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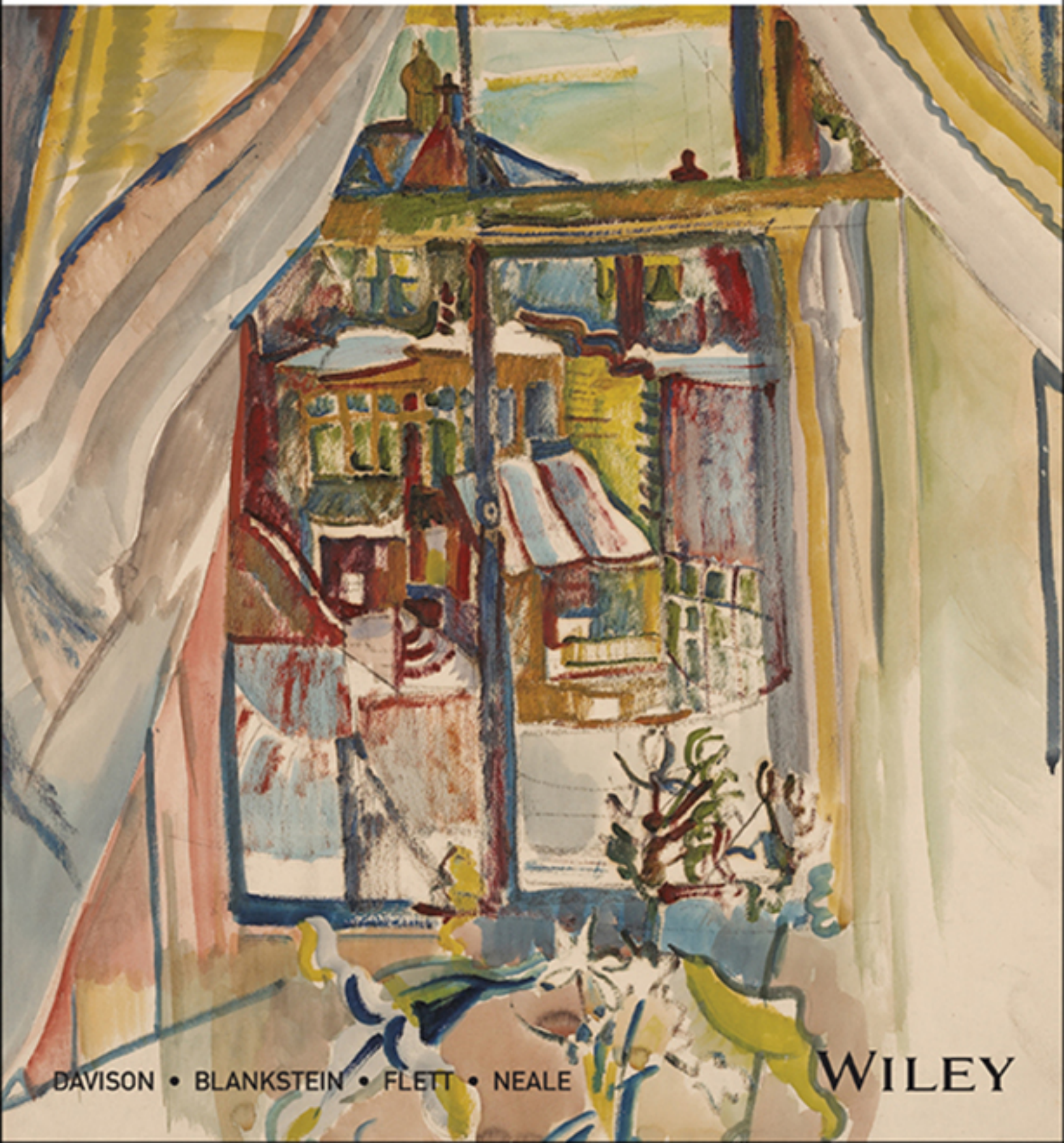
FIFTH CANADIAN EDITION



DAVISON • BLANKSTEIN • FLETT • NEALE

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FIFTH CANADIAN EDITION

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Vice President & Publisher: Veronica Visentin
Acquisitions Editor: Rodney Burke
Marketing Manager: Patty Maher
Editorial Manager: Karen Staudinger
Production Manager: Tegan Wallace
Developmental Editor: Andrea Grzybowski
Media Editor: Channade Fenandoe
Publishing Services Coordinator: Lynda Jess
Editorial Assistant: Luisa Begani
Layout: MPS Limited
Cover Design: Joanna Vieiera
Cover Image: Pegi Nicol MacLeod. *Cold Window*, 1937. Oil and watercolour over graphite on wove paper, 74.8 x 55.7 cm
Gift from the Douglas M. Duncan Collection, 1970. National Gallery of Canada, Ottawa. Photo © National Gallery of Canada

Library and Archives Canada Cataloguing in Publication

Davison, Gerald C., author
Abnormal psychology / Gerald C. Davison, Kirk R. Blankstein, Gordon L. Flett, John M. Neale.—Fifth Canadian edition.

Includes bibliographical references and index.

ISBN 978-1-118-76481-7 (bound)
1. Psychology, Pathological—Textbooks. I. Title.
RC454.A255 2013 616.89 C2013-906948-8

Printing and binding: Courier Ltd.
Printed and bound in the United States.
1 2 3 4 5 CC 18 17 16 15 14

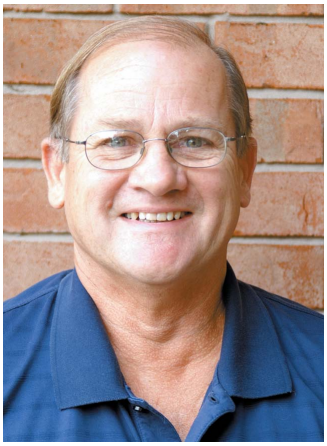
John Wiley & Sons Canada, Ltd.
5353 Dundas St. W., Suite 400.
Etobicoke, Ontario M9B 6H8

Visit our website at: www.wiley.ca

Dedicated from Gordon Flett to

Kathy, Hayley, and Alison

ABOUT THE AUTHORS



KIRK R. BLANKSTEIN is Professor Emeritus of Psychology at the University of Toronto Mississauga (UTM). He received his Honours B.A. from McMaster University and M.A. and Ph.D. in Clinical Psychology from the University of Waterloo. He completed his clinical internship at Duke University Medical Center in 1970 following a period as a Research Associate at the Institute of Psychiatry in London, England. One of his passions has been teaching undergraduate students and training future psychologists.

Professor Blankstein is a past recipient of the UTM Teaching Excellence Award. In 2003 he was recognized as an Exceptional Teacher in celebration of "175 Years of Great Teaching" at the University of Toronto. In 2007, he received the inaugural Leadership in Faculty Teaching Award from the Government of Ontario awarded to "faculty who influence, motivate and inspire students and demonstrate leadership in teaching methods for the diverse student body." Many of his students have gone on to distinguished careers as professional psychologists, physicians, social workers, lawyers, criminologists, a High Commissioner, and an Ontario court judge.

Professor Blankstein's research focuses on the psychological problems of young people, especially anxiety, depression, somatic distress, and poor academic performance. He has conducted research in diverse areas, including early work on the applications of biofeedback, and the assessment and treatment of test anxiety. A major focus of current research is on factors (such as stress, coping, and social support) that mediate and moderate the link between cognitive-personality vulnerability factors (such as self-critical perfectionism) and negative adaptational outcomes. He recently developed two new measures of the key maladaptive aspects of perfectionism that are employed in treatment studies with anxiety and mood disorder clients (e.g., *International Journal of Cognitive Therapy,* 2011). Besides his many journal articles and invited chapters, Professor Blankstein co-edited a series of volumes on communication and affect. He serves as a regular reviewer for numerous professional journals.

In 2005, Professor Blankstein received the prestigious Northrop Frye Award in recognition of his contributions to the integration of teaching and research. The award recognizes faculty who have set "themselves apart through innovation in teaching and commitment to conveying the excitement and importance of research to undergraduate and graduate students." After 39 years at UTM, Professor Blankstein retired in June 2009 to devote more time to family and friends.

GORDON L. FLETT is a Professor of Psychology at York University in Toronto. He has served as Associate Dean of Research and Graduate Education in York's Faculty of Health and as Director of Undergraduate Studies in the Department of Psychology at York University. He received the Outstanding Teaching Award from the Faculty of Arts at York University in 1993 and again in 1997. Dr. Flett has taught courses in abnormal psychology, introduction to personality, and personality theory and behavioural disorders at the undergraduate level, as well as courses in personality theory and research and in the self-concept at the graduate level. He received his B.Sc., M.A., and Ph.D. from the University of Toronto, and he began his appointment at York University in 1987.

In 1996, Dr. Flett was recognized by the American Psychological Society as one of the top 25 scholars in psychology, based on the number of publications over a five-year period. In 1999, he received the Dean's Award for Outstanding Research from the Faculty of Arts at York University. In 2004, Dr. Flett was awarded a Tier I Canada Research Chair in Personality and Health which he currently holds and in 2007, he was nominated and made a Fellow of the Association for Psychological Science in recognition of his "distinguished contributions to psychological science."

His research interests include the role of personality factors in depression, as well as the continuity of depression, and the interpersonal aspects of anxiety. Dr. Flett is a member of York's LaMarsh Centre for Child and Youth Research and he is extensively involved in raising awareness about the mental health problems of children and adolescents, including serving as one of the guest editors of a 2013 special issue of the *Canadian Journal of School Psychology* focused on the role of schools in a new mental health strategy. One of his current projects is a collaborative venture with the York Region

District School Board funded by the Ontario Ministry of Education that is focused on increasing resilience among children and youth.

Dr. Flett is perhaps most recognized for his seminal contributions to research and theory on the role of perfectionism in psychopathology. His collaborative work with Dr. Paul Hewitt (University of British Columbia) has helped establish that perfectionism is multidimensional with salient interpersonal components that contribute to personal and interpersonal maladjustment. Their work on perfectionism has received international attention and has been the subject of numerous media stories, including coverage on CTV, CNN, and the BBC.

Dr. Flett has published over 200 journal articles and chapters as well as collaborating on the first academic book on perfectionism, published in 2002. In 2007, he authored the book *Personality Theory and Research: An International Perspective*, which is also published by John Wiley & Sons Canada. His work with Dr. Hewitt on perfectionism has led to the creation of the Multidimensional Perfectionism Scale, the Child-Adolescent Perfectionism Scale, the Perfectionism Cognitions Inventory, and the Perfectionistic Self-Presentation Scale. Dr. Flett is also the co-creator of the Endler Multidimensional Anxiety Scales (EMAS)—Social Anxiety Scales. He has also worked extensively with Dr. Marnin Heisel on the development of the Geriatric Suicide Ideation Scale and related research. Dr. Flett has also served as guest editor on four special issues on perfectionism for the *Journal of Rational-Emotive & Cognitive-Behavior Therapy* and an upcoming special issue on perfectionism in *Psychology in the Schools*.

In addition to his academic interests, Dr. Flett has been involved actively in the school system. Dr. Flett served for many years as the chair of the school council at Middlebury Public School in Mississauga, Ontario, and he was the spokesperson for the Parents of Peel, an advocacy group for parents interested in improving and protecting public education. In 1999, his civic contributions were acknowledged when Dr. Flett was awarded the City of Mississauga Certificate of Recognition for "Outstanding Commitment to the Community." Dr. Flett was honoured with the Community and Leadership Award from Toastmasters International in May 2006.

GERALD C. DAVISON is Professor of Psychology at the University of Southern California (USC). Previously he was Professor and Chair of the Department of Psychology at USC and served also as Director of Clinical Training. He recently served as Dean of the USC Davis School of Gerontology. He earned his B.A. in social relations from Harvard and his Ph.D. in psychology from Stanford. He is a Fellow of the American Psychological Association, a Charter Fellow of the Association for Psychological Science, and a Distinguished Founding Fellow of the Academy of Cognitive Therapy. Among his other honours are the USC Associates Award for Excellence in Teaching, and the Outstanding Educator Award and the Lifetime Achievement Award of the Association for Behavioral and Cognitive Therapies. Among his more than 150 publications is his book *Clinical Behavior Therapy*, co-authored in 1976 with Marvin Goldfried and reissued in expanded form in 1994. It is one of two publications that have been recognized as Citation Classics by the Social Sciences Citation Index. He is also on the editorial board of several professional journals. His research has emphasized experimental and philosophical analyses of psychopathology, assessment, therapeutic change, and the relationships between cognition and a variety of behavioural and emotional problems via his articulated thoughts in simulated situations paradigm.

JOHN M. NEALE was Professor of Psychology at the State University of New York at Stony Brook, retiring in 2000. He received his B.A. from the University of Toronto and his M.A. and Ph.D. from Vanderbilt University. He won numerous awards, including the American Psychological Association's Early Career Award (1974), the Distinguished Scientist Award from the American Psychological Association's Society for a Science of Clinical Psychology (1991), and the Sustained Mentorship Award from the Society for Research in Psychopathology (2011). Besides his numerous articles in professional journals, he published books on the effects of televised violence on children, research methodology, schizophrenia, case studies in abnormal psychology, and psychological influences on health. Schizophrenia was a major focus of his research, and he also conducted research on the influence of stress on health. Dr. Neale passed away in 2011.

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PREFACE

Davison and Neale's classic text *Abnormal Psychology* introduced the field of abnormal psychology to over one million readers over several decades. Kirk Blankstein and Gordon Flett responded to calls for a text with a greater focus on Canadian issues by adapting this classic work. The publication in 2002 of the first edition of Davison, Neale, Blankstein, & Flett, *Abnormal Psychology*, Canadian Edition meant that Canadian students could now benefit from the structure and principles of the classic text but within the context of extensive Canadian content that highlighted the unique aspects of the people of Canada. The publication of this new volume, the fifth edition, represents a substantial change because it coincides with the publication of the new *Diagnostic and Statistical Manual of Mental Disorders* and has been thoroughly revised to reflect the key changes in the *DSM-5*. An equally important catalyst for revising the text was our ongoing attempts to not only keep abreast of new developments in the field and in Canadian society, but also provide a book that meets the emerging learning needs of students. This new version of the text is shorter and more focused than the previous edition. These changes were made in light of our ultimate goal of providing broad coverage of key themes and issues in a way that is highly engaging for today's student.

GOALS OF THE BOOK

Our other main goals in writing *Abnormal Psychology*, Fifth Canadian Edition, were to continue to build upon the strengths of a classic text and present abnormal psychology from a unique Canadian perspective with a contemporary emphasis. Acknowledged strengths are as follows:

A SCIENTIFIC, CLINICAL APPROACH The study of abnormal psychology is a science and this edition, like its predecessors, retains a strong commitment to the scientific approach and Davison and Neale's goal of encouraging readers to think critically and consider the merits of various viewpoints. Tough choices have to be made when selecting from among the vast literature and these choices are guided by the need to accurately represent the field and continue to make a fair and comprehensive presentation of the various conceptualizations in contemporary psychopathology.

PARADIGMS AS AN ORGANIZING PRINCIPLE One of the reasons we have used the Davison text over many years and sought to use it as a base for our Canadian text is that it has always been consistent with our orientation toward abnormal psychology and with our teaching philosophy. A recurrent theme in the book is the importance of major points of view or, to use Kuhn's (1962) phrase, "paradigms." Our experience in teaching undergraduates has made us very much aware of the importance of making explicit the unspoken assumptions underlying any quest for knowledge. In our handling of the paradigms, we have tried to make their premises clear. Long after specific facts are forgotten, the student should retain a grasp of the basic problems in the field of psychopathology and understand that the answers one arrives at are constrained by the questions one poses and the methods employed to ask those questions. Throughout the book we discuss four major paradigms: psychoanalytic, learning (behavioural), cognitive, and biological (neuroscientific).

AN AUTHORITATIVE, CONTEMPORARY APPROACH *Abnormal Psychology,* Fifth Canadian Edition furthers its reputation as one of the most current, authoritative overviews of the theories and research in psychopathology and intervention. It maintains the widely praised scientific clinical approach that blends the clinical and empirical/experimental, as the authors examine each disorder from multiple perspectives. The field of abnormal psychology continues to evolve and expand at a phenomenal rate. As always, additions and modification to this text are significant and not merely cosmetic. Why? Because it is vitally important to incorporate a wide range of new findings in this edition to ensure that this text is an accurate source of contemporary developments. This is most clearly exemplified by the changes made in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), which appeared in May 2013. Most chapters in this book were modified to incorporate these changes. More generally, however, four primary questions continue to guide our writing: What causes psychopathology? Which treatments are most effective in preventing or reducing psychological suffering? What are the key implications for Canadian society and Canada's mental health system? And, what will students find particularly meaningful and engaging? We tried to not only present theories and research in psychopathology and intervention, but also to convey the intellectual excitement that is associated with the search for answers to some of life's most puzzling questions.

NEW TO THIS EDITION

Preparation for the new edition starts as soon as the previous edition is published. It begins with an exhaustive evaluation of the contents of the previous edition by several reviewers, including current users of the text. We have been responsive to their insightful feedback while remaining consistent with the sage approach and framework used historically by Davison and Neale. Typically, suggestions focus on incorporating new research developments and modifying how much focus is placed on various theoretical orientations. For instance, reviewers suggested placing less emphasis on

the classical psychoanalytic orientation and instead placing greater emphasis on the cognitive-behavioural orientation and the biological/physiological orientation. The book is also assessed by various individuals on an ongoing basis to ensure that we retain a high level of readability and continue to highlight the relevance of the material by incorporating case studies and case vignettes of interest to our readers. Key additions and changes to the book are outlined below.

CONTEMPORARY FOCUS

As a reflection of the important new developments, over 800 new references have been integrated throughout the text, with the vast majority of these references published in the last three years. New material was added only if it represented important new research or key themes. A trend that continued with this volume is to continue to emphasize new research conducted in Canada, but placing increasing emphasis on international developments in order to provide a contemporary representation of the current state of the field.

Historically, with each revision of this text, three or more chapters are selected and extensive changes and updates are made. However, in this instance, in light of the *DSM-5* changes, extensive changes have been made throughout the text. The most comprehensive updates occurred in Chapter 4, "Classification and Diagnosis" and in Chapter 15, "Disorders of Childhood." One key change is that the sequencing of Chapters 3 and 4 is now switched to reflect the tendency in the clinical world for assessment issues to come before diagnostic considerations and to enable the use of material introduced in Chapter 3 to explicate material in Chapter 4.

CONTENT REVISION

Content areas have been considerably strengthened. Our decision to update and expand the biological perspective that began in the second edition has continued in this edition and this continuing emphasis reflects key advances in the field. Any book purporting to be representative must have increased coverage of advances in neuroscience and genetic research but it is also important to consider these developments within broad conceptual frameworks such as the biopsychosocial model that is outlined later in the book. Accordingly, new groundbreaking research is incorporated. For instance, Chapter 11 has been updated to include new biological and genetic advances that have enhanced our understanding of schizophrenia, and to report on new research on the pharmacological treatment of schizophrenia. Another example is the extended summary of new genetic breakthroughs in Alzheimer's research in Chapter 16.

A central aim in revising the content was to provide expanded descriptions of several "hot topics." We further explored those topics already included in the previous edition, but also added emerging issues, including key issues specific to Canada. These issues cover various themes, including the federal government's attempt to stop harm reduction efforts to treat addiction in Vancouver. Other key emerging themes of growing significance and new developments discussed at length in this edition include the latest efforts to combat mental health stigma in Canada (Chapter 1), the fate of assisted suicide legislation in Canada (Chapter 8), Canadian efforts to address homelessness and mental illness (Chapter 11), excessive use of OxyContin and other painkillers in Canada (Chapter 12), the mental health crisis facing our children and adolescents (Chapter 15), and Bill C-54 and the treatment of people who have engaged in violent attacks but were deemed not criminally responsible due to mental disorder (Chapter 18).

FOCUS ON DISCOVERY

While a few new Focus on Discovery boxes have been added to the fifth edition (such as a discussion of hoarding disorder in Chapter 4), our focus was primarily on significant updates to existing boxes. Significant additions include:

- Focus on Discovery 4.2: Ethnic and Cultural Considerations in *DSM-5*
- Focus on Discovery 12.2: Our Tastiest Addiction: Caffeine and the Rise of Energy Drinks
- Focus on Discovery 16.1: The Nun Study: Unlocking the Secrets of Alzheimer's?

CANADIAN PERSPECTIVES

- Updated Canadian Perspectives 5.1 on early risk factors and psychological disorders and the role of abuse
- Updated Canadian Perspectives 8.1 on postpartum, perinatal, and prenatal depression in Canadian women
- Updated Canadian Perspectives 10.1 on the prevention of eating disorders in Canada
- Updated Canadian Perspectives 16.2 to reflect emerging issues and concerns involving home care for elderly Canadians

CANADIAN CONTRIBUTIONS

- Updated Canadian Contributions 9.2 on Norman Endler and the interaction model of anxiety, stress, and coping
- Updated Canadian Contributions 15.1 on Richard Tremblay and the GRIP Research Unit
- Updated Canadian Contributions 16.1 on Charles Morin and the treatment of insomnia in older adults

SUPPLEMENTARY MATERIALS

- A collection of CBC videos has been compiled to accompany *Abnormal Psychology*, Fifth Canadian Edition.
- *The Brief Student Guide to DSM-5* is packaged with this text at no additional cost. This handy guide lists selected *DSM-5* criteria to some of the disorders mentioned in the text. Further, there are two case studies in the booklet that help show the reader how the *DSM* criteria are used in real-life situations.
- The Test Bank, Instructor's Manual, PowerPoint slides, and Study Guide have also been thoroughly revised.

ORGANIZATION OF THE TEXT

In Part 1 (Chapters 1–5), we place the field in historical context, present the concept of paradigms in science, describe the major paradigms in psychopathology and intervention, discuss the role of cultural factors in a Canadian setting, and introduce our readers to Canada's mental health care system. A central focus is our extensive overview of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) and the process used to arrive at it. The order of chapters in this segment has been changed so that assessment is now the focus of Chapter 3 and classification and diagnosis are now the focuses of Chapter 4.

Specific disorders and their treatment are discussed in Parts 2 and 3 (Chapters 6–16). Chapter 16 on aging provides comprehensive coverage of this important topic from a uniquely Canadian perspective. Note that we have retained a change that was made in the order of the chapters in the fourth edition. Mood disorders is now covered in Chapter 8 and Chapter 9 is now "Psychophysiological Disorders and Health Psychology." This change was made in order to more meaningfully discuss the role of mood disorders in health problems in Chapter 9. Here it should be noted that certain disorders, such as the ones in the *DSM-5* that have now been distinguished from disorders that they were grouped with previously (e.g., obsessive-compulsive disorder and post-traumatic stress disorder vs. the anxiety disorders), are still included in the anxiety disorders chapter since they involve strong links with anxiety. We will explore whether these topics merit their own chapters in future editions.

The final section, Part 4, consists of Chapters 17 and 18. Chapter 17 discusses process and outcome research on treatment and controversial issues surrounding the therapy enterprise. Chapter 17 was rewritten, in part, to highlight the non-specific factors (e.g., client motives and beliefs) that influence and impact on the effectiveness of treatment. Indeed, there is now extensive discussion with new sections focused on client factors and factors related to the client–therapist relationship. In Chapter 18, legal and ethical issues are discussed and extensive Canadian content is provided. This closing chapter is devoted to an in-depth study of the complex interplay between scientific findings and theories, on the one hand, and the role of ethics and the law on the other hand.

FEATURES OF THIS BOOK

In addition to the content and organization, a variety of pedagogical features support the approach of this text. These features were introduced in the first edition and are designed to make it easier for students to master and enjoy the material.

CANADIAN FOCUS BOXES

There are two types of boxes in the text that focus solely on placing the material in a Canadian context and on highlighting past and current practices in the treatment of abnormal psychology in Canada as well as the research contributions Canadians have made in the field. They are Canadian Perspectives and Canadian Contributions. Several of these boxes have been updated with recent anecdotes and key developments from news reports to illustrate important mental health issues in Canada today.

STUDENT PERSPECTIVES BOXES

In addition to representing the DSM-5, the most substantial revision in this edition is the addition of Student Perspectives boxes in almost all of the chapters in this book. This material was added to further increase students' engagement with the material by illustrating the relevance of mental health issues to the experiences of university and college students in Canada and elsewhere. A wide range of issues is explored, including the prevalence of anxiety and depression in students and the growing problem of the abuse of attention-deficit/hyperactivity disorder medication as a type of study aid. Other topics that are addressed include binge drinking on university campuses, internet addiction disorder on campus, and the prevalence and prevention of depressive disorders among students. The addition of these boxes distinguishes this book from other abnormal psychology books and this change was made primarily in recognition of the growing concern about the mental health issues facing college and university students and the importance of examining issues within the context of campus settings.

FOCUS ON DISCOVERY BOXES

There are many in-depth discussions of selected topics encased in Focus on Discovery boxes throughout the book. This feature allows us to involve the reader in topics that are sometimes very specialized, in a way that does not detract from the flow of the regular text. Sometimes a Focus on Discovery box expands on a point in the text; sometimes it deals with an entirely separate but relevant issue, often a controversial one; and often it presents material of particular interest to the Canadian student. Reading these boxes with care will deepen understanding of the subject matter.

CHAPTER-OPENING CASES AND IN-TEXT CASES

Several chapters open with extended case illustrations. These accounts provide a clinical context for the theories and research that occupy most of our attention in the chapters and help make vivid the real-life implications of the empirical work of psychopathologists and clinicians. We have reintroduced a fictional case used in previous editions of this textbook (the case of Ernest H.) to illustrate how he would be diagnosed with the old *DSM-IV* approach versus the contemporary *DSM-5* approach.

New case examples and case vignettes have been added throughout the chapters to further illustrate key concepts. We have also retained most of the compelling cases introduced in earlier versions of this text, including the horrible abusiveness of Joseph Fritzl (see Chapter 2) and the case of Donald S., who suffered from psychopathy and who once claimed to have worked as a research assistant for Robert Hare (see Chapter 13). Detailed case studies have been added to illustrate hoarding disorders (Chapter 4: the man with clinical hoarding who

had to be saved by emergency response workers in Burnaby, B.C.); depression in students (Chapter 8: Billy, the depressed 20-year-old); psychosocial factors that contribute to eating disorders (Chapter 10: the case study of the blind Dutch woman who used her sense of touch from a Barbie doll to feel a pressure to conform to body image ideals); the onset of first episode psychosis (Chapter 11: the symptom expression of Peter, an adolescent boy); and the remarkable personal story of the battle with borderline personality disorder by a famous clinical psychologist (Chapter 13: Marsha Linehan's personal account). This incredible story should provide a sense of hope to students facing their own challenges.

CHAPTER SUMMARIES

A summary appears at the end of each chapter. We suggest that the student read it before beginning the chapter itself to get a good sense of what lies ahead. Rereading the summary after completing the chapter will enhance the student's understanding and provide an immediate sense of what has been learned in just one reading of the chapter. These summaries are presented in bulleted format to enhance student retention.

KEY TERMS

When an important term is introduced, it is boldfaced and defined or discussed immediately. Most such terms appear again later in the book, in which case they will not be highlighted in this way. All of these terms are listed after each chapter summary as key terms and are defined in the end-of-text glossary. The page number on which the term is defined appears in this list.

REFERENCES

As noted above, our commitment to current and forward-looking scholarship is reflected in the inclusion of hundreds of new references among the more than 4,000 references, with about one-half of them published since the first edition. We have also included many important Canadian references.

ACKNOWLEDGEMENTS

It is a pleasure to recognize the contributions of a number of colleagues who helped with their valuable comments and feedback in the writing of five Canadian editions. We would like to acknowledge a number of our colleagues whose thoughtful comments and expert feedback helped us in writing the fifth Canadian edition. They are John Conklin, Camosun College; Nukte Edguer, Brandon University; Ross Keele, University of Saskatchewan; Ron Laye, University of the Fraser Valley; and Timothy Parker, University of Alberta.

Many thanks to the staff at John Wiley & Sons Canada, Ltd. for their ongoing enthusiastic support of this project. Members of the very impressive team at Wiley we would like to thank include Karen Staudinger, Editorial Manager, who has shown her continuing faith in this project over the years. We extend a special thank you to our Acquisitions Editor, Rodney Burke, for overseeing this edition of the text and providing helpful and timely advice. We also thank Andrea Grzybowski, our Developmental Editor, for her exemplary efforts on the project and her exceptional patience. We also offer our gratitude to Patty Maher, Marketing Manager, and of course all the sales representatives who brought the text to you. The exceptional editorial contributions of Laurel Hyatt and the proofreading expertise of Emma Cole deserve special mention, as well as the assistance provided by Laura Couperthwaite in compiling the reference section and the glossary. Special thanks to Linda Williams (Algoma University) for compiling the Study Guide and Instructor's Manual, Carrie Scherzer (Mount Royal University) for updating the Test Bank, and Andrew Haag (University of Alberta) for working on the PowerPoints, Clicker Questions, and Student Quizzes. Also, we would be remiss if we did not acknowledge Joel Goldberg's impressive contributions that are reflected in the new *The Brief Student Guide to DSM-5*.

Our sincere gratitude is extended to the authors who graciously provided us with preprints that described their research; this was a great help to us as we wrote the manuscript. These people are too numerous to name, but you know who you are! A sincere note of gratitude is also in order to recognize a number of scholars who provided valuable assistance, advice, and suggestions for this version or previous editions of the text, including Lynne Angus, Lindsay Ayearst, Jacques Barber, Randy Frost, Abby Goldstein, Marnin Heisel, Paul Hewitt, Gail McVey, Stanley Messer, Danielle Molnar, Patricia Pliner, Zindel Segal, and Mary Lou Smith. A special thank you is extended to the Honourable Mr. Justice Richard Schneider for his contributions over the years to Chapter 18. Most importantly, more than thanks is due to family members for their endless support and encouragement throughout the writing of every edition of this text. We are exceptionally fortunate, plain and simple. In particular, thank you Kathy, for your patience, affection, timely advice, and the reminder that there is much more to life than writing books. And thank you, Alison Flett, senior student in Psychology at Carleton University, for your timely suggestions and feedback from the student perspective.

Finally, a special note of gratitude is extended to Kirk Blankstein who is transitioning off this book while he enjoys a well-deserved retirement. Kirk, your incredible influence and commitment to students is reflected throughout this book and it will always be evident. Thanks for being an exceptional mentor and for bringing abnormal psychology alive. Three members of the Flett family have had the exceptional good fortune of being students in your abnormal psychology class over the years. More importantly, we have all benefitted from the personal and family values you have expressed and the life lessons and insights you have provided.

Gordon Flett

October 2013

CHAPTER

1

INTRODUCTION: DEFINITIONAL AND HISTORICAL CONSIDERATIONS, AND CANADA'S MENTAL HEALTH SYSTEM

- What is Abnormal Behaviour?
- History of Psychopathology
- Mental Health Problems and Their Treatment In Canada
- Delivery of Psychotherapy: Issues and Challenges
- Summary

"We are all born mad. Some remain so."
—Samuel Beckett, Waiting for *Godot*, II

"There can be no question though that where the insane are concerned the public are not only indifferent, but terror stricken and very often heartless."
—C. K. Clarke, Canada's first professor of psychiatry (Greenland, 1996)

"More than seven million Canadians will experience mental health problems this year and the sad reality is that many of them will find the stigma they face is actually worse than the illness itself."
—Michael Pietras, Director of the Mental Health Commission of Canada's anti-stigma initiative *Opening Minds* (June 6, 2012, at the 5th annual International Stigma Conference, Ottawa)

Greg Curnoe, Canadian 1936–1992, *Self*, 1960, Oil on untempered hardboard, 91.0 × 60.8 cm, Art Gallery of Ontario, Toronto. Gift of the Bick Family, 2001. © Estate of Greg Curnoe/SODRAC (2013)

Every day of our lives we try to understand other people. Acquiring insight into what we consider normal, expected behaviour is difficult. It is even more difficult to understand human behaviour that is beyond the normal range.

This book deals with abnormality as it applies to psychological disorders, including their description, causes, and treatment. As you will see, we know with certainty much less about our field than we would like. As we approach the study of **psychopathology**, the field concerned with the nature and development of abnormal behaviour, thoughts, and feelings, we do well to keep in mind that the subject offers few hard and fast answers.

Another challenge we face in studying abnormal psychology is the need to remain objective. Our subject matter is personal and it is powerfully affecting, making objectivity difficult but no less necessary. The disturbing effects of abnormal

behaviour intrude on our own lives. Who has not experienced irrational thoughts, fantasies, and feelings? Who has not felt profound sadness that is more extreme than circumstances can explain? Most of you will have known someone whose behaviour was upsetting and impossible to fathom, and realize how frustrating and frightening it is to try to help a person suffering psychological difficulties.

This feeling of familiarity with the subject matter adds to its intrinsic fascination—undergraduate courses in abnormal psychology are among the most popular in psychology departments and indeed in the entire university or college curriculum. But it has one distinct disadvantage. All of us bring to our study preconceived notions of what the subject matter is. We have developed certain ways of thinking and talking about behaviour, certain words and concepts that somehow seem to fit.

As scientists, we have to grapple with the difference between what we may feel is the appropriate way to talk about human behaviour and experience and what may be a more productive way of defining it in order to study and learn about it. The concepts and labels we use in the scientific study of abnormal behaviour must be free of the subjective feelings of appropriateness ordinarily attached to certain human phenomena. As you read this book and try to understand the mental disorders it discusses, you may be asked to adopt frames of reference different from those to which you are accustomed.

We will now turn to a discussion of what we mean by the term "abnormal behaviour." Then we will look briefly at how our view of abnormality has evolved through history to the more scientific perspectives of today. Chapter 1 concludes with a discussion of current attitudes toward people with psychological problems and with an introduction to the system of mental health care in Canada.

Before we embark on this journey, it is important to note that this is an exceptionally good time to be a student learning about abnormal psychology, especially in Canada. Important research discoveries continue to emerge, in part fuelled by developments in neuroscience. The field is also under great scrutiny as a result of the introduction in May 2013 of the next edition of the diagnostic system, the *Diagnostic and Statistical Manual–Fifth Edition* (*DSM-5*; see www.dsm5.org). Moreover, mental health issues are very much at the forefront of the public consciousness at present, and this is partly due to the efforts of heroic famous Canadians such as Clara Hughes and the many individuals and corporations who are determined to make a difference. Arguably, there has been no time in our past when public interest and determination to make positive changes has been higher. Another important development is that due to the exceptional efforts of the Mental Health Commission of Canada and individuals across our nation, Canada finally has its first comprehensive Mental Health Strategy (see http://strategy.mentalhealthcommission.ca/). And even politicians seemed poised to do their part. For instance, Canada is now seriously considering a national suicide prevention strategy as a result of public support for a nonpartisan motion put forth in October 2011 by then-Liberal leader Bob Rae.

The Canadian Press Images/Dominic Chan

Clara Hughes, Olympic champion, also champions awareness of mental health issues and has been open about her own bouts with depression. She is shown here in October 2012 speaking to graduates when receiving an honorary Doctor of Laws degree from York University for her tireless efforts.

These efforts and initiatives are important because the challenges still facing us are very significant ones. We can talk about challenges in terms of filling key gaps in knowledge, but more importantly, we can talk about remaining challenges in terms of the sheer prevalence of psychological problems among people of various ages in Canada and elsewhere. We will see that the number of people who require treatment and other services for mental health issues far outweighs the services that are available. Ideally, we will get to the point that, collectively, we will have all of the resources needed to put timely preventions in place and thereby substantially decrease the suffering that accompanies mental illness.

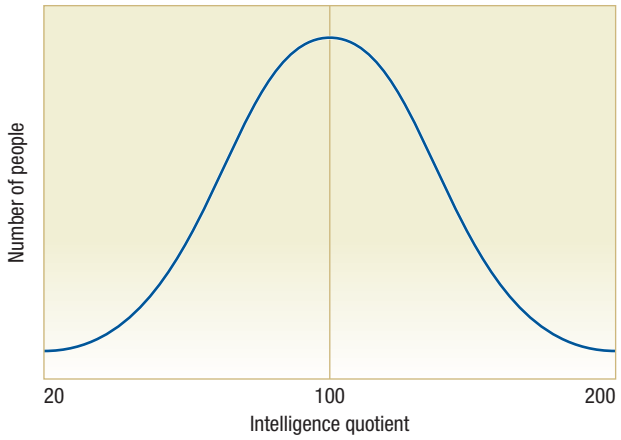
WHAT IS ABNORMAL BEHAVIOUR?

One of the more difficult issues facing us is how to define abnormal behaviour. Several characteristics have been proposed as components. No single one is adequate, although each has merit and captures some part of what might be a full definition. Consequently, abnormality is usually determined by the presence of several characteristics at one time. Our best definition of **abnormal behaviour** includes such characteristics as statistical infrequency, violation of norms, personal distress, disability or dysfunction, and unexpectedness.

STATISTICAL INFREQUENCY

One aspect of abnormal behaviour is that it is *infrequent* in the general population. The **normal curve**, or bell-shaped curve, places the majority of people in the middle as far as any

FIGURE 1.1 The distribution of intelligence among adults, illustrating a normal, or bell-shaped, curve.



particular characteristic is concerned; very few people fall at either extreme. An assertion that a person is normal implies that he or she does not deviate much from the average in a particular trait or behaviour pattern.

Statistical infrequency is used explicitly in diagnosing mental retardation. Figure 1.1 shows the normal distribution of intelligence quotient (IQ) measures in the population. Though a number of criteria are used to diagnose mental retardation, low intelligence is a principal one. When an individual's IQ is below 70, his or her intellectual functioning is considered sufficiently subnormal to be designated as mental retardation. Although some infrequent behaviours or characteristics of people do strike us as abnormal, in some instances, the relationship breaks down. Having great athletic ability is infrequent, but few would regard it as part of the field of abnormal psychology. Only certain infrequent behaviours, such as experiencing hallucinations or deep depression, fall into the domain considered in this book. Unfortunately, the statistical component gives us little guidance in determining which infrequent behaviours psychopathologists should study.

VIOLATION OF NORMS

Another characteristic to consider is whether the behaviour *violates social norms* or threatens or makes anxious those observing it. Violation of norms explicitly makes abnormality a relative concept; various forms of unusual behaviour can be tolerated, depending on the prevailing cultural norms. Yet violation of norms is at once too broad and too narrow. Criminals and prostitutes, for example, violate social norms but are not usually studied within the domain of abnormal psychology, and the highly anxious person, who is generally regarded as a central character in the field of abnormal psychology, typically does not violate social norms and would not be bothersome to many lay observers.

In addition, cultural diversity can affect how people view social norms. What is the norm in one culture may be abnormal in another. This subtle issue is addressed throughout the book (see especially chapters 2 and 4).

PERSONAL SUFFERING

Another characteristic is *personal suffering*; that is, behaviour is abnormal if it creates great distress and torment in the person experiencing it. Personal distress clearly fits many of the forms of abnormality considered in this book—people experiencing anxiety disorders and depression truly suffer greatly—but some disorders do not necessarily involve distress. The psychopath, for example, treats others cold-heartedly and may continually violate the law without experiencing any guilt, remorse, or anxiety whatsoever. And not all forms of distress—for example, hunger or the pain of childbirth—belong to the field.

DISABILITY OR DYSFUNCTION

Disability—that is, impairment in some important area of life (e.g., work or personal relationships) because of an abnormality—can also be a component of abnormal behaviour. Substance-use disorders are defined in part by the social or occupational disability (e.g., poor work performance, serious arguments with one's spouse) created by substance abuse and addiction. Similarly, a phobia can produce both distress and disability; for example, a severe fear of flying may prevent someone from taking a job promotion. Like suffering, disability applies to some, but not all, disorders. Transvestism (cross-dressing for sexual pleasure), for example, which is currently diagnosed as a mental disorder if it distresses the person, is not necessarily a disability. Most transvestites are married, lead conventional lives, and usually cross-dress in private. Other characteristics that might in some circumstances be considered disabilities—such as being short if you want to be a professional basketball player—do not fall within the domain of abnormal psychology. We do not have a rule that tells us which disabilities belong and which do not.

UNEXPECTEDNESS

We have just described how not all distress or disability falls into the domain of abnormal psychology. Distress and disability are considered abnormal when they are *unexpected* responses to environmental stressors (Wakefield, 1992). For example, an anxiety disorder is diagnosed when the anxiety is unexpected and out of proportion to the situation, as when a person who is well off worries constantly about his or her financial situation.

We have considered here several key characteristics of a definition of abnormal behaviour. Again, none by itself yields a fully satisfactory definition, but together they offer a useful framework for beginning to define abnormality. In this volume we will study a list of human problems that are currently considered abnormal. The disorders on the list will undoubtedly change with time, for the field is continually evolving,

CP Image Archive/Jonathan Hayward

Although abnormal behaviour is infrequent, so, too, is great athletic talent, such as that of the proud members of the Canadian multiple gold medal-winning Olympic women's hockey team. Therefore, infrequency is not a sufficient definition of abnormal behaviour.

Ryan McVay/Photodisc/Getty Images, Inc.

Abnormal behaviour frequently produces disability or dysfunction, but some diagnoses, such as transvestism, are not clearly disabilities.

and it is not possible to offer a simple definition of abnormality that captures it in its entirety. The characteristics presented constitute a partial definition, but they do not equally apply to every diagnosis.

Focus on Discovery 1.1 describes the education and training of professionals who study and treat mental disorders. Goering, Wasylenki, and Durbin (2000) estimated that approximately 3,600 practising psychiatrists, about 13,000 psychologists and psychological associates, and about 11,000 nurses specialize in the mental health area in Canada. Thousands of social workers also work in the mental health field. Goering et al. (2000) also noted that, "The major proportion of primary mental health care in Canada is delivered by general practitioners (GPs)" (p. 350). Psychiatrists (who are medical doctors) have a great deal of clinical autonomy. The majority are self-employed professionals whose clinical income is usually based on billing their provincial health plan. As noted by Latimer (2005), "Psychiatrists are essentially free to choose the patient population they wish to care for, and how" (p. 566).

Analyses of the results of the National Population Health Survey (NPHS; Statistics Canada, 1995) indicated that approximately 2% of respondents had consulted with a psychologist one or more times in the preceding 12 months (Hunsley, Lee, & Aubry, 1999)—equivalent to almost 515,000 people in the Canadian population aged 12 and older. Hunsley and colleagues concluded, however, that psychological services are vastly underused. They also determined that psychological

FOCUS ON DISCOVERY 1.1

THE MENTAL HEALTH PROFESSIONS

The training of **clinicians**, the various professionals authorized to provide psychological services, takes different forms. Here, we discuss several types of clinicians, the training they receive, and a few related issues.

To be a **clinical psychologist** typically requires a Ph.D. or Psy.D. degree, which entails four to seven years of graduate study. However, in Canada, professional regulation of the psychology profession is within the jurisdiction of the provinces and territories and, depending upon regulatory statutes, a psychologist may have either a doctoral- or a master's-level degree (Hunsley & Johnston, 2000). In some jurisdictions the title "psychologist" is reserved for doctoral-level registrants, whereas master's-level registrants are referred to as "psychological associates." Specific curriculum requirements vary across jurisdictions. Gauthier (2002) concluded that there was effectively no consensus among the provinces on the minimal academic requirements, the required length of supervised practice, and the timing of such practice (i.e., before or after the degree is achieved).

The 1995 Agreement on Internal Trade stipulated that a framework for mobility had to be developed so that the credentials of professional psychologists from one part of Canada would be recognized in other parts of Canada. A Mutual Recognition Agreement was signed in June 2001. According to Gauthier (2002), this requires a person to obtain five core competencies in order to become a registered psychologist: (1) interpersonal relationships, (2) assessment and evaluation (including diagnosis), (3) intervention and consultation, (4) research, and (5) ethics and standards.

Training for a Ph.D. in clinical psychology requires a heavy emphasis on laboratory work, research design, statistics, and the empirically based study of human and animal behaviour. The Ph.D. is basically a research degree, and candidates are required to research and write a dissertation on a specialized topic. But candidates in clinical psychology learn skills in two additional areas, which distinguishes them from other Ph.D. candidates in psychology. First, they learn techniques of **assessment** and **diagnosis** of mental disorders. Second, they learn how to practise **psychotherapy**, a primarily verbal means of helping troubled individuals change their thoughts, feelings, and behaviour to reduce distress and to achieve greater life satisfaction. Students take courses in which they master specific techniques under close professional supervision; then, during an intensive internship or post-doctoral training, they gradually assume increasing responsibility for the care of clients.

Other clinical graduate programs are more focused on practice. These programs offer the relatively new degree of Psy.D. (doctor of psychology). The curriculum is similar to that required of Ph.D. students, with less emphasis on research and more on clinical training. The Ph.D. approach is based on a scientist-practitioner model, while the Psy.D. approach is based on a scholar-practitioner model, which is described below. Note that a recent survey of clinical psychology students in Ph.D. programs in Canada found that most students enrolled in current programs were satisfied with their level of science training, and as was the case in the United States, students felt that the training received was slightly more weighted toward research than toward clinical practice (Peluso, Carleton, & Asmundson, 2010).

The Canadian Psychological Association (CPA) Psy.D. Task Force (1998) described a scholar-practitioner as a "flexible, socially responsible, thinking practitioner who derives his/her skills from core knowledge in scientific psychology. This comprehensively trained professional is capable of performing in a number of roles, and would not be trained simply to be a technician in specific areas" (p. 13). As of 2007 there were two Psy.D. programs in Canada, at the Université du Québec and Université Laval, both offered in French. Later, Memorial University initiated a Psy.D. program in 2009 and in 2013, a Psy.D. program was introduced in Vancouver at a campus of the Adler School of Professional Psychology. According to the CPA, psychologists are Canada's single largest group of licensed and specialized mental health care providers. Further, psychologists are the primary researchers and providers of evidence-based psychological treatments.

A **psychiatrist** holds an MD degree and has had postgraduate training, called a residency, in which he or she has received supervision in the practice of diagnosis and psychotherapy. By virtue of the medical degree, and in contrast with psychologists, psychiatrists can also continue functioning as physicians—giving physical examinations, diagnosing medical problems, and the like. Most often, however, the primary aspect of medical practice in which psychiatrists engage is prescribing **psychoactive drugs**, chemical compounds that can influence how people feel and think. Nonetheless, a recent study (Hadjipavlou & Ogrodniczuk, 2007) concluded that current psychiatry residents in Canada have a strong interest in psychotherapy training.

A **psychoanalyst** has received specialized training at a psychoanalytic institute. The program usually involves several years of clinical training as well as the in-depth psychoanalysis of the trainee. It can take up to 10 years of graduate work to become a psychoanalyst and there are proportionally fewer psychoanalysts in modern times.

A **social worker** obtains an M.S.W. (master of social work) degree. Programs for **counselling psychologists** are somewhat similar to graduate training in clinical psychology but usually have less emphasis on research and the more severe forms of psychopathology. How does counselling psychology differ from clinical psychology in Canada? First, they differ in number. A survey reported in 2012 compared 22 accredited clinical psychology programs and 4 counselling psychology programs in Canada (see Bedi, Klubben, & Barker, 2012). While there are many similarities, there also key differences. Another key difference is that counselling programs tend to be terminal, meaning that students earn a master's degree and there is no doctoral progress that follows. Also, clinical psychology programs tend to have a large proportion of their faculty members registered as clinical psychologists (see Bedi et al., 2012).

services are more available in urban areas than in rural areas and that psychiatrists tend to practise in major urban centres. Thus, many areas of Canada are underserved by two important mental health professions.

There has been a lively and sometimes acrimonious debate concerning the merits of allowing clinical psychologists with suitable training to prescribe psychoactive drugs (see Westra, Eastwood, Bouffard, & Gerritsen, 2006). Predictably, granting **prescriptive authority** to psychologists is opposed by psychiatrists for various reasons (see McGrath, 2010). It is also opposed by many psychologists, who view it as an ill-advised dilution of the behavioural science focus of psychology. Is it possible for a non-MD to learn enough about biochemistry and physiology to monitor the effects of drugs and protect clients from adverse side effects and drug interactions? This debate will undoubtedly continue for some time; at present, prescriptive authority has been granted to psychologists in three U.S. jurisdictions (New Mexico, Louisiana, and the U.S. territory of Guam) (see McGrath, 2010).

HISTORY OF PSYCHOPATHOLOGY

> "Those who cannot remember the past are condemned to repeat it."
>
> —George Santayana, *The Life of Reason*

The search for the causes of deviant behaviour has gone on for a long time. Before the age of scientific inquiry, all good and bad manifestations of power beyond the control of humankind—eclipses, earthquakes, storms, fire, serious and disabling diseases, the passing of the seasons—were regarded as supernatural. Behaviour seemingly outside individual control was subject to similar interpretation. Many early philosophers, theologians, and physicians who studied the troubled mind believed that deviancy reflected the displeasure of the gods or possession by demons.

EARLY DEMONOLOGY

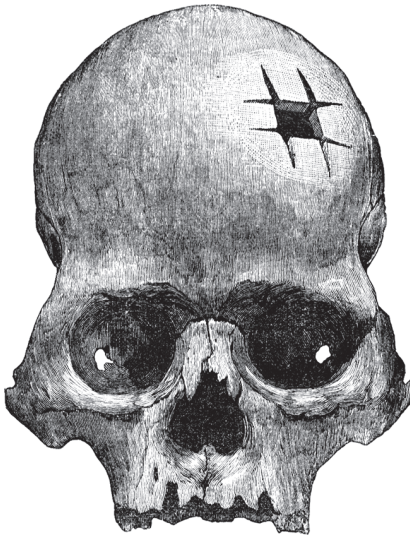
The doctrine that an evil being, such as the devil, may dwell within a person and control his or her mind and body is called **demonology**. Examples of demonological thinking are found in the records of the early Chinese, Egyptians, Babylonians, and Greeks. Among the Hebrews, deviancy was attributed to possession of the person by bad spirits, after God in his wrath had withdrawn protection. Christ is reported to have cured a man with an unclean spirit by casting out the devils from within him and hurling them into a herd of swine (Mark 5:8–13).

Following from the belief that abnormal behaviour was caused by possession, its treatment often involved **exorcism**, the casting out of evil spirits by ritualistic chanting or torture. Exorcism typically took the form of elaborate rites of prayer, noisemaking, forcing the afflicted to drink terrible-tasting brews, and on occasion more extreme measures, such as flogging and starvation, to render the body uninhabitable to devils.

Trepanning of skulls (the making of a surgical opening in a living skull by some instrument) by Stone Age or neolithic cave dwellers was quite widespread. One popular theory is that it was a way of treating conditions such as epilepsy, headaches, and psychological disorders attributed to demons within the cranium. It was presumed that the individual would return to a normal state by creating an opening through which evil spirits could escape. Trepanning was presumably introduced into the Americas from Siberia. Although the practice was most common in Peru and Bolivia, three Aboriginal specimens have been found in Canada, all on the Pacific coast in British Columbia. One skull is that of a young male believed to be of high rank, since he received a "copper burial" (his forehead and chest were covered by thin sheets of copper). Despite the extensive focus in Aboriginal cultures on possession by spirits, the widely accepted interpretation of the historical data has been disputed. Kidd (1946) suggested that the trepannings "were done to relieve pressure resulting from depressed fractures caused by war clubs" (p. 515).

SOMATOGENESIS

In the fifth century B.C., Hippocrates (ca. 460–377 B.C.), often regarded as the father of modern medicine, separated medicine from religion, magic, and superstition. He rejected the prevailing Greek belief that the gods sent serious physical diseases and mental disturbances as punishment and insisted instead that such illnesses had natural causes and hence should be treated like other, more common maladies, such as colds and constipation. Hippocrates regarded the brain as the organ of consciousness, of intellectual life and emotion; thus, he thought that deviant thinking and behaviour were indications of some kind of brain pathology. Hippocrates is often considered one of the very earliest proponents of **somatogenesis**—the notion that something wrong with the soma, or physical body, disturbs thought and action. **Psychogenesis**, in contrast, is the belief that a disturbance has psychological origins.



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Was trepanning by the Aboriginals of British Columbia performed to allow evil spirits to escape the body?