ANN M. KRING • SHERI L. JOHNSON

ABNORMAL PSYCHOLOGY 12e

GERALD DAVISON • JOHN NEALE

DSM 5

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DSM-5 Diagnoses

NEURODEVELOPMENTAL DISORDERS

Intellectual Disability

Intellectual Disability (Intellectual Development Disorder)

Communication Disorders

Language Disorder / Social (Pragmatic) Communication Disorder / Speech Sound Disorder / Childhood Onset Fluency Disorder (Stuttering)

Autism Spectrum Disorder

Autism Spectrum Disorder

Attention-Deficit / Hyperactivity Disorder

Attention-Deficit / Hyperactivity Disorder

Specific Learning Disorder

Motor Disorders

Developmental Coordination Disorder / Stereotypic Movement Disorder / Tourette's Disorder / Persistent (Chronic) Motor or Vocal Tic Disorder / Provisional Tic Disorder

SCHIZOPHRENIA SPECTRUM DISORDERS

Schizophrenia / Schizotypal (Personality) Disorder / Schizophreniform Disorder / Brief Psychotic Disorder / Delusional Disorder / Schizoaffective Disorder

BIPOLAR AND RELATED DISORDERS

Bipolar I Disorder / Bipolar II Disorder / Cyclothymic Disorder

DEPRESSIVE DISORDERS

Disruptive Mood Dysregulation Disorder / Major Depressive Disorder / Persistent Depressive Disorder (Dysthymia) / Premenstrual Dysphoric Disorder

ANXIETY DISORDERS

Panic Disorder / Agoraphobia / Specific Phobia / Social Anxiety Disorder (Social Phobia) / Generalized Anxiety Disorder / Separation Anxiety Disorder / Selective Mutism

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

Obsessive-Compulsive Disorder / Body Dysmorphic Disorder / Hoarding Disorder / Trichotillomania (Hair-Pulling Disorder) / Excoriation (Skin Picking Disorder)

TRAUMA- AND STRESSOR-RELATED DISORDERS

Reactive Attachment Disorder / Disinhibited Social Engagement Disorder / Acute Stress Disorder / Posttraumatic Stress Disorder / Adjustment Disorders

DISSOCIATIVE DISORDERS

Depersonalization / Derealization Disorder / Dissociative Amnesia / Dissociative Identity Disorder

SOMATIC SYMPTOM AND RELATED DISORDERS

Somatic Symptom Disorder / Illness Anxiety Disorder / Conversion Disorder / Psychological Factors Affecting other Medical Conditions / Factitious Disorder

FEEDING AND EATING DISORDERS

Pica / Rumination Disorder / Avoidant/Restrictive Food Intake Disorder / Anorexia Nervosa / Bulimia Nervosa /Binge Eating Disorder

ELIMINATION DISORDERS

Enuresis / Encopresis

SLEEP-WAKE DISORDERS

Insomnia Disorder / Hypersomnolence Disorder / Narcolepsy / Obstructive Sleep Apnea Hypopnea / Central Sleep Apnea / Sleep-related Hypoventilation / Circadian Rhythm Sleep-Wake Disorders / Nightmare Disorder / Rapid Eye Movement Sleep Behavior Disorder / Restless Legs Syndrome / Non-Rapid Eye Movement Sleep Arousal Disorders

SEXUAL DYSFUNCTIONS

Erectile Disorder / Female Orgasmic Disorder / Delayed Ejaculation / Early Ejaculation / Femal Sexual Interest/Arousal Disorder / Male Hypoactive Sexual Desire Disorder/ Genito-Pelvic Pain / Penetration Disorder

GENDER DYSPHORIA

Gender Dysphoria in Children, in Adolescents, or Adults

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

Oppositional Defiant Disorder / Intermittent Explosive Disorder / Conduct Disorder

SUBSTANCE USE AND ADDICTIVE DISORDERS

Alcohol Use Disorder / Amphetamine Use Disorder / Cannabis Use Disorder / Stimulant Use Disorder / Other Hallucinogen Use Disorder / Inhalant Use Disorder / Nicotine Use Disorder / Opioid Use Disorder / Phencyclidine Use Disorder / Sedative, Hypnotic, or Anxiolytic Use Disorders / Tobacco Use Disorder / Gambling Disorder

NEUROCOGNITIVE DISORDERS

Delirium / Mild Neurocognitive Disorder / Major Neurocognitive Disorder

PERSONALITY DISORDERS

Antisocial Personality Disorder / Avoidant Personality Disorder / Borderline Personality Disorder / Narcissistic Personality Disorder / Obsessive-Compulsive Personality Disorder / Schizotypal Personality Disorder / Dependent Personality Disorder / Schizoid Personality Disorder / Paranoid Personality Disorder / Histrionic Personality Disorder

PARAPHILIC DISORDERS

Exhibitionistic Disorder / Fetishistic Disorder / Frotteuristic Disorder / Pedophilic Disorder / Sexual Masochism Disorder / Sexual Sadism Disorder / Transvestic Disorder / Voyeuristic Disorder

CONDITIONS FOR FURTHER STUDY

Attenuated Psychosis Syndrome / Depressive Episodes with Short-Duration Hypomania / Persistent Complex Bereavement Disorder / Caffeine Use Disorder / Internet Gaming Disorder / Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure / Suicidal Behavior Disorder / Non-Suicidal Self Injury

DSM-5 Classification System

Neurodevelopmental Disorders
Schizophrenia Spectrum and Other Psychotic Disorders
Bipolar and Related Disorders
Depressive Disorders
Anxiety Disorders
Obsessive-Compulsive and Related Disorders
Trauma- and Stressor-Related Disorders
Dissociative Disorders
Somatic Symptom and Related Disorders
Feeding and Eating Disorders
Elimination Disorders
Sleep-Wake Disorders
Sexual Dysfunctions
Gender Dysphoria
Disruptive, Impulse-Control, and Conduct Disorders
Substance-Related and Addictive Disorders
Neurocognitive Disorders
Personality Disorders
Paraphilic Disorders
Other Mental Disorders
Medication-Induced Movement Disorders and Other Adverse Effects of Medication
Other Conditions That My Be a Focus of Clinical Attention

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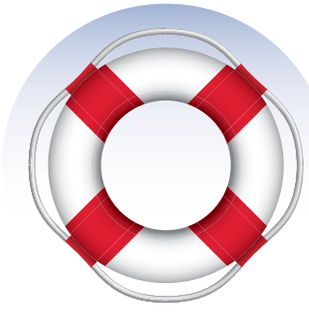

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Abnormal Psychology

Twelfth Edition—DSM-5 Update

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Abnormal Psychology

Twelfth Edition—DSM-5 Update

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To

Angela Hawk

Daniel Rose

About the Authors

ANN M. KRING is Professor of Psychology at the University of California at Berkeley, where she is a former Director of the Clinical Science Program and Psychology Clinic. She received her B.S. from Ball State University and her M.A. and Ph.D. from the State University of New York at Stony Brook. Her internship in clinical psychology was completed at Bellevue Hospital and Kirby Forensic Psychiatric Center, in New York. From 1991 to 1998, she taught at Vanderbilt University. She received a Distinguished Teaching Award from UC Berkeley in 2008. She is on the editorial board of *Schizophrenia Bulletin, Journal of Abnormal Psychology,* and *Psychological Science in the Public Interest*, an Associate Editor for *Applied and Preventive Psychology,* and a former Associate Editor for *Journal of Abnormal Psychology* and *Cognition and Emotion.* She is a former member of the Executive Board of the International Society for Research on Emotion.

She has won several awards, including a Young Investigator Award from the National Alliance for Research on Schizophrenia and Depression in 1997 and the Joseph Zubin Memorial Fund Award in recognition of her research in schizophrenia in 2006. In 2005, she was named a fellow of the Association for Psychological Science. Her research has been supported by grants from the Scottish Rite Schizophrenia Research program, the National Alliance for Research on Schizophrenia and Depression, and the National Institute of Mental Health. She is a co-editor (with Denise Sloan) of the book *Emotion Regulation and Psychopathology* (Guilford Press) and is the author on more than 70 articles and chapters. Her current research focus is on emotion and psychopathology, with a specific interest in the emotional features of schizophrenia, assessing negative symptoms in schizophrenia, and the linkage between cognition and emotion in schizophrenia.

SHERI L. JOHNSON is Professor of Psychology at the University of California at Berkeley, where she directs the Cal Mania (Calm) program, and is a visiting professor at the University of Lancaster, England. She received her B.A. from Salem College and her Ph.D. from the University of Pittsburgh. She completed an internship and postdoctoral fellowship at Brown University, and she was a clinical assistant professor at Brown from 1993 to 1995. From 1995 to 2008, she taught in the Department of Psychology at the University of Miami, where she was recognized three times with the Excellence in Graduate Teaching Award. In 1993, she received the Young Investigator Award from the National Alliance for Research in Schizophrenia and Depression. She is an Associate Editor for *Applied and Preventive Psychology,* and she serves on the editorial board for *Psychological Bulletin* and *International Journal of Cognitive Therapy*. She is a member of the Executive Board for the Society for Research in Psychopathology and a Fellow of the Academy of Behavioral Medicine Research and the Association for Psychological Science.

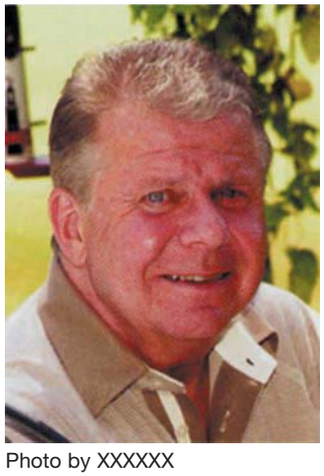
For the past 25 years, her work has focused on understanding the factors that predict the course of mania and depression. She uses social, psychological, and neurobiological paradigms to understand these processes. Her work has been funded by the National Alliance for Research on Schizophrenia and Depression and by the National Institute of Mental Health. She has published over 100 articles and chapters, and her findings have been published in leading journals such as the *Journal of Abnormal Psychology* and the *American Journal of Psychiatry*. She is co-editor of several books, including *Psychological Treatment of Bipolar Disorder* (Guilford Press).

A bit of authorship history…

Nearly 40 years ago, Gerald Davison and John Neale sat down to share their experiences teaching the undergraduate abnormal psychology course at the State University of New York at Stony Brook. Arising from that conversation was the outline of a textbook on which they decided to collaborate, one that was different from the texts available at the time. The first edition of this book, co-authored by Davison and Neale, was published in 1974. Ann Kring joined the team in 2001, and she invited Sheri Johnson to join in 2004, when Kring and Johnson took over full authorship responsibilities. The legacy of Davison and Neale remains in this and every edition, and we are forever indebted to these two pioneering authors who developed and wrote many editions of this textbook. Near the end of our work on the twelfth edition, we learned that John Neale had passed away after a long illness. He will be greatly missed by many.

Photo by Christine McDowell.

GERALD C. DAVISON is Professor of Psychology at the University of Southern California. 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 honors 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 behavioral and emotional problems via his articulated thoughts in simulated situations paradigm.



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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.

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Preface

It has been nearly 40 years since the first edition of this book was published. From the beginning, the focus of the book has always been on the balance and blending of research and clinical application; on the use of paradigms as an organizing principle; and on the effort to involve the reader in the problem solving engaged in by clinicians and scientists. These qualities have continued to be the cornerstones of subsequent editions, and we have been both surprised and delighted at the favorable reception the book has received and, perhaps more importantly, the impact it has had on the lives of so many students of psychopathology throughout the years.

With the DSM-5 update of the twelfth edition, we continue to emphasize the recent and comprehensive research coverage that has been the hallmark of the book as well as to expand the pedagogical features. We have added additional clinical cases, figures, tables, and clarifying writing to make this material accessible to a broad audience. Now more than ever, we emphasize an integrated approach, showing how psychopathology is best understood by considering multiple perspectives and how these varying perspectives can provide us with the clearest accounting of the causes of these disorders as well as the best possible treatments.

The cover image is a satellite image of the Great Sandy Desert in Australia. The light-colored, fan-like parts of the image are of the scars left by a wildfire that tore through the desert in the year 2000. Wildfires are a necessary part of the life cycle of a healthy ecosystem, and they are a powerful means for reshaping the landscape. Beyond the beauty of this image, it illustrates a number of key principles about our book. Like landscapes, humans are shaped by neurobiology and environmental events, which is what the study of psychopathology is all about: different paradigms (genetic, neuroscience, cognitive–behavioral) coming together to shape the development and course of different psychological disorders. This is also how science works. New discoveries help to reshape the landscape of scientific inquiry. Our book is first and foremost grounded in the latest science of mental illness. However, just as landscapes continually change and shift, so does the field of psychopathology. As new discoveries and new treatments are developed, our understanding shifts toward a better conceptualization of mental illness.

Goals of the Book

With each new edition, we update, make changes, and streamline features to enhance both the scholarly and pedagogical characteristics of the book. We also devote considerable effort to couching complex concepts in prose that is sharp, clear, and vivid. In the past 40 years, the domains of psychopathology and intervention have become increasingly multifaceted and technical. Therefore, a good abnormal psychology textbook must engage the careful and focused attention of students so that they can acquire a deep and critical understanding of the issues and the material. Some of the most exciting breakthroughs in psychopathology research and treatment that we present in the book have come in areas that are complex, such as molecular genetics, neuroscience, and cognitive science. Rather than oversimplify these complex issues, we have instead added a number of pedagogical features to enhance understanding of this vital material.

We endeavor to present up-to-date theories and research in psychopathology and intervention as well as to convey some of the intellectual excitement that is associated with the search for answers to some of the most puzzling questions facing humankind. A reviewer of an earlier edition once said that our book reads like a detective story, for we do more than just state the problem and then its solution. Rather, we try to involve the student in the search for clues, the follow-up of hunches, and the evaluation of evidence—all of which are part and parcel of the science and art of the field. We try to encourage students to participate with us in a process of discovery as we sift through the evidence on the origins of psychopathology and the effectiveness of specific interventions.

In this edition, we continue to emphasize ways in which we can do away with the stigma that is unfortunately still associated with mental illness. Psychopathology is something that affects all of us in one way or another. As many as half of us may experience a psychological disorder at some time or another, and most of us know someone who has had a mental disorder. Despite the ubiquity of psychopathology, the stigma associated with it can keep some from seeking treatment, keep our legislatures from providing adequate funding for treatment and research, and keep some terms as accepted popular vernacular (e.g., *crazy, nuts*). Thus, another of our goals for the book is to combat this stigma and present a positive and hopeful view on the causes and treatments of mental illness.

Organization of the Twelfth Edition—DSM-5 Update

In Chapters 1 through 4, we place the field in historical context, present the concept of paradigms in science, describe the major paradigms in psychopathology, describe the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), critically discuss its validity and reliability, provide an overview of major approaches and techniques in clinical assessment, and then describe the major research methods of the field. These chapters are the foundation on which the later chapters can be interpreted and understood. As in the eleventh edition, specific disorders and their treatment are discussed in Chapters 5 through 15. However, we have reorganized these chapters for better flow in a typical abnormal psychology course. In Chapter 16, we discuss legal and ethical issues.

A recurrent theme in the book is the importance of perspectives, or, to use Kuhn's (1962/1970) phrase, paradigms. Throughout the book we discuss three major paradigms: genetic, neuroscience, and cognitive behavioral. We also emphasize the importance of factors that are important to all paradigms, including emotion, gender, culture, ethnicity, socioeconomic status, and interpersonal relationships. A related issue is the use of more than one paradigm in studying abnormal psychology. Rather than force an entire field into, for example, a cognitive behavioral paradigm, we argue from the available information that different problems in psychopathology are amenable to analyses within different frameworks. For instance, genetic factors are important in bipolar disorder and attention-deficit/hyperactivity disorder, but genes do their work via the environment. In disorders such as depression, cognitive behavioral factors are essential, but neurotransmitters also exert an influence. For still other disorders—for example, dissociative disorders—cognitive factors involving consciousness are important to consider. Furthermore, the importance of a diathesis–stress approach remains a cornerstone to the field. Emerging data indicate that nearly all mental disorders arise from subtle interactions between genetic or psychological predispositions and stressful life events.

We continue to include considerable material on culture and ethnicity in the study of psychopathology and intervention. In Chapter 2, we present a separate section that emphasizes the importance of culture and ethnicity in all paradigms. We point to the important role of culture and ethnicity in the other chapters as well. For example, in the Diagnosis and Assessment chapter (3), we discuss cultural bias in assessment and ways to guard against this selectivity in perception. We have expanded and updated information on ethnicity with respect to how stress impacts health in Chapter 2, we have provided new findings about families and culture in schizophrenia (Chapter 9), and we have updated coverage of culture and ethnicity in substance use disorders (Chapter 10).

We continue to emphasize and expand our discussion of genetics and psychopathology throughout the book. We repeatedly emphasize that psychopathology is best understood by considering how genes do their work via the environment. Thus, rather than asking whether genes or the environment is more important in a particular disorder, we emphasize that both of these factors are important. Exciting new discoveries have made it clear that nature and nurture work together, not in opposition to each another. Without the genes, a behavior might not be possible. But without the environment, genes could not express themselves and thus contribute to the behavior. Genes are remarkably flexible at responding to different types of environments. In turn, human beings are quite flexible at adapting to different environments.

New to This Edition

The DSM-5 update of the twelfth edition has many new and exciting additions and changes. By the time current students graduate and join our field, DSM-5 will be in use. Our goal is to help prepare them for this. Thus, we have added significant new material about DSM-5 in every chapter. We have added two new chapters to reflect the organization of the DSM-5. We have also added many new tables and figures throughout the book to illustrate the similarities and differences between DSM-5 and older diagnostic symptoms.

In addition, we continue to update and innovate. We no longer apologetically cover theories that don't work or don't have empirical support. As the research on each disorder has burgeoned, we've moved to just highlighting the most exciting and accepted theories, research, and treatments. This edition, as always, contains hundreds of updated references. Throughout the book, we have further streamlined the writing to increase the clarity of presentation and to highlight the key issues in the field. We have included many more figures to carefully illustrate the genetics and brain networks involved in different disorders.

One of our major changes was to shift the chapter structure of the book to make the material more integrated and accessible. First, we have reorganized the order of chapters so that the disorder chapters are presented in an order that maximizes their similarities and research base. In past editions, we included a chapter late in the book on therapies, and yet we covered therapies throughout the book as well. In this edition, we've integrated the material on the different types of therapies in each and every chapter, and we introduce these concepts in Chapters 1 and 2. So that students will be equipped to understand the state of research on treatments as they consider each disorder, we've described how to evaluate treatment outcome studies early in the book, as we discuss other research methods in Chapter 4. To bring treatment to life, we've added new Clinical Cases throughout the chapters on specific disorders.

We have continued to add additional pedagogy based on feedback from students and professors. In addition to the new Clinical Case boxes, we have also added a number of new Focus on Discovery boxes in order to illustrate what the different disorders look like in the context of real people's lives. In addition, we have modified and added new Check Your Knowledge questions so that students can do a quick check to see if they are learning and integrating the material. There are many new photos to provide students with additional real-world examples and applications of psychopathology. The end-of-chapter summaries continue to be consistent across the chapters, using a bulleted format and summarizing the descriptions, causes, and treatments of the disorders covered.

New and Expanded Coverage

We are really excited about the new features of this edition. Some of the major new material in this DSM-5 update edition includes:

Chapter 1: Introduction and Historical Overview

New research on stigma and mental illness
New material on the DSM-5 definition of mental disorder
Expanded section on the history of psychoanalysis and psychodynamic thought
New Focus on Discovery box on Freud and depression
New section on cognition
New material on the mental health professions

Chapter 2: Current Paradigms in Psychopathology

Paradigms reorganized to include genetic, neuroscience, and cognitive behavioral

New section on interpersonal factors that cut across paradigms, including discussion of interpersonal psychotherapy
New material on cutting-edge molecular genetics, including SNPs, CNVs, and genome-wide association studies, including new figures to illustrate these issues
Genetics section revised to amplify how genes interact with the environment
Updated coverage on cognitive science contributions to cognitive behavioral paradigm
New Clinical Case in the cognitive behavioral paradigm section
Expanded coverage of factors that cut across paradigms: emotion, sociocultural factors, and interpersonal factors
Three new Focus on Discovery boxes on: (1) gender and health, (2) socioeconomics and health, (3) couples and family therapies
New Check Your Knowledge questions

Chapter 3: Diagnosis and Assessment

Completely reorganized section on diagnosis to reflect DSM-5
New tables and figures comparing DSM-IV-TR to DSM-5
New Focus on Discovery box on the history of stress research
Expanded section on the assessment of stress, including current methods for comprehensively assessing stress with interviews and self-report checklists
New research on IQ assessment
Updated and expanded coverage of cultural factors in diagnosis and assessment

Chapter 4: Research Methods in Psychopathology

Updated section on molecular genetics research methods
New material on methods and issues involved in evaluating treatments, including the randomized controlled clinical trial, to give students a more solid understanding of treatment issues as they read through that material in each of the chapters on psychopathology
New material on the issue of nonrepresentative samples and its impact on research
New material on dissemination efforts designed to diminish the gap between research and practice

Chapter 5: Mood Disorders

New evidence for the lower rates of depression among immigrants to the United States
New evidence for light therapy as a successful treatment for nonseasonal forms of affective disorder
New evidence about the prevalence of bipolar disorder worldwide
Discussion of base rates of bipolar II disorder in the context of the growing awareness of the low reliability of structured interviews for the disorder
Substantially updated material on the neurobiology (brain imaging) findings for depression, including experimental manipulations using deep brain stimulation and new neurobiological models of emotion regulation
Removal of research that has not been well replicated
Three new Focus on Discovery boxes on (1) cardiovascular disease and depression, (2) non-suicidal self-injury, and (3) the overlap between anxiety and depression
Several new tables to provide an overview of the subtype specifiers for depression and bipolar disorder, key neurobiological models of mood disorders, and key terms in suicidality
Substantial updates to cognitive theories of depression, including new research on information processing and rumination
New figure to illustrate the basic components of hopelessness theory
New research on sleep deprivation and schedule disruption as a predictor of manic symptoms
More succinct coverage of the history of research and debate regarding the efficacy of cognitive therapy
New findings showing that computerized cognitive therapy can be helpful
New findings on suicide prevention
Entire section on suicide streamlined and updated to cover recent evidence of the role of the social environment

Chapter 6: Anxiety Disorders

Chapter reorganized to reflect removal of OCD and PTSD from the anxiety disorders chapter in the DSM-5
Most of the risk factors are now general to the different anxiety disorders, making this a simpler chapter for students to comprehend
Recent findings on the neurobiology of fear conditioning and, in the treatment section, on how neurobiology helps us understand extinction
Etiology section reorganized with clarity and current research in mind
New material on the use of computerized interventions and virtual reality
Focus in treatment sections on the principles and efficacy across anxiety disorders, reflecting the growing research base on commonalities across anxiety disorders

Chapter 7: Obsessive-Compulsive-Related and Trauma-Related Disorders

Brand new chapter for this edition, covering obsessive-compulsive disorder, hoarding disorder, body dysmorphic disorder, post-traumatic stress disorder, and acute stress disorder

Chapter 8: Dissociative Disorders and Somatic Symptom-Related Disorders

Reorganized to fit with DSM-5 changes—reflected in the clinical description, etiology, and treatment sections, which are now much simpler
New section on neurobiology of somatic symptoms and pain
New Clinical Case on factitious disorder

Chapter 9: Schizophrenia

New information on DSM-5
New Focus on Discovery box on attenuated psychosis syndrome

Outdated material on genetics trimmed and new research on GWAS studies, including a new figure, added
Developmental section reorganized to distinguish familial high-risk from clinical high-risk studies
New material on schizophrenia and the brain
New material on culture and expressed emotion
New section on environmental factors impacting the cause of schizophrenia, including cannabis use
Updated material on second-generation antipsychotic medications
Updated material on cognitive remediation treatments
New section on psychoeducation

Chapter 10: Substance Use Disorders

New material on DSM-5 changes, including abuse and dependence as indicators of severity of alcohol and drug use disorders
New statistics and two new figures on use of all drugs
New material on cravings for substances
New figures on use of drugs and emergency room visits for pain medications (nonmedical uses)
New material on medical marijuana
New treatment studies for smoking, heroin, alcohol, and cocaine
New information on drug replacement treatment
New information on treatment instead of prison for drug offenders

Chapter 11: Eating Disorders

Expanded section on binge eating disorder, consistent with its inclusion in DSM-5, including physical consequences and prognosis
New Clinical Case on binge eating disorder
Updated material on obesity
Updated section on family factors
Updated material on family treatment for anorexia
New material on treatment for binge eating disorder
Updated sections on symptoms, physical consequences, and prognosis for all eating disorders

Chapter 12: Sexual Disorders

Gender identity disorder no longer covered, as we believe this diagnosis stigmatizes more than it helps; this diagnosis placed in cultural and historical context
Similarly, transvestic fetishism no longer covered, given the lack of evidence that this behavior causes harm
DSM-5 changes in sexual dysfunction and paraphilic disorders described
Lack of validity for Kaplan's phases of the sexual response cycle in women described
Graph added to show rates of HIV diagnoses by age, showing highest incidence among people in their early 20s
Material on rape covered in a new Focus on Discovery box
New material from the first randomized controlled trial for CBT among sex offenders, showing poor outcomes

Chapter 13: Disorders of Childhood

New figures and tables showing the changes in DSM-5 for these disorders
Updated material on conduct disorder types and traits
Major revision to section on intellectual disability, including use of new name adopted in DSM-5
Updated material on dyslexia and dyscalculia
Updated material on genetics in autism spectrum disorder
Updated material in the Focus on Discovery box covering controversies in the field
Updated material on treatment for ADHD, longitudinal studies of the course of ADHD, and environmental toxins and ADHD
Updated material on depression and anxiety in children
Two new Focus on Discovery boxes on (1) asthma and (2) history of autism

Chapter 14: Late-Life and Neurocognitive Disorders

Chapter substantially reorganized to focus mostly on neurocognitive disorders
Updated material on methods and issues involved in understanding late life
New material on mild cognitive impairment, Alzheimer's disease, frontotemporal dementia, and preclinical risk for Alzheimer's disease
New material to show how lifestyle factors such as exercise, cognitive engagement, and depression can influence the onset and course of Alzheimer's disease
New material to capture recent findings on the emotional and social deficits associated with frontotemporal dementia
Updated sections on treatments, with a discussion of the emergent focus on early identification

Chapter 15: Personality Disorders

New section on new aspects of personality assessment included in DSM-5 appendix
New material on mentalization-based treatment, which has shown effects across an 8-year follow-up period for the treatment of borderline personality disorder
Treatment section reorganized and simplified
New material demonstrating comorbidity, etiological overlap, and treatment parallels of obsessive-compulsive personality disorder type with obsessive-compulsive disorder and of schizotypal personality disorder type with schizotypy

Chapter 16: Legal and Ethical Issues

Material on the insanity defense trimmed and reorganized
New material on violence and mental illness
New material on competency to stand trial
Overall chapter trimmed and tightened up

Special Features for the Student Reader

Several features of this book are designed to make it easier for students to master and enjoy the material.

Clinical Case Boxes We have expanded and added a number of new Clinical Cases throughout the book to provide a clinical context for the theories and research that occupy most of our attention in the chapters and to help make vivid the real-life implications of the empirical work of psychopathologists and clinicians.

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 readers in specialized topics 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. We have added a number of new boxes in this edition, replacing a number of the older ones. Additional boxes feature real-life examples of individuals living with different disorders.

Quick Summaries We include short summaries throughout the chapters to allow students to pause and assimilate the material. These should help students keep track of the multifaceted and complex issues that surround the study of psychopathology.

End-of-Chapter Summaries Summaries at the end of each chapter have been rewritten in bulleted form. In Chapters 5–15, we organize these by clinical descriptions, etiology, and treatment—the major sections of every chapter covering the disorders. We believe this format will make it easier for readers to review and remember the material. In fact, we even suggest that students read the summary before beginning the chapter itself in order to get a good sense of what lies ahead. Then re-reading it after completing the chapter itself will enhance students' understanding and provide an immediate sense of what has been learned in just one reading of the chapter.

Check Your Knowledge Questions Throughout each chapter, we provide between three and six boxes that ask questions about the material covered in the chapter. These questions are intended to help students assess their understanding and retention of the material as well as provide them with samples of the types of questions that often are found in course exams. The answers to the questions in these boxes are at the end of each chapter, just before the list of key terms. We believe that these will be useful aids for students as they make their way through the chapters.

Glossary 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 these terms are listed again at the end of each chapter, and definitions appear at the end of the book in a glossary.

DSM-5 Table The endpapers of the book contain a summary of the psychiatric nomenclature for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, known as DSM-5. This provides a handy guide to where particular disorders appear in the "official" taxonomy or classification. We make considerable use of DSM-5, though in a selective and sometimes critical vein. Sometimes we find it more effective to discuss theory and research on a particular problem in a way that is different from DSM's conceptualization.

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- Chapter exams and quizzes, prepared by Courtney Worley of the University of Alabama and Kathy Sexton of Elmhurst College, give students a way to test themselves on course material before exams. Each question is also linked by a specific learning objective within the book to aid in concept mastery.
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From time to time, students and faculty colleagues have written us their comments on the book; these communications are always welcome. Readers can e-mail us at akring@berkeley.edu, sljohnson@berkeley.edu.

Finally and most importantly, our heartfelt thanks go to the most important people in our lives for their continued support and encouragement along the way. A great big thanks to Angela Hawk (AMK) and Daniel Rose (SLJ), to whom this book is dedicated with love and gratitude.

July 2013

Ann M. Kring, *Berkeley, CA*

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1 Introduction and Historical Overview

LEARNING GOALS

1. Be able to explain the meaning of stigma as it applies to people with mental disorders.
2. Be able to describe and compare different definitions of mental disorder.
3. Be able to explain how the causes and treatments of mental disorders have changed over the course of history.
4. Be able to describe the historical forces that have helped to shape our current view of mental disorders, including biological, psychoanalytic, behavioral, and cognitive views.
5. Be able to describe the different mental health professions, including the training involved and the expertise developed.

Clinical Case: Jack

Jack dreaded family gatherings. His parents' house would be filled with his brothers and their families, and all the little kids would run around making a lot of noise. His parents would urge him to "be social" and spend time with the family, even though Jack preferred to be alone. He knew that the kids called him "crazy Uncle Jack." In fact, he had even heard his younger brother Kevin call him "crazy Jack" when he stopped by to see their mother the other day. Jack's mother admonished him, reminding Kevin that Jack had been doing very well on his new medication. "Schizophrenia is an illness," his mother had said.

Jack had not been hospitalized with an acute episode of schizophrenia for over 2 years. Even though Jack still heard voices, he learned not to talk about them in front of his mother because she would then start hassling him about taking his medication or ask him all sorts of questions about whether he needed to go back to the hospital. He hoped he would soon be able to move out of his parents' house and into his own apartment. The landlord at the last apartment he had tried to rent rejected his application once he learned that Jack had schizophrenia. His mother and father needed to cosign the lease, and they had inadvertently said that Jack was doing very well with his illness. The landlord asked about the illness, and once his parents mentioned schizophrenia, the landlord became visibly uncomfortable. The landlord called later that night and said the apartment had already been rented. When Jack's father pressed him, the landlord admitted he "didn't want any trouble" and that he was worried that people like Jack were violent.

Clinical Case: Felicia

Felicia didn't like to think back to her early school years. Elementary school was not a very fun time. She couldn't sit still or follow directions very well. She often blurted out answers when it wasn't her turn to talk, and she never seemed to be able to finish her class papers without many mistakes. As if that wasn't bad enough, the other girls often laughed at her and called her names. She still remembers the time she tried to join in with a group of girls during recess. They kept running away, whispering to each other, and giggling. When Felicia asked what was so funny, one of the girls laughed and said, "You are hyper, girl! You fidget so much in class, you must have ants in your pants!"

When Felicia started fourth grade, her parents took her to a psychologist. She took a number of tests and answered all sorts of questions. At the end of these testing sessions, the psychologist diagnosed Felicia with attention-deficit/hyperactivity disorder (ADHD). Felicia began seeing a different psychologist, and her pediatrician prescribed the medication Ritalin. She enjoyed seeing the psychologist because she helped her learn how to deal with the other kids' teasing and how to do a better job of paying attention. The medication helped, too—she was able to concentrate better and didn't seem to blurt out things as much anymore.

Now in high school, Felicia is much happier. She has a good group of close friends, and her grades are better than they have ever been. Though it is still hard to focus sometimes, she has learned a number of ways to deal with her distractibility. She is looking forward to college, hoping she can get into the top state school. Her guidance counselor has encouraged her, thinking her grades and extracurricular activities will make for a strong application.

WE ALL TRY TO understand other people. Determining why another person does or feels something is not easy to do. In fact, we do not always understand our own feelings and behavior. Figuring out why people behave in normal, expected ways is difficult enough; understanding seemingly abnormal behavior, such as the behavior of Jack and Felicia, can be even more difficult.

In this book, we will consider the description, causes, and treatments of a number of different mental disorders. We will also demonstrate the numerous challenges professionals in this field face. As you approach the study of **psychopathology**, the field concerned with the nature, development, and treatment of mental disorders, keep in mind that the field is continually developing and adding new findings. As we proceed, you will see that the field's interest and importance is ever growing.

One challenge we face is to remain objective. Our subject matter, human behavior, is personal and powerfully affecting, making objectivity difficult. The pervasiveness and potentially disturbing effects of psychopathology intrude on our own lives. Who has not experienced irrational thoughts, or feelings? Most of us have known someone, a friend or a relative, whose behavior was upsetting and impossible to fathom, and we realize how frustrating and frightening it can be to try to understand and help a person suffering psychological difficulties. You can see that this personal impact of our subject matter requires us to make a conscious, determined effort to remain objective.

The other side of this coin is that our closeness to the subject matter adds to its intrinsic fascination; undergraduate courses in abnormal psychology are among the most popular in the entire college curriculum, not just in psychology departments. Our feeling of familiarity with the subject matter draws us to the study of psychopathology, but it also has a distinct disadvantage: we bring to the study our preconceived notions of what the subject matter is. Each of us has developed certain ways of thinking and talking about mental disorders, certain words and concepts that somehow seem to fit. As you read this book and try to understand the psychological disorders it discusses, we may be asking you to adopt different ways of thinking and talking from those to which you are accustomed.

Perhaps most challenging of all, we must not only recognize our own preconceived notions of mental disorders, but we must also confront and work to change the stigma we often associate with these conditions. **Stigma** refers to the destructive beliefs and attitudes held by a society that are ascribed to groups considered different in some manner, such as people with mental illness. More specifically, stigma has four characteristics (see Figure 1.1):

1. A label is applied to a group of people that distinguishes them from others (e.g., "crazy").
2. The label is linked to deviant or undesirable attributes by society (e.g., crazy people are dangerous).
3. People with the label are seen as essentially different from those without the label, contributing to an "us" versus "them" mentality (e.g., we are not like those crazy people).
4. People with the label are discriminated against unfairly (e.g., a clinic for crazy people can't be built in our neighborhood).

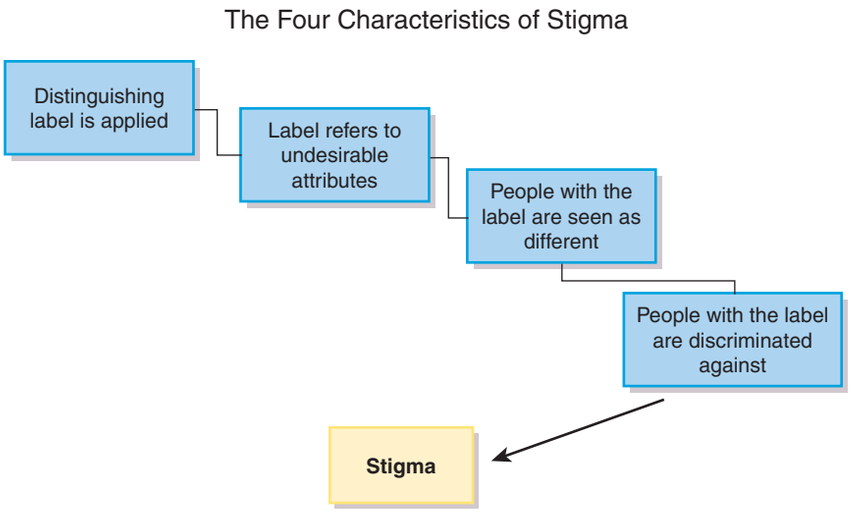


Figure 1.1 The four characteristics of stigma.

The case of Jack illustrates how stigma can lead to discrimination. Jack was denied an apartment due to his schizophrenia. The landlord believed Jack's schizophrenia meant he would be violent. This belief is based more in fiction than reality, however. A person with mental illness is not necessarily any more likely to be violent than a person without mental illness (Steadman et al., 1998; Swanson et al., 1990).

As we will see, the treatment of individuals with mental disorders throughout recorded history has not generally been good, and this has contributed to their stigmatization, to the extent that they have often been brutalized and shunned by society. Torturous treatments have been described to the public as miracle cures, and even today, terms such as *crazy, insane, retard,* and *schizo* are tossed about without thought of the people who actually suffer from mental illnesses and for whom these insults and the intensely distressing feelings and behaviors they refer to are a reality of daily life. The cases of Jack and Felicia illustrate how hurtful using such careless and mean-spirited names can be.

Mental illness remains one of the most stigmatized of conditions in the twenty-first century, despite advances in the public's knowledge about the origins of mental disorders (Hinshaw, 2007). In 1999, David Satcher, then Surgeon General of the United States, wrote that stigma is the "most formidable obstacle to future progress in the arena of mental illness and mental health" in his groundbreaking report on mental illness (U.S. Department of Health and Human Services, 1999). Sadly, this remains true more than 10 years later.

Throughout this book, we hope to fight this stigma by showing you the latest evidence about the nature, causes, and treatments for these disorders, dispelling myths and other misconceptions as we go. As part of this effort, we will try to put a human face on mental disorders, by including descriptions of actual people with these disorders in the chapters that follow. Additional ways to fight stigma are presented in Focus on Discovery 1.1.

But you will have to help in this fight, for the mere acquisition of knowledge does not ensure the end of stigma (Penn, Chamberlin, & Mueser, 2003). As we will see in Chapter 2, we have learned a great deal about neurobiological contributors to mental illness, such as neurotransmitters and genetics, in the last 20 years. Many mental health practitioners and advocates hoped that the more people learned about the neurobiological causes of mental disorders, the less stigmatized these disorders would be. However, results from a recent study show that this may not be true (Pescosolido et al., 2010). People's knowledge has increased, but unfortunately stigma has not decreased. In the study, researchers surveyed people's attitudes and knowledge about mental disorders at two time points: in 1996 and 2006. Compared to 1996, people in 2006 were more likely to believe that mental disorders like schizophrenia, depression, and alcohol addiction had a neurobiological cause, but stigma toward these disorders did not decrease. In fact, in some cases it increased. For example, people in 2006 were less likely to want to have a person with schizophrenia as their neighbor compared to people in 1996. Clearly, there is work to be done to reduce stigma.

In this chapter, we first discuss what we mean by the term *mental disorder.* Then we look briefly at how our views of mental disorders have evolved through history to the more scientific perspectives of today. We conclude with a discussion of the current mental health professions.

FOCUS ON DISCOVERY 1.1

Fighting against Stigma: A Strategic Approach

In 2007, psychologist Stephen Hinshaw published a book entitled *The Mark of Shame: The Stigma of Mental Illness and an Agenda for Change.* In this important book, Hinshaw outlines several steps that can be taken to end stigma surrounding mental illness. Here we briefly discuss some of the key suggestions for fighting stigma across many arenas, including law and policy, community, mental health professions, and individual/family behaviors and attitudes.

Policy and Legislative Strategies

Parity in Insurance Coverage In 1996, the Federal Mental Health Parity Act required that insurance coverage for mental illness be at the same level as for other illnesses, which was an important first step. However, the law had a number of problems (e.g., addiction was not included; companies could set limits on coverage). In March 2008, the U.S. House of Representatives passed an even broader parity bill, the Paul Wellstone Mental Health Parity and Addiction Equity Act, which comes closer to offering true parity. With this law, insurance companies cannot charge higher co-payments or deductibles for mental illness than they do for other types of illnesses. House and Senate committees produced a bill that was signed into law on October 3, 2008, and rules regarding the implementation of the law were put into place in early 2010.

Discriminatory Laws Some states have rules banning people with mental illness from voting, marrying, serving on juries, or holding public office. In an analysis of bills submitted for consideration in state legislatures in 2002, there were about as many bills to take away liberties as there were to grant liberties to people with mental illness. Similarly, there were roughly equal numbers of new bills that would effectively increase discrimination against people with mental illness as there were bills that would diminish discrimination (Corrigan et al., 2005). Speaking to state legislators about the importance of nondiscriminatory laws is something we can all do to help fight stigma in this arena.

Employment Unemployment rates among people with mental illness are extremely high, despite provisions of the Americans with Disabilities Act (ADA) that make it illegal to keep someone with mental illness from obtaining or keeping a job. The cruel irony here is that only a small number of ADA claims deal with job discrimination for people with mental illness (likely because people with mental illness are afraid to come forward due to the stigma surrounding their illness), yet these claims are among the easiest, at least in terms of cost, to fix (e.g., contrast the cost of allowing time off for therapy to the cost of redesigning and building a wheelchair-accessible area). Further training in job-relevant skills, such as provision of extra educational benefits to those whose education might have been curtailed by mental illness, would help with employment opportunities. Similarly, training in social skills relevant to the workplace and other structured programs to enhance workplace success is an important goal.

Decriminalization People with mental illness, particularly substance use disorders, often end up in jail rather than a hospital. Large urban jails, such as the Los Angeles County jail, Riker's Island in New York, and Cook County jail in Chicago, now house more people with mental illness than any hospital, public or private, in the United States. Many substance-related problems are first detected within the criminal justice system, and people may need more intensive treatment to address underlying substance use problems. Minimal or no treatment is provided in jail, and this is thus not an optimal place for people with mental illness. Many states have adopted assisted outpatient treatment (AOT) laws that provide court-mandated outpatient treatment rather than jail time for people with mental illness.

Community Strategies

Housing Options Rates of homelessness in people with mental illness are too high, and more programs to provide community residences and group homes are needed. However, many neighborhoods are reluctant

Defining Mental Disorder

A difficult but fundamental task facing those in the field of psychopathology is to define **mental disorder.** The best current definition of mental disorder is one that contains several characteristics. The definition of *mental disorder* presented in the fifth edition of the American diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), which was released in May 2013, includes a number of characteristics essential to the concept of mental disorder (Stein et al., 2010), including the following:

- The disorder occurs within the individual.
- It involves clinically significant difficulties in thinking, feeling, or behaving.
- It involves dysfunction in processes that support mental functioning.
- It is not a culturally specific reaction to an event (e.g., death of a loved one).
- It is not primarily a result of social deviance or conflict with society.

In the following sections, we consider four key characteristics that any comprehensive mental disorder definition ought to have including disability, distress, violation of social

to embrace the idea of people with mental illness living too close. Lobbying legislatures and community leaders about the importance of adequate housing is a critically important step toward providing housing and reducing stigma.

Personal Contact Providing greater housing opportunities for people with mental illness will likely mean that people with mental illness will shop and eat in local establishments alongside people without mental illness. Research suggests that this type of contact—where status is relatively equal—can reduce stigma. Informal settings, such as local parks and churches, can also help bridge the personal contact gap between people with and without mental illness.

Education Educating people about mental illness (one of the goals of this book!) is an important step toward reducing stigma. Education alone won't completely eradicate stigma, however. By learning about mental illness, though, people may be less hesitant to interact with people who have different disorders. Many of you already know someone with a mental disorder. Sadly, though, stigma often prevents people from disclosing their history with mental illness. Education may help lessen the hesitancy of people to talk about their illnesses.

Mental Health and Health Profession Strategies

Mental Health Evaluations Many children see their pediatricians for well-baby or well-child exams. The goal of these is to prevent illness before it occurs. Hinshaw (2007) makes a strong case for the inclusion of similar preventive efforts for mental illness among children and adolescents by, for example, including rating scale assessments from parents and teachers in order to help identify problems before they become more serious.

Education and Training Mental health professionals should receive training in stigma issues. This type of training would undoubtedly help professionals recognize the pernicious signs of stigma, even within the very profession that is charged with helping people with mental illness. In addition, mental health professionals need to keep current in their knowledge of the descriptions, causes, and empirically supported treatments for mental illness. This would certainly lead to better interactions with patients and might also help in educating the public about the important work that is done by mental health professionals.

Individual and Family Strategies

Education for Individuals and Families It can be frightening and disorienting for families to learn that a loved one has been diagnosed with an illness, and this may be particularly true for mental illness. Receiving current information about the causes and treatments of mental illness is crucial because it would help to alleviate blame and stereotypes families might hold about mental illness. Educating people with mental illness is also extremely important. Sometimes termed *psychoeducation*, this type of information is built into many types of treatments, whether they are pharmacological or psychosocial. In order for people to understand why they should adhere to certain treatment regimens, it is important for them to know the nature of their illness and the treatment alternatives available.

Support and Advocacy Groups Participating in support or advocacy groups can be a helpful adjunct to treatment for people with mental illness and their families. Websites such as Mind Freedom International (**http://www.mindfreedom.org**) are designed to provide a forum for people with mental illness to find support. Some such groups also encourage people not to hide their mental illness, but rather to consider it a point of pride—"Mad Pride" events are scheduled all over the world. Many people with mental illness have created their own blogs to discuss their illness and help to demystify and therefore destigmatize it. For example, the nonprofit BringChange2Mind is a group that seeks to demystify mental illness in several ways, including a blog that is written by people with mental illness (http://bringchange2mind.wordpress.com/). The site Patients Like Me (http://www.patientslikeme.com/) is a social networking site for people with all sorts of different illnesses. These sites, developed and run by people with mental illness, contain useful links, blogs, and other helpful resources. In-person support groups are also helpful, and many communities have groups supported by the National Alliance on Mental Illness (www.nami.org). Finding peers in the context of support groups can be beneficial, especially for emotional support and empowerment.

norms, and dysfunction. We will see that no single characteristic can fully define the concept, although each has merit and each captures some part of what might be a full definition. Consequently, mental disorder is usually determined based on the presence of several characteristics at one time. Figure 1.2 shows these four characteristics of a comprehensive definition of mental disorder.

Personal Distress

One characteristic used to define mental disorder is personal distress—that is, a person's behavior may be classified as disordered if it causes him or her great distress. Felicia felt distress about her difficulty with paying attention and the social consequences of this difficulty—that is, being called names by other schoolgirls. Personal distress also characterizes many of the forms of mental disorder considered in this book—people experiencing anxiety disorders and depression suffer greatly. But not all mental disorders cause distress. For example, an individual with the antisocial type of personality disorder may treat others coldheartedly and violate the law

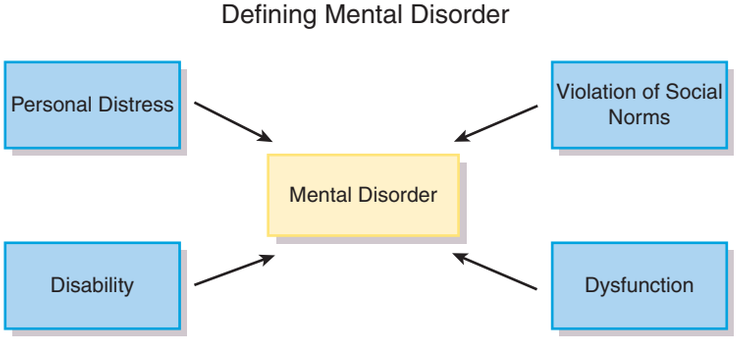
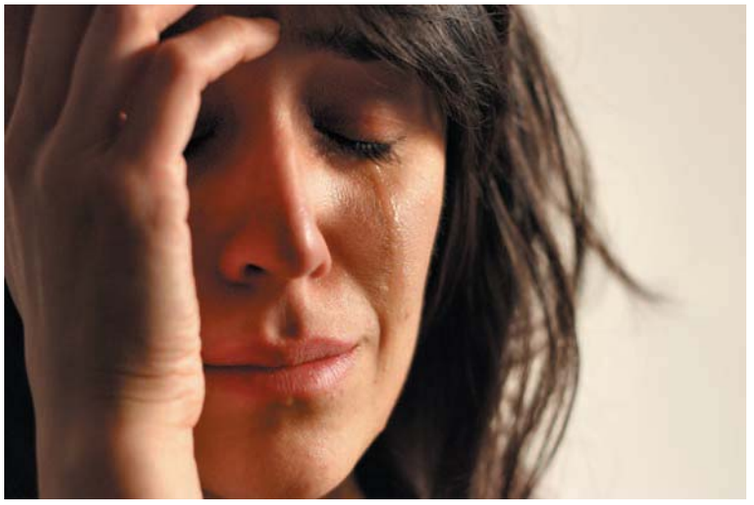


Figure 1.2 Four characteristics of a comprehensive definition of mental disorder.

Clinical Case: José

José didn't know what to think about his nightmares. Ever since he returned from the war, he couldn't get the bloody images out of his head. He woke up nearly every night with nightmares about the carnage he witnessed as a soldier stationed in Fallujah. Even during the day, he would have flashbacks to the moment his Humvee was nearly sliced in half by a rocket-propelled grenade. Watching his friend die sitting next to him was the worst part; even the occasional pain from shrapnel still embedded in his shoulder was not as bad as the recurring dreams and flashbacks. He seemed to be sweating all the time now, and whenever he heard a loud noise, he jumped out of his chair. Just the other day, his grandmother stepped on a balloon left over from his "welcome home" party. To José, it sounded like a gunshot, and he immediately dropped to the ground.

His grandmother was worried about him. She thought he must have *ataque de nervios*, just like her father had back home in Puerto Rico. She said her father was afraid all the time and felt like he was going crazy. She kept going to Mass and praying for José, which he appreciated. The army doctor said he had posttraumatic stress disorder (PTSD). José was supposed to go to the Veterans Administration (VA) hospital for an evaluation, but he didn't really think there was anything wrong with him. Yet his buddy Jorge had been to a group session at the VA, and he said it made him feel better. Maybe he would check it out. He wanted these images to get out of his head.



Personal distress can be part of the definition of mental disorder. (© michele piacquadio/iStockphoto.)

without experiencing any guilt, remorse, anxiety, or other type of distress. And not all behavior that causes distress is disordered—for example, the distress of hunger due to religious fasting or the pain of childbirth.

Disability

Disability—that is, impairment in some important area of life (e.g., work or personal relationships)—can also characterize mental disorder. For example, substance use disorders are defined in part by the social or occupational disability (e.g., serious arguments with one's spouse or poor work performance) created by substance abuse. Being rejected by peers, as Felicia was, is also an example of this characteristic. Phobias can produce both distress and disability—for example, if a severe fear of flying prevents someone living in California from taking a job in New York. Like distress, however, disability alone cannot be used to define mental disorder, because some, but not all, disorders involve disability. For example, the disorder bulimia nervosa involves binge eating and compensatory purging (e.g., vomiting) in an attempt to control weight gain but does not necessarily involve disability. Many people with bulimia lead lives without impairment, while bingeing and purging in private. Other characteristics that might, in some circumstances, be considered disabilities—such as being blind and wanting to become a professional race car driver—do not fall within the domain of psychopathology. We do not have a rule that tells us which disabilities belong in our domain of study and which do not.

Violation of Social Norms

In the realm of behavior, social norms are widely held standards (beliefs and attitudes) that people use consciously or intuitively to make judgments about where behaviors are situated on such scales as good–bad, right–wrong, justified–unjustified, and acceptable–unacceptable. Behavior that violates social norms might be classified as disordered. For example, the repetitive rituals performed by people with obsessive-compulsive disorder (see Chapter 7) and the conversations with imaginary voices that some people with schizophrenia engage in (see Chapter 9) are behaviors that violate social norms. José's dropping to the floor at the sound of a popping balloon does not fit within most social norms. Yet this way of defining mental disorder is both too broad and too narrow. For example, it is too broad in that criminals violate social norms but are not usually studied within the domain of psychopathology; it is too narrow in that highly anxious people typically do not violate social norms.

Also, of course, social norms vary a great deal across cultures and ethnic groups, so behavior that clearly violates a social norm in one group may not do so at all in another. For example,

in some cultures but not in others it violates a social norm to directly disagree with someone. In Puerto Rico, Josè's behavior would not likely have been interpreted in the same way as it would be in the United States. Throughout this book, we will address this important issue of cultural and ethnic diversity as it applies to the descriptions, causes, and treatments of mental disorders.

To some people, extreme tattoos are a social norm violation. However, social norm violations are not necessarily signs of a mental disorder. (Roger Spooner/GettyImages, Inc.)

Dysfunction

In an influential and widely discussed paper, Wakefield (1992) proposed that mental disorders could be defined as **harmful dysfunction.** This definition has two parts: a value judgment ("harmful") and an objective, scientific component—the "dysfunction." A judgment that a behavior is harmful requires some standard, and this standard is likely to depend on social norms and values, the characteristic just described. Dysfunctions are said to occur when an internal mechanism is unable to perform its natural function—that is, the function that it evolved to perform. By grounding this part of the definition of mental disorder in evolutionary theory, Wakefield hoped to give the definition scientific objectivity.

Numerous critics have argued that the dysfunction component of Wakefield's definition is not so easily and objectively identifiable in relation to mental disorders (e.g., Houts, 2001; Lilienfeld & Marino, 1999). One difficulty is that the internal mechanisms involved in mental disorders are largely unknown; thus, we cannot say exactly what may not be functioning properly. Wakefield (1999) has tried to meet this objection by, in part, referring to plausible dysfunctions rather than proven ones. In the case of Jack, for example, hallucinations (hearing voices) could be construed as a failure of the mind to "turn off" unwanted sounds. Nevertheless, we have a situation in which we judge a behavior or set of behaviors to be harmful and then decide that the behavior represents a mental disorder because we believe it is caused by a dysfunction of some unknown internal mechanism. Clearly, like the other definitions of mental disorder, Wakefield's concept of harmful dysfunction has its limitations.

The DSM definition provides a broader concept of dysfunction, which is supported by our current body of evidence. Specifically, the DSM definition of dysfunction refers to the fact that behavioral, psychological, and biological dysfunctions are all interrelated. That is, the brain impacts behavior, and behavior impacts the brain; thus dysfunction in these is interrelated. This broadening does not entirely avoid the problems that Wakefield's definition suffers from, but it is an attempt that formally recognizes the limits of our current understanding.

Indeed, it is crucial to keep in mind that this book presents human problems that are currently considered mental disorders. Over time, because the field is continually evolving, the disorders discussed in books like this will undoubtedly change, and so will the definition of mental disorder. It is also quite possible that we will never be able to arrive at a definition that captures mental disorder in its entirety and for all time. Nevertheless, at the current time, the characteristics that are included in the definition constitute a useful partial definition, but keep in mind that they are not equally or invariably applicable to every diagnosis.

Quick Summary

The focus of this book is on the description, causes, and treatments of a number of different mental disorders. It is important to note at the outset that the personal impact of our subject matter requires us to make a conscious, determined effort to remain objective. Stigma remains a central problem in the field of psychopathology. Stigma has four components that involve the labels for mental illness and their uses. Even the use of everyday terms such as *crazy* or *schizo* can contribute to the stigmatization of people with mental illness.

Defining mental disorder remains difficult. A number of different definitions have been offered, but none can entirely account for the full range of disorders. Whether or not a behavior causes personal distress can be a characteristic of mental disorder. But not all behaviors that we consider to be part of mental disorders cause distress. Behaviors that cause a disability or are unexpected can be considered part of a mental disorder. But again, some behaviors do not cause disability, nor are they unexpected. Behavior that violates social norms can also be considered part of a mental disorder. However, not all such behavior is considered part of a mental disorder, and some behaviors that are characteristic of mental disorders do not necessarily violate social norms. Harmful dysfunction involves both a value component and a scientific component. Like the other definitions, however, it cannot fully account for what we study in psychopathology. Taken together, each definition of mental disorder has something helpful to offer in the study of psychopathology.

Check Your Knowledge 1.1 (Answers are at the end of the chapter.)

1. Characteristics of stigma include all of the following *except*:
   - **a.** a label reflecting desirable characteristics
   - **b.** discrimination against those with the label
   - **c.** focus on differences between those with and without the label
   - **d.** labeling a group of people who are different
2. Which of the following definitions of mental disorder is currently thought best?
   - **a.** personal distress
   - **b.** harmful dysfunction
   - **c.** norm violation
   - **d.** none of the above
3. Why is the DSM definition of mental disorder perhaps the best current definition?
   - **a.** It includes information about both violation of social norms and dysfunction.
   - **b.** It includes many components, none of which alone can account for mental disorder.
   - **c.** It is part of the current diagnostic system.
   - **d.** It recognizes the limits of our current understanding.

History of Psychopathology

Many textbooks begin with a chapter on the history of the field. Why? It is important to consider how concepts and approaches have changed (or not) over time, because we can learn not to make the same mistakes made in the past and because we can see that our current concepts and approaches are likely to change in the future. As we consider the history of psychopathology, we will see that many new approaches to the treatment of mental illness throughout time appear to go well at first and are heralded with much excitement and fanfare. But these treatments eventually fall into disrepute. These are lessons that should not be forgotten as we consider more contemporary approaches to treatment and their attendant excitement and fanfare.

The search for causes of mental disorders has gone on for a considerable period of time. At different periods in history, explanations for mental disorders have been supernatural, biological, and psychological. As we quickly travel through these different periods, ask yourself what level of explanation was operating at different times.

Early Demonology

Before the age of scientific inquiry, all good and bad manifestations of power beyond human control—eclipses, earthquakes, storms, fire, diseases, the changing seasons—were regarded as supernatural. Behavior seemingly outside individual control was also ascribed to supernatural causes. Many early philosophers, theologians, and physicians who studied the troubled mind believed that disturbed behavior reflected the displeasure of the gods or possession by demons.

Christ driving the evil spirits out of a possessed man. (© SuperStock/SuperStock.)

The doctrine that an evil being or spirit can 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, odd behavior was attributed to possession of the person by bad spirits, after God in his wrath had withdrawn protection. The New Testament includes the story of Christ curing a man with an unclean spirit by casting out the devils from within him and hurling them onto a herd of swine (Mark 5:8–13).

The belief that odd behavior was caused by possession led to treating it by **exorcism**, the ritualistic casting out of evil spirits. 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.

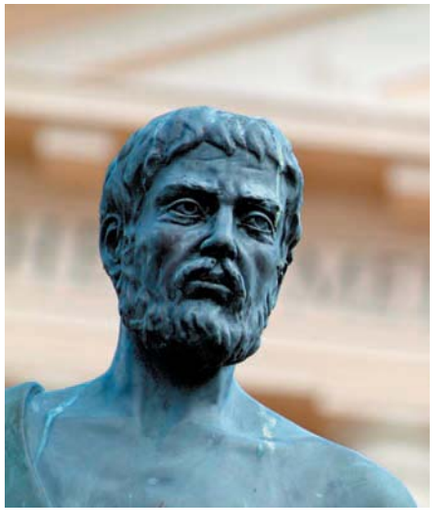
Early Biological Explanations

In the fifth century B.C., Hippocrates (460?–377? B.C.), often called the father of modern medicine, separated medicine from religion, magic, and superstition. He rejected the prevailing Greek belief that the gods sent 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, intellectual life, and emotion; thus, he thought that disordered thinking and behavior were indications of some kind of brain pathology. Hippocrates is often considered one of the earliest proponents of the notion that something wrong with the brain disturbs thought and action.

Hippocrates classified mental disorders into three categories: mania, melancholia, and phrenitis, or brain fever. Further, Hippocrates believed that normal brain functioning, and therefore mental health, depended on a delicate balance among four humors, or fluids of the body, namely, blood, black bile, yellow bile, and phlegm. An imbalance of these humors produced disorders. If a person was sluggish and dull, for example, the body supposedly contained a preponderance of phlegm. A preponderance of black bile was the explanation for melancholia; too much yellow bile explained irritability and anxiousness; and too much blood, changeable temperament.

Through his teachings, the phenomena associated with mental disorders became more clearly the province of physicians rather than priests. The treatments Hippocrates suggested were quite different from exorcism. For melancholia, for example, he prescribed tranquility, sobriety, care in choosing food and drink, and abstinence from sexual activity. Because Hippocrates believed in natural rather than supernatural causes, he depended on his own keen observations and made valuable contributions as a clinician. He also left behind remarkably detailed records clearly describing many of the symptoms now recognized in seizure disorders, alcohol dependence, stroke, and paranoia.

Hippocrates' ideas, of course, did not withstand later scientific scrutiny. However, his basic premise—that human behavior is markedly affected by bodily structures or substances and that odd behavior is produced by some kind of physical imbalance or even damage—did foreshadow aspects of contemporary thought. In the next seven centuries, Hippocrates' naturalistic approach to disease and disorder was generally accepted by other Greeks as well as by the Romans, who adopted the medicine of the Greeks after their empire became the major power in the ancient European world.



The Greek physician Hippocrates held a biological view of mental illness, considering mental disorders to be diseases of the brain. (© Bruce Miller/Alamy.)

The Dark Ages and Demonology

Historians have often pointed to the death of Galen (A.D. 130–200), the second-century Greek who is regarded as the last great physician of the classical era, as the beginning of the so-called Dark Ages in western European medicine and in the treatment and investigation of mental disorders. Over several centuries of decay, Greek and Roman civilization ceased to be. The Church gained in influence, and the papacy was declared independent of the state. Christian monasteries, through their missionary and educational work, replaced physicians as healers and as authorities on mental disorder.[1]

The monks in the monasteries cared for and nursed the sick, and a few of the monasteries were repositories for the classic Greek medical manuscripts, even though the monks may not have made use of the knowledge in these works. Monks cared for people with mental disorders by praying over them and touching them with relics; they also concocted fantastic potions for them to drink in the waning phase of the moon. Many people with mental illness roamed the countryside, destitute and progressively becoming worse. During this period, there was a return to a belief in supernatural causes of mental disorders.

Galen was a Greek physician who followed Hippocrates' ideas and is regarded as the last great physician of the classical era. (Corbis Images.)

The Persecution of Witches Beginning in the thirteenth century, in response to widespread social unrest and recurrent famines and plagues, people in Europe turned to demonology to explain these disasters. Witchcraft, now viewed as instigated by Satan, was seen as a heresy and

[1]The teachings of Galen continued to be influential in the Islamic world. For example, the Persian physician al-Razi (865–925) established a facility for the treatment of people with mental illness in Baghdad and was an early practitioner of psychotherapy.