PERSPECTIVES

David J. A. Dozois

SIXTH EDITION

Abnormal Psychology

PERSPECTIVES

David J. A. Dozois
University of Western Ontario

SIXTH EDITION

Dedicated to my kochana,
Dr. Andrea Piotrowski

Vice President, Editorial: Anne Williams
Executive Acquisitions Editor: Kimberley Veevers
Marketing Manager: Lisa Gillis
Content Manager: Madhu Ranadive
Project Manager: Susan Johnson
Content Developer: Katherine Goodes
Production Services: Cenveo® Publisher Services
Permissions Project Manager: Kathryn O'Handley
Photo Permissions Research: Integra Publishing Services, Inc.
Text Permissions Research: Integra Publishing Services, Inc.
Cover and Interior Designer: Anthony Leung
Cover Image: FCSCAFEINE/Shutterstock

Pearson Canada Inc., 26 Prince Andrew Place, North York, Ontario M3C 2H4.

Copyright © 2019, 2015, 2013 Pearson Canada Inc. All rights reserved.

Printed in the United States of America. This publication is protected by copyright, and permission should be obtained from the publisher prior to any prohibited reproduction, storage in a retrieval system, or transmission in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise. For information regarding permissions, request forms, and the appropriate contacts, please contact Pearson Canada's Rights and Permissions Department by visiting www.pearson.com/ca/en/contact-us.html/permissions-requests.

Attributions of third-party content appear on the appropriate page within the text.

PEARSON is an exclusive trademark owned by Pearson Canada Inc. or its affiliates in Canada and/or other countries.

Unless otherwise indicated herein, any third party trademarks that may appear in this work are the property of their respective owners and any references to third party trademarks, logos, or other trade dress are for demonstrative or descriptive purposes only. Such references are not intended to imply any sponsorship, endorsement, authorization, or promotion of Pearson Canada products by the owners of such marks, or any relationship between the owner and Pearson Canada or its affiliates, authors, licensees, or distributors.

978-0-13-442887-1

10 9 8 7 6 5 4 3 2 1

Library and Archives Canada Cataloguing in Publication

Abnormal psychology (Toronto, Ont.)
Abnormal psychology: perspectives / [edited by] David J.A. Dozois, University of Western Ontario.—Sixth edition.

Includes bibliographical references and index.
ISBN 978-0-13-442887-1 (perfect bound)

1. Psychology, Pathological—Textbooks. 2. Textbooks.
I. Dozois, David J. A., editor II. Title.

RC454.A26 2018 616.89 C2017-907821-6

Brief Contents

Preface xiii

Acknowledgments xix

About the Editor xxi

About the Contributors xxii

CHAPTER 1

Concepts of Abnormality Throughout History 1

DAVID J. A. DOZOIS • DANIEL MACHADO

CHAPTER 2

Theoretical Perspectives on Abnormal Behaviour 24

DAVID J. A. DOZOIS • LINDSAY SZOTA

CHAPTER 3

Classification and Diagnosis 48

DAVID J. A. DOZOIS • KATERINA RNIC

CHAPTER 4

Psychological Assessment and Research Methods 63

DAVID J. A. DOZOIS • MONICA F. TOMLINSON

CHAPTER 5

Anxiety, Obsessive-Compulsive, and Trauma-Related Disorders 95

DAVID J. A. DOZOIS • JESSE LEE WILDE • PAUL A. FREWEN

CHAPTER 6

Dissociative and Somatic Symptom and Related Disorders 127

ROD A. MARTIN • NADIA MAIOLINO

CHAPTER 7

Psychological Factors Affecting Medical Conditions 145

JOSHUA A. RASH • KENNETH M. PRKACHIN • GLENDA C. PRKACHIN • TAVIS S. CAMPBELL

CHAPTER 8

Mood Disorders and Suicide 171

KATE HARKNESS

CHAPTER 9

Schizophrenia Spectrum and Other Psychotic Disorders 202

R. WALTER HEINRICHS • FARENA PINNOCK • MELISSA PARLAR

CHAPTER 10

Eating Disorders 229

DANIELLE MACDONALD • KATHRYN TROTTIER

CHAPTER 11

Substance-Related and Addictive Disorders 255

DAVID C. HODGINS • MAGDALEN SCHLUTER

CHAPTER 12

The Personality Disorders 288

STEPHEN P. LEWIS • STEPHEN PORTER

CHAPTER 13

Sexual and Gender Identity Disorders 318

CAROLINE F. PUKALL • KATE S. SUTTON

CHAPTER 14

Neurodevelopmental Disorders 350

JESSICA K. JONES • PATRICIA M. MINNES • MARJORY L. PHILLIPS

CHAPTER 15

Behaviour and Emotional Disorders of Childhood and Adolescence 384

TRACY VAILLANCOURT • KHRISTA BOYLAN

CHAPTER 16

Aging and Mental Health 411

COREY S. MACKENZIE • KRISTIN A. REYNOLDS

CHAPTER 17

Therapies 437

JOHN HUNSLEY • CATHERINE M. LEE

CHAPTER 18

Prevention and Mental Health Promotion in the Community 463

JULIAN HASFORD • ISAAC PRILLELTENSKY

CHAPTER 19

Mental Disorder and the Law 482

STEPHEN D. HART • RONALD ROESCH

Glossary 504

References 519

Name Index 593

Subject Index 611

Contents

Preface xiii

Acknowledgments xix

About the Editor xxi

About the Contributors xxii

CHAPTER 1

Concepts of Abnormality Throughout History 1

DAVID J. A. DOZOIS • DANIEL MACHADO

Attempts at Defining Abnormality 4
Statistical Concept 4
Personal Distress 4
Personal Dysfunction 5
Violation of Norms 5
Diagnosis by an Expert 6
Summary of Definitions 7

Historical Concepts of Abnormality 7
Evidence from Prehistory 8
Greek and Roman Thought 8
The Arab World 10
Europe in the Middle Ages 10
The Beginnings of A Scientific Approach 12

Development of Modern Views 15
Biological Approaches 15
Psychological Approaches 18

The Growth of Mental Health Services in Canada 19

Recent Developments 20
Access to Care 21
A Changing Landscape 22

Summary 22
Key Terms 23

CHAPTER 2

Theoretical Perspectives on Abnormal Behaviour 24

DAVID J. A. DOZOIS • LINDSAY SZOTA

The General Nature of Theories 25
Levels of Theories 26
Testing Theories: The Null Hypothesis 26

The Search for Causes 27

Biological Models 28
The Role of the Central Nervous System 29
The Role of the Peripheral Nervous System 31
The Role of the Endocrine System 32
Genetics and Behaviour 32

Psychosocial Theories 33
Psychodynamic Theories 34
Behavioural Theories 36
Cognitive Theories 39
Newer (Third Wave) Approaches to CBT 41
Humanistic and Existential Theories 41
Socio-Cultural Influences 43

Integrative Theories 45
Systems Theory 45
The Diathesis-Stress Perspective 46
The Biopsychosocial Model 46

Summary 46
Key Terms 47

CHAPTER 3

Classification and Diagnosis 48

DAVID J. A. DOZOIS • KATERINA RNIC

Why Do We Need a Classification System for Mental Disorders? 50

The Perfect Diagnostic System 50

Characteristics of Strong Diagnostic Systems 50

The History of Classification of Mental Disorders 51

DSM-5: Organizational Structure 53
Section I: Introduction and Use of The Manual 53
Section II: Diagnostic Criteria and Codes 53
Section III: Emerging Measures and Models 53

Categories of Disorder in DSM-5 53
Neurodevelopmental Disorders 53
Schizophrenia Spectrum and Other Psychotic Disorders 53
Mood Disorders 54
Anxiety and Related Disorders 54
Dissociative Disorders 54
Somatic Symptom and Related Disorders 55
Feeding and Eating Disorders 55
Elimination Disorders 55
Sleep–Wake Disorders 55
Sexual Disorders and Gender Dysphoria 55
Disruptive, Impulse-Control, and Conduct Disorders 56
Substance-Related and Addictive Disorders 56
Neurocognitive Disorders 56
Personality Disorders 56
Other Conditions That May Be a Focus of Clinical Attention 56
Innovations of DSM-5 56

Issues in the Diagnosis and Classification of Abnormal Behaviour 57
Against Classification 57

Criticisms Specific to the DSM Diagnostic System 59
The Prevalence of Mental Disorders 60

Summary 61
Key Terms 62

CHAPTER 4

Psychological Assessment and Research Methods 63

DAVID J. A. DOZOIS • MONICA F. TOMLINSON

Assessment 65
Assessment Tools: Striving for the Whole Picture 65
Reliability and Validity 65
Clinical versus Actuarial Prediction 66

Biological Assessment 66
Brain Imaging Techniques 67
Neuropsychological Assessments 69

Psychological Assessment 71
Clinical Interviews 71
Assessment of Intelligence 72
Personality Assessment 74
Behavioural and Cognitive Assessment 80

Research Methods 82

Experimental Methods 83
Controlled Experimental Research 83
Quasi-Experimental Methods 85

Non-Experimental Methods 85
Correlational Research 85
The Case Study 86
Single-Subject Research 87
Epidemiological Research 87
Studies of Inheritance 88

Statistical Versus Clinical Significance 92

Summary 92
Key Terms 93

CHAPTER 5

Anxiety, Obsessive-Compulsive, and Trauma-Related Disorders 95

DAVID J. A. DOZOIS • JESSE LEE WILDE • PAUL A. FREWEN

The Characteristics of Anxiety 96

Historical Perspective 96

Diagnostic Organization of Anxiety and Anxiety-Related Disorders 97

Etiology 97
Biological Factors 97
Psychological Factors 98
Comment on Etiology 99

Anxiety Disorders 99
Panic Disorder 100
Agoraphobia 101
Specific Phobia 103
Social Anxiety Disorder 105
Generalized Anxiety Disorder 108
Diagnosis and Assessment 108

Obsessive-Compulsive and Related Disorders 110
Obsessive-Compulsive Disorder 110
Body Dysmorphic Disorder 113

Trauma and Stressor Related Disorders 114
Post-Traumatic Stress Disorder 114

Treatment of Anxiety and Anxiety-Related Disorders 117
Pharmacotherapy 118
Cognitive Restructuring 118
Exposure Techniques 119
Problem Solving 121
Relaxation 121
Other Techniques 122

Treatment Efficacy 122
Treatment of Panic Disorder 122
Treatment of Specific Phobias 122
Treatment of Social Anxiety Disorder 123
Treatment of Generalized Anxiety Disorder 123
Treatment of Obsessive-Compulsive and Body Dysmorphic Disorders 123
Treatment of Post-Traumatic Stress Disorder 124
Comment on Treatments That Work 124

Summary 126
Key Terms 126

CHAPTER 6

Dissociative and Somatic Symptom and Related Disorders 127

ROD A. MARTIN • NADIA MAIOLINO

Historical Perspective 129

Dissociative Disorders 130
Prevalence 131

Dissociative Amnesia 132

Depersonalization/Derealization Disorder 132

Dissociative Identity Disorder 133

Etiology 134

Treatment 136
Psychotherapy 136
Hypnosis 136
Medication 136
Neurosurgical Treatments 136

Somatic Symptom and Related Disorders 136
Prevalence 137

Conversion Disorder 138

Somatic Symptom Disorder 139

Illness Anxiety Disorder 140

Factitious Disorder 140

Etiology 141

Treatment 141
Medication 141
Psychotherapy 142
Summary 143
Key Terms 143

CHAPTER 7

Psychological Factors Affecting Medical Conditions 145

JOSHUA A. RASH • KENNETH M. PRKACHIN • GLENDA C. PRKACHIN • TAVIS S. CAMPBELL

Historical Perspective 146
Diagnostic Issues 147
Psychosocial Mechanisms of Disease 148
The Endocrine System 149
The Autonomic Nervous System 150
The Immune System 150
The Psychology of Stress 152
Psychosocial Factors That Influence Disease 155
Social Status 155
Social Support 156
Personality 156
Disease States and Psychosocial Factors 157
Infectious Disease 157
Ulcer 158
Cardiovascular Disease 161
Treatment 167
Summary 169
Key Terms 170

CHAPTER 8

Mood Disorders and Suicide 171

KATE HARKNESS

Historical Perspective 173
Diagnostic Issues 174
Depressive Disorders 174
Major Depressive Disorder 174
Prevalence and Course 174
Persistent Depressive Disorder 176
Bipolar Mood Disorders 176
Bipolar I and Bipolar II 177
Cyclothymia 177
Rapid Cycling Specifier 178
Mood Disorder with Seasonal Pattern 178
Mood Disorder with Peri- or Postpartum Onset 179
Premenstrual Dysphoric Disorder (PMDD) 179
Etiology 180
Psychological and Environmental Causal Factors 180
Psychodynamic Personality Theories 180
Cognitive Theories 180
Interpersonal Models 182
Life Stress Perspective 182
Biological Causal Factors 183
Genetics 183
Neurotransmitters 184
Stress and The Hypothalamic-Pituitary-Adrenal Axis 185
Sleep Neurophysiology 185
Neuroimaging 186
Treatment 187
Psychotherapy for Unipolar Depression 187
Pharmacotherapy 190
Medications to Treat Bipolar Disorder 191
Combinations of Psychological and Pharmacological Treatments 192
Phototherapy for Seasonal Affective Disorder 193
Neurostimulation and Neurosurgical Treatments 194
Suicide 195
Definition 195
Epidemiology and Risk Factors 196
What Causes Suicide? 197
Prevention 198
Treatment 198
Summary 200
Key Terms 201

CHAPTER 9

Schizophrenia Spectrum and Other Psychotic Disorders 202

R. WALTER HEINRICHS • FARENA PINNOCK • MELISSA PARLAR

Introduction and Historical Perspective 204
Prevalence, Onset, Demographic and Socio-Economic Features 204
Historical Perspective: The Missing Illness 205
Typical Characteristics 207
Positive (Psychotic) and Negative Symptoms 207
Diagnosis and Assessment 208
DSM-5 Diagnostic Criteria 208
Other Psychotic Disorders 210
Critique of DSM-5 and Areas for Further Study 211
Markers and Endophenotypes for Schizophrenia 211
Etiology 212
Theories of Schizophrenia 213
Biological Factors 215
Treatment 223
Antipsychotic Medication 223
Psychotherapy and Skills Training 224
Summary 227
Key Terms 228

CHAPTER 10

Eating Disorders 229

DANIELLE MACDONALD • KATHRYN TROTTIER

Introduction and Historical Perspective 230

Typical Characteristics 231
Anorexia Nervosa 231
Bulimia Nervosa 232
Binge-Eating Disorder 233

Incidence and Prevalence 233
Prognosis 234

Diagnosis and Assessment 234
Diagnostic Criteria 234
Diagnostic Issues 238
Assessment 239

Physical and Psychological Complications 239

Etiology 240
Genetic and Biological Theories 240
Psychological Theories 242
Integrative Models 246

Eating Disorders in Males 246

Treatment 248
Biological Treatments 248
Psychological Treatments 248
Prevention 251

Summary 253
Key Terms 254

CHAPTER 11

Substance-Related and Addictive Disorders 255

DAVID C. HODGINS • MAGDALEN SCHLUTER

Historical Perspective 257

Diagnosis and Assessment 257
Diagnosing Substance Use Disorders 257
Polysubstance Use Disorder 258

Alcohol 260
History of Use 260
Canadian Consumption Patterns 260
Effects 264
Etiology 266
Treatment 269

Barbiturates and Benzodiazepines 273
Prevalence 274
Effects 274
Dependency 274
Treatment 274

Stimulants 274
Tobacco 274
Amphetamines and Designer Drugs 277
Cocaine 278
Opioids 279
Prevalence 279
Effects 279
Dependency 281
Treatment 281

Cannabis 281
Prevalence 282
Effects 282
Dependency 283
Treatment 283

Hallucinogens 283
Prevalence 284
Effects 284
Dependency 284

Gambling 284
Prevalence 284
Dependency 285
Treatment 285

Summary 286
Key Terms 287

CHAPTER 12

The Personality Disorders 288

STEPHEN P. LEWIS • STEPHEN PORTER

The Concept of Personality Disorder 290

Diagnostic Issues 293
Gender and Cultural Issues 294
Reliability of Diagnosis 295
Comorbidity and Diagnostic Overlap 295

Historical Perspective 296

Etiology 296
Psychodynamic Views 296
Attachment Theory 297
Cognitive-Behavioural Perspectives 297
Biological Factors 298
Summary of Etiology 298

The Specific Disorders 299

Cluster A: Odd and Eccentric Disorders 299
Paranoid Personality Disorder 299
Schizoid Personality Disorder 299
Schizotypal Personality Disorder 300

Cluster B: Dramatic, Emotional, or Erratic Disorders 300
Antisocial Personality Disorder and Psychopathy: A Confusion of Diagnoses 300
Borderline Personality Disorder 308
Histrionic Personality Disorder 311
Narcissistic Personality Disorder 311

Cluster C: Anxious and Fearful Disorders 312
Avoidant Personality Disorder 312
Dependent Personality Disorder 312
Obsessive-Compulsive Personality Disorder 313

Treatment 313
Object-Relations Therapy 313
Cognitive-Behavioural Approaches 314
Pharmacological Interventions 314
Summary 316
Key Terms 317

CHAPTER 13

Sexual and Gender Identity Disorders 318

CAROLINE F. PUKALL • KATE S. SUTTON

Historical Perspective 320
Diagnostic Issues 320
Sexual Response 321
Sexual Dysfunctions 325
Sexual Desire and Arousal Disorders 326
Orgasmic Disorders 327
Genito-Pelvic Pain/Penetration Disorder 327
Hypersexuality 328
Etiology of Sexual Dysfunctions 329
Treatment of Sexual Dysfunctions 330
Gender Identity 333
Gender Dysphoria 333
Etiology of Gender Dysphoria 334
Treatment of Gender Dysphoria 335
The Paraphilias 337
Paraphilic Disorders 338
Summary 348
Key Terms 349

CHAPTER 14

Neurodevelopmental Disorders 350

JESSICA K. JONES • PATRICIA M. MINNES • MARJORY L. PHILLIPS

Historical Perspective 351
A Note About Terminology 353
Intellectual Disability 353
Prevalence 353
Diagnostic Issues 354
The Challenges of Assessing Intelligence 356
Measuring Adaptive Behaviour 356
Interviewing Strategies 357
Etiology 357
Genetic Causes 357
Environmental Causes 360
Postnatal Environmental Factors: Psychosocial Disadvantage 362
Two Specific Disorders 363
Down Syndrome 363
Fragile X Syndrome 364
The Effect of Developmental Disorders on the Family 366
Deinstitutionalization and Community Integration or Inclusion 367
Mainstreaming and Inclusion of Students with Disabilities in Educational Settings 367
Preparation for Community Living 367
Evaluating Quality of Life 368
The Issue of Sex Education 368
Challenging Behaviours and Dual Diagnosis (i.e. ID and Mental Disorder) 369
Dignity of Risk and Offending Behaviour 370
Autism Spectrum Disorder 370
Prevalence 371
Description 371
Social Interaction 372
Verbal and Nonverbal Communication 373
Behaviour and Interests 373
Diagnostic Issues 373
Asperger's Disorder 374
Assessment 375
Etiology 375
Treatment and Intervention 376
Medications and Nutritional Supplements 376
Behavioural Interventions 376
Learning Disorders 378
Historical Perspective 378
Diagnostic Criteria 379
Controversy in Diagnosis 379
Specific Learning Disorders 379
Prevalence 380
Etiology 380
The Relationship between Learning Disorders and Mental Health 380
Intervention 381
Summary 382
Key Terms 383

CHAPTER 15

Behaviour and Emotional Disorders of Childhood and Adolescence 384

TRACY VAILLANCOURT • KHRISTA BOYLAN

Historical Perspective of Child and Adolescent Mental Health 385
Current Issues in Assessing and Treating Children and Adolescents 386
Prevalence of Childhood Disorders 387
Attention Deficit/Hyperactivity Disorder 389
Clinical Description 389
Etiology 391
Assessment and Treatment 393
Oppositional Defiant Disorder and Conduct Disorder 395
Clinical Description 395
Etiology 399
Treatment 400

Anxiety Disorders 402
Clinical Description 403
Etiology 406
Treatment 407
Summary 408
Key Terms 410

CHAPTER 16

Aging and Mental Health 411

COREY S. MACKENZIE • KRISTIN A. REYNOLDS

Changing Demography 412
Vulnerability Versus Resilience in Old Age 413
Prevalence of Mental Disorders in Older Adults 414
Historical Perspective 415
Misconceptions about Treating Older Adults 415
Age-Specific Issues of Diagnosis and Treatment 417
Theoretical Frameworks of Aging 418
Selective Optimization With Compensation 418
Socio-Emotional Selectivity Theory 418
Strength and Vulnerability Integration Theory 419
Depressive Disorders 419
Suicide 420
Etiology 420
Depressive Disorders 421
Sleep–Wake Disorders 422
Diagnostic Issues 423
Normal Changes in Sleeping Patterns 424
Insomnia Disorder 424
Breathing-Related Sleep Disorders 425
Anxiety Disorders 426
Diagnostic Issues 426
Treatment 426
Schizophrenia 427
Diagnostic Issues 427
Treatment 427
Delirium 428
Etiology 428
Diagnostic Issues 428
Treatment and Outcomes 428
Neurocognitive Disorders (NCDs) 429
Mild Neurocognitive Disorders 430
Alzheimer's Disease 431
Vascular NCD 433
Other forms of NCD 434
Caregiver Stress 435
Summary 436
Key Terms 436

CHAPTER 17

Therapies 437

JOHN HUNSLEY • CATHERINE M. LEE

Biological Treatments 439
Electroconvulsive Therapy 439
Psychopharmacology 439
Psychotherapy: A Definition 443
Theoretical Orientations 443
Psychodynamic Approaches 444
Humanistic-Experiential Approaches 445
Cognitive-Behavioural Approaches 446
Integrative Approaches 448
Psychotherapy: Treatment Modalities 449
Individual Therapy 449
Couples Therapy 449
Family Therapy 451
Group Therapy 451
The Context of Psychotherapy 452
Who Provides Psychotherapy? 452
Who Seeks Psychotherapy? 452
After Making an Appointment... 453
Evaluating the Effects of Psychotherapy 453
Historical Context 453
Meta-Analysis 454
A Brief Review of Meta-Analytic Evidence 454
Effects of Psychotherapy for Specific Disorders 455
Couple Distress 457
Modular and Transdiagnostic Approaches 457
Generalizing to Clinical Settings 458
Evidence-Based Practice 459
Summary 461
Key Terms 462

CHAPTER 18

Prevention and Mental Health Promotion in the Community 463

JULIAN HASFORD • ISAAC PRILLELTENSKY

Community Psychology 464
Prevention and Mental Health Promotion: Some Definitions 465
Primary, Secondary, and Tertiary Prevention 465
Universal, Selective, and Indicated Prevention 465
Mental Health Promotion 465
Historical Perspective 467
Pre–Germ Theory ERA 467
Public Health Approach 467
School-Based Approach 467
Resilience, Risk, and Protection 468
Resilience, Risk, and Protective Factors 468

Interactionist and Constructionist Perspectives on Resilience 468
Cumulative Risk 469
Mechanisms of Risk and Protection 470
Implications of Resilience, Risk, and Protection for Prevention 470

A Conceptual Framework for Prevention and Promotion 470
The Contextual Field 471
The Affirmation Field 472

Research and Practice in Prevention and Promotion 473
High-Risk (Selective) Prevention Programs 474
Universal Prevention and Promotion Programs 475

Prevention and Promotion Policy in Canada 477
The Federal Role 477
The Provincial Role 478
Return on Investment 478

Implementation, Dissemination, and Social Justice 479
Implementation 479
Dissemination 479
Social Justice 480
Cultural Competence and Anti-Racism 480

Summary 481
Key Terms 481

CHAPTER 19

Mental Disorder and the Law 482

STEPHEN D. HART • RONALD ROESCH

Mental Disorder in Canadian Law 485

The Canadian Legal System 486
Constitutional Law 486
Statutory Law 487
Common Law 487

A Closer Look at Civil Mental Health Law 488
Involuntary Admission 488
Involuntary Treatment 489
Reviews and Appeals 490
Some Examples of Research on Mental Health Law in Canada 490

A Closer Look at Mentally Disordered Offenders 493
Criminal Responsibility: Mental State at the Time of the Offence 494
Competency to Make Legal Decisions: Mental State at the Time of Trial 496
Some Examples of Research on Mentally Disordered Offenders in Canada 496

Psychology in the Legal System 498

Psychological Ethics 499
General Ethical Principles of Psychology 499
Specialized Ethical Guidelines 499

The Status of Psychology in the Legal System 500

Summary 502
Key Terms 503

Glossary 504
References 519
Name Index 593
Subject Index 611

Focus and Clinical Research

Focus Boxes

Treatment and Mistreatment: The Depiction of Mental Asylums in the Movies 14
Governmental and Corporate Initiative 21
Neurotransmission 30
Comorbidity 55
Research Domain Criteria: A New Classification Framework 61
Test Security: Posting of the Rorschach Inkblot Test 75
The MMPI-2: A Sample Profile 78
Cultural Differences in Anxiety 105
OCD and Checking: Poor Memory or Poor Memory Confidence? 113
Therapeutic Strategies for Enhancing Exposure Therapy 120
Repressed Memory or False Memory? 131
Putting It All Together: Stress, Marriage, Physiological Changes, and Health 153
Inferring Causality in Health Psychology 160
Sex Differences in Depression 187
An Eighteenth-Century Sculptor with Schizophrenia 206
Schizophrenia: Fact and Fiction 210
How Different Are Patients with Schizophrenia from Healthy People? 218
Thin Ideal Media Images Make Women Feel Bad, Right? 242
Back to the Future: Addiction in the DSM-5 258
Canada's Indigenous People 261
Non-abstinence Drinking Goals in Treatment 270
The Fentanyl Crisis 280
Paul Bernardo and Karla Homolka 301
A Hot Topic: Measuring Sexual Arousal in Men and Women 323
Nonspecificity of Sexual Response in Androphilic Women 324
The Dangers of Hope: Lessons from Facilitated Communication and Other Miracle Cures 377
Youth at Risk 381
Famous People with Learning Disabilities 381
Suicidal Thoughts and Self-Harm in Youth 405
Perfectionism and Mental Health 408
Older Adults: The Missing Clients 416
Should Psychologists Prescribe Medication? 444
Technological Advances in the Provision of Psychological Treatments 451
Preventing Substance Abuse and Dependence Among Canadian Children and Youth: Policy and Programs 477
Reports Documenting Return on Investment in Prevention 478
A Sample Item from the FIT-R Manual 497

Canadian Research Centre Boxes

Dr. Candice Monson 124
Dr. Laurence J. Kirmayer 142
Dr. Kim Lavoie 168
Dr. Zindel Segal 200
Dr. Sean Kidd 226
Eating Disorder Program, University Health Network (Toronto, Ontario) 252
Dr. Robert Hare 315
Dr. Elke Reissing, Human Sexuality Research Laboratory 347
Jean Vanier, Founder of L'Arche 382
Baycrest Centre for Geriatric Care 435
Dr. Martin M. Antony 450
Better Beginnings, Better Futures 475
Dr. Christopher Webster 501

Applied Clinical Case

An Olympian Speaks out about Mental Health 44
Howie Mandel 58
Dissociative Amnesia with Fugue 136
John Candy 161
Demi Lovato 178
John Nash's Beautiful Mind: When Schizophrenia and Genius Coexist 214
Sheena Carpenter 247
Robert Downey Jr. 269
Sophie's Experience 307
Dr. Richard Raskin 336
Actors with Disabilities 353
Bullying and Children's Mental Health 388
Ronald Reagan 434

Preface

The subtitle *Perspectives* was chosen for this text because it expresses the essence of its approach. First, since it is a contributed volume, a number of individual perspectives are discussed. Second, we have taken care to present a balance of the psychological perspectives by discussing various relevant paradigms. Although different perspectives are highlighted, we place greater emphasis on the conceptual approaches and therapeutic interventions that have garnered the most empirical support in the research literature. Finally, this text is written by Canadian experts. While it does pay tribute to the best of international research, it does not ignore the world-class scholarship happening in our own country, and this gives the book its uniquely Canadian perspective.

We feel that *Abnormal Psychology: Perspectives* offers a different approach from many of the abnormal psychology texts available:

1. *Canadian content, from the ground up.* Not just an adaptation of an American text, *Abnormal Psychology: Perspectives* was written entirely by Canadian authors with Canadian students in mind. Our universal health care system and relatively high level of secondary education in Canada have resulted in mental health issues that are unique in North America, and they are reflected in this text. As well, a large number of important issues—legal cases, laws governing therapists, ethical issues, prevention programs, ground-breaking research, even the history of abnormal psychology in this country—are considered from the perspective of people who will be studying, living, and working in Canada. Chapter 19 (Mental Disorder and the Law), for example, covers the topic most requested by Canadian instructors tired of having to supplement texts that discuss only the American situation. Each chapter also highlights many of the important contributions that Canadian researchers have made to the understanding and treatment of psychopathology.
2. *Expert contributors.* One of the advantages of a contributed abnormal psychology text is that each disorder chapter can be written by experts in that field, ensuring that the research discussed and the approach taken in each chapter are as accurate and up to date as possible. The panoply of well-known and highly respected contributors to this volume speaks for itself.
3. *A different approach.* The organization of the text has been fine-tuned to reflect the emerging importance of several areas of abnormal psychology. For example, an entire chapter is devoted to prevention and mental health promotion in the community because no matter how adept we become at diagnosing and treating mental disorders, their *incidence* will never decrease without programs designed to prevent them from occurring in the first place. As the familiar adage states, "An ounce of prevention is worth a pound of cure."
4. *Chapter organization.* The chapters in this text provide an excellent flow that we believe progresses well, from general historical and conceptual issues, to an overview of issues related to diagnosis and assessment, to a detailed review of specific disorders, to important issues in the field—such as mental disorders and aging, the efficacy of psychological interventions, prevention of disorders and promotion of mental health, and legal and ethical issues in mental health.

Although the book is multi-authored, we have striven at all times for consistency of level, depth, and format across the chapters. Where applicable, each chapter follows this pattern:

- Learning objectives
- Opening case
- Overview/introduction of the disorder
- Discussion of diagnostic issues (with DSM-5 criteria)
- Historical perspective
- Full description of the disorder
- Etiology (from various theoretical perspectives)
- Treatment (from various theoretical perspectives)
- Within-chapter critical thinking questions ("Before Moving On")
- Within-chapter Applied Clinical Case
- Within-chapter Canadian Research Centre box
- Summary
- Key words

We hope that students and instructors alike will benefit from this collaboration of many individuals who, no doubt like them, will always find the study of abnormal psychology endlessly challenging and utterly absorbing.

What's New in the Sixth Edition

Throughout the text this edition reflects the latest DSM-5 criteria. Our sixth edition was also heavily revised with updated references and statistics, more Canadian research and studies, and five new senior authors (Chapters 7, 10, 12, 14, and 18). To provide you with a brief overview of these changes, we offer some chapter-by-chapter highlights:

CHAPTER 1

- Provides an overview of the strategies used to define abnormality over the course of history, with updated Canadian content
- Covers the developments of the Mental Health Commission of Canada

- Highlights the work of the Canadian Psychological Association's task force on evidence-based practice of psychological treatments and addresses issues related to access to care, including recent government and corporate initiatives for ensuring that Canadians get the right help at the right time.
- Features a Focus box "Treatment and Mistreatment," which examines how Hollywood films depict mental asylums
- Discusses how technology introduces new opportunities and challenges for mental health care.

CHAPTER 2

- Provides an updated overview of the different theoretical perspectives on abnormal behaviour
- Illustrates how theorists from biological, psychodynamic, behavioural, cognitive, humanistic/existential, and socio-cultural perspectives would view a particular case of abnormal behaviour
- Discusses new research on gene–environment interactions
- Highlights research on self-schemas
- Discusses new "third wave" approaches, including Mindfulness-Based Cognitive Therapy and Acceptance and Commitment Therapy
- Addresses the impact of public stigma and self-stigma and recent anti-stigma campaigns

CHAPTER 3

- Describes why we need a classification system, outlines the criteria used to define abnormal behaviour, and provides a history of the classification of mental disorders
- Describes the history of the DSM and the organization of the DSM-5
- Includes a new Focus box on Howie Mandel and his struggles with OCD
- Highlights the Research Domain Criteria initiated by the National Institute of Mental Health
- Discusses the prevalence of mental disorders in Canada

CHAPTER 4

- Updates the literature on psychological and neuropsychological assessment
- Examines the issue of test security in a Focus box on the posting of the Rorschach Inkblot Test on Wikipedia
- Discusses new research on the MMPI-2 and MMPI-2_RF, including a new sample profile
- Updates the literature on cognitive-behavioural assessment
- Highlights new Canadian epidemiological research

CHAPTER 5

- Organizes anxiety and related disorders into three distinct sections within the chapter: Anxiety Disorders, Obsessive-Compulsive and Related Disorders, and Trauma- and Stressor-Related Disorders.
- Updates findings on the etiology of anxiety and related disorders and describes DSM-5 criteria
- Includes a new Focus box highlighting research on OCD, memory confidence, and checking
- Body Dysmorphic Disorder is now included in Chapter 5
- Discusses therapeutic strategies for enhancing exposure therapy
- Features a new Canadian Research Centre box describing the work of Dr. Candice Monson, Ryerson University professor and expert on PTSD
- Discusses the latest treatment and epidemiological research on anxiety and related disorders

CHAPTER 6

- Highlights DSM-5 criteria for dissociative and somatic symptom and related disorders
- Provides updated information regarding the epidemiology of dissociative and somatic symptom and related disorders
- Covers updated research on the etiology and treatment of dissociative amnesia, depersonalization/derealization disorder, and dissociative identity disorder
- Discusses contemporary research concerning the etiology and treatment of somatic symptom disorders

CHAPTER 7

- New authors provide an updated historical review of psychological factors involved in physical illness
- Highlights changes to the classification of psychological factors affecting medical conditions in DSM-5
- Includes a review of alternative systems for measuring and classifying psychological factors affecting medical conditions
- Includes an expanded breadth of coverage of psychological factors affecting medical conditions.
- Includes a balanced and comprehensive review of cardiovascular reactivity, including exaggerated reactivity, blunted reactivity, and cardiovascular recovery
- Updates and expands upon the association between depression and cardiovascular disease
- Details an innovative Canadian research centre

CHAPTER 8

- Provides additional information on historical views of depression
- Highlights changes to the mood disorder diagnoses in DSM-5
- Features work by Dr. Daniel Klein on chronic depression
- New Applied Clinical Case focuses on the difficulties experienced by singer and actor Demi Lovato
- Provides information on the symptoms and causal models of Premenstrual Dysphoric Disorder (PMDD)
- Provides additional information on information-processing biases in unipolar depression and bipolar disorder
- Provides additional information on the role of stress in bipolar disorder
- Provides additional information on the effects of childhood stress on the brain
- Provides additional information on the role of neurotransmitters in bipolar disorder
- Provides information on the role of the immune system and stress in depression
- Examines Mindfulness-Based Cognitive Therapy, developed by Canadian psychologist Dr. Zindel Segal and his colleagues
- Reviews recent data on neurostimulation and neurosurgical treatments
- Highlights the National Suicide Prevention Strategy recently approved by the federal government
- Highlights two psychological models of suicide—the interpersonal model and the motivational-volitional model
- Introduces information on the pharmacological treatment of suicide with ketamine

CHAPTER 9

- Showcases common delusions experienced by individuals with schizophrenia
- Provides updated information on cognitive subtypes and genetic markers of schizophrenia
- Reviews findings from functional and structural imaging research on schizophrenia
- Describes the dopamine hypothesis of psychosis and recent developments in medication
- Clinical Research Centre focuses on the work of Queen's University researcher Dr. Christopher Bowie
- Provides new information on CBT, social skills training, and cognitive remediation programs for schizophrenia
- Introduces a new Clinical Research Centre focusing on the work of Dr. Sean Kidd at Toronto's Centre for Addiction and Mental Health.

CHAPTER 10—NEW

- New additional authors provide updated statistics on the incidence and prevalence of eating disorders
- Contains new information aimed at dispelling myths and stereotypes about eating disorders
- Provides additional information on eating disorders in diverse populations
- Updated research on the role of psychological trauma and other severe adverse experiences has been included in the section on the etiology of eating disorders
- Features updated information on "enhanced CBT" and on family therapy
- Contains new information on integrative etiological models
- New Canadian Research Centre focuses on the newly redesigned Eating Disorder Program at the University Health Network in Toronto

CHAPTER 11

- Provides new prevalence data on substance use and gambling behaviour
- Provides updated information on the etiology of alcohol use disorder
- Supplies new information on the opioid crisis in Canada
- Contains a discussion on the relationship between cannabis and psychosis
- Significant reorganization of hallucinogen and gambling sections
- Provides new information on gambling disorder and its treatment

CHAPTER 12—NEW

- New senior author provides information on the DSM-5 criteria for personality disorders and a fundamentally different diagnostic model being considered for future research
- Presents updated case examples throughout the chapter
- Discusses "The Dark Triad"—a constellation of personality traits deemed to be socially aversive
- Highlights new research on psychopathy, including the "selective impulsivity theory"
- Discusses social media and narcissism
- Introduces psychological autopsies as a means to study suicide

- Discusses non-suicidal self-injury and its relation to, and distinction from, borderline personality disorder
- Discusses borderline personality disorder in adolescence
- Provides an updated overview of borderline personality disorder and its treatment

CHAPTER 13

- Updates prevalence rates for sexual dysfunctions
- Expands information related to the treatments for sexual dysfunctions
- Provides the latest information related to gender dysphoria and gender affirming procedures
- Includes new discussions on hypersexuality and sexual sadism/masochism
- Describes new work on the measurement of sexual arousal
- Includes increased breadth of information about pedophilic disorder and rape

CHAPTER 14—NEW

- New senior author highlights DSM-5 criteria for the diagnosis of neurodevelopmental disorders
- Discusses the new terminology for intellectual developmental disabilities and learning disorders
- Examines changes to genetic testing and the impact of new screening technologies
- Highlights updated profiles of Fetal Alcohol Spectrum Disorder, Down syndrome, and Fragile X Syndrome.
- Describes new developments on the effect of disabilities on the family and issues related to community integration and quality of life
- Examines community inclusion and attitudes toward education and sexuality for individuals with disabilities
- Provides new information and approaches to individuals with dual diagnoses i.e. intellectual disability and mental illness; including issues relating to challenging behaviour and offending behaviour in the community
- Highlights diagnostic changes to Autism Spectrum Disorders and explores advances and challenges in assessment, intervention and treatment
- Provides information about specific learning disabilities and the relationship with mental health, including implications for intervention

CHAPTER 15

- Provides new information on the prevalence of childhood mental disorders
- Discusses the impact of bullying on the brain and on children's mental health
- Details DSM-5 criteria for different disorders
- Provides new discussion of the comorbidity of internalizing and externalizing problems
- Discusses the newly added diagnostic category of Disruptive Mood Dysregulation Disorder
- Provides new discussion of the developmental trajectories of various childhood problems
- Discusses a proposed disorder: Nonsuicidal Self-injury Disorder
- A new Focus box highlights the relation of perfectionism and mental health

CHAPTER 16

- Reviews evidence that mental health tends to improve with age, and explores reasons why
- Highlights ways of preventing mental health problems in older adults
- Compares the efficacy of psychological and drug treatments
- Presents new data on the development and treatment of insomnia in later life
- Updates information on the prevalence and treatment of anxiety disorders
- Focuses on updates concerning cognitive disorders (e.g., delirium) in older adults

CHAPTER 17

- Reviews evidence-based guidelines for the pharmacological treatment of mental disorders
- Highlights the recommendations of the Canadian Psychological Association's Task Force on Prescriptive Authority for Psychologists in Canada
- Discusses recent trends in cognitive-behavioural therapy and other "third wave" approaches
- A new Canadian Research Centre focuses on Dr. Martin Antony from Ryerson University
- Highlights technological advances in the provision of psychological treatments
- Provides new information on the effectiveness of psychological treatments for different disorders
- Discusses modular and transdiagnostic approaches to treatment
- Identifies key issues in the development of evidence-based psychological practice and presents a new model endorsed by the Canadian Psychological Association

CHAPTER 18—NEW

- New senior author discusses updated research on ecological protective factors and cumulative risk
- Describes a school-based approach to public health, prevention, and mental health
- Discusses interactionist and constructionist perspectives on resilience
- Highlights issues related to the implementation and dissemination of prevention programs
- Provides a new subsection on issues related to cultural competence and anti-racism

CHAPTER 19

- Presents a revised and expanded summary of provincial civil mental health laws
- Updates the discussion of risk assessment to include Version 3 of the HCR-20
- Discusses amendments to the *Criminal Code* related to the designation of High Risk Accused
- Incorporates the new fourth edition of the *Canadian Code of Ethics for Psychologists*

Features

Learning Objectives. Each chapter opens with a set of learning objectives. These learning objectives focus on student performance. Each chapter begins with a statement about what the student should be able to learn. Critical thinking questions (titled "Before Moving On") that correspond to the learning objectives are positioned at appropriate locations within the chapter to allow the student to pause and reflect on the material. We believe that this new feature will better allow students to absorb, reflect on, and integrate the course material.

"Before Moving On" Critical Thinking Questions. Throughout each chapter is a series of critical thinking questions positioned within the text so that students can stop and think about the content of the chapter before moving on. Each of these critical thinking questions links to one of the learning objectives identified at the beginning of the chapter, providing students with an excellent way to absorb, integrate, and apply the material. The questions help promote in-class discussions and small group work.

Cases. Cases are, without a doubt, what students find most fascinating about abnormal psychology. Each chapter of this text opens with a case or cases designed to engage student interest. Subsequent cases or clinical examples appear throughout the remainder of the chapter, highlighted in the design by a box, to illustrate nuances between related disorders. Clinical examples are used to illustrate the discussion wherever possible.

Applied Clinical Cases. In addition to the cases that open each chapter, Applied Clinical Cases focus on celebrities or other well-known people. These interesting case examples serve to bring to life some of the concepts outlined in the text.

Focus boxes. These feature boxes present such interesting topical subjects as Depicting Mental Asylums in Movies; The New Classification Framework; OCD; Sex Differences in Depression; Paul Bernardo and Karla Homolka; Measuring Sexual Arousal, and much more!

Canadian Research Centre. These insightful boxes highlight Canadian facilities and Canadian psychologists who have made major contributions in their fields as related to each chapter.

DSM-5 Coverage. A discussion of the DSM-5, its strengths and its limitations, first appears in Chapter 3, Classification and Diagnosis. Thereafter, explanations of the various disorders are always accompanied by tables listing DSM-5 criteria for the disorder.

Key Terms. These are bolded and clearly defined where they are first discussed in the chapter. These definitions also appear in the Glossary at the end of the book.

Summary and Key Terms lists. Each chapter ends with a concise bulleted summary of the important points of the chapter. A list of the key terms for that chapter, with page references, follows.

Instructor Supplements

MyTest from Pearson Canada is a powerful assessment generation program that helps instructors easily create and print quizzes, tests, and exams, as well as homework or practice handouts. Questions and tests can all be authored online, allowing instructors ultimate flexibility and the ability to efficiently manage assessments at any time, from anywhere. MyTest for *Abnormal Psychology: Perspectives*, Sixth Edition, includes over 1900 fully referenced multiple-choice, true/false, and essay questions. Each question is accompanied by a difficulty level, type designation, topic, and answer justification. Instructors can access MyTest at www.pearsonmytest.com.

Test Item File. The MyTest questions in multiple-choice, true/false, and essay formats are also provided in a Word document.

Instructor's Manual. The Instructor's Manual contains chapter summaries, key points, key terms, important names, supplementary lecture material, and questions to provoke class discussion.

PowerPoints. The PointPoint supplement contains a comprehensive selection of 20 to 25 slides per chapter, highlighting key concepts featured in the text. The slides have been specifically developed for clear and easy communication of themes, ideas, and definitions.

The above instructor supplements are available for download from a password-protected section of Pearson Canada's online catalogue (**www.pearson.com/higher-education**). Navigate to your book's catalogue page to view a list of those supplements that are available. See your local sales representative for details and access.

LEARNING SOLUTIONS MANAGERS

Pearson's Learning Solutions Managers work with faculty and campus course designers to ensure that Pearson technology products, assessment tools, and online course materials are tailored to meet your specific needs. This highly qualified team is dedicated to helping schools take full advantage of a wide range of educational resources, by assisting in the integration of a variety of instructional materials and media formats. Your local Pearson Canada sales representative can provide you with more details on this service program.

Acknowledgments

I would like to thank the team at Pearson Canada who provided the initial encouragement to undertake this project and who helped so much in the process of generating the final result. In particular, I would like to thank our Executive Acquisitions Editor, Kim Veevers; our Marketing Manager, Lisa Gillis; our Content Manager, Madhu Ranadive; and our Content Developer, Katherine Goodes, for their hard work on this volume.

In addition, I would like to thank my parents (John and Judy Dozois) for their constant love, support, and encouragement. I would also like to express gratitude to Greg Barrett and Faith Hennessy who have been an incredible source of support, particularly over the past couple of years. A special thanks to Dr. Andrea Piotrowski, who has helped me—to paraphrase Thoreau—to suck the marrow out of life. I would also like to thank my current graduate students who have been an incredible encouragement and source of joy: Katerina Rnic, Monica Tomlinson, Daniel Machado, Lindsay Szota, Jesse Lee Wilde, and Jennifer Gillies. I am also extremely grateful to the chapter authors for their excellent contributions to this text.

Finally, I gratefully acknowledge the comments and suggestions of the many knowledgeable colleagues who reviewed the earlier editions of this text.

This page intentionally left blank

About the Editor

David J. A. Dozois, Ph.D., is a Full Professor of Psychology and Director of the Clinical Psychology Graduate Program at the University of Western Ontario in London, Ontario. He completed his undergraduate and graduate studies at the University of Calgary. He is a Fellow of the Canadian Psychological Association (CPA), the Canadian Association of Cognitive and Behavioural Therapies, the CPA Section on Clinical Psychology, the Association for Behavioural and Cognitive Therapies, and the Academy of Cognitive Therapy. He is also a former Beck Institute Scholar at the Beck Institute for Cognitive Therapy and Research. Dr. Dozois' research focuses on cognitive vulnerability to depression and cognitive-behavioural theory/therapy. He has published 162 scientific papers, book chapters and books and has presented over 300 research presentations at national and international conferences. He is editor of *Cognitive-Behavioral Therapy: General Strategies* (2014, Wiley) and co-editor of the *Handbook of Cognitive-Behavioral Therapies* (in press; Guilford), *Prevention of Anxiety and Depression: Theory Research and Practice* (2004, American Psychological Association) and *Risk Factors in Depression* (2008; Elsevier/Academic Press). Dr. Dozois was twice President of the Canadian Psychological Association (2011–12; 2016–17). He is also on the Board of Directors for the Ontario Mental Health Foundation and the International Association of Applied Psychology. Dr. Dozois is a licensed psychologist, and practises cognitive therapy in London, Ontario.

http://dozoislab.com/

http://psychology.uwo.ca/people/faculty/profiles/dozois.html

About the Contributors

Concepts of Abnormality Throughout History

Daniel Machado received his B.A. (Honours) in psychology from the University of Waterloo and his M.Sc. in clinical psychology from Western University. He is currently completing his Ph.D. in clinical psychology at Western University. Daniel's research interests centre on cognitive vulnerabilities to depression, and his current research examines the predictors of relapse/recurrence in the disorder.

Theoretical Perspectives on Abnormal Behaviour

Lindsay Szota received her B.Sc. (Honours) in psychology from the University of Western Ontario and is currently completing her M.Sc. in clinical psychology at the University of Western Ontario. Her research interests focus on cognitive predictors of information-processing biases in depression-prone individuals.

Classification and Diagnosis

Katerina Rnic received her B.A. (Honours) in psychology from Queen's University and her M.Sc. in clinical psychology from the University of Western Ontario. She is currently completing her doctoral degree in clinical psychology at the University of Western Ontario. Her research examines how cognitive and behavioural vulnerabilities relate to the generation of and response to depressogenic life events, particularly those involving rejection or social evaluation.

Psychological Assessment and Research Methods

Monica Tomlinson completed her Bachelor of Arts in Psychology and English at McGill University and her Master's of Science in Clinical Psychology at The University of Western Ontario (UWO). Monica is currently completing her Ph.D. in Clinical Psychology at UWO with Dr. David Dozois. Monica has two major programs of research. Monica's dissertation research, which is funded by the Social Sciences and Humanities Research Council, is looking at the relationship between substance use and depression. She also has a program of research with St. Joseph's Health Care London developing and evaluating rehabilitation programs in forensic psychiatric populations.

Anxiety and Related Disorders

Jesse Lee Wilde received her B.Sc. (Honours) in psychology from the University of Toronto and is currently completing her M.Sc. in clinical psychology at the University of Western Ontario. Her research focuses on cognitive correlates of intimate relationship dysfunction within the context of depression.

Paul A. Frewen completed his Ph.D. in clinical psychology from Western University in London, Ontario, where he is now associate professor in the Department of Psychiatry. Dr. Frewen completed his clinical psychology residency with the Royal Ottawa Health Care Group. His research interests include psychological assessment, and functional magnetic resonance imaging of emotional processing and sense of self in people with mood and anxiety disorders. He received the President's New Researcher Award from the Canadian Psychological Association (CPA) and the Scientist-Practitioner Early Career Award from the Clinical Section of CPA.

Dissociative and Somatic Symptom and Related Disorders

Rod A. Martin completed his Ph.D. in clinical psychology at the University of Waterloo in 1984, and was subsequently a professor in the Department of Psychology at Western University until his retirement in 2016. During his time at Western he served for 12 years as director of the clinical psychology program, and taught courses in abnormal psychology at both the graduate and undergraduate levels for many years. In general, his research has focused on personality variables associated with resiliency and effective coping. A major focus of his research has been on the psychology of humour, particularly as it relates to psychological health and well-being. He has authored numerous journal articles and book chapters on this topic, and his book, *The Psychology of Humor: An Integrative Approach*, has become the leading text in the field. He has also conducted research on depression, Type A personality, and the effects of stress on immunity. He is now a professor emeritus and is enjoying retirement.

Nadia Maiolino is a doctoral candidate in the clinical psychology program at the University of Western Ontario. Nadia also received her M.Sc. in clinical psychology at Western and completed her B.A. (Honours) at Brescia University College. Her research interests include the impact of psychological factors on major mental disorders, and primarily, the role of cognitive and behavioural mechanisms in producing manic symptoms.

Psychological Factors Affecting Medical Conditions

Joshua A. Rash received his Ph.D. in clinical psychology from the University of Calgary in 2017. He is an Assistant Professor of Clinical Psychology at Memorial University of Newfoundland. His research focuses on elucidating the biobehavioural mechanisms involved in the development, progression, and management of chronic disease, including pain, cardiovascular disease, and cancer.

Kenneth M. Prkachin received his Ph.D. in clinical psychology from the University of British Columbia in 1978. Subsequently, he taught in the Department of Psychology at the University of British Columbia and the Department of Health Studies at the University of Waterloo. He is currently professor of psychology and health sciences at the University of Northern British Columbia. His research is in

the area of measurement of emotion, psychological determinants of cardiovascular reactivity, and psychological risk factors for heart disease.

Glenda C. Prkachin received her Ph.D. in biopsychology from the University of British Columbia in 1978. Subsequently, she was a Killam Postdoctoral Fellow in the Department of Neuroanatomy at the University of Washington and a Natural Sciences and Engineering Council of Canada University Research Fellow. She has taught at the University of Western Ontario, Mt. Allison University, Wilfrid Laurier University, and the Universities of Guelph and Waterloo. She is currently associate professor of psychology at the University of Northern British Columbia. Her current research is in the perception and neuroscience of emotion.

Tavis Campbell is a Professor of Clinical Psychology and Oncology at the University of Calgary, where he also holds the position of Director of Clinical training. He obtained his Ph.D. from McGill University and completed a Postdoctoral Fellowship at Duke University Medical Centre. His research interests involve identifying and understanding the bio-behavioural mechanisms involved in the development, progression, and management of chronic diseases, such as hypertension, cancer and insomnia. In addition, he is actively involved in the Canadian Hypertension Education Program (CHEP) and is Chair of the Adherence Committee and a member of the Knowledge Translation Committee at Hypertension Canada. Finally, Dr. Campbell is regularly sought out by a variety of healthcare professionals (e.g., physicians, rheumatologists, nurses, dermatologists) to deliver training with a focus on motivating health behaviour change and improving patient-provider communication.

Mood Disorders and Suicide

Kate Harkness, Ph.D., C. Psych., received her Honours B.Sc. in Psychology from the University of Toronto and her M.Sc. and Ph.D. from the University of Oregon. She then completed a residency and post-doctoral fellowship at the Western Psychiatric Institute and Clinic in Pittsburgh. She is a Professor in the Departments of Psychology and Psychiatry at Queen's University. Her research has focused on the role of stress in the onset and recurrence of major depression in adolescents and adults, and she is currently conducting studies examining interactions between biomarkers in the neuroendocrine and neuroinflammatory systems and early life stress in the etiology and syndromal presentation of major depressive disorder. Dr. Harkness's research has been funded by the Canadian Institutes for Health Research, the Canadian Foundation for Innovation, the Ontario Mental Health Foundation, and the Hospital for Sick Children Foundation.

Schizophrenia

R. Walter Heinrichs is Professor in the Department of Psychology at York University in Toronto, Ontario. He became interested in schizophrenia as a student at the Ontario College of Art, where he was exposed to the history of artistic expression in people with serious mental illness. After an undergraduate degree in psychology, he studied esthetic perception and neuropsychology, obtaining his Ph.D. at the University of Toronto. Dr. Heinrichs then spent several years in hospital practice as a clinical neuropsychologist before embarking on a career in teaching and research. His interests include the history of schizophrenia, meta-analysis of neuroscience evidence, cognition and psychopathology and functional outcome. He is the author of In Search of Madness: Schizophrenia and Neuroscience (2001) published by Oxford University Press.

Farena Pinnock is a Clinical Psychology doctoral student at York University. She completed her Honour's B.A. at Wilfrid Laurier University and M.Sc. at the University of Western Ontario in the Department of Anatomy and Cell Biology. Farena has a passion for clinical research that integrates neurobiological and behavioural techniques and she has benefited from clinical experience in several neuropsychology facilities. Her current research involves examining the neural correlates of cognitive impairment and psychosis among individuals with schizophrenia.

Melissa Parlar received a Ph.D. in Neuroscience at McMaster University, where she conducted research on the interplay between cognitive and emotional processes in psychiatric populations. Melissa is now pursuing doctoral studies in Clinical Psychology at York University where she is combining her clinical and research interests in neuropsychology and schizophrenia. Her current research investigates factors related to functional outcome in patients with schizophrenia.

Eating Disorders

Danielle MacDonald received her Ph.D. from Ryerson University and is currently a staff psychologist (supervised practice) at the University Health Network Eating Disorder Program. Her research has examined rapid response to cognitive behaviour therapy for eating disorders, emotion regulation and eating disorders, and the efficacy and effectiveness of evidence based treatments for eating disorders.

Kathryn Trottier received her Ph.D. from the University of Toronto and is currently a staff psychologist and clinical team leader at Toronto General Hospital's University Health Network Eating Disorder Program and lecturer assistant professor at the University of Toronto, Department of Psychiatry. Her research has examined the interrelationship between eating disorders and posttraumatic stress disorder, as well as socio-cultural influences on eating and body image, the overvaluation of weight and shape in eating disorders, and treatment efficacy and effectiveness in eating disorders.

Substance-Related Disorders

David Hodgins, Ph.D., is a professor in the clinical psychology program in the Department of Psychology, University of Calgary. Dr. Hodgins is a coordinator with the Alberta Gaming Research Institute. He received his B.A. from Carleton University, and his M.A. and Ph.D. from Queen's University.

His research interests focus on various aspects of addictive behaviours, including relapse and recovery from substance abuse and gambling disorders. He has a particular interest in concurrent mental health disorders. He has developed a brief treatment for gambling problems that uses a motivational enhancement model, and research examining its efficacy is funded by the Canadian Institutes of Health Research. Dr. Hodgins teaches in the clinical psychology program and has an active cadre of graduate students. He maintains a private practice in Calgary in addition to providing consultation to a number of organizations internationally.

Magdalen Schluter, B.A., is a master's student in the clinical psychology program at the University of Calgary under the supervision of Dr. David Hodgins. Magdalen received her bachelor's degree in psychology from the University of British Columbia. Her research interests focus on reward-related decision making and executive dysfunction in gambling and substance-related addictive disorders.

The Personality Disorders

Stephen P. Lewis, Ph.D. is an Associate Professor in the Department of Psychology at the University of Guelph. Dr. Lewis completed his doctoral training at Dalhousie University and his clinical residency at the Royal Ottawa Hospital. His areas of expertise are self-injury and youth mental health. His research has been featured in national and international media outlets, including The New York Times, Time, USA Today, ABC, CBS, The Globe and Mail, and the BBC. Dr. Lewis is co-author of the book *Non-Suicidal Self-injury*, which is part of the Advances in Psychotherapy series by the Society of Clinical Psychology (APA Division 12). He is an invited member of the International Society for the Study of Self-Injury (ISSS) and will be taking on the role of ISSS President in June 2017.

Stephen Porter, Ph.D. is a professor of psychology at the University of British Columbia–Okanagan, working as an educator, researcher, and consultant in the area of psychology and law. He is the founding director of the Centre for the Advancement of Psychological Science and Law (CAPSL). He has published numerous research and theoretical articles on forensic issues ranging from personality disorders, credibility assessment, and deception detection to psychopathy, violent crime, and memory for trauma. As a registered forensic psychologist, Dr. Porter has conducted nearly 200 assessments on offenders or accused persons, and has been called as an expert witness in several Canadian legal cases. He has also been consulted by police to aid in detecting deception and strategic interviewing during criminal investigations. In addition, he has provided training to professional groups, including parole officers, private investigators, police, psychologists, psychiatrists, numerous groups of Canadian judges, and other adjudicators. His current research is supported by SSHRC, NSERC, and CFI. Visit the Porter Forensic Psychology Lab website at **https://people.ok.ubc.ca/stporter/Welcome.html.**

Sexual and Gender Identity Disorders

Caroline F. Pukall completed her undergraduate degree in psychology at McGill University, and she received her Ph.D. in clinical psychology from McGill University. She is professor of Psychology at Queen's University, the director of the Sexual Health Research Laboratory (sexlab.ca), and the director of the Sex Therapy Service at the Queen's Psychology Clinic. Her research focuses on vulvodynia (i.e., chronic genital pain in women), persistent genital arousal disorder, and other sexual health issues, as well as diverse relationships. Her work is funded by several organizations, including the Canadian Institutes of Health Research and the National Vulvodynia Association. Dr. Pukall is an associate editor of *Sexual Medicine Reviews* and is on the editorial board of several journals, including *The Archives of Sexual Behavior*.

Katherine S. Sutton, Ph.D., completed her undergraduate degree in Human Sexuality and Gender (Psychology) at the University of Western Ontario. She received her Ph.D. in Clinical Psychology from Queen's University in 2014. She is presently working as a licensed clinical psychologist with sexual offenders in the state of California. Her research has focused on various aspects of health and human sexuality, including vulvodynia, hypersexuality, and paraphilias. She has published numerous articles and book chapters on these topics. Her clinical areas of practice include sex therapy, gender dysphoria, and the assessment and treatment of adult sexual offenders.

Developmental Disorders

Jessica K. Jones is a Professor of Psychiatry and Psychology at Queen's University. Dr. Jones received a doctoral degree in clinical psychology at the University of Wales, Cardiff and her undergraduate psychology degree at University of Ottawa. She completed her specialty training in forensic intellectual disability in Britain and is a registered clinical forensic psychologist in Ontario and a chartered fellow of the BPS in the UK. Dr Jones is the co-chair of the psychiatry Division of Developmental Disabilities and Clinical Director for the dual diagnosis academic-service consulting program. Dr. Jones is an active clinical supervisor for graduate psychology students and residents; and regularly provides invited lectures for scholarly conferences and community engagement workshops. She has authored multiple publications, books, chapters and ministerial briefs relating to individuals with dual diagnosis i.e. intellectual disabilities and/or autism spectrum disorders with psychiatric illness or challenging behaviour. Her research interests include risk assessment, challenging behaviour, sex offending and offenders with autism spectrum disorders/Asperger's syndrome. Dr. Jones has provided expert testimony on a number of cases involving risk assessment and capacity for offenders with intellectual disabilities and autism spectrum disorders. Dr. Jones provides clinical consultation to developmental and mental health partners with a focus on forensics and works alongside policy makers on the service system impact that offenders with disabilities have on the community.

Patricia M. Minnes received a B.A. (Hons.) degree in psychology from Queen's University in Kingston, Ontario, and a master's degree in clinical psychology from the University of Edinburgh, Scotland. She completed her doctorate in psychology at York University, Toronto. Dr. Minnes is a professor emerita in the Departments of Psychology and Psychiatry at Queen's University. Dr. Minnes is a member of the Developmental Disabilities Consulting Program in the Department of Psychiatry at Queen's, serving individuals with dual diagnoses and their families. As part of her clinical responsibilities, Dr. Minnes contributes to the supervision of psychology practicum students and psychology interns.

Dr. Minnes's research focuses on three major areas relating to individuals with disabilities: stress and coping in families and caregivers, community inclusion and quality of life, and attitudes toward persons with disabilities. Within these areas, she has focused primarily on two disability groups: developmental disability and acquired brain injury, as well as issues related to aging and disability. Throughout her career, Dr. Minnes has worked as a scientist practitioner.

Marjory L. Phillips received a doctoral degree in clinical psychology from the University of Waterloo in 1992. Dr. Phillips is the director of clinical services and community education at Integra, the only accredited children's mental health agency in Canada to specialize in providing mental health services to children, youth, and families with learning disabilities. Previously, Dr. Phillips worked with children with disabilities in a children's treatment rehabilitation centre. She joined the Queen's University Psychology Department on a full-time basis in 2004 to establish a psychology training clinic for graduate students. Dr. Phillips also has held cross-appointments as an adjunct assistant professor at Queen's University and York University, and is a clinical supervisor with the University of Toronto.

Behaviour and Emotional Disorders of Childhood and Adolescence

Tracy Vaillancourt is a Canada Research Chair in Children's Mental Health and Violence Prevention at the University of Ottawa, where she is cross-appointed as a full professor in the Faculty of Education (counselling psychology program) and in the School of Psychology, Faculty of Social Sciences. Dr. Vaillancourt is also an adjunct professor in the Department of Psychology, Neuroscience, and Behaviour at McMaster University. She received her B.A., M.A., and Ph.D. from the University of British Columbia (human development), her post-doctoral diploma from the University of Montreal and Laval University (developmental psychology), and post-doctoral re-specialization in applied child psychology (clinical) from McGill University. Dr. Vaillancourt's research examines the links between aggression and children's mental health functioning, with a particular focus on social neuroscience. She is currently funded by the Canadian Institutes of Health Research, the Social Sciences and Humanities Council of Canada, and the Ontario Mental Health Foundation.

Khrista Boylan, MD Ph.D. is a child and adolescent psychiatrist at McMaster Children's Hospital in Hamilton Ontario. She is associate professor in the Departments of Psychiatry and Behavioural Neurosciences and Health Research Methodology at McMaster. Her clinical work and research focuses on emotion dysregulation, suicidal behaviour and personality disorder symptoms in adolescents. She is the editor of the Journal of the Canadian Academy of Child and Adolescent Psychiatry.

Aging and Mental Health

Corey Mackenzie, Ph.D., C. Psych., is a Clinical Psychologist, Professor and Director of Clinical Training in the Department of Psychology, Adjunct Professor in Psychiatry, and a Research Affiliate with the Centre on Aging at the University of Manitoba. His research, clinical, and teaching interests focus on older adults' mental health. Three lines of research, that are being explored in his Aging and Mental Health laboratory (www.coreymackenzie.com), are investigating ways of improving the mental health of older individuals. Using both primary quantitative and qualitative methods, and secondary analyses of national population surveys, research in his lab aims to: (a) understand how age affects mental health, (b) enhance older adults' access to mental health services, and (c) help individuals cope with stress when caring for older adults with dementia. His research is currently funded by the University of Manitoba, the Manitoba Gambling Research Foundation, CIHR, and SSHRC.

Kristin Reynolds, Ph.D., is an Assistant Professor in the Department of Psychology at the University of Manitoba, and a Clinical Psychologist Candidate. As Director of the Health Information Exchange Lab, Dr. Reynolds is interested in decreasing gaps in the translation of health-related knowledge to the public, and increasing access to health-related information and services. Her areas of research and clinical interest and expertise include knowledge translation, mental health literacy, mental health service use, community mental health, geriatric psychology, perinatal health, and health psychology. Dr. Reynolds is passionate about clinical psychology and the advancement of science and practice. She is the Chair-Elect of the Clinical Section of the Canadian Psychological Association and the Communications Director for the Manitoba Psychological Society.

Therapies

John Hunsley is a professor of psychology in the School of Psychology at the University of Ottawa, and is director of the clinical psychology program. He is a registered psychologist who provides psychological services for the treatment of anxiety and mood disorders. He conducts research on evidence-based psychological assessment and the impact of psychological services. Dr. Hunsley has served as editor of the journal *Canadian Psychology* and is a recipient of the Canadian Psychological Association Award for Distinguished Contributions to Education and Training in Psychology.

He is a fellow of the Association of State and Provincial Psychology Boards, the Canadian Psychological Association, and the Canadian Psychological Association's Section on Clinical Psychology.

Catherine M. Lee is a full professor of psychology at the University of Ottawa where she has taught graduate courses in evidence-based services for children and families and an undergraduate course on Clinical Psychology, as well as supervising practicum students and interns at the Centre for Psychological Services and Research. Her research interests focus on the provision of evidence-based services to promote positive parenting. Dr. Lee was President of the CPA in 2008–2009. She is a site visitor for the Canadian Psychological Association Accreditation Panel. She is an accredited trainer and Implementation Consultant for Triple P International.

Prevention and Mental Health Promotion in the Community

Julian Hasford is an assistant professor in the School of Child and Youth Care at Ryerson University. He has a B.A. in environmental studies from York University, a master's degree in health promotion from the University of Toronto, and Ph.D. in community psychology from Wilfrid Laurier University. Julian's scholarly interests are in anti-racism, empowerment, and systems change toward promoting the well-being of racialized youth and communities. He is also interested in community-based mixed method research and evaluation methodologies. Julian's professional experience includes work in child welfare, urban agriculture, and African Canadian community advocacy. He was a recipient of the Donald T. Fraser Award for Academic Excellence at the University of Toronto (2005) and the Council of Canadian Departments of Psychology Teaching Assistantship Award (2007).

Isaac Prilleltensky is dean of the School of Education at the University of Miami in Coral Gables, Florida, where he is also a professor of educational and psychological studies and a professor of psychology. Isaac was born in Argentina and has studied and worked in Israel, Canada, Australia, and the United States. He has lectured widely in South America, Europe, North America, Israel, Australia, and New Zealand. Isaac is concerned with value-based ways of promoting child, family, and community well-being. He is the author, co-author, or co-editor of seven books dealing with psychological and community well-being. He has been involved in community research and action in various countries and is a fellow of the American Psychological Association and of the Society for Community Research and Action. In 2002 he was visiting fellow of the British Psychological Society.

Mental Disorder and the Law

Stephen D. Hart obtained his Ph.D. in clinical psychology from the University of British Columbia. He holds appointments as a professor in the Department of Psychology at Simon Fraser University (SFU) and the Faculty of Psychology at the University of Bergen. His work focuses on forensic assessment, including the assessment of psychopathic personality disorder and violence risk. Outside of SFU, he served as President of the AP-LS and the International Association of Forensic Mental Health Services, as well as a Founding Editor of the *International Journal of Forensic Mental Health* and the *Journal of Threat Assessment and Management*. Among other recognitions, he received the Saleem Shah Award for Early Career Contributions to Psychology and Law from the American Academy of Forensic Psychology and the American Psychology Law Society (AP-LS, Div. 41 of the American Psychological Association), and the Career Contributions Award from the Society of Clinical Psychology (Division 12 of the American Psychological Association).

Ronald Roesch obtained his Ph.D. in clinical psychology from the University of Illinois at Urbana-Champaign. He is a professor in the Department of Psychology at Simon Fraser University. He is director of the Mental Health, Law, and Policy Institute at Simon Fraser University (SFU), and prior to that served for many years as director of clinical training. His research focuses on improving the delivery of mental health services in forensic settings. Outside SFU, he has served as president of the American Psychology-Law Society (AP-LS, Div. 41 of the American Psychological Association) and the International Association of Forensic Mental Health Services; Editor of the journals *Law and Human Behavior* and *Psychology, Public Policy, and Law*; and a Founding Editor of the *International Journal of Forensic Mental Health*. In 2010 he received the Outstanding Contributions to Psychology and Law Award from AP-LS.

DAVID J. A. DOZOIS

DANIEL MACHADO

CHAPTER

1

Ranplett/Vetta/Getty Images

Concepts of Abnormality Throughout History

LEARNING OBJECTIVES

AFTER READING THIS CHAPTER, STUDENTS WILL BE ABLE TO:

1. Describe the principles that have been used to define abnormality and then apply them to determine whether a particular behaviour may meet the definition of abnormal behaviour.
2. Understand how the conceptualization of psychological disorders changed from antiquity to the 1800s.
3. Describe at least two treatments that are associated with the biological approach and outline the current status of these treatments.
4. Describe the contributions of at least two influential Canadian individuals in the field of mental health care.
5. Describe two recent significant developments associated with mental health in Canada and discuss implications of recent technological advances on the field of psychology.

Lisa appeared at a clinic saying that her husband and two teenage children had persuaded her to seek treatment for what they saw as dysfunctional behaviour. She told the clinician that after she took a shower (which she did at least three times a day), she felt she had to wash the floor and walls of the bathroom in order to ensure that no dirt or bacteria had splashed off her body and contaminated the room. Lisa also insisted that her family not touch the faucets in the bathroom with their bare hands because she was sure that they would leave germs. The family members agreed to use a tissue to turn the taps on and off. Visits to the house by friends and relatives were not allowed because Lisa felt she could not ask them to follow these instructions and, even if she could bring herself to ask them, she did not believe they would go along with her request. This, of course, meant that her husband and children could never invite friends to their house. This restriction, and various other limits that Lisa imposed upon them, led the family to send her for treatment. Lisa did not consider her problems to be quite as bad as her family saw them.

***

Since childhood, Paul had been sexually aroused by the sight of women's underwear. This had caused him considerable distress as a teenager and young adult. The fact that he could become sexually aroused only in the presence of women's underwear made him feel different from others, and he was afraid that people would find out about his secret desires and ridicule him. When Paul was 26 years old, after years of secrecy, he decided to consult a therapist in an attempt to deal with his unusual desires.

***

Arnold had begun to develop odd ways of perceiving the world and had begun to have unusual thoughts shortly after he entered university. After he graduated from high school, his parents put pressure on him to enrol in an engineering degree program at university so he could earn a large salary. Arnold resisted this pressure for some time, but finally gave in and took up the program. However, he was afraid he would fail and let everyone down. He was afraid they would find out he was really not competent. The pressures from his family, the threat of failure, and the heavy workload of his studies soon became too much for Arnold. He began to develop odd interpretations of world events and of his role in them, and he began to perceive personally relevant messages on the nightly television newscasts. These unusual thoughts and perceptions quickly escalated until finally Arnold went to the local police station requesting a meeting with Canada's prime minister and the American president so he could give them instructions for solving the world's problems. Not surprisingly, Arnold's grades dropped and he had to leave school. He was placed in hospital.

Clearly, Lisa, Paul, and Arnold all have abnormalities of behaviour and thought, but they are also very different from one another. There is no doubt, however, that most people would agree that each of them displayed very unusual, if not bizarre, behaviour. Arnold's problems seriously interfered with his life and his ambitions. Lisa was not as concerned about her problems as her family was, but they nevertheless markedly restricted her social life and interfered with other aspects of her functioning. Paul's case, on the other hand, turned out well. A few months after receiving treatment, he found a partner who apparently could share in his unusual sexual activities, and his life was happy and fulfilled.

What these three cases have in common is that each meets the criteria outlined in current diagnostic manuals for one or another psychological disorder. The current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) of the American Psychiatric Association (2013) is the most broadly accepted system for identifying particular types of disorders, although the *International Classification of Mental and Behavioral Disorders* (ICD-10),

issued by the World Health Organization (1992b), is also used by practitioners, primarily outside North America (for details of these diagnostic systems, see Chapter 3). Both of these diagnostic manuals would classify the three cases described above as disordered: Lisa would be classified as manifesting obsessive-compulsive disorder, Paul as having a paraphilic disorder (in this case, a fetishistic disorder), and Arnold as suffering from schizophrenia.

However, there are many people who engage in behaviours or express thoughts that most of us would consider to be strange or deviant, and who may cause distress to others, yet who are not identified in diagnostic systems as disordered. Consider the cases in the following box.

Case Notes

Eileen is a 19-year-old female whose religious beliefs forbid her to wear makeup or colourful clothes, or to listen to the radio or watch television. She must only go out with potential boyfriends in the company of her parents, and she will not attend dances or parties. Along with the rest of the people who attend her church, Eileen believes that the end of the world is imminent, and she has been peacefully preparing herself for that day. In addition, and somewhat contrary to her religious teachings, Eileen believes that the planets and stars control our destiny, and she subscribes to a monthly astrology magazine and consults daily astrological forecasts. Eileen also believes that she can communicate with the spirits of the dead and occasionally participates in seances with her family and their friends.

***

Roger is a professor at a large university. At age 46, he has never married and lives alone in a house whose windows he has painted black to shut out, as he says, "the views of his nosy neighbours." Roger has worn the same tattered suit for years and he wears a rather dirty baseball cap that he says is a family heirloom. He often wears heavy coats in the summer and sandals in the winter. His office is cluttered and he never seems able to find things; in fact, on several occasions he has lost students' essays. In the classroom, Roger wanders about among the desks as he lectures, and his lessons are rambling and difficult for the students to follow. He often introduces odd ideas that seem to have little to do with the topic on which he is lecturing. However, his research is greatly admired, and his colleagues do their best to make up for his teaching inadequacies.

***

James has been a career criminal since his early teenage years. He has broken into many homes and stolen property, he has been convicted of selling marijuana on several occasions, and he has stolen and then sold numerous bicycles and cars. Not surprisingly, James has spent some of his 42 years in prison. Recently, he was living with a woman whom he had met at a bar one week prior to moving in with her and her three children. This was the most recent in a series of relatively short-lived common-law relationships that James had been involved in throughout his adult life. He did not have a job and, despite his promises to his partner, he made little effort to get one. Instead, he stayed home watching television and drinking beer. This led to numerous arguments with his partner and, over time, these arguments became more physical, with each partner hitting the other. Finally, during one of these clashes, James lost his temper and beat his partner with his fists so severely that she lapsed into a coma and died.

Most people would consider Eileen and Roger to be eccentric and, indeed, some students found Roger scary, although he never did anything that would suggest he was dangerous. However, neither Roger nor Eileen has ever been diagnosed as having a psychological disorder. Many people think that anyone who murders is insane, at least temporarily. However, careful examination of James by three independent psychiatrists led them to conclude that, although he had a personality disorder, James was otherwise normal, and the killing resulted from the persistent antagonistic relationship he had with the victim. Therefore, James was held responsible for his actions and duly convicted and imprisoned.

These cases illustrate two problems with defining abnormality. First, eccentric and unusual behaviour or beliefs are not necessarily abnormal according to diagnostic criteria, although the boundary between eccentricity and abnormality is not always clear. Arnold was clearly eccentric but also obviously disturbed. Both Eileen and Roger were eccentric but not so obviously disturbed. Second, behaviours that are repugnant and threatening to others, such as aggression and murder, are not always signs of an underlying psychological disorder. James has acted very badly and in a damaging way to others throughout his life, yet he is not considered to be seriously psychologically disordered. Neither Paul nor Lisa caused distress to other people, but they are judged to be suffering from a disorder.

This book describes our present understanding of the nature of psychological abnormality, the different forms such abnormality takes, how people become abnormal, and what, if anything, can be done to make their functioning normal. A fundamental issue we will have to consider from the outset, then, is just what it is we mean when we say that someone (or a particular behaviour of that person) is psychologically abnormal.

Our notions about abnormality have a long history. From the time of the earliest written records, and no doubt long before that, humans have identified some of their fellow

humans as abnormal and offered various explanations and treatments for their behaviours. It is also clear that, over time, definitions of what constitutes abnormal functioning have changed, as have the explanations and treatments for abnormal behaviour. In this chapter, we first consider the various ways in which abnormality has been defined, and then examine the historical developments in the explanations and treatment of abnormality.

First, let us clarify some terms. **Psychological abnormality** refers to behaviour, speech, or thought that impairs the ability of a person to function in a way that is generally expected of him or her, in the context where the unusual functioning occurs. **Mental illness** is a term often used to convey the same meaning as psychological abnormality, but it implies a medical rather than psychological cause. A **psychological disorder** is a specific manifestation of this impairment of functioning, as described by some set of criteria that have been established by a panel of experts. In this book, we will use the term **psychopathology** to mean both the scientific study of psychological abnormality and the problems faced by people who suffer from such disorders. Psychological disorders occur in all societies and have been apparent at all times in history. However, what is considered a disorder varies across time and place.

Attempts at Defining Abnormality

Why is there such confusion about normality and abnormality, and is it possible to resolve the issue? Perhaps the answer to the last part of the question is no, because the concept of abnormality changes with time and differs across cultures and subcultures. However, it is also possible that we cannot easily resolve these problems because, despite the attempts of many writers to provide clear criteria, the concepts of normality and abnormality are so vague.

Several principles are commonly considered in attempts to establish criteria for abnormality. As will become evident, however, no one principle can be considered sufficient to define this elusive concept. Rather, depending on circumstances, the contribution of several criteria may be necessary. The following principles, either alone or in combination, have at one time or another been used to define abnormality.

STATISTICAL CONCEPT

According to this view, behaviour is judged as abnormal if it occurs infrequently in the population. It would, of course, make little sense to describe as abnormal ways of functioning that characterize the majority of people. Relative infrequency, then, ought to be one defining feature of abnormality. However, not all infrequent behaviours or thoughts should be judged abnormal. For instance, innovative ideas are necessarily scarce or they would hardly be original, but most people would not consider the person who had such ideas as displaying abnormality, at least not in its usual pejorative sense. The same is true of athletic prowess. We admire people like professional hockey player Sidney Crosby, who grew up in Cole Harbour, Nova Scotia, and is currently the captain of the Pittsburgh Penguins (the youngest captain in NHL history). In 2006–07 Crosby became the youngest player in NHL history to win the scoring title and the only teenager in major North American sports leagues to have ever done so. In 2009, he became the youngest captain in NHL history to win the Stanley Cup. Although it is true that individuals like "Sid the Kid" are abnormal in the sense that their athletic skills are rare, we would usually describe such people as exceptional, a term that has no derogatory overtones.

An additional problem with the statistical criterion is that it is not clear how unusual a given behaviour has to be in order to be considered abnormal. For example, a study of Canadian undergraduate students from a small university found that 7 percent of males and 14 percent of females met diagnostic criteria for clinical depression in the preceding year. Thirteen percent of men and 19 percent of women also met criteria for one or more anxiety disorders (Price, McLeod, Gleish, & Hand, 2006). Although the depression rates reported in this study are higher than other one-year Canadian prevalence figures (e.g., Patten, 2009; Pearson, Janz, & Ali, 2013), neither depression nor anxiety can be considered that statistically infrequent—yet both are thought to reflect a disorder in need of treatment. Similarly, the common cold is considered an illness and yet it has a lifetime prevalence of 100 percent (Lilienfeld & Landfield, 2008).

PERSONAL DISTRESS

Many people who are considered to have a psychological disorder report being distressed. Someone who has an anxiety disorder, for example, will report feeling afraid or apprehensive most of the time. Depressed patients are obviously distressed. Yet distress is not present for all people identified as abnormal. An elderly manic patient who was evaluated at a local hospital would persistently pace rapidly around the ward, frequently bumping into people in his rush, despite having no obvious destination. While striding about quickly, he would keep up a constant conversation with no one in particular, and he would leap from topic to unrelated topic. He seemed to be in exuberant spirits, and he described himself as being extremely happy. Obviously, he was not personally distressed and yet, just as obviously, he was suffering from a mental disorder. An individual with antisocial personality disorder, who violates the rights of others, breaks numerous laws, and lacks empathy and remorse is not distressed by his or her behaviour; instead, it is the individuals this person encounters who are distressed by this behaviour.

Some people who outwardly appear happy and successful may reveal to intimate friends that they feel a vague sense of dissatisfaction. They may complain that, despite their apparent success, they feel unfulfilled. There may even be an associated sense of despair at not having achieved something significant, and such people may seek

professional help. It is unlikely, however, that they would be labelled abnormal.

In fact, all of us are distressed, or even depressed, at times. When someone we love dies, it is normal to be distressed; indeed, if we do not mourn, our response might be judged to be abnormal. If this distress passes within a reasonable amount of time, our response would be considered normal. However, if our grief did not abate with time, and our depression deepened and persisted for several years, our suffering would be described as abnormal. Distress, then, appears to be a frequent, but not essential, feature of abnormality.

PERSONAL DYSFUNCTION

When behaviour is clearly maladaptive (i.e., it interferes with appropriate functioning), it is typically said to be abnormal. Yet the definition of dysfunction itself is not clear-cut. What is appropriate functioning? What is appropriate functioning in a given context? Many of us responded with feelings of vulnerability, anxiety, anger, and sadness following the terrorist attacks on the World Trade Center and Pentagon on September 11, 2001. Some of us have become increasingly vigilant about possible threats when going through airport security or attending large gatherings such as Canada Day celebrations. Students and faculty have also become more vigilant at universities and colleges following the Dawson College shootings in Montreal (2006) that claimed one life and injured 19 people, and the Virginia Tech massacre (2007) that killed 32. Public schools and religious institutions have also been on higher alert after some were the targets of violent incidents. For example, in 2012, a shooting took place at Sandy Hook Elementary School in Newtown, Connecticut, that killed 27 individuals. In 2017, a shooter in a Quebec City mosque killed six individuals and injured three.

Within reason, such vigilance and anxiety, although distressing, are not abnormal given the circumstances. In fact, scanning the environment for such threats is, to some extent, adaptive as it serves a survival function.

Wakefield (1997, 1999, 2014) has concluded that harmful dysfunction is the key notion—where dysfunctions refer to "failures of internal mechanisms to perform naturally selected functions." To conclude that a given behaviour is disordered "requires both a scientific judgment that there exists a failure of designed function and a value judgment that the design failure harms the individual" (Wakefield, 1999, p. 374). By their functions, Wakefield is referring to what an artifact or behaviour was originally designed to do. For example, the function of a pen is to write—that is the purpose of a pen's design. The fact that we can also use a pen as something to chew on when we are nervous or as a weapon for self-defence does not explain why pens were designed the way they were. Thus, the failure of a pen to help protect an individual would not entail a failure of its function (Wakefield, 1997). Wakefield (1997, 1999) argues that unless there are dysfunctional consequences to the individual, in that he or she is unable to perform a natural function, it makes little sense to call behaviour abnormal.

Using harmful dysfunction as a potential criterion for abnormal behaviour also creates an interesting link between abnormal and evolutionary psychology. In terms of evolutionary theory, a trait may be dysfunctional if it harms an organism's capacity to reproduce successfully. Antisocial behaviour, for example, may result in being excluded from everyday society, thereby hurting such a person's capacity to reproduce. If the underlying reason for the antisocial behaviour is a lack of inhibition, this may be seen as abnormal. Certain forms of antisocial behaviour, such as unethical business practices, may, however, actually increase an individual's wealth and therefore increase his or her capacity to reproduce (Murphy, 2005).

The boundaries between normal and abnormal and what specifically constitutes "harmful dysfunction" are therefore not clear and are a matter of considerable controversy (e.g., Castel, 2014; Fabrega, 2007; Lilienfeld & Landfield, 2008; Lilienfeld & Marino, 1995). These fuzzy boundaries notwithstanding, categorical distinctions between normal and abnormal can be useful. We discuss this issue further in Chapter 3.

VIOLATION OF NORMS

The behaviour and thoughts of many psychologically disordered individuals run counter to what we might consider appropriate. The thoughts expressed by individuals with schizophrenia, for example, are often so bizarre that observers do not hesitate to declare the ideas irrational and reflecting an extreme departure from what would be expected in the context. Similarly, a man who dresses in women's clothing for the sole purpose of sexual arousal would be judged by most people to be displaying behaviours that are contrary to socially acceptable ideas. On the other hand, criminals clearly engage in behaviours that violate social norms, but few of them meet the criteria for any disorder. No doubt their criminal acts upset others, but discomfort in an observer alone cannot count as the basis for judging someone's behaviour to be disordered. For example, popular Youtube user Felix Kjellberg (a.k.a. Pewdiepie) whose videos have compiled nearly 14.7 billion views as of February 2017, was dropped by Disney following public outcry over anti-Semitic images Kjellberg included in several of his videos (Chokshi, 2017). The lyrics of some songs also make many people uncomfortable. Radio stations were banned from playing the song "Money for Nothing" (performed by Dire Straits) for a period of nine months in 2011, because the song included a word that was deemed to be offensive for homosexual men (CTV, 2011). More recently, rapper Tyler, the Creator was banned from the UK for three to five years based on the claim that his lyrics, which involve the artist taking on a violent alter ego, glamorize abusive and illegal behaviour (Kornhaber, 2015). In a more innocuous example, following the terrorist attacks of 9/11, Clear Channel Communications distributed a list to the 1000+ radio stations under their corporate umbrella of

songs that should not be played. The 165 songs on the list contained lyrics Clear Channel deemed to be "questionable" and potentially offensive to American citizens following 9/11, even though many of the songs on the list had links to terrorism that were dubious at best (e.g., "In the Air Tonight" by Phil Collins; It's the End of the World, 2001). These examples show that subjective evaluation of lyrics as containing offensive content would not justify classifying the artists as psychologically abnormal, although that is a characteristic response that people often make to ideas and behaviours they find personally repulsive.

Related to the notion of violating norms is the idea that psychologically abnormal people are unpredictable and somehow dangerous. In fact, very few people suffering from a psychiatric disorder are dangerous to others. Even psychotic patients, who are the most bizarre of all disordered people, rarely attempt to hurt anyone. Most psychologically disordered people are no more dangerous, and no more unpredictable, than are the rest of the population. Conversely, while television and movies like to portray all killers and rapists as "mad", most are not. Apparently, it comforts us to think that someone who would do something as repugnant as maiming or killing another person must be insane.

Perhaps the most serious flaw in this criterion is that social norms vary over time and place. In fact, few disorders are truly universal across different cultures. Depression, for example, has a much higher prevalence rate in Canada (12.6%; Statistics Canada, 2013) and the United States (16.6% lifetime prevalence; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012) than in some other parts of the world, such as Taiwan (1.2%; Liao et al., 2012) or Korea (3.3–5.6%; Park & Kim, 2011). Different cultural and ethnic groups also manifest psychopathology differently and exhibit their own strategies for dealing with psychological distress. For example, the lower prevalence of depression in Asian cultures may be due to the emphasis placed on physical symptoms and avoiding the stigma of mental disorders. Neurasthenia is a condition that includes many of the physical symptoms of depression and it is still frequently diagnosed in Asia, but this diagnosis has largely been abandoned in the West. It is important to bear in mind that how we define abnormality is **culturally relative**. The norms of a particular culture determine what is considered to be normal behaviour, and abnormality can be defined only in reference to these norms. Fortunately, the most recent versions of the DSM (e.g., DSM-5) have been far more explicit than previous editions were in encouraging clinicians and researchers to consider cultural diversity.

Society's criteria for defining behaviour as acceptable or unacceptable are also not temporally universal; rather, they reflect the predominant view in society, which changes over time. Thirty-five years ago, when homosexuality was classified as abnormal, it was also considered to be a violation of social norms. Is it a reflection of changing norms that psychologists no longer consider homosexuality to be abnormal? Much earlier, in the late 1800s, masturbation was considered to be a manifestation of a mental disorder without any consideration of the base rate of this behaviour in the general population (see Mash & Dozois, 2003). To take a more extreme example, in Germany in the 1930s, individuals who were identified as Jews, homosexuals, gypsies, or mentally retarded were persecuted, tortured, or killed on the basis that they represented inferior specimens of human beings. These views, which are repugnant to our society, were apparently sufficiently acceptable to the German populace at the time to allow the Nazis to carry out their so-called ethnic cleansing. Do we conclude that 1930s Germany was an abnormal society—and if so, what does it mean to say that a whole population is abnormal?

DIAGNOSIS BY AN EXPERT

Before we consider this issue, it is an opportune time to identify the professionals involved in the mental health field. **Clinical psychologists** are initially trained in general psychology and then receive graduate training in the application of this knowledge to the understanding, diagnosis, and amelioration of disorders of thinking and behaviour. Psychologists have a thorough grounding in research methods, and some of them spend their careers doing research on abnormal functioning, although many also provide treatment. The treatment methods of clinical psychologists primarily involve psychological interventions of one kind or another. **Psychiatrists** are trained in medicine prior to doing specialized training in dealing with mental disorders. This specialized training focuses on diagnosis and medical treatment that emphasize the use of pharmacological agents in managing mental disorders. Not surprisingly, most psychiatrists attend to the medical aspects and biological foundations of these disorders, although they usually also consider psychological and environmental influences.

The identification of a psychological disorder in any specific individual is ultimately left to a professional to judge. In the final analysis, the opinions of particular mental health workers (usually psychologists and psychiatrists) determine whether a person is said to suffer from a psychological abnormality. In this sense, the DSM-5 (or ICD-10) provides the operational criteria for the various disorders and thereby defines abnormality. This, of course, does not clarify the criteria by which such judgments are made, and an examination of the various criteria for the different disorders suggests that different aspects of the notions outlined above serve to define different disorders. It is hard to discern any clear common thread in the different criteria.

Thomas Szasz (1961), in a book entitled *The Myth of Mental Illness*, suggested that the idea of mental disorders was invented by psychiatry to give control to its practitioners to the exclusion of other people, such as clergymen, who in the past had greater power over the psychologically disordered (see also Schaler, 2004). In addition, Szasz (1970) contended that the institution of the church and the person identified as, for example, a "witch" were replaced by the institution of psychiatry and the patient being treated, respectively. Such criticisms, while perhaps overstating the case (Lilienfeld &

Landfield, 2008), do serve a valuable function by encouraging the generation of evidence to support the existence of mental disorders. There seems to be little doubt today that there is overwhelming evidence of the reality of various disorders. Nevertheless, the power held by mental health professionals remains an issue.

SUMMARY OF DEFINITIONS

As we have seen, not one of the various criteria that have been offered for defining abnormality seems satisfactory on its own. There are many ways to approach defining a person's functioning as normal or abnormal, and the criteria discussed above do not exhaust all possible approaches. Nevertheless, together they represent the core defining features of abnormality. To identify a person or a behaviour as abnormal, no single criterion is either necessary (i.e., must be present) or sufficient (enough on its own). Typically, some combination of these criteria is used, with one or more features having greater relevance depending upon the specific circumstances or features of the client. Our purpose in discussing various criteria for abnormal psychological functioning is to alert the reader to the rather elusive nature of the concept and to suggest that, while such a notion may have some general value, it has little practical application. In practice, most diagnosticians avoid the use of the term *abnormality* and simply prefer to match their clients' symptoms to a set of criteria appearing in the latest edition of the diagnostic manual. While this approach does not clarify the nature of abnormality, it works effectively in practice. Defining specific behaviours, thoughts, and feelings as representing particular disorders, as does the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), is useful because then we can plan the management and treatment of the person displaying such problems. Searching for criteria that will define any and all instances of disordered functioning (or abnormality), however, may be pointless. Nevertheless, throughout the ages people have held quite different views, not only about what abnormality is, but also about its causes.

1 BEFORE MOVING ON

How do you determine when someone's behaviour is abnormal? What are the strengths and weaknesses of the *four* general attempts at defining abnormality?

Historical Concepts of Abnormality

We now turn to an examination of the different notions that have, over time, guided approaches to dealing with abnormality. Looking at changes in the conceptualization of abnormal psychological functioning can provide a basis for understanding how we arrived at our current formulations and responses to abnormality. We will see how societal concepts are shaped by the prevailing views of the time concerning all manner of phenomena. Indeed, as Erwin Ackerknecht, a historian of psychiatry, has suggested, "The criterion by which a person in any society is judged to be mentally ill is not primarily the presence of certain unvarying and universally occurring symptoms. It depends rather on whether the affected individual is capable of some minimum of adaptation and social functioning within his [or her] society" (Ackerknecht, 1968, p. 3).

Revolutions in philosophy and science, such as the Renaissance and the era of Enlightenment, generally had profound effects on all aspects of society, including a change in the way that mad people were seen. For example, Darwin's radical conceptualization of the mechanism of evolution, which he called natural selection, had an immediate influence not only on all the biological sciences but also on psychology, politics, and economics. Modern evolutionary biologists have since rejected the implications that were drawn from Darwin's theory by eugenicists (Gould, 1985). Proponents of this view, who included Darwin's cousin Sir Francis Galton (1822–1911), interpreted Darwin's work to mean that those whose intellectual, social, or economic functioning was seen as inferior were defective, or maladaptive. Many further argued that because society and the advancement of medicine now protected these deficiencies from the forces of natural selection, they ought to be selected by society for sterilization in order to eliminate their defective genes. In the hands of the Nazis, eugenics led to the extermination of millions of people. Our own Canadian history was also affected by this type of thinking. In 1928, Alberta passed the *Sexual Sterilization Act* under which individuals who were deemed "feebleminded," "mentally deficient," or "mentally ill" were to be involuntarily sterilized to prevent deterioration of the intellectual level of the general population. A total of 2832 individuals were sterilized in Alberta alone (British Columbia passed a similar act in 1933). One case involved a 17-year-old woman from Edmonton who was diagnosed as a "moron." The rationale for her sterilization was that she was "rather bossy and bad tempered" and had a tendency to go "out alone a lot" and "pick up with anyone and talk and chat with them" (Park & Radford, 1998, p. 327). In 1999, the government of Alberta publicly apologized for the suffering experienced by those who were sterilized under this *act* and negotiated a financial settlement with victims (Government of Alberta, 1999).

An examination of the historical development of our ideas about abnormality, then, will reveal that such ideas are simply one aspect of the general views of the time. This is important for another reason. When we consider some past notions about abnormality, we might tend to scoff and treat them as absurd, and so they may be from the perspective of the present day. However, they must have seemed correct at the time because they matched the general ideas of the day. Reflecting on this may help us to recognize that perhaps our own conceptualization of abnormality seems so right to us only because it fits with our current world views and beliefs (see Mash & Dozois, 2003). Remember that earlier ideas

about abnormality were accepted not only by those who made decisions about the insane, but also by many of the sufferers and their families. Treatments that seem bizarre or even cruel to us today may have helped sufferers because they believed that the procedures would be effective. Perhaps the same is true to some degree of our current ideas and treatments (Kirsh et al., 2008). We encourage the student of psychopathology to be a critical consumer of research—it is possible, after all, that at some point in the future we will view our current ideas as archaic and ill-founded.

Throughout recorded history, and no doubt long before that, people have been concerned with identifying and treating psychological dysfunction. What has been seen as evidence of madness or of other disturbed thinking or behaving, however, has changed over the course of evolving societies. For many years, people who claimed to be able to foretell the future were revered and frequently given jobs in royal courts to assist kings and queens in their decision making. Today, most people regard with skepticism the claims of soothsayers and may even doubt the sanity of people who repeatedly say that they can foresee future events. Not only have the notions about what constitutes abnormality changed over time, so too have explanations for the causes of such behaviour. Likewise, treatments have also differed across time. They have ranged from compassionate care to brutal torture, depending upon the type of abnormality and the accepted account of its origin.

All these changes in the acceptability, treatment, and theories of etiology of abnormal behaviour have reflected, and continue to reflect, the values of society at a particular time. A society that explains everyday events (e.g., weather, seasons, war, and so on) as a result of **supernatural causes**—causes beyond the understanding of ordinary mortals, such as the influence of gods, demons, or magic—will view madness similarly. Psychological dysfunction in various historical periods was thought to result from either possession by demons or the witchcraft of evil people. Treatment involved ridding the mad person of these influences by exorcism or other magical or spiritual means. When worldly events are seen to have **natural causes** (i.e., causes that can be observed and examined), so too are mental afflictions, and they are treated in a way that addresses these presumed natural causes.

EVIDENCE FROM PREHISTORY

Paleoanthropologists have discovered Stone Age human remains that were originally interpreted as providing evidence of supernatural beliefs as early as half a million years ago. Skulls have been found with circular sections cut out of them. Since there are clear signs of bone regeneration around these holes, it was concluded that the operations (called **trephination**) were done while the person was still alive. Apparently a stone tool was used to cut the holes, and it was originally presumed that this was done to let out evil spirits that were causing the victim to engage in severely abnormal behaviour. There may, however, be simpler explanations. Maher and Maher (1985), for example, suggest that trephination may have been intended to remove bone splinters or blood clots caused by blows to the head during warfare. Piek, Lidke, and Terberger (2011) presented evidence consistent with this medical explanation. Whatever the reason for these neat circular holes in the skulls of Stone Age people, we know from early written records that demonic possession was popularly accepted in early human societies as the cause of madness. Egyptian papyri from almost 4000 years ago describe supernatural explanations for various disorders and the use of magic and incantations as treatment procedures. These early Egyptians recognized that the brain was the site of mental activities, although they believed that demonic possession disrupted its functioning in mad people. Thus, their belief was something of a mixture of natural and supernatural assumptions.

Hunter-gatherer societies that have been examined over the past 100 years may provide clues to how our own prehistoric ancestors viewed madness. These societies characteristically do not distinguish mental from physical disorders; both are seen as having supernatural causes. Sadly, the belief in a demonological view of abnormality still exists even today. In February 2001, the CBC program *The National* broadcast a documentary entitled "The Mentally Ill of Africa's Ivory Coast." This documentary featured a man named Koffi and his struggle with schizophrenia. The people in Koffi's community believed that he was possessed by demons and chained him to a tree outside of the village for more than 10 years. Many more people are incarcerated in a similar way in this area of the continent. Food and water are provided on occasion, but often such individuals are forced to go for days without eating anything.

GREEK AND ROMAN THOUGHT

With the rise of Pericles (495–429 BCE) to the leadership of Athens, the Golden Age of Greece began. Temples of healing were soon established that emphasized natural causes for mental disorders and that developed a greater understanding of the causes and treatment of these problems. The great

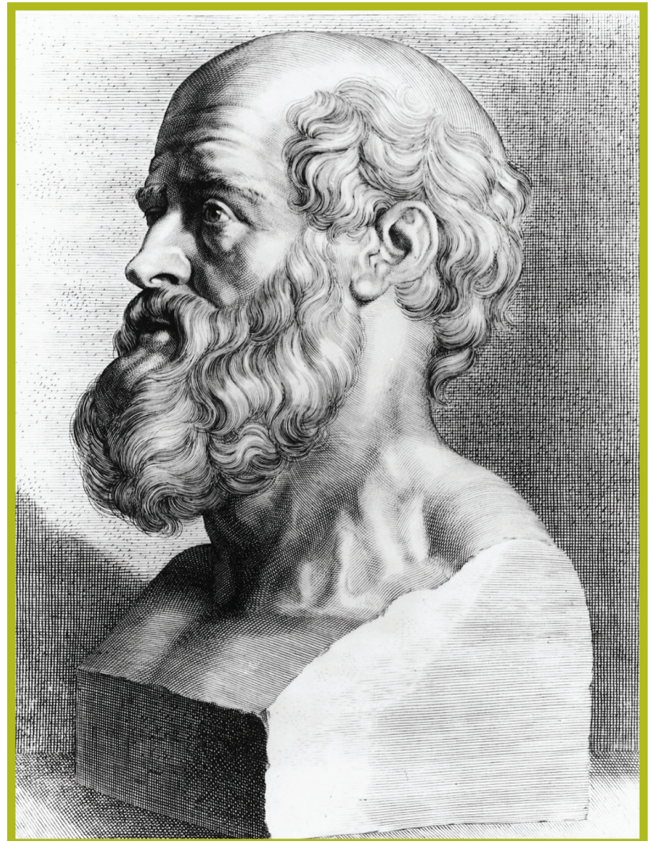
National Museum, Denmark/ Munoz-Yague/Science Photo Library

Trephination, the prehistoric practice of chipping a hole into a person's skull, was an early form of surgery, possibly intended to let out evil spirits.

physician Hippocrates (460–377 BCE), who has been called the father of modern medicine, denied the popular belief of the time that psychological problems were caused by the intervention of gods or demons. This represented the first recorded instance of a rejection of supernatural causes for mental illness. Hippocrates did not distinguish mental diseases from physical diseases. Instead, he thought that all disorders had natural causes. Although he emphasized the primacy of brain dysfunctions, Hippocrates argued that stress could influence mental functioning. He also thought that dreams were important in understanding why a person was suffering from a mental disorder, and in this he predated Freud and the psychoanalysts of the twentieth century. As for treatment, Hippocrates advocated a quiet life, a vegetarian diet, healthful exercise, and abstinence from alcohol. If these procedures did not work, and sometimes as a supplement to them, Hippocrates considered induced bleeding or vomiting to be of value.

This latter claim for the value of vomiting or bleeding arose primarily as a result of Hippocrates' idea that psychological functioning resulted from disturbances of bodily fluids, or **humours**, as they were then called. Both vomiting and bleeding were thought to reduce excesses of one or another of the humours. Cheerfulness, so Hippocrates thought, was caused by an excess of blood; ill-temper by an excess of yellow bile; gloom by an excess of black bile; and listlessness by an excess of phlegm. Hippocrates was the first to describe what he called *hysteria*, which is now known as *conversion disorder*: psychologically induced blindness, deafness, or other apparent defects in perceptual or bodily processes (see Chapter 6). Hippocrates claimed that hysteria occurred only in women and was due to a "wandering" uterus. While Hippocrates' ideas seem absurd to us now, at the time they represented a significant advance because they pointed to natural causes rather than demonic possession and other supernatural events. As a consequence, Hippocrates' theories encouraged the beginnings of a scientific understanding of disordered behaviour and thought.

Many of Hippocrates' ideas were taken up by the Greek philosophers Plato (427–347 BCE) and Aristotle (384–322 BCE). However, Plato placed more emphasis on sociocultural influences on thought and behaviour. Elaborating on Hippocrates' notions about dreams, Plato suggested that they served to satisfy desires because the inhibiting influences of the higher faculties were not present during sleep. This view foreshadows Freud's theory of dreams. Plato declared that mentally disturbed people who commit crimes should not be held responsible, since they could not be said to understand what they had done. In this respect, he anticipated modern notions of not being criminally responsible by reason of mental disorder (Bill C-30; see Chapter 19). Plato also suggested treatment responses that presaged current approaches. For example, he said that in most cases, the mentally ill should be cared for at the homes of relatives, anticipating the present trend toward community care. For those who must be hospitalized, Plato said their thinking must be rationally challenged in a conversational style of therapy that was remarkably like some forms of present-day psychotherapy.


National Library of Medicine

Hippocrates (460–377 BCE).

Aristotle wrote extensively on mental disorders and on other aspects of psychological functioning. He accepted Hippocrates' bodily fluids theory and denied the influence of psychological factors in the etiology of dysfunctional thinking and behaving. In keeping with Greek tradition, Aristotle advocated the humane treatment of mental patients.

After Alexander the Great founded Alexandria, Egypt, in 332 BCE, the Egyptians adopted and expanded the medical and psychological ideas of the Greeks. They established temples to Saturn, which came to be sanatoriums for people who were psychologically unwell. These temples provided pleasant and peaceful surroundings, the opportunity for interesting and calming activities, healthful diets, soothing massages, and education. The priests who attended to these disturbed clients also employed bleeding, purges, and restraints, but only when all other attempts had failed.

After 300 BCE, there emerged in ancient Greece various schools of thought that rejected Hippocrates' theories of mental illness. The most important and best known of these was Methodism, its principal advocate being Soranus of Ephesus (circa CE 100). Methodism regarded mental illness as a disorder that resulted either from a constriction of body tissue or from a relaxation of those tissues due to exhaustion. The head was seen as the primary site of this affliction. Mania, Soranus said, resulted from overexertion,