

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 and received the 2015 Jacobson Award for Critical Thinking from the American Psychological Association for his body of work in the field of autism spectrum disorder. Dr. Durand was elected to serve as President of the American Psychological Association's Division 33 (Intellectual and Developmental Disabilities/Autism Spectrum Disorders) for 2019. Dr. Durand is currently a member of the Professional Advisory Board for the Autism Society of America and was on the board of directors of the International Association of Positive Behavioral Support. He was 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 five-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.

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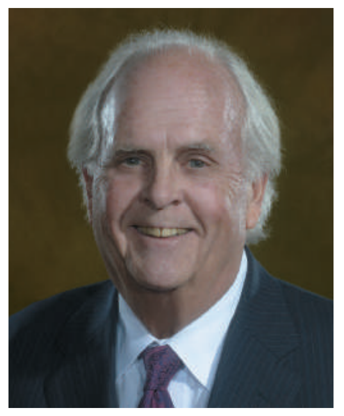
David H. Barlow



David H. Barlow is an internationally recognized pioneer and leader in clinical psychology. Currently Professor Emeritus 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 Medical Center, where he founded the 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." He was awarded an Honorary Doctorate of Science from the University of Vermont, an Honorary Doctorate of Humane Letters from William James College, as well as the C. Charles Burlingame Award from the Institute of Living in Hartford Connecticut "for his outstanding leadership in research, education, and clinical care." In 2014 he was awarded a Presidential Citation from the American Psychological Association "for his lifelong dedication and passion for advancing psychology through science, education, training, and practice."

He also has received career/lifetime contribution awards from the Massachusetts, Connecticut, and California Psychological Associations, as well as the University of Mississippi Medical Center and the Association for Behavioral and Cognitive Therapies. In 2000, he was named Honorary Visiting Professor at the Chinese People's Liberation Army General Hospital and Postgraduate Medical School in Beijing, China, and in 2015 was named Honorary President of the Canadian Psychological Association. In addition, the annual Grand Rounds in Clinical Psychology at Brown University was named in his honor. During the 1997–1998 academic year, he was Fritz Redlich Fellow at the Center for Advanced Study in the Behavioral Sciences in Palo Alto, California. His research has been continually funded by the National Institute of Mental Health for over 40 years.

Dr. Barlow has edited several journals including *Clinical Psychology: Science and Practice* and *Behavior Therapy,* 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 600 scholarly articles and written or edited more than 80 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 Boston University. The books 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

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About the Authors

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 the creation of 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 on Nantucket Island, where he loves to write, walk on the beach, and visit with his island friends.

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Stefan G. Hofmann

Stefan G. Hofmann is an international expert on psychotherapy for emotional disorders. He is a professor of psychology at Boston University, where he directs the Psychotherapy and Emotion Research Laboratory. He was born in a little town near Stuttgart in Germany, which may explain his thick German accent. He studied psychology at the University of Marburg, Germany, where he received his B.A., M.S., and Ph.D. A brief dissertation fellowship to spend some time at Stanford University turned into a longer research career in the United States. He eventually moved to the United States in 1994 to join Dr. Barlow's team at the University at Albany–State University of New York, and has been living in Boston since 1996.

Dr. Hofmann has an actively funded research program studying various aspects of emotional disorders with a particular emphasis on anxiety disorders, cognitive behavioral therapy, and neuroscience. More recently, he has been interested in mindfulness approaches, such as yoga and meditation practices, as treatment strategies of emotional disorders. Furthermore, he has been one of the leaders in translational research methods to enhance the efficacy of psychotherapy and to predict treatment outcome using neuroscience methods.

He has won many prestigious professional awards, including the Aaron T. Beck Award for Significant and Enduring Contributions to the Field of Cognitive Therapy by the Academy of Cognitive Therapy. He is a fellow of the American Psychological Association and the Association for Psychological Science and was president of various national and international professional societies, including the Association for Behavioral and Cognitive Therapies and the International Association for Cognitive Psychotherapy. He was an advisor to the *DSM-5* Development Process and a member of the *DSM-5* Anxiety Disorder Sub-Work Group. As part of this, he participated in the discussions about the revisions of the *DSM-5* criteria for various anxiety disorders, especially social anxiety disorder, panic disorder, and agoraphobia. Dr. Hofmann is a Thomson Reuters' Highly Cited Researcher.

Dr. Hofmann has been the editor in chief of *Cognitive Therapy and Research* and is also the Associate Editor of *Clinical Psychological Science*. He has published more than 300 peer-reviewed journal articles and 15 books, including *An Introduction of Modern CBT* (Wiley-Blackwell) and *Emotion in Therapy* (Guilford Press).

At leisure, he enjoys playing with his sons. He likes traveling to immerse himself into new cultures, make new friends, and reconnect with old ones. When time permits, he occasionally gets out his flute.

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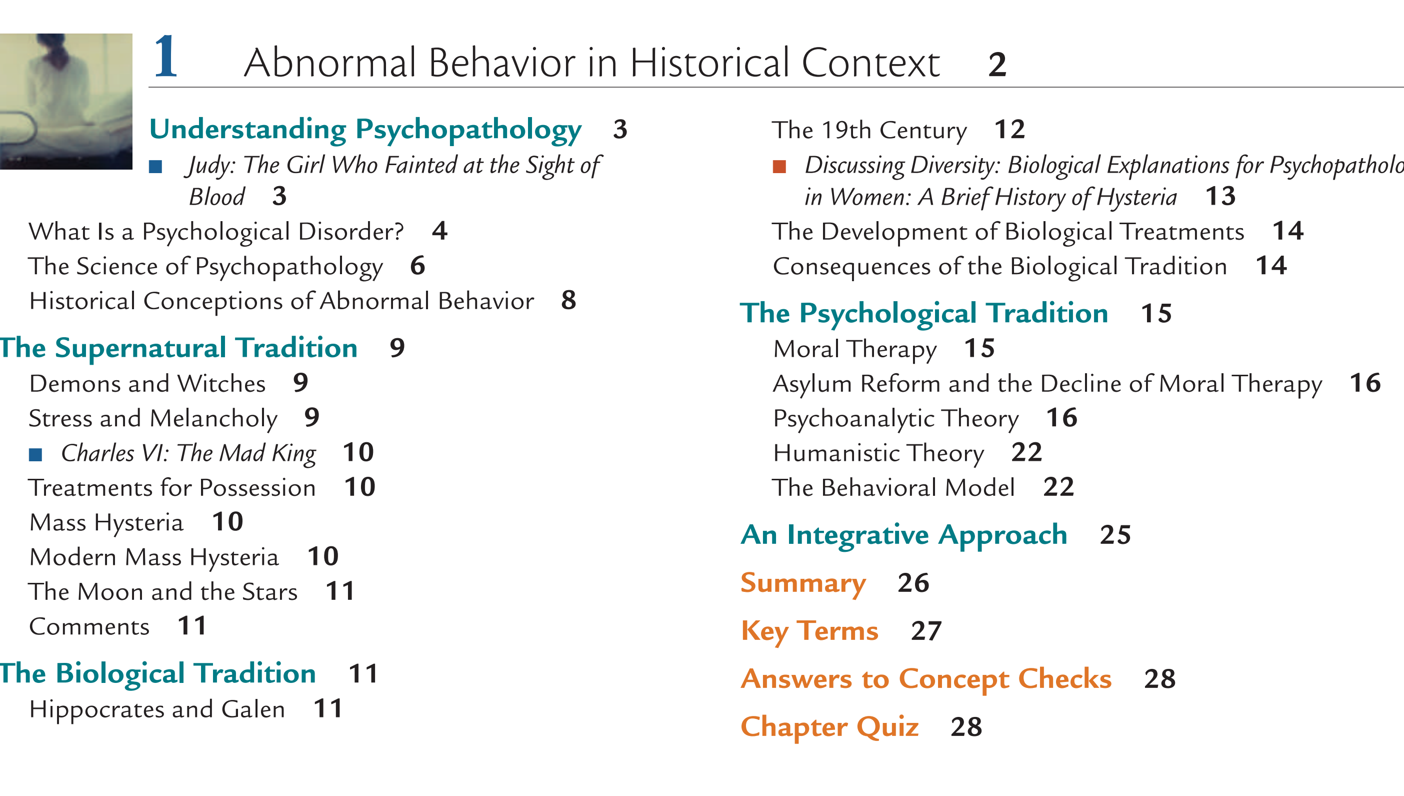

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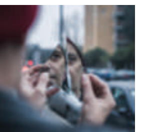

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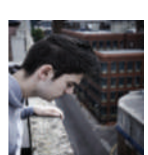

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Preface

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 7 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 *Essentials 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 perspectives on our field.) 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

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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 chapter describing Neurodevelopmental Disorders (Chapter 13), 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 4). 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 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 10 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 several of us were appointed Advisors to the *DSM-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 seven editions was our strategy of 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. This is accomplished both in the narrative and in "Discussing Diversity" boxes throughout the disorders chapters. 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

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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 2015 to 2017 (and some still "in press") appear for the first time in this edition, and some of the information they contain stuns the imagination. Non-essential 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 4), Mood Disorders and Suicide (Chapter 6), Physical Disorders and Health Psychology (Chapter 7), Eating and Sleep–Wake Disorders (Chapter 8), Substance-Related, Addictive, and Impulse-Control Disorders (Chapter 10), Schizophrenia Spectrum and Other Psychotic Disorders (Chapter 12), and Neurodevelopmental Neurocognitive Disorders (Chapter 13) 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; new studies illustrating the psychosocial influence on the development of brain structure and function in general and on neurotransmitter systems specifically; 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, Diagnosis, and Research in Psychopathology 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;) 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 addition, a new example of how behavioral scientists develop research hypotheses is presented 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 4, entitled Anxiety, Trauma- and Stressor-Related, and Obsessive-Compulsive and Related Disorders, is organized according to the three major groups of disorders: anxiety disorders, trauma- and stressor-related disorders, and obsessive-compulsive and related disorders. Two disorders new to *DSM-5* (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). Some of the revisions to Chapter 4 include the following:

- Updated information about the neuroscience and genetics of fear and anxiety;
- Updated information on the relationship of anxiety and related disorders to suicide;
- Updated information on the influence of personality and culture on the expression of anxiety;
- Updated generalized anxiety disorder discussion, especially about newer treatment approaches;
- Updated information on description, etiology, and treatment for specific phobia, social anxiety disorder, and posttraumatic stress disorder.

The grouping of disorders in Chapter 5, titled Somatic Symptom and Related Disorders and Dissociative Disorders, reflects a major overarching change, specifically for somatic symptom disorder, illness anxiety disorder (formerly known as hypochondriasis), and psychological factors affecting medical conditions. The chapter discusses the differences between these overlapping disorders and provides a summary of the causes and treatment approaches of these problems. In addition, Chapter 5 now has an updated discussion on the false memory debate related to trauma in individuals with dissociative identity disorder.

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Chapter 6, Mood Disorders and Suicide, provides an updated discussion on the psychopathology and treatment of the *DSM-5* Mood Disorders, including persistent depressive disorder, seasonal affective disorder, disruptive mood dysregulation disorder, bipolar disorder, and suicide. The chapter discusses new data on the genetic and environmental risk factors and protective factors, such as optimism. Also included is an update on the pharmacological and psychological treatments.

Chapter 7, Physical Disorders and Health Psychology, includes 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 supporting the efficacy of stress management on cardiovascular disease; an updated review of developments into causes and treatment of chronic pain; updated information eliminating certain viruses (XMRV and pMLV) as possible causes of chronic fatigue syndrome; and updated review of psychological and behavioral procedures for preventing injuries.

Thoroughly rewritten and updated, Chapter 8, Eating and Sleep–Wake Disorders, contains new information on mortality and suicide 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 substantial contribution of emotion dysregulation to etiology and maintenance of anorexia, 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 including the role of ovarian hormones, transdiagnostic treatment applicable to all eating disorders, results from a large multinational trial comparing CBT to psychoanalysis in the treatment of bulimia, 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, the phenomenon of night eating syndrome and its role in the development of obesity, and new public health policy developments directed at the obesity epidemic.

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, 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 9 also includes updated information on contributing factors to gender dysphoria as well as the latest recommendations on treatment options, recommended treatment options (or the decision not to treat) for gender non-conformity 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 10, 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 11, 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 12, 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 13 (Neurodevelopmental and Neurocognitive Disorders), the neurodevelopmental disorders are presented, instead of Pervasive Developmental Disorders, to be consistent with the major changes in *DSM-5*. In addition, Chapter 13 now describes new research to show that

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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 13 also 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 discussion of new neurocognitive disorders (e.g., neurocognitive disorder due to Lewy bodies or prion disease).

And Chapter 14, 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.

Additional Features

In addition to the changes highlighted earlier, *Essentials of Abnormal Psychology* features other distinct features:

- *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 a 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 there are controversial views on this. Psychologists and psychiatrists are often concerned about their own specific areas of interest 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.

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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.

MindTap for Durand, Barlow, and Hofmann's *Essentials of Abnormal Psychology*

MindTap is a personalized teaching experience with relevant assignments that guide students to analyze, apply, and improve thinking, allowing you to measure skills and outcomes with ease.

- Guide Students: A unique learning path of relevant readings, media, and activities that moves students up the learning taxonomy from basic knowledge and comprehension to analysis and application.
- Personalized Teaching: Becomes yours with a Learning Path that is built with key student objectives. Control what students see and when they see it. Use it as-is or match to your syllabus exactly—hide, rearrange, add, and create your own content.
- Promote Better Outcomes: Empower instructors and motivate students with analytics and reports that provide a snapshot of class progress, time in course, engagement, and completion rates.
- In addition to the benefits of the platform, MindTap for Durand, Barlow, and Hofmann's *Essentials of Abnormal Psychology* includes:
  - Profiles in Psychopathology, an exciting new product that guides users through the symptoms, causes, and treatments of individuals who live with mental disorders.
  - Videos, assessment, and activities from the *Continuum Video Project*.
  - *Concept Clip Videos* that visually elaborate on specific disorders and psychopathology in a vibrant, engaging manner.
  - Case studies to help students humanize psychological disorders and connect content to the real world.
- Section quizzes aid student understanding.
- Master Training, powered by Cerego, for student personalized learning plans to help them understand and retain key topics and discussions.

Teaching and Learning Aids

Instructor Resource Center

Everything you need for your course in one place! This collection of book-specific lecture and class tools is available online via www.cengage.com/login. Access and download videos, PowerPoint presentations, images, instructor's manual, and more.

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.

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.

Profiles in Psychopathology

In Profiles of Psychopathology, students explore the lives of individuals with mental disorders to better understand the etiology, symptoms, and treatment. Each of the ten modules focuses on one type of disorder. Students learn about six individuals—historical and popular culture figures—and then match the individual to the disorder that best explains their symptoms and causes. The experiences of a real-life person from the population-at-large is also featured, with video footage of that individual discussing their experience with psychopathology.

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.

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PowerPoint

The Online PowerPoints feature lecture outlines and important images from the text.

Titles of Interest

- *DSM-5 Supplement* by Boettcher, Wu, 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: 0534354165
- *Casebook in Abnormal Psychology*, 5th edition, by Timothy A. Brown and David H. Barlow, is a comprehensive casebook fully updated to be consistent with *DSM-5* 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: 9781305971714.

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Numerous colleagues and students provided superb feedback on the previous editions, and to them we express our deepest gratitude. Although not all comments were favorable, all were important. Readers who take the time to communicate their thoughts offer the greatest reward to writers and scholars.

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.

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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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1 Abnormal Behavior in Historical Context

CHAPTER OUTLINE

Understanding Psychopathology
- What Is a Psychological Disorder?
- The Science of Psychopathology
- Historical Conceptions of Abnormal Behavior

The Supernatural Tradition
- Demons and Witches
- Stress and Melancholy
- Treatments for Possession
- Mass Hysteria
- Modern Mass Hysteria
- The Moon and the Stars
- Comments

The Biological Tradition
- Hippocrates and Galen
- The 19th Century
- The Development of Biological Treatments
- Consequences of the Biological Tradition

The Psychological Tradition
- Moral Therapy
- Asylum Reform and the Decline of Moral Therapy
- Psychoanalytic Theory
- Humanistic Theory
- The Behavioral Model

An Integrative Approach

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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 1.1b) (*see textbook pages 3–6, 22–25*) ▶ Use basic psychological terminology, concepts, and theories in psychology to explain behavior and mental processes (APA SLO 1.1a) *(see textbook pages 3–5, 7–13, 16–20, 22–26)*
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 1.2c) *(see textbook pages 8–27, 30–31)* ▶ Identify key characteristics of major content domains in psychology (e.g., cognition and learning, developmental, biological, and sociocultural) (APA SLO 1.2a) *(see textbook pages 3–5, 11–25)*
Use scientific reasoning to interpret behavior	▶ See APA SLO 1.1b listed above ▶ Incorporate several appropriate levels of complexity (e.g., cellular, individual, group/system, society/cultural) to explain behavior (APA SLO 2.1c) *(see textbook pages 8–9, 11–16, 18–26)*

* Portions of this chapter cover learning outcomes suggested by the American Psychological Association (2013) 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

- How do psychologists define a psychological disorder?
- What is a scientist–practitioner?

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.

This was a graphic film, with vivid images of blood, tissue, and muscle. About halfway through, Judy felt lightheaded and left the room. But the images did not leave her. She continued to be bothered by them and occasionally felt queasy. She began to avoid situations in which she might see blood or injury. She found it difficult to look at raw meat, or even Band-Aids, because they brought the feared images to mind. Eventually, anything anyone 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 fainted when she unavoidably encountered something bloody. Physicians could find nothing wrong with her. 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 and disruptive; each time Judy fainted, the other students flocked around her, trying to help, and class was interrupted. 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 severe, thereby meeting the criteria for **phobia**, a psychological disorder characterized by marked and persistent fear of an object

psychological disorder Psychological dysfunction associated with distress or impairment in functioning that is not a typical or culturally expected response.

phobia A psychological disorder characterized by marked and persistent fear of an object or situation.

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or situation. But many people have similar reactions that are not as severe when they receive an injection or see someone who is injured. 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.

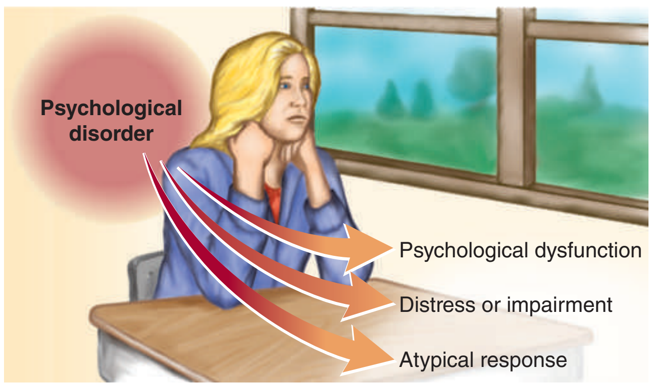
What Is a Psychological Disorder?

A psychological disorder, or problematic **abnormal behavior**, is a psychological dysfunction that is associated with distress or impairment in functioning and a response that is not typical or culturally expected (see ● Figure 1.1). These three criteria may seem obvious, but they were not easily arrived at and it is worth a moment to explore what they mean.

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, even though there is nothing to be afraid of, and the fear happens on every date, your emotions are not functioning properly. However, if your friends agree that the person who asked you out is unpredictable and dangerous in some way, it would not be dysfunctional to be fearful.

A dysfunction was clearly present for Judy. But many people experience a mild version of this reaction (feeling queasy at the sight of blood) without meeting the criteria for the disorder. Drawing the line between normal and abnormal dysfunction is often difficult. For this reason, these problems are often considered to be on a continuum rather than either present or absent (McNally, 2011; 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.

Distress or Impairment

That the behavior must be associated with distress to be classified as a disorder seems clear: The criterion is satisfied if the individual is extremely upset. We can certainly say that Judy was distressed. But remember, by itself this criterion does not define problematic **abnormal behavior**. It is often normal to be distressed—for example, if someone close to you dies. Suffering and distress are part of life. Furthermore, for some disorders, by definition, suffering and distress are absent. Consider the person who feels elated and acts impulsively as part of a manic episode. As you will see in Chapter 6, one of the major difficulties with this problem is that some people enjoy the manic state so much they are reluctant to receive treatment for it. Thus, defining psychological disorder by distress alone doesn't work.

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

Judy was clearly impaired by her phobia, but many people with less severe reactions are not impaired. This difference again illustrates the important point that most psychological disorders are extreme expressions of otherwise normal emotions, behaviors, and cognitive processes.

Atypical or Not Culturally Expected

The criterion that the response be *atypical* or *not culturally expected* is also insufficient to determine if a disorder is present by itself. At times, something is considered abnormal because 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, but this obviously isn't a definition of disorder. Many people's behavior is far from average, but we call them *talented or eccentric*, not disordered. For example, it's not normal to wear a dress made out of meat, but when Lady Gaga wore this to an awards show, it only enhanced her celebrity. 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 problematic abnormal behavior.

Another view is that your behavior is disordered if you are violating social norms. This definition is useful in considering 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 5). An example is provided by Robert Sapolsky (2002), a neuroscientist who worked closely with the Masai tribe in East Africa. One day, Sapolsky's Masai friend Rhoda asked him to bring his jeep to the village where a woman had been acting aggressively and hearing voices. The woman had killed a goat with her

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own hands. Sapolsky and several Masai were able to subdue her and transport her to a health center. Realizing 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* can be misused, however. Consider 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. Although such behavior clearly violates social norms, it should not alone be cause for commitment.

Jerome Wakefield (1999, 2009) uses the shorthand definition of *harmful dysfunction*. A related concept 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, 2013), which contains the current listing of criteria for psychological disorders (Stein *et al*., 2010).

An Accepted Definition

In conclusion, it is difficult to define what constitutes a psychological disorder (Lilienfeld & Marino, 1999)—and the debate continues (Blashfield, Keeley, Flanagan, & Miles, 2014; McNally, 2011; Zachar & Kendler, 2014). The most widely accepted definition used in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) 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 if we pay attention to what is dysfunctional (or out of control) in a given society. But it is never easy to decide what represents dysfunction, and some scholars have argued that we can never satisfactorily define *disease* or *disorder* (see, for example, Lilienfeld & Marino, 1995, 1999; Zachar & Kendler, 2014). 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-5* found throughout this book are all prototypes. This means that the patient may have only some features or symptoms of the disorder and still meet criteria for the disorder because those symptoms are close to the prototype. But one of the differences between *DSM-5* and its predecessor, *DSM-IV,* is the addition of dimensional estimates of the severity of specific disorders in *DSM-5* (American Psychiatric Association, 2013; Regier , Narrow, Kuhl, & Kupfer, 2009). Thus, for the anxiety disorders, for example, the intensity and frequency of anxiety within a given disorder is

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

abnormal behavior Actions that are unexpected and often evaluated negatively because they differ from typical or usual behavior.

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rated on a 0 to 4 scale, where a rating of 1 indicates mild or occasional symptoms and a rating of 4 indicates continual and severe symptoms (Beesdo-Baum *et al.*, 2012; LeBeau, Bogels, Moller, & Craske, 2015).

The Science of Psychopathology

Psychopathology is the scientific study of psychological disorders. Within this field are 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., doctor of philosophy, 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. 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. Psychologists with other specialty training, such as experimental and social psychologists, investigate the basic determinants of behavior but do not assess or treat psychological disorders.

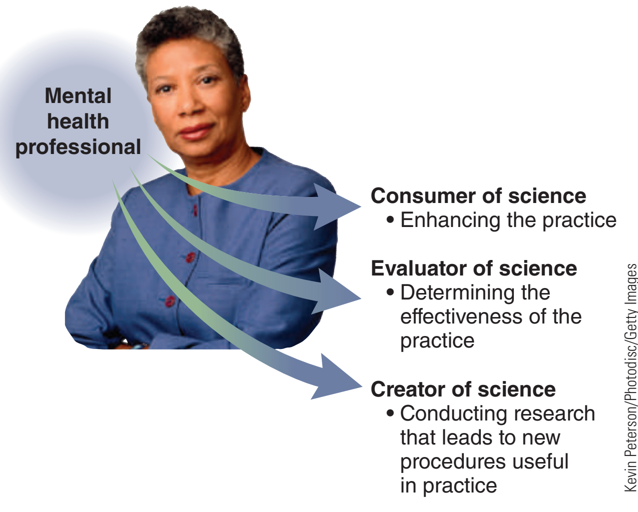
Psychiatrists first earn an M.D. degree in medical school and then specialize in psychiatry during residency training that lasts 3 to 4 years. Psychiatrists also investigate the nature and causes of psychological disorders, make diagnoses, and offer treatments. Many psychiatrists emphasize drugs or other 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 and specialize in the care and treatment of patients with psychological disorders, usually in hospitals as part of a team.

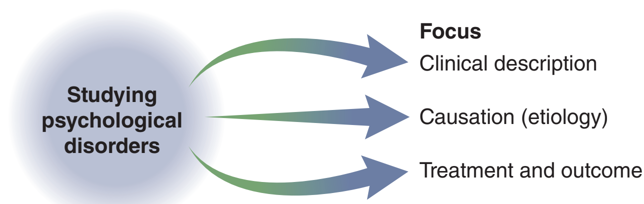
Finally, *marriage and family therapists* and *mental health counselors* typically spend 1 to 2 years earning a master's degree and are employed to provide clinical services by hospitals or clinics.

The Scientist-Practitioner

The most important recent development in psychopathology is the adoption of scientific methods to learn more about psychological disorders, their causes, and 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 function as scientist-practitioners in three ways (see ● Figure 1.2). First, they keep up with the latest developments in their field and use the most current diagnostic and treatment procedures. In this sense, they are consumers of the science of psychopathology. Second, they evaluate their own assessments or treatment procedures to see whether they work. They are accountable not only to their patients but also to government agencies and insurance companies that pay for the treatments, so they must demonstrate whether their treatments are effective. Third, scientist-practitioners conduct research that produces new information about disorders or their treatment. Such research 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. A general overview of them will give you a clearer perspective on our efforts to understand abnormality.



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



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

Clinical Description

In hospitals and clinics, we often say that a patient "presents" with a specific problem or we discuss the **presenting problem**. Describing Judy's presenting problem is the first step in determining her **clinical description**, the unique combination of behaviors, thoughts, and feelings that make

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up a specific disorder. The word *clinical* refers both to the types of disorders you would find in a clinic or hospital and to the activities connected with assessment and treatment.

An 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*—what percentage of males and females has the disorder—and the typical age of onset.

In addition, most disorders follow a particular pattern, or **course**. For example, some disorders, such as schizophrenia (see Chapter 12), follow a *chronic course*, meaning they tend to last a long time. Other disorders, like mood disorders (see Chapter 6), follow an *episodic course*, in that the individual is likely to recover within a few months only to suffer a recurrence of the disorder. Still other disorders may have a *time-limited course*, meaning they will improve without treatment in a relatively short period with little or no risk of recurrence.

Closely related to differences in course of disorders are differences in onset. Some disorders have an *acute onset*, meaning 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 we can know what to expect and how best to deal with the problem. 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. If the disorder is likely to last a long time (become chronic) however, the individual might want to seek treatment. The anticipated course of a disorder is called the **prognosis**.

The patient's age may be an important part of the clinical description. A psychological disorder occurring in childhood may present differently from the same disorder in adulthood or old age. For example, children experiencing severe anxiety often assume they are physically ill. Because their thoughts and feelings are different from those experienced by adults with anxiety, 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*. Because we change throughout our lives, researchers study development in children, adolescents, and adults. Study of abnormal behavior across the entire age span is referred to as *life-span developmental psychopathology*.

Causation, Treatment, and Etiology Outcomes

Etiology, or the study of origins, has to do with why a disorder begins and includes biological, psychological, and social dimensions. Chapter 2 is devoted to this key aspect of abnormal psychology.

Treatment is also 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

Hung Chung Chih/Shutterstock.com

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

psychopathology Scientific study of **psychological disorders**.

scientist-practitioners Mental health professional expected to apply scientific methods to his or her work. A scientist–practitioner must know the latest research on **diagnosis** and treatment, must evaluate his or her methods for effectiveness, and may generate research to discover information about disorders and their treatment.

presenting problem Original complaint reported by the client to the therapist. The actual treated problem may be a modification derived from the presenting problem.

clinical description Details of the combination of behaviors, thoughts, and feelings of an individual that make up a particular disorder.

prevalence Number of people displaying a disorder in the total population at any given time (compare with **incidence**).

incidence Number of new cases of a disorder appearing during a specific period (compare with **prevalence**).

course Pattern of development and change of a disorder over time.

prognosis Predicted development of a disorder over time.

course Pattern of development and change of a disorder over time.

etiology Cause or source of a disorder.

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example, if a drug with a specific known effect within the nervous system alleviates a specific disorder, we know that something in that part of the nervous system might either be causing the disorder or helping maintain it. As you will see in the next chapter, psychopathology is rarely simple because the *effect* does not necessarily imply the *cause*. For example, you might take an aspirin to relieve a headache. If you then feel better, that does not mean the headache was caused by a lack of aspirin. Nevertheless, many people seek treatment for psychological disorders, and treatment can provide 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 trained in a single theoretical approach, such as psychoanalysis or behavior therapy, and then use that approach on every disorder. More recently, 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 treatments 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. In Chapter 2, we examine 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 4 through 13, we examine specific disorders. Finally, in Chapter 14 we examine legal, professional, and ethical issues relevant to psychological disorders and their treatment. With that overview in mind, let us turn to the past.

1.1 Concept CHECK

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, he finds himself feeling down much of the time and 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. 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. 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? ____________

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. 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, 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, the *biological model* and the *psychobiological model*.

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The Supernatural Tradition

▶ What supernatural influences were formerly believed to explain abnormal behavior?

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.

Demons and Witches

One current of opinion put the causes and treatment of psychological disorders in the realm of the supernatural. During the late 14th century, religious and lay authorities supported these popular superstitions, and society as a whole increasingly turned to magic and sorcery to solve their problems. During these 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 community, which inspired action against the possessed. Treatments included **exorcism**, in which religious rituals were performed 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, which resulted in the hanging deaths of 20 women.

DEA PICTURE LIBRARY/De Agostini/Getty Images

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

Stress and Melancholy

An equally strong opinion reflected the view that insanity was a natural phenomenon, caused by mental or emotional stress, and 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 *acadia* or sloth (Tuchman, 1978). Common treatments were rest, sleep, and a healthy environment. Other treatments included baths, ointments, and 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 took turns caring for them. We now know that this medieval practice of keeping people with psychological disturbances in their own community is beneficial (see Chapter 13).

In the 14th century, one of the chief advisers to the king of France, Nicholas Oresme, suggested that 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 natural and supernatural explanations for mental disorders are represented more or less strongly in historical works, depending on the sources consulted by

exorcism Religious ritual that attributes disordered behavior to possession by demons and seeks to treat the individual by driving the demons from the body.

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