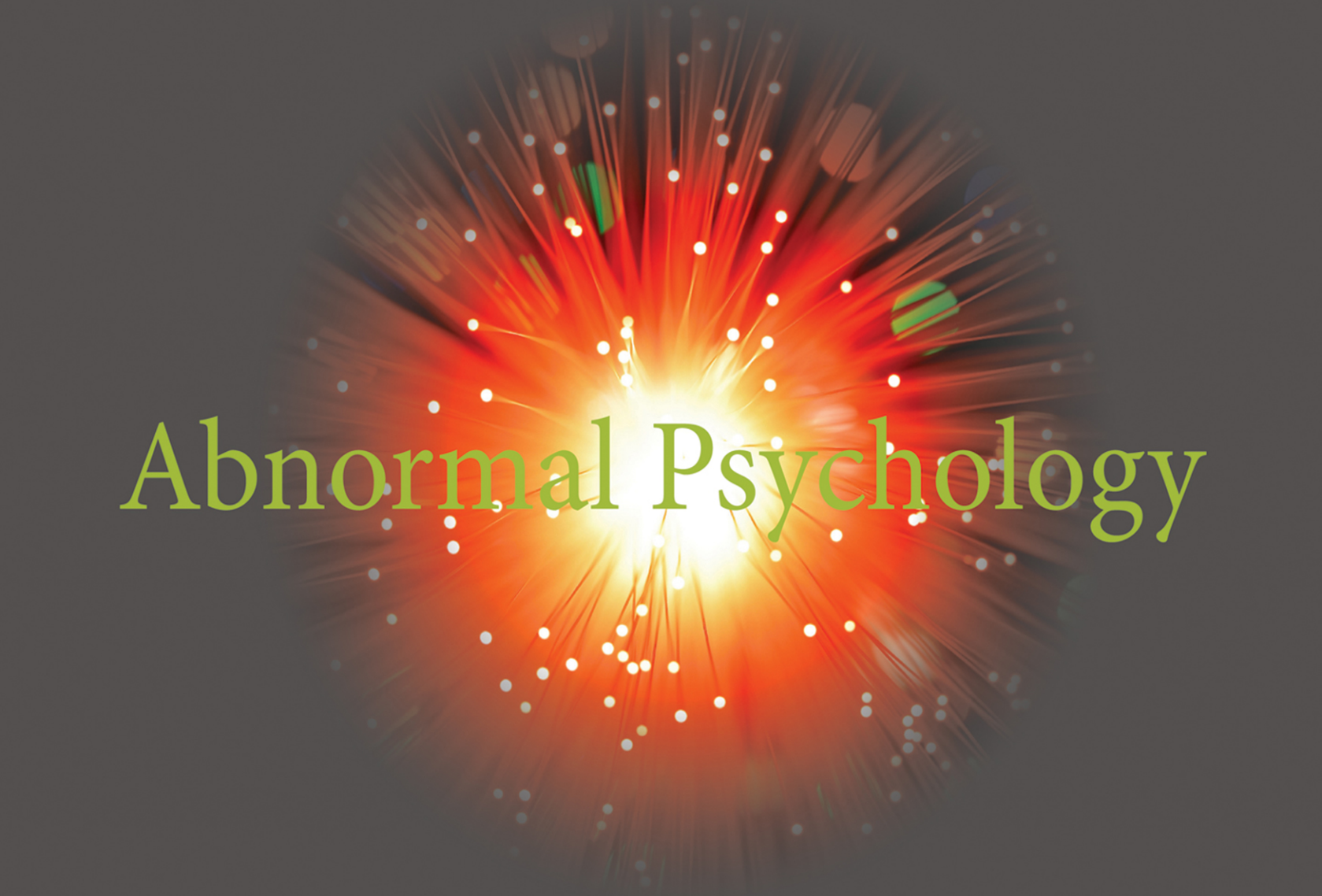
ANN M. KRING • SHERI L. JOHNSON



Abnormal Psychology

THE SCIENCE AND TREATMENT OF PSYCHOLOGICAL DISORDERS

THIRTEENTH EDITION

GERALD DAVISON • JOHN NEALE

WILEY

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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 / Female 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 May Be a Focus of Clinical Attention

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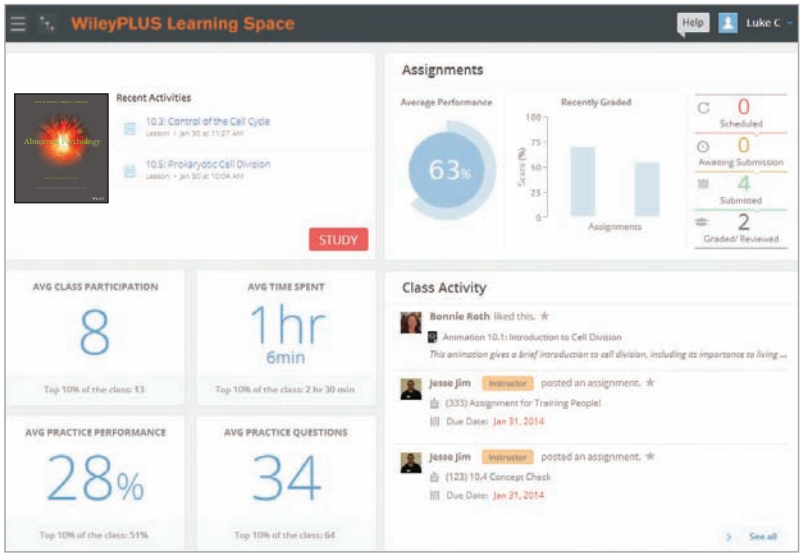

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Abnormal Psychology

The Science and Treatment of Psychological Disorders

Thirteenth Edition

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Abnormal Psychology

The Science and Treatment of Psychological Disorders

Thirteenth Edition

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University of California, Berkeley

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With former contributions from

Gerald C. Davison
University of Southern California

John M. Neale
State University of New York at Stony Brook

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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 will assume the role of Department Chair in July 2015. 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 joined the faculty at UC Berkeley in 1999 and has served two terms as Director of the Clinical Science Program and Psychology Clinic. 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*, and is a former Associate Editor for *Journal of Abnormal Psychology*, *Cognition and Emotion,* and *Applied and Preventive Psychology.* She was elected President of the Society for Research in Psychopathology, and she is a member of the Executive Board of the Society for Affective Science.

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 co-author (with Janelle Caponigro, Erica Lee, and Sheri Johnson) of the book *Bipolar Disorder for the Newly Diagnosed* (New Harbinger Press). She is also the author of more than 100 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 she 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 a consulting editor for *Clinical Psychological Science* and *Journal of Abnormal Psychology,* she was an associate editor for *Applied and Preventive Psychology* and *Cognition and Emotion,* and she has served on editorial boards for six journals, including *Psychological Bulletin*. She is has served as the secretary for the Society for Research in Psychopathology and is 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, the National Cancer Institute, the National Science Foundation, and by the National Institute of Mental Health. She has published over 175 articles and chapters, and her findings have been published in leading journals such as the *Journal of Abnormal Psychology, Psychological Bulletin,* and the *American Journal of Psychiatry*. She is co-editor of several books, including *Psychological Treatment of Bipolar Disorder* (Guilford Press), *Bipolar Disorder for the Newly Diagnosed* (New Harbinger Press), and *Emotion and Psychopathology* (American Psychological Association).

A bit of authorship history…

For the past 10 years, Ann Kring and Sheri Johnson have been the sole authors of the book. However, the book's history dates back 40 years. Back then, 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 is 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.

Photo by John M. Neale

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 thirteenth 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 more questions to the Check Your Knowledge boxes, additional clinical cases, figures, tables, and clear 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 kaleidoscope of lights chosen to represent the myriad factors that contribute to psychological disorders. This image illustrates a number of key principles about our book. Just as a kaleidoscope offers an extensive and diverse array of colorful patterns, many people are differently impacted by psychological disorders. People are shaped by the interaction of their neurobiology and environment, which is what the study of psychological disorders 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 domains of scientific inquiry, shifting the perspective of our current understanding of psychological disorders in the same way as moving the lights in a kaleidoscope changes the way we see the colors. Our book is first and foremost grounded in the latest science of psychological disorders. As new discoveries and new treatments are developed, our understanding moves toward a better conceptualization of psychological disorders.

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. The domains of psychopathology and intervention continue to become increasingly multifaceted and technical. Therefore, a good textbook covering psychological disorders 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 us today. 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 psychological disorders. Despite the ubiquity of psychopathology, the stigma associated with it can keep some individuals 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.

Another change to this edition is the broadening of our title. Older terms such as abnormal psychology reflect vestiges of the past in many ways, even though many courses that cover the causes and treatment of psychological disorders retain this title. It is our hope that the term *abnormal psychology* will soon be replaced, as it can unwittingly perpetuate the stigma that people with psychological disorders are "abnormal" in many ways. Our contention is that people with psychological disorders are first and foremost people and that the term *abnormal* can be overly broad and misconstrued to the detriment of people impacted by psychological disorders.

Organization of the Thirteenth Edition

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 twelfth edition, specific psychological disorders and their treatment are discussed in Chapters 5 through 15.

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, and socioeconomic status. A related issue is the use of more than one paradigm in studying psychological disorders. 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 psychological disorders arise from subtle interactions between genetic or psychological predispositions and stressful life events.

We continue to emphasize that psychopathology is best understood by considering how genes do their work via psychological processes and 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. In this edition, we have added several examples to highlight how genetic, social, and cognitive risk factors operate in tandem.

We continue to include considerable material on culture and ethnicity in the study of causes and treatment of psychological disorders. 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 updated coverage of culture and ethnicity in substance use disorders (Chapter 10).

New to This Edition

The thirteenth edition has many new and exciting additions and changes. We have added significant new material about the impact of DSM-5 in every chapter, and we continue to organize the chapters to reflect the organization of the DSM-5. Now that DSM-5 is in use, material on DSM-IV-TR has been largely removed. 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 new figures to carefully illustrate the genetics and brain networks involved in different disorders. Finally, we have added new photos to illustrate current events and news regarding mental health.

We have continued to add additional pedagogy based on feedback from students and professors. In addition to multiple new Clinical Case boxes, we have also included 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 as well as to showcase cutting-edge research on particular topics. In addition, we have modified and added new Check Your Knowledge questions in nearly all chapters so that students can do a quick check to see if they are learning and integrating the material. Drawing on evidence for the importance of generative thinking for learning, many of the new questions are open-ended. There are many new photos to provide students with additional real-world examples and applications of psychopathology, including examples of some of the highly successful and well-known people who have come forward in the past several years to discuss their own psychological disorders. 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 edition includes:

Chapter 1: Introduction and Historical Overview

New material on stigma, including updates to current legislation and support/advocacy groups and stigma reduction efforts
Some of the history sections are streamlined
New section on what we can learn from history
New material on the mental health professions

Chapter 2: Current Paradigms in Psychopathology

New material on cultural factors that cut across paradigms
New material on cutting-edge molecular genetics, including single nucleotide polymorphisms (SNPs), copy number variations (CNVs), and genome-wide association studies
Updated coverage of the latest neuroscience findings
Updated coverage on cognitive science contributions to the cognitive behavioral paradigm
Updated material in the Focus on Discovery boxes on gender and health and socioeconomics and health

Chapter 3: Diagnosis and Assessment

New information on DSM-5, including reliability from the field trials, additional material on cultural assessment, and cross-cutting symptom assessment materials
New information on the Research Domain Criteria (RDoC)
Clinical cases presented with DSM-5 diagnoses
Older diagnostic information moved to the Focus on Discovery box covering the history of diagnosis
Updated data on cultural bias in assessment
Updated information on assessment measures
Updated information on underreporting of stigmatized behaviors

Chapter 4: Research Methods

New material on genome-wide association studies (GWAS)
New content on the efficacy of culturally competent psychotherapies

Chapter 5: Mood Disorders

Added a dual-factor model of seasonal affective disorder
Described the high prevalence of depression in the offspring of mothers with depression
Added a population-based study that supports the link of creativity with bipolar disorder
Added a richer clinical description of mania
Updated findings on the mechanisms through which the serotonin transporter polymorphism may interact with environmental risk factors to influence neurobiological and cognitive risk factors for depression
New discussion of the importance of childhood adversity in depression
New material on the role of interpersonal stress in depression, and the debate about whether bereavement-related depressive symptoms should be distinguished from other forms of depression
New studies on the prospective evidence for cognitive models of depression
New theory and data regarding the mechanisms driving rumination in depression
New Focus on Discovery Box on how research on cytokines serves as a link between biological and social risk factors for depression
Updates on the number of people who have tried antidepressants
New data on mindfulness treatment for depression
New findings on deep brain stimulation
New data on transcranial magnetic stimulation, now licensed by the FDA for treatment-resistant depression
New material on public health approaches to suicide prevention

Chapter 6: Anxiety Disorders

New data on the prevalence and functional outcomes of anxiety disorders
Enhanced clinical description of generalized anxiety disorder
New evidence regarding a specific genetic polymorphism relevant across the anxiety disorders (PPARGC1A gene) and one that is relevant to panic disorder (neuropeptide S NPSR gene)
Better discussion of the nature of attentional impairment in anxiety disorder
New evidence that attentional training can reduce cortisol response to daily stress
Summary of findings on mindfulness and acceptance-based treatments

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

More detail and a new clinical case to enrich understanding of the clinical picture of obsessions and compulsions
New data on the high rate of absenteeism associated with body dysmorphic disorder
New section more concisely reviewing the epidemiology of obsessive-compulsive disorder (OCD) and related disorders as a whole, given the substantial parallels across the three disorders
New data on the heritability of the obsessive-compulsive and related disorders
New studies showing that hoarding disorder is related to neural activation in regions that are similar to those implicated in OCD and body dysmorphic disorder
New behavioral model for OCD, emphasizing difficulties stopping engagement in a behavior that effectively warded off threat in the past
Greater detail on the process of conducting exposure and ritual prevention for a person with OCD, with less emphasis on the historical development of this approach
New section on deep brain stimulation for OCD
New information on the definition of complex posttraumatic stress disorder (PTSD) and on the reasons this was not included as a subtype in the DSM-5
New clinical case for PTSD focused on a college student who was raped
Refined discussion of the hippocampus as helping organize memories but also placing them in context, and how this might lead to PTSD
Coverage of the PTSD specifier for depersonalization or derealization

Chapter 8: Dissociative Disorders and Somatic Symptom-Related Disorders

More description of the different forms of dissociation
More detail on the difficulties in estimating the prevalence of dissociative disorders
Reorganized to cover controversies about memory as part of the discussion of dissociative amnesia
New case study for dissociative amnesia, fugue subtype
Updates on the high prevalence of depersonalization and derealization symptoms among college students, and the most typical dissociative experiences
New criticisms regarding the case of Sybil
New evidence on the medical costs of treating somatic symptom disorders
More detail on how somatic symptom disorders relate to disorders with contentious etiology
Updated theory on whether conversion disorder has truly changed in prevalence over time
Neurofeedback for pain control discussed

New example of mass hysteria, illustrating an important social facet of conversion disorder
Enhanced description of cognitive techniques for somatic symptom disorders
New treatment outcome data for somatic symptom disorders

Chapter 9: Schizophrenia

New research on genetics
New material on schizophrenia and the brain
New section on brain connectivity
New material on culture and expressed emotion
New findings on clinical high risk for schizophrenia
New material on cannabis use as a risk factor for schizophrenia
Updated material on first and second-generation antipsychotic medications
Updated material on psychosocial treatments for schizophrenia
New Focus on Discovery Box on misdiagnosis of schizophrenia

Chapter 10: Substance Use Disorders

New material on DSM-5 indicators of severity of alcohol and drug use disorders
New statistics on use of all drugs
New material on e-cigarettes
New material on marijuana
New material on the neuroscience of addiction
New material on tobacco and stimulants, including cocaine
New treatment studies for smoking, alcohol, and cocaine
New section on delayed versus immediate rewards in the neurobiology of addiction

Chapter 11: Eating Disorders

Expanded section on binge eating disorder, consistent with its inclusion in DSM-5, including physical consequences and prognosis
Updated and expanded material on obesity
New information on cognitive behavior therapy for anorexia
New information on DSM-5 severity ratings for all eating disorders
New material on prevention of eating disorders

Chapter 12: Sexual Disorders

Description of a more accurate penile plethysmograph
New case studies of orgasmic disorder and voyeuristic disorder
New data on the prevalent use of testosterone off-label, and the sexual side effects of such usage
Now noted that more than 20 trials have tested cognitive behavioral therapy (CBT) for sexual dysfunction disorders
Updated statistics on success rates with directed masturbation treatment for orgasmic disorders
Additional detail regarding cognitive interventions for sexual dysfunction
New data on the percentage of people who have engaged in sadomasochistic sexual practices
More detail on the DSM-5 diagnostic criteria for pedophilia
New data on lower IQ and neurocognitive problems among men diagnosed with pedophilia
Updated material on the etiology of pedophilia and sexual coercion, with attention to the idea that there may be multiple pathways to both problems
Research evidence for the role of impulsivity in paraphilias added
Satiation treatment described for paraphilias
New information about civil liberties and diagnoses of paraphilias

Chapter 13: Disorders of Childhood

Updated material on attention-deficit/hyperactivity disorder (ADHD)
New material on prevalence rates, risk factors, and treatment in childhood ADHD and expanded information on ADHD in adulthood
New information on genetics and conduct disorder
New information on preventing conduct disorder
New material on intermittent explosive disorder
New material on disruptive mood dysregulation disorder
New information on genetics, neuroscience, and prevention of conduct disorder
New information on treatment of anxiety in childhood
New information on etiology of depression in childhood
Updated material on dyslexia
New clinical case box on dyslexia
New material on stimulant medications in children
Updated prevalence data for all disorders
Updated material on genetics in autism spectrum disorder
Updated material in the Focus on Discovery box covering controversies in the field
New information on autism spectrum disorder

Chapter 14 Late Life and Neurocognitive Disorders

New section on the negative consequences of internalizing negative stereotypes about aging
New data regarding specific genes and immune function in Alzheimer's disease
New information about the prevalence of frontotemporal dementia (FTD)
Updated information about prevention trials
New information about training programs for memory in dementia

Chapter 15 Personality Disorders

Emphasis on the pervasive influence of personality on a broad range of outcomes
Added data on unstructured clinical interviews, noting poor interrater reliability in the DSM-5 field trials and poor validity compared to structured interviews
Discussion of findings from several studies showing that personality disorders are more common during adolescence and that the prevalence decreases over the life course, and that many people recover from personality disorders
Richer clinical descriptions throughout the chapter and new case vignettes to illustrate paranoid personality disorder, antisocial personality disorder, and obsessive-compulsive personality disorder
Reorganized to discuss evidence that heritability, parenting styles, and child abuse are important as common risk factors across the

personality disorders. The etiology of more specific personality disorders is then focused strictly on those disorders with more available research.
New Focus on Discovery box on media images of psychopathy
New Focus on Discovery box on whether narcissism is increasing over time among college students
New data from discordant twin studies regarding the relative weight of family risk and abuse in risk for borderline personality disorder
Data on parenting styles related to narcissism and dependent personality disorder
More discussion of the implications of dependent personality disorder for outcomes
Streamlined discussion of the risk factors for antisocial personality disorder and borderline personality disorder, and of psychotherapy for borderline personality disorder

Chapter 16: Legal and Ethical Issues

Reorganized for better readability
New material on intellectual disability and capital punishment
New Clinical Case box
New information on specific states and the insanity defense

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 updated for DSM-5 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 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 are 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 rereading 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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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.

September 2014
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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 psychological disorders.
2. Be able to describe and compare different definitions of psychological disorder.
3. Be able to explain how the causes and treatments of psychological 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 psychological 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'd stopped by to see their mother the other day. Jack's mother admonished Kevin, reminding him 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 **psychological 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 psychological 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 are 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 or difficult to understand, 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 clinical or 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 psychological 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 psychological 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 psychological disorders. 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).

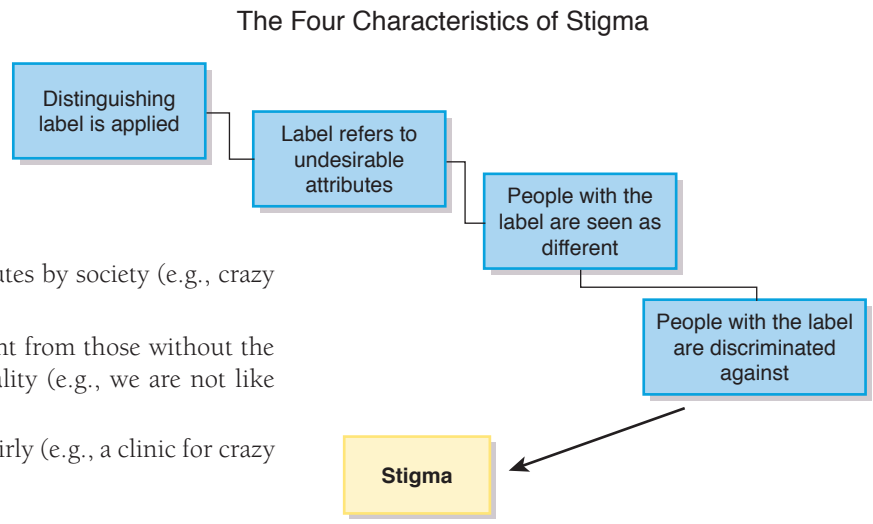


Figure 1.1 The four characteristics of stigma.

The case of Jack illustrates how stigma can lead to discrimination. Jack was denied an apartment because of 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 a psychological disorder is not necessarily any more likely to be violent than a person without such a disorder (Steadman, Mulvey, Monahan, et al., 1998; Swanson, Holzer, Ganju, & Jono, 1990), even though people with psychological disorders can be violent if they do not receive treatment (Torrey, 2014).

As we will see, the treatment of people with psychological 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. In the past, torturous treatments were held up 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 psychological disorders 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.

Psychological disorders remain the most stigmatized of conditions in the twenty-first century, despite advances in the public's knowledge about the origins of psychological disorders (Hinshaw, 2007). In 1999, then Surgeon General of the United States David Satcher, in his groundbreaking report on mental illness, wrote that stigma is the "most formidable obstacle to future progress in the arena of mental illness and mental health" (U.S. Department of Health and Human Services, 1999). Sadly, this remains true more than 15 years later.

Throughout this book, we hope to fight this stigma by showing you the latest evidence about the nature and causes of these disorders, together with treatments, dispelling myths and other misconceptions as we proceed. As part of this effort, we will try to put a human face on psychological disorders by including descriptions of actual people with these disorders 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, in the last 20 years we have learned a great deal about neurobiological contributors to psychological disorders, such as neurotransmitters and genetics. Many mental health practitioners and advocates hoped that the more people learned about the neurobiological causes of psychological disorders, the less stigmatized these disorders would be. However, results from an important study show that this may not be true (Pescosolido, Martin, Long, 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 psychological disorders at two points in time: 1996 and 2006. Compared to 1996, people in 2006 were more likely to believe that psychological disorders such as 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.

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 psychological disorders. 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 2008, an even broader parity bill, the Mental Health Parity and Addiction Equity Act (MHPAE), came 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. Rules regarding the implementation of the law were put into place in 2010. The Affordable Care Act, the large expansion of all types of health care in the United States, continues to honor the provisions set forth by the MHPAE with a set of regulations signed by President Barack Obama in 2013. These regulations specify that insurers cannot approve fewer doctor visits or less time in a hospital for people with psychological disorders than for people with other disorders and illnesses. Unfortunately, however, these regulations do not yet apply to the broad health care programs in the United States for the elderly (Medicare) and the poor (Medicaid). One recent study found that the number of **psychiatrists** who accepted new people under Medicare or Medicaid declined by nearly 20 percent between 2005 and 2010 (Bishop, Press, Keyhani, & Pincus, 2014).

Discriminatory Laws Some states have rules banning people with a psychological disorder 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 psychological disorders. Similarly, there were roughly equal numbers of new bills that would effectively increase discrimination against people with psychological disorders as there were bills that would diminish discrimination (Corrigan, Watson, Heyrman, 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 psychological disorders are extremely high, despite provisions of the Americans with Disabilities Act (ADA) that make it illegal to keep someone with a psychological disorder 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 a psychological disorder (likely because people with psychological disorders 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 a psychological disorder, 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 psychological disorders, 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 psychological disorders than any hospital, public or private, in the United States. Many substance use problems are first detected within the criminal justice system, and people may need more intensive treatment to address these issues. Minimal or no treatment is provided in jail, and so this is not an optimal place for people with psychological disorders. Many states have adopted assisted outpatient treatment (AOT) laws that provide court-mandated outpatient treatment rather than jail time for people with psychological disorders.

Community Strategies

Housing Options Rates of homelessness in people with psychological disorders are too high, and more programs to provide community residences and group homes are needed. However, many neighborhoods are reluctant to embrace the idea of people with a psychological disorder living too close by. Lobbying legislatures and community leaders about the importance of adequate housing is a critically important step toward providing housing for people with psychological disorders and reducing stigma.

Personal Contact Providing greater housing opportunities for people with psychological disorders will likely mean that people with these disorders will shop and eat in local establishments alongside people without these disorders. 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 psychological disorders.

Education Educating people about psychological disorders (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 psychological disorders, though, people may be less hesitant to interact with people who have different disorders. Many of you already know someone with a psychological disorder. Sadly, though, stigma often prevents people from disclosing their history with a psychological disorder. Education may help lessen people's hesitancy 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 visits is to prevent illness before it occurs. Hinshaw (2007) makes a strong case for including similar preventive efforts for psychological disorders 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 psychological disorders. In addition, mental health professionals need to keep current on the descriptions, causes, and empirically supported treatments for psychological disorders. This would certainly lead to better interactions with people and might also help educate the public about the important work being 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 psychological disorders. Receiving current information about the causes and treatments of psychological disorders is crucial because it helps to alleviate blame and stereotypes families might hold about psychological disorders. Educating people with a psychological disorder is also extremely important. Sometimes termed *psychoeducation*, this type of information is built into many types of treatments, whether 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 psychological disorders and their families. Websites such as Mind Freedom International (http://www.mindfreedom.org) and the Icarus Project (http://www.theicarusproject.net) are designed to provide a forum for people with psychological disorders to find support. Some such groups also encourage people not to hide their disorders, but rather to consider it a point of pride—"Mad Pride" events are scheduled all over the world (Quart, 2013). These sites, developed and run by people with psychological disorders, 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 (http://www.nami.org). Finding peers in the context of support groups can be beneficial, especially for emotional support and empowerment.

Recent efforts to reduce stigma have been quite creative in their use of social media and other means to get the message out that psychological disorders are common and affect us all in one way or another. Indeed, one of the largest and most recent epidemiological studies (see Chapter 4 for more on epidemiology) reported that the lifetime prevalence of any psychological disorder in the United States was 46.4 percent (Kessler, Berglund, Demler, et al., 2005), suggesting that nearly half of the U.S. population may experience some type of psychological disorder in their lifetimes. Many people with blogs have talked poignantly about their lives with different psychological disorders, and these accounts help to demystify and therefore destigmatize it. For example, Allie Brosh writes a blog called Hyperbole and a Half and discusses her experiences with depression on her blog (http://hyperboleandahalf.blogspot.com) and in a book (Brosh, 2013). The site Patients Like Me (http://www.patientslikeme.com) is a social networking site for people with all sorts of different illnesses. Other creative efforts include the design of T-shirts by a graphic designer named Dani Balenson (http://danibalenson.com). In her work, she seeks to use color and graphics to depict the symptoms, behaviors, and struggles that characterize psychological disorders such as ADHD, obsessive-compulsive disorder, depression, and bipolar disorder (http://www.livingwith.co).

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

Defining Psychological Disorder

A difficult but fundamental task facing those in the field of psychopathology is to define psychological disorder. The best current definition of psychological 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 psychological disorder (Stein, Phillips, Bolton, et al., 2010), including the following:

- The disorder occurs within the individual.
- It involves clinically significant difficulties in thinking, feeling, or behaving.
- It usually involves personal distress of some sort, such as in social relationships or occupational functioning.
- It involves dysfunction in psychological, developmental, and/or neurobiological 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 should be part of any comprehensive psychological disorder definition: personal distress, disability, violation of social norms, and dysfunction (see Figure 1.2). 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, psychological disorder is usually determined based on the presence of several characteristics at one time.

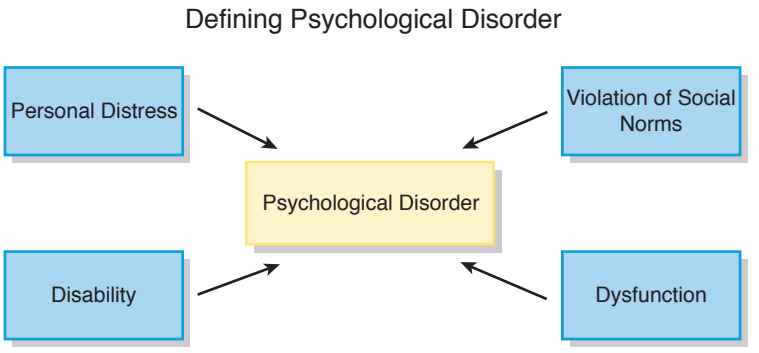


Figure 1.2 Four characteristics of a comprehensive definition of psychological disorder.

Personal Distress

One characteristic used to define psychological 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 in 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 psychological disorder considered in this book—people experiencing anxiety disorders and depression suffer greatly. But not all psychological disorders cause distress. For example, an individual with the antisocial type of personality disorder may treat others coldheartedly and violate the law 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.

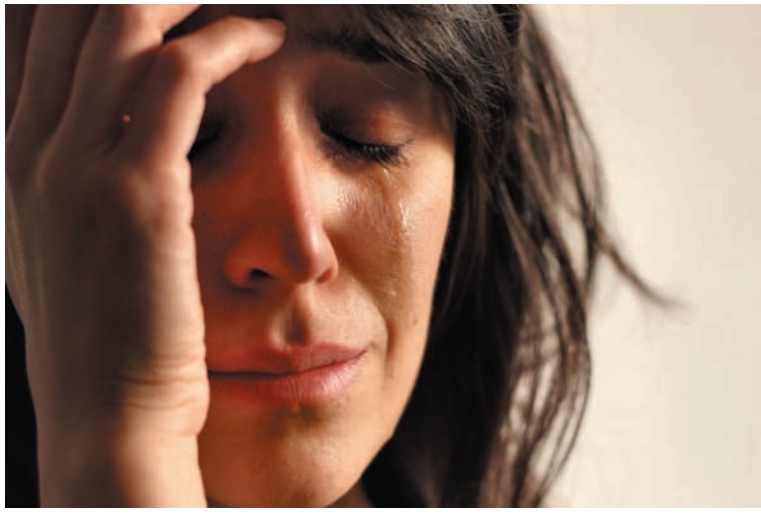
Clinical Case: José

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 had been 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.

Disability

Disability—that is, impairment in some important area of life (e.g., work or personal relationships)—can also characterize psychological 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 psychological 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 it 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.



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Personal distress can be part of the definition of psychological disorder.

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 psychological 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, José'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 psychological disorders.

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To some people, extreme tattoos are a violation of the social norm. However, social norm violations are not necessarily signs of a psychological disorder.

Dysfunction

In an influential and widely discussed paper, Wakefield (1992) proposed that psychological 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 psychological 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 psychological disorders (e.g., Houts, 2001; Lilienfeld & Marino, 1999). One difficulty is that many internal mechanisms involved in psychological disorders are 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 psychological disorder because we believe it is caused by a dysfunction of some unknown internal mechanism. Clearly, like the other definitions of psychological 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 developmental, psychological, and biological dysfunctions are all interrelated. That is, the brain impacts behavior, and behavior impacts the brain; thus dysfunction in these areas is interrelated. This broadening does not entirely avoid the problems associated with Wakefield's definition, but it is an attempt to formally recognize the limits of our current understanding.

Indeed, it is crucial to keep in mind that this book presents human problems that are currently considered psychological 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 psychological disorder. It is also quite possible that we will never be able to arrive at a definition that captures psychological disorder in its entirety and for all time. Nevertheless, at the current time, the characteristics included in the definition constitute a useful partial definition, but keep in mind that they do not equally or invariably apply to every diagnosis.

Quick Summary

This book focuses on the description, causes, and treatments of a number of different psychological 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 psychological disorders and their uses. Even the use of everyday terms such as *crazy* or *schizo* can contribute to the stigmatization of people with psychological disorders.

Defining psychological 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 psychological disorder. But not all behaviors that we consider to be part of psychological disorders cause distress. Behaviors that cause a disability or are unexpected can be considered part of a psychological 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 psychological disorder. However, not all such behavior is considered part of a psychological disorder, and some behaviors that are characteristic of psychological disorders do not necessarily violate social norms. Harmful dysfunction involves both a value and a scientific component. Like the other definitions, however, it cannot fully account for what we study in psychopathology. Taken together, each definition of psychological 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 psychological 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 psychological 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 psychological 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 from 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 psychological disorders 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 the causes of psychological disorders has gone on for a considerable period of time. At different periods in history, explanations for psychological 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.

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 psychological 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.