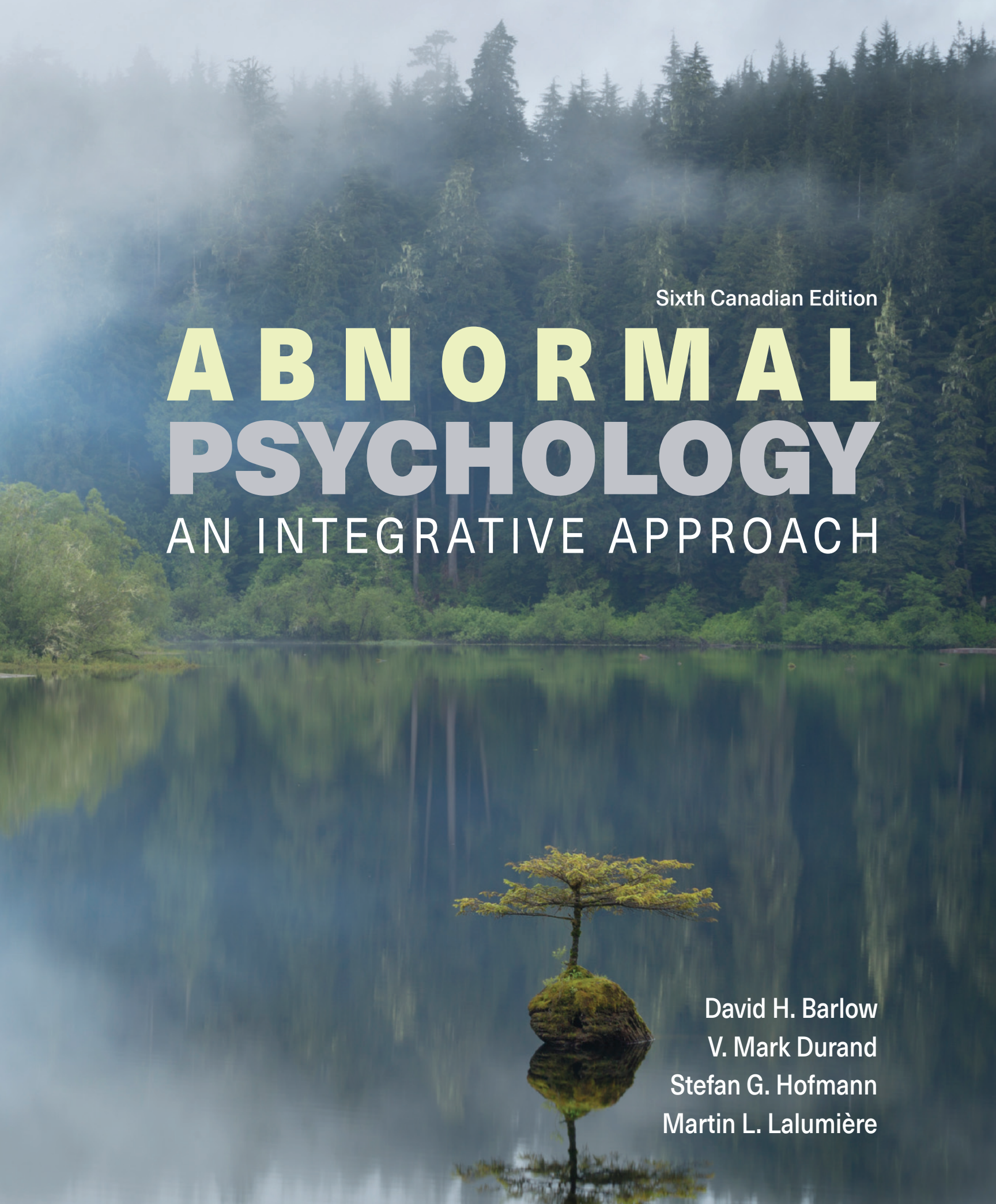

Sixth Canadian Edition

ABNORMAL PSYCHOLOGY

AN INTEGRATIVE APPROACH

David H. Barlow
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STEFAN G. HOFMANN

Courtesy of Stefan G. Hofmann

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

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

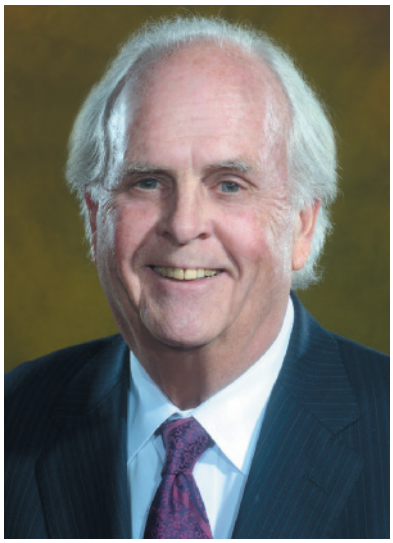
He has won many prestigious professional awards, including the Aaron T. Beck Award for Significant and Enduring Contributions to the Field of Cognitive Therapy by the Academy of Cognitive Therapy. He is a Fellow of the American Psychological Association and the Association for Psychological Science, and was president of various national and international professional societies, including the Association for Behavioural and Cognitive Therapies and the International Association for Cognitive Psychotherapy. He was an Advisor to the *DSM-5* Development Process and a member of the *DSM-5* Anxiety Disorder Sub-Work Group. As part of this, he participated in the discussions about the revisions of the *DSM-5* criteria for various anxiety disorders, especially social anxiety disorder, panic disorder, and agoraphobia. Dr. Hofmann is a Thomson Reuters Highly Cited Researcher.

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

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

ABOUT THE AUTHORS

DAVID H. BARLOW



Courtesy of David H. Barlow

David H. Barlow is an internationally recognized pioneer and leader in clinical psychology. Currently Professor Emeritus of Psychology and Psychiatry at Boston University, Dr. Barlow is Founder and Director Emeritus of the Center for Anxiety and Related Disorders, one of the largest research clinics of its kind in the world. From 1996 to 2004, he directed the clinical psychology programs at Boston University. From 1979 to 1996, he was distinguished professor at the University at Albany–State University of New York. From 1975 to 1979, he was professor of psychiatry and psychology at Brown University, where he also founded the clinical psychology internship program. From 1969 to 1975, he was professor of psychiatry at the University of Mississippi Medical Center, where he founded the psychology residency program. Dr. Barlow received his B.A. from the University of Notre Dame, his M.A. from Boston College, and his Ph.D. from the University of Vermont.

A fellow of every major psychological association, Dr. Barlow has received many awards in honour of his excellence in scholarship, including the National Institute of Mental Health Merit Award for his long-term contributions to the clinical research effort, the Distinguished Scientist Award for applications of psychology from the American Psychological Association, and the James McKeen Cattell Fellow Award from the Association for Psychological Science honouring individuals for their lifetime of significant intellectual achievements in applied psychological research. Other awards include the Distinguished Scientist Award from the Society of Clinical Psychology of the American Psychological Association and a certificate of appreciation from the APA section on the clinical psychology of women for "outstanding commitment to the advancement of women in psychology." He was awarded an Honorary Doctorate of Science from the University of Vermont, an Honorary Doctorate of Humane Letters from William James College, and the C. Charles Burlingame Award from the Institute of Living in Hartford Connecticut "for his outstanding leadership in research, education, and clinical care." In 2014, he was awarded a Presidential Citation from the American Psychological Association "for his lifelong dedication and passion for advancing psychology through science, education, training, and practice."

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

Dr. Barlow has edited several journals, including *Clinical Psychology: Science and Practice*, and *Behavior Therapy*, has served on the editorial boards of more than 20 different journals, and is currently Editor in Chief of the "Treatments That Work" series for Oxford University Press. He has published more than 600 scholarly articles and written or edited more than 75 books and clinical manuals, including *Anxiety and Its Disorders*, Second Edition, Guilford Press; *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual*, Fifth Edition, Guilford Press; *Single-Case Experimental Designs: Strategies for Studying Behaviour Change*, Third Edition, Allyn & Bacon (with Matthew Nock and Michael Hersen); *The Scientist-Practitioner: Research and Accountability in the Age of Managed Care*, Second Edition, Allyn & Bacon (with Steve Hayes and Rosemary Nelson-Gray); *Mastery of Your Anxiety and Panic*, Oxford University Press (with Michelle Craske); and more recently *The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders* with the Unified Team at Boston University. The books and manuals have been translated into more than 20 languages, including Arabic, Chinese, and Russian.

Dr. Barlow was one of three psychologists on the task force that was responsible for reviewing the work of more than 1000 mental health professionals who participated in the creation of *DSM-IV*, and he continued on as an Advisor to the *DSM-5* Task Force. He also chaired the APA Task Force on Psychological Intervention Guidelines, which created a template for the development of clinical practice guidelines. His current research program focuses on the nature and treatment of anxiety and related emotional disorders.

At leisure he plays golf, skis, and retreats to his home on Nantucket Island, where he loves to write, walk on the beach, and visit with his island friends.

V. MARK DURAND

Courtesy of V. Mark Durand

V. Mark Durand is known worldwide as an authority in the area of autism spectrum disorder. He is a Professor of Psychology at the University of South Florida–St. Petersburg, where he was the founding Dean of Arts & Sciences and Vice Chancellor for Academic Affairs. Dr. Durand is a Fellow of the American Psychological Association. He has received more than $4 million in federal funding since the beginning of his career to study the nature, assessment, and treatment of behaviour problems in children with disabilities. Before moving to Florida, he served in a variety of leadership positions at the University at Albany, including Associate Director for Clinical Training for the doctoral psychology program from 1987 to 1990, Chair of the Psychology Department from 1995 to 1998, and Interim Dean of Arts and Sciences from 2001 to 2002. There he established the Center for Autism and Related Disabilities at the University at Albany, SUNY. He received his B.A., M.A., and Ph.D.—all in psychology—at the State University of New York–Stony Brook.

Dr. Durand was awarded the University Award for Excellence in Teaching at SUNY–Albany in 1991 and received the Chancellor's Award for Excellence in Research and Creative Scholarship at the University of South Florida–St. Petersburg in 2007. He was named a 2014 Princeton Lecture Series Fellow and received the 2015 Jacobson Award for Critical Thinking from the American Psychological Association for his body of work in the field of autism spectrum disorder. Dr. Durand is currently a member of the Professional Advisory Board for the Autism Society of America and was on the board of directors of the International Association of Positive Behavioural Support. He was co-editor of the *Journal of Positive Behavior Interventions*, serves on a number of editorial boards, and has written more than 125 publications on functional communication, educational programming, and behaviour therapy. His books include *Severe Behavior Problems: A Functional Communication Training Approach*; *Sleep Better! A Guide to Improving Sleep for Children with Special Needs*; *Helping Parents with Challenging Children: Positive Family Intervention*; the multiple national award-winning *Optimistic Parenting: Hope and Help for You and Your Challenging Child*; and most recently *Autism Spectrum Disorder: A Clinical Guide for General Practitioners*.

Dr. Durand developed a unique treatment for severe behaviour problems that is currently mandated by states across the United States and is used worldwide. He also developed an assessment tool that is used internationally and has been translated into more than 15 languages. Most recently, he developed an innovative approach to help families work with their challenging child (optimistic parenting), which was validated in a five-year clinical trial. He has been consulted by the departments of education in numerous states and by the U.S. Departments of Justice and Education. His current research program includes the study of prevention models and treatments for such serious problems as self-injurious behaviour.

In his leisure time, he enjoys long-distance running and has completed three marathons.

MARTIN L. LALUMIÈRE

Courtesy of Martin L. Lalumière

Martin L. Lalumière is recognized for his work in forensic psychology and sexology. He is a Professor of Clinical Psychology in the School of Psychology at the University of Ottawa and has taught courses in forensic psychology, psychopathology, evolutionary psychology, and clinical research. He obtained his B.Sc. (1989) and M.Ps. (1990) from the Université de Montréal and his Ph.D. (1995) from Queen's University at Kingston, where he won the Governor General's Academic Gold Medal for best graduating Ph.D. student.

Previously, Dr. Lalumière was on faculty in the Department of Psychology at the University of Lethbridge in Alberta (2004–2012) and a Research Psychologist in the Law and Mental Health Program at the Centre for Addiction and Mental Health (1997–2004), a psychiatric teaching hospital in Toronto. He was on faculty in the Department of Psychiatry and the Centre for Criminology at the University of Toronto (1997–2004) and a research psychologist at the maximum secure unit of the Mental Health Centre Penetanguishene (1996–1997)—a psychiatric hospital on Georgian Bay, Ontario (now called the Waypoint Mental Health Centre). He became a registered psychologist in Québec in 1991 and in Ontario in 1996.

Dr. Lalumière is currently on the editorial boards of the journals *Archives of Sexual Behavior*, *The Canadian Journal of Human Sexuality*, *Evolutionary Psychology*, and *Sexual Abuse*. He has published over 135 books, book chapters, and articles on sexual offending, the paraphilias, and psychopathy, among other topics. He has received over $2 million in research funds from the Social Sciences and Humanities Research Council, the Natural Sciences and Engineering Research Council, the Canadian Institutes of Health Research, and the Ontario Mental Health Foundation.

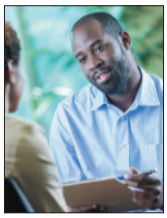
His current research at the University of Ottawa focuses on the assessment, treatment, and etiology of the paraphilias. He also conducts research on the measurement of sexual attraction and sexual arousal by using psychophysiological and cognitive methods with men and women. He has also started to think and write about the role of the placebo in psychotherapy.

He would like to thank Andrea Ashbaugh, Cary Kogan, Allison Ouimet, Rebecca Robillard, Michael Seto, and George Tasca for commenting on parts of the book; Gail Hepburn for her superb work locating and digesting Canadian statistics and other information; and Christine Gilbert, Natalia Denesiuk Harris, Dawn Hunter, and Lenore Taylor-Atkins at Nelson and Sangeetha Vijay at SPi Global for their support and competence in bringing this book to fruition. He would also like to thank undergraduate students who have taken his psychopathology course over the years at the University of Lethbridge and the University of Ottawa, for their feedback and stimulating discussions.

In his spare time, Dr. Lalumière enjoys fly-fishing, cycling, Tai Chi, reading, cooking, and watching hockey.

BRIEF CONTENTS

CONTENTS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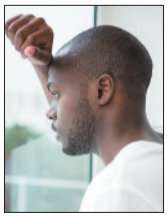
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PREFACE

Science is constantly evolving, but every now and then something groundbreaking occurs that alters our way of thinking. For example, evolutionary biologists, who long assumed that the process of evolution was gradual, suddenly had to adjust to evidence that says evolution happens in fits and starts in response to such cataclysmic environmental events as meteor impacts. Similarly, geology has been revolutionized by the discovery of plate tectonics.

Until recently, the science of psychological disorders (psychopathology) had been compartmentalized, with psychopathologists examining the separate effects of psychological, biological, and social influences. This approach is still reflected in popular media accounts that describe, for example, a newly discovered gene, a biological dysfunction (chemical imbalance), or early childhood experiences as a "cause" of a psychological disorder. This way of thinking still dominates discussions of causality and treatment in some psychology textbooks: "The psychoanalytic views of this disorder are . . . ," "the biological views are . . . ," and, often in a separate chapter, "psychoanalytic treatment approaches for this disorder are . . . ," "cognitive-behavioural treatment approaches are . . . ," or "biological treatment approaches are. . . ."

In the first edition of this text, we tried to do something very different. We thought the field had advanced to the point that it was ready for an integrative approach in which the intricate interactions of biological, psychological, and social factors are explicated in as clear and convincing a manner as possible. Recent advances in knowledge confirm this approach as the only viable way of understanding psychopathology. To take just two examples, Chapter 2 contains a description of a study demonstrating that stressful life events can lead to depression but that not everyone shows this response. Rather, stress is more likely to cause depression in individuals who already carry a particular gene that influences serotonin at the brain synapses. Similarly, Chapter 2 describes how the placebo effect involves changes in the brain. In addition, the entire section on genetics is revised with each new edition to highlight the new emphasis on gene–environment interaction, along with recent thinking from leading behavioural geneticists that the goal of basing the classification of psychological disorders on the firm foundation of genetics is fundamentally flawed. Descriptions of the emerging field of epigenetics, or the influence of the environment on gene expression, is also woven into the chapter, along with new studies on the seeming ability of extreme environments to largely override the effects of genetic contributions. Studies elucidating the mechanisms of epigenetics or specifically how environmental events influence gene expression are described.

These results confirm the integrative approach in this book: psychological disorders cannot be explained by genetic or environmental factors alone but rather arise from their interaction. We now understand that psychological and social factors directly affect neurotransmitter function and even genetic expression. Similarly, we cannot study behavioural, cognitive, or emotional processes without appreciating the contribution of biological and social factors to psychological expression. Instead of compartmentalizing psychopathology, we use a more accessible approach that accurately reflects the current state of our clinical science.

As colleagues, you are aware that we understand some disorders better than others. But we hope you will share our excitement in conveying to students both what we currently know about the causes and treatments of psychological disorders and how far we have yet to go in understanding these complex interactions.

INTEGRATIVE APPROACH

As noted earlier, the first edition of *Abnormal Psychology* pioneered a new generation of abnormal psychology textbooks, which offer an integrative and multidimensional perspective. (We acknowledge such one-dimensional approaches as biological, psychosocial, and supernatural as historic perspectives on our field, described in Chapter 1.) We include substantial current evidence of the reciprocal influences of biology and behaviour and of psychological and social influences on biology. Our examples hold the reader's attention; for example, we discuss genetic contributions to divorce, the effects of early social and behavioural experience on later brain function and structure, and new information on the relation of social networks to the common cold. We note that in the phenomenon of implicit memory and blind sight, which may have parallels in dissociative experiences, psychological science verifies the existence of the unconscious (although it does not much resemble the seething cauldron of conflicts envisioned by Freud). We present new evidence confirming the effects of psychological treatments on neurotransmitter flow and brain function. We acknowledge the often-neglected area of emotion theory for its rich contributions to psychopathology (e.g., the effects of anger on cardiovascular disease). We weave scientific findings from the study of emotions together with behavioural, biological, cognitive, and social discoveries to create an integrated tapestry of psychopathology.

LIFESPAN DEVELOPMENTAL INFLUENCES

No modern view of abnormal psychology can ignore the importance of lifespan developmental factors in the manifestation and treatment of psychopathology. Studies highlighting developmental windows for the influence of the environment on gene expression are explained. Accordingly, although we include a neurodevelopment

chapter and an aging and neurocognition chapter, we consider the importance of development throughout the text; we discuss childhood and geriatric anxiety, for example, in the context of the anxiety chapter. This system of organization, which is for the most part consistent with the *DSM-5*, helps students appreciate the need to study each disorder from childhood through adulthood and old age. We note findings on developmental considerations in separate sections of each disorder chapter and, as appropriate, discuss how specific developmental factors affect causation and treatment.

SCIENTIST-PRACTITIONER APPROACH

We go to some lengths to explain why the scientist-practitioner approach to psychopathology is both practical and ideal. Like most of our colleagues, we view this as something more than simple awareness of how scientific findings apply to psychological disorders. We show how every clinician contributes to general scientific knowledge through astute and systematic clinical observations, functional analyses of individual cases, and systematic observations of series of cases in clinical settings. For example, we explain how information on dissociative phenomena provided by early psychoanalytic theorists remains relevant today. We also describe the formal methods used by scientist-practitioners, showing how complex research designs are actually implemented in research programs.

CLINICAL CASES OF REAL PEOPLE

We have enriched the book with authentic clinical histories to illustrate scientific findings on the causes and treatment of psychological disorders. We have run active clinics for years, so 95 percent of the cases are from our own files, and they provide a fascinating frame of reference for the findings we describe. The beginnings of most chapters include a case description, and most of the discussion of the latest theory and research is related to these very human cases.

DISORDERS IN DETAIL

We cover the major psychological disorders in 12 chapters, focusing on three broad categories: clinical description, causal factors, and treatment and outcomes. We pay considerable attention to case studies and *DSM-5* criteria, and we include statistical data, such as prevalence rates, sex ratio, age of onset, and the general course or pattern for the disorder. Throughout, we explore how biological, psychological, and social dimensions may interact to cause a particular disorder. Thus, by covering treatment and outcomes within the context of specific disorders, we provide a realistic sense of clinical practice.

TREATMENT

One of the best received innovations in the earlier Canadian and U.S. editions was our strategy of discussing treatments in the same chapter as the disorders themselves instead of in a separate chapter, an approach that is supported by the development of specific psychosocial and pharmacological treatment procedures for specific disorders. We have retained this integrative format and have improved upon it, and we include treatment procedures in the key terms and glossary.

LEGAL AND ETHICAL ISSUES

In our closing chapter, we integrate many of the approaches and themes that have been discussed throughout the text. We include case studies of people who have been involved directly with many legal and ethical issues and with the delivery of mental health services. We also provide a historical context for current perspectives so students will understand the effects of social and cultural influences on legal and ethical issues.

DIVERSITY

Issues of culture and gender are integral to the study of psychological disorders. Throughout the text, we describe current thinking about which aspects of the disorders are culturally specific and which are universal, and about the strong and sometimes puzzling effects of gender roles. For instance, we discuss the current information on such topics as the gender imbalance in depression, how panic disorders are expressed differently in various Asian cultures, ethnic differences in eating disorders, treatment of schizophrenia across cultures, and the diagnostic differences of attention-deficit/hyperactivity disorder (ADHD) in boys and girls. Clearly, our field will grow in depth and detail as these subjects and others become standard research topics. For example, why do some disorders overwhelmingly affect females and others appear predominantly in males? And why does this apportionment sometimes change from one culture to another? In answering questions like these, we adhere closely to science, emphasizing that gender and culture are each one dimension among several that constitute psychopathology.

NEW TO THE SIXTH CANADIAN EDITION

This exciting field moves at a rapid pace, and we take particular pride in how our book reflects the most recent developments. Therefore, once again, every chapter has been carefully revised to reflect the latest research studies on psychological disorders. In particular, new Canadian content has been added, such as statistics based on the most recent surveys, new information on mental health service delivery in Canada, and more information about Indigenous peoples in Canada. Some new headings have been added, and *DSM-5* criteria are included in their entirety as tables in the appropriate chapters. Additionally, to address reviewer feedback and in spite of these additions, non-essential material has been eliminated and the rest streamlined. We also revised the text to improve readability.

There are three major changes in this new edition. First, we reorganized some of the chapters so that each now refers to a major topic, and chapters describing specific disorders are organized in a more conceptually satisfying and clear manner. Thus, Chapter 5, Anxiety, is now about anxiety and the major and well-recognized anxiety disorders (generalized anxiety, panic/agoraphobia, phobias, and social anxiety). Chapter 6 is Preoccupation and Obsession and includes the somatic symptoms disorders and

obsessive-compulsive and related disorders. Chapter 7 is Trauma and Dissociation (two phenomena that are often associated) and includes trauma- and stressor-related disorders, and dissociative disorders. Chapter 8, Mood, includes the depressive and bipolar disorders. Chapter 9 is Eating and Chapter 10 is Sleeping. Each describes disorders in these major life domains, along with their connection to disorders in other categories. Sex and Gender are covered in Chapter 11, and we make sure to mention that the three types of disorders discussed in this chapter (sexual dysfunctions, paraphilias, and gender dysphoria), although they fall under the topic of sex and gender, are quite independent from each other. We also provide a more nuanced discussion of gender dysphoria and the controversies associated with it. Other chapters describing disorders include Substance Use and Impulse Control (Chapter 12), Personality (Chapter 13), Psychosis (Chapter 14), Neurodevelopment (Chapter 15), and Aging and Neurocognition (Chapter 16). We think this organization will be more intuitive for students, allowing them to better digest and integrate the material. In addition, this change allowed us to reduce the length of some of the longer chapters; the chapters are now more even in length than they were before. We provide a thoroughly updated discussion of the important topic of suicide in the Mood chapter, but have also added relevant information about suicide in other chapters. In total, there are now 17 chapters, with one other chapter (Stress, Pain, and Health) in the supplementary material that can be found online at nelson.com/student.

The second major change has to do with Canadian statistics. Most of the statistics presented in the book have been updated and more clearly presented. We are now more specific about the people included in Canadian surveys, and also mention the people who are excluded. For example, the Canadian Community Health Survey is used widely by researchers, and we refer to it repeatedly in this text, but the survey excludes Indigenous people living on reserve, people living in remote regions, members of the Canadian Armed Forces, and people living in institutions (e.g., long-term-care homes, prisons). Clearly, then, this representative survey of Canadians is not quite about Canadians. Fortunately, improvements are being made and future surveys will more validly represent Canadians. One very useful feature of recent Canadian Community Health Surveys is that it asks Canadians about whether they are currently diagnosed with a psychological disorder, allowing us to match the responses to the disorders described in this book. Other surveys we relied on for this edition include the First Nations Regional Health Survey, the Survey on Living with Chronic Diseases in Canada, the Canadian Survey on Disability, the Canadian Health Measures Survey, and many others. We also accessed reports that are based on various health databases in Canada (e.g., the Hospital Mental Health Database out of the Canadian Institute for Health Information). Finally, we include more statistics about minority groups and about the fastest growing age group in Canada, older people.

The third major change is that we now include information about Indigenous people in Canada. Previous editions of this book had very limited information on Indigenous peoples and communities, despite the fact that Indigenous people represent 5 percent of the Canadian population. Fortunately, new surveys provide information about Indigenous peoples. Unfortunately, though, this information is incomplete: there is a focus in these surveys and studies on suicide and substance use, with information on mental disorders sadly lacking. In addition, Indigenous people in Canada are made up of hundreds of widely diverse communities, but most available information is for the wider group, hiding large variations. Finally, there is little information about Indigenous people living in urban areas, despite the fact that more than half of Indigenous people live in urban areas.

Nevertheless, the new information presented in the textbook provides a useful picture for this important group, or at least a starting point. In a recent review of mental health research about Indigenous people, University of Toronto researchers Sarah Nelson and Kathi Wilson (2017) wrote that "articles included in this study almost universally state that rates of mental health problems among Indigenous people are higher" (p. 101), and the statistics we present in this book concur. But Nelson and Wilson were also quick to point out that this general conclusion hides huge variations and many positive stories. For example, high rates of alcohol use are more frequently seen in First Nations women in Ontario, but high rates of alcohol abstinence are also observed in these same women. For another example, youth suicide is higher in general in some Indigenous communities, but some Indigenous communities have very low rates, lower than the Canadian average. For one last example, in a 2010 report on the prevalence of psychological distress and mental disorders in Canada by Montréal researchers Caron and Liu, Canadians identifying as Aboriginal (First Nations, Métis, or Inuit) who were living off-reserve had the highest rates of distress and disorders of all self-identified ethnic groups (i.e., white, black, Chinese, South Asian, Latin American, Others). However, when low socioeconomic status was considered, "non-low-income Aboriginal Canadians report a prevalence of high psychological distress quite similar to that for most of the other ethnic subgroups" (p. 87).

Canadian researchers agree that the history of colonialism in Canada, along with current policies, racism, health and employment inequalities, and trauma history (e.g., residential schools) are responsible for the difficulties experienced by some Indigenous communities. Carleton researchers Amy Bombay and Kim Matheson have proposed the concept of historical trauma: "the idea that the accumulation of collective stressors and trauma that began in the past may contribute to increased risk for negative health and social outcomes among contemporary Aboriginal peoples" (Bombay et al., 2014, p. 321). There is some evidence for this concept, and researchers are now investigating the possibility of epigenetic effects. We cover these ideas in this edition.

Other additions to this new edition include an update of the Canadian Code of Ethics for Psychologists (2017, Chapter 1), a discussion of difficulties in replicating gene–environment interaction results (Chapter 2), updated information on the forthcoming ICD-11, and more information on anti-stigma campaigns in Canada (Chapter 3). We now include a discussion of the current replication crisis in the field (Chapter 4), a description of virtual reality work at the Université du Québec en Outaouais (Chapter 5), culture-specific examples of somatic disorders, and an update on the interesting story of Howie Mandel and his struggles with obsessive-compulsive disorder (Chapter 6). There are better statistics on post-traumatic stress disorder (Chapter 7), the prevention

of suicide in Inuit communities (Chapter 8), and information on a newly recognized and dangerous eating disorder in children, avoidant/restrictive food intake disorder (Chapter 9). There are new statistics about required amounts of sleep and bed sharing in Canada (Chapter 10) and new information on the neurological basis of pedophilia and the use of mindfulness meditation in the treatment of sexual dysfunctions (Chapter 11), as well as information about the legality of cannabis in Canada, the opioid crisis in Canada, and an Indigenous historical perspective on tobacco use and gambling (Chapter 12). We include a more streamlined description of antisocial personality disorder, introduce the interesting case of Christopher Knight, a man who lived in the woods by himself for 27 years (Chapter 13), and provide an update on the Genain quadruplets (Chapter 14). There is new information on accommodation for learning disabilities and access to postsecondary education, and the role of sleep in attention-deficit/hyperactivity disorder (Chapter 15), as well as much better statistics on dementia (Chapter 16), and new information about people who have been found not criminally responsible on account of a mental disorder (Chapter 17). These are only a few of the additions, but they give a flavour to our efforts to make the text stimulating, informative, and relevant.

PREVENTION

Looking to the future of abnormal psychology as a field, the prospect of helping the greatest number of people who display psychological disorders may lie in our ability to prevent these difficulties. Although this has long been a goal of many, we are now at the beginning of what appears to be a new age in prevention research. Numerous scientists from all over the globe are developing the methodologies and techniques that may finally provide us with the means to interrupt the debilitating toll of emotional distress caused by the disorders chronicled in this book. We therefore highlight these cutting-edge prevention efforts—such as preventing eating disorders, suicide, substance abuse, and health problems like HIV infection—in appropriate chapters as a means of celebrating these important events, as well as to encourage the field to continue this important work.

RETAINED FEATURES

STUDENT LEARNING OUTCOMES

Placed at the start of each chapter, Student Learning Outcomes assist instructors to accurately assess and map questions throughout the chapter. The outcomes are mapped to the core APA goals and are integrated throughout the instructor resources and testing program.

DSM CONTROVERSIES

DSM Controversies is a box that encourages critical thinking about issues related to updates to the *DSM-5*. Topics include binge-eating disorder, personality disorders, and attenuated psychosis, among others.

FROM THE INSIDE

The popularity of the case studies indicates that students appreciate the humanization of data that might otherwise appear dry and lifeless. To emphasize that psychological disorders affect real people who respond in a variety of ways, nearly all chapters on specific disorders include a compassionate review of a first-person memoir by someone who survived or is living with a challenging psychological condition. Many of these are first-person accounts by Canadian writers. These stories were chosen for the value of their deeply personal points of view; they complement the research-based text without pretending to be scientific.

INNOVATIVE APPROACHES

Most disorder chapters include a feature called Innovative Approaches that discusses forward-thinking treatments, such as dialectical behaviour therapy, the use of "vice vaccines" to manage addiction, and the development of designer drugs for attention-deficit/hyperactivity disorder and other conditions, based on a person's genetic profile.

VISUAL SUMMARIES

At the end of each chapter on disorders is a colourful two-page chart that succinctly summarizes the causes, development, symptoms, and treatment of each disorder covered in the chapter. Our integrative approach is instantly evident in these diagrams, which show the interaction of biological, psychological, and social factors in the etiology and treatment of disorders. The visual summaries will help the instructor wrap up discussions, and students will appreciate them as study aids.

PEDAGOGY

Each chapter contains several Concept Checks that let students verify their comprehension at regular intervals. Answers are at the end of each chapter, along with a detailed Summary; the Key Terms are listed in alphabetical order.

INSTRUCTOR RESOURCES

The **Nelson Education Teaching Advantage (NETA)** program delivers research-based instructor resources that promote student engagement and higher-order thinking to enable the success of Canadian students and educators. Visit Nelson's **Inspired Instruction** website at **nelson.com/inspired** to find out more about NETA.

The following instructor resources have been created for *Abnormal Psychology*, Sixth Canadian Edition. Access these ultimate tools for customizing lectures and presentations at nelson.com/instructor.

NETA TEST BANK

This resource was written by Jamie Prouse-Turner of Red Deer College. It includes over 1600 multiple-choice questions written according to NETA guidelines for effective construction and development of higher-order questions. Also included are more than 150 essay questions.

The NETA Test Bank is available in a new, cloud-based platform. **Nelson Testing Powered by Cognero®** is a secure online testing system that allows instructors to author, edit, and manage test bank content from anywhere Internet access is available. No special installations or downloads are needed, and the desktop-inspired interface, with its dropdown menus and familiar, intuitive tools, allows instructors to create and manage tests with ease. Multiple test versions can be created in an instant, and content can be imported or exported into other systems. Tests can be delivered from a learning management system, the classroom, or wherever an instructor chooses. Nelson Testing Powered by Cognero for *Abnormal Psychology* can be accessed through nelson.com/instructor.

NETA POWERPOINT

Microsoft® PowerPoint® lecture slides for every chapter have been created by Barinder Bhavra. There is an average of 25 slides per chapter, many featuring key figures, tables, and photographs from *Abnormal Psychology*. NETA principles of clear design and engaging content have been incorporated throughout, making it simple for instructors to customize the deck for their courses.

IMAGE LIBRARY

This resource consists of digital copies of figures, short tables, and photographs used in the book. Instructors may use these jpegs to customize the NETA PowerPoint or create their own PowerPoint presentations. An Image Library Key describes the images and lists the codes under which the jpegs are saved.

MINDTAP

Offering personalized paths of dynamic assignments and applications, **MindTap** is a digital learning solution that turns cookie-cutter into cutting-edge, apathy into engagement, and memorizers into higher-level thinkers. MindTap enables students to analyze and apply chapter concepts within relevant assignments, and allows instructors to measure skills and promote better outcomes with ease. A fully online learning solution, MindTap combines all student learning tools—readings, multimedia, activities, and assessments—into a single Learning Path that guides the student through the curriculum. Instructors personalize the experience by customizing the presentation of these learning tools to their students, even seamlessly introducing their own content into the Learning Path.

VIDEOS

Instructors can enhance the classroom experience with the exciting and relevant videos provided to students through MindTap. These videos have been specifically selected to accompany *Abnormal Psychology*.

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REVIEWERS

Creating this sixth Canadian edition would not have been possible without the superb feedback of the reviewers. To them we express our deepest gratitude. The reviewers read the fifth Canadian edition and provided extraordinarily perceptive critical comments, pointed to relevant information, and offered new insights. Readers who take the time to communicate their thoughts offer the greatest rewards to writers and scholars. For their assistance and their feedback, we would like to thank all of our reviewers, including Deborah Gural, Red River College; Naomi Koerner, Ryerson University; and Elaine Ply, Dalhousie University.

01 Abnormal Behaviour in Historical Context

Jerry Cooke/Science Source

CHAPTER OUTLINE

A clear and complete insight into the nature of madness, a correct and distinct conception of what constitutes the difference between the sane and the insane has, as far as I know, not been found.

—SCHOPENHAUER, The World as Will and Idea

STUDENT LEARNING OUTCOMES*

Describe key concepts, principles, and overarching themes in psychology:	› Explain why psychology is a science with the primary objectives of describing, understanding, predicting, and controlling behaviour and mental processes (APA SLO 1.1b) › Use basic psychological terminology, concepts, and theories in psychology to explain behaviour and mental processes (APA SLO 1.1a)
Develop a working knowledge of the content domains of psychology:	› Summarize important aspects of history of psychology, including key figures, central concerns, methods used, and theoretical conflicts (APA SLO 1.2C) › Identify key characteristics of major content domains in psychology (e.g., cognition and learning, developmental, biological, and sociocultural) (APA SLO 1.2a)
Use scientific reasoning to interpret behaviour:	› See APA SLO 1.1b listed above › Incorporate several appropriate levels of complexity (e.g., cellular, individual, group/system, society/cultural) to explain behaviour (APA SLO 2.1C)

* Portions of this chapter cover learning outcomes suggested by the American Psychological Association (2013) in its guidelines for the undergraduate psychology major. Chapter coverage of these outcomes is identified above by APA Goal and APA Suggested Learning Outcome (SLO).

Today you may have gotten out of bed, had breakfast, gone to class, studied, and at the end of the day, enjoyed the company of your friends before falling asleep. It probably did not occur to you that many healthy people are unable to do some or any of these things. What they have in common is a **psychological disorder**, a psychological dysfunction within an individual that is associated with distress or impairment in functioning and a response that is not typical or culturally expected. Before examining exactly what this means, let's look at one individual's situation.

JODY | *The Boy Who Fainted at the Sight of Blood*

Jody, a 16-year-old boy, was referred to our anxiety disorders clinic after increasing episodes of fainting. Jody reported that he had always been somewhat queasy at the sight of blood. About two years before coming to our clinic, in his first biology class, the teacher showed a movie of a frog dissection to illustrate various points about anatomy. The film was particularly graphic, with vivid images of blood, tissue, and muscle. About halfway through, Jody felt a bit lightheaded and left the room, but the images did not leave him. He continued to be bothered by them and occasionally felt slightly queasy. He began to avoid situations in which he might see blood or an injury. He stopped looking at magazines that might have gory pictures. He found it difficult to look at raw meat, or even Band-Aids, because they brought the feared images to mind. Eventually, anything his friends or parents said that evoked an image of blood or injury caused Jody to feel lightheaded. It became so bad that if one of his friends exclaimed, "Cut it out!" he felt faint. Beginning about six months before his visit to the clinic, Jody actually fainted when he unavoidably encountered something bloody. His family physician could find nothing wrong with him, nor could several other physicians. By the time he was referred to our clinic, he was fainting five to ten times a week, often in class. Clearly, these episodes were problematic for him and disruptive in school; each time he fainted, the other students flocked around him, trying to help, and class was interrupted. Because no one could find anything wrong with Jody, the principal finally concluded that he was being manipulative and suspended him from school, even though he was an honour student.

Jody had what we now call blood-injury-injection phobia. His reaction was quite severe, thereby meeting the criteria for **phobia**, a psychological disorder characterized by marked and persistent fear of an object or a situation. But many people have similar reactions that are not as severe when they receive an injection or see someone who is injured, whether or not blood is visible. For people who react as severely as Jody, this phobia can be very disabling. They may avoid certain careers, such as medicine or nursing. If they are so afraid of needles and injections that they avoid them even when they are necessary, they put their health at risk.

WHAT IS A PSYCHOLOGICAL DISORDER?

Keeping in mind the real-life problems faced by Jody, let's look more closely at the definition of a psychological disorder, or abnormal behaviour: It is a *psychological dysfunction within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected.* On the surface, these three elements may seem obvious, but they were not easily arrived at, and it is worth exploring what they mean.

PSYCHOLOGICAL DYSFUNCTION

Psychological dysfunction refers to a breakdown in cognitive, emotional, or behavioural functioning. For example, if you are out on a date, it should be fun. If you experience severe fear all evening and just want to go home, even though you have nothing to be afraid of, and if the severe fear happens on every date, your emotions are not functioning properly. If all your friends agree that the person who asked you out is dangerous, however, then it would not be "dysfunctional" for you to be fearful and avoid the date.

A dysfunction was present for Jody—he fainted at the sight of blood. But many people experience a mild version of this reaction (feeling queasy at the sight of blood) without meeting the criteria for the disorder; knowing where to draw the line between normal and abnormal dysfunction is often difficult. For this reason, these problems are often considered to exist on a continuum or as a dimension, rather than as categories that are either present or absent. This is one reason that just having a dysfunction is not enough to meet the criteria for a psychological disorder.

PERSONAL DISTRESS OR IMPAIRMENT

That the disorder or behaviour must be associated with distress adds an important component and seems clear: The criterion is satisfied if the individual is extremely upset. We can certainly say that Jody was very distressed and even suffered with his phobia. But remember, by itself this criterion does not define abnormal behaviour. It is often quite normal to be distressed—for example, if someone close to you dies. The human condition is such that suffering and distress are very much part of life—and that is not likely to change. Furthermore, for some disorders, by definition, suffering and distress are absent. Consider the person who feels extremely elated and acts impulsively as part of a manic episode. As we see in Chapter 8, one major difficulty with this problem is that people enjoy the manic state so much they are reluctant to begin treatment or stay in treatment very long. Thus, defining psychological disorder by distress alone doesn't work, although the concept of distress contributes to a good definition. The concept of impairment is also useful, though it is not entirely satisfactory. For example, many people consider themselves shy or lazy, but this doesn't mean that they're abnormal. But if you are so shy that you find it impossible to date or even interact with people, and if you make every attempt to avoid interactions even though you would like to have friends, then your social functioning is impaired. Jody was clearly impaired by his phobia, but many people with similar, less severe reactions are not impaired. This difference again illustrates the important point that most psychological disorders are simply extreme expressions of otherwise normal emotions, behaviours, and cognitive processes.

The Canadian Press/AP/Charles Rex Arbogast

▲ Distress and suffering are a natural part of life and do not in themselves constitute psychological disorder.

ATYPICAL OR NOT CULTURALLY EXPECTED

The criterion that the response be atypical or *not culturally expected* is important but also insufficient to determine abnormality. At times, something is considered abnormal because it occurs infrequently; it deviates from the average. The greater the deviation, the more abnormal it is. You might say that someone is abnormally short or abnormally tall, meaning that the person's height deviates substantially from average, but this obviously isn't a definition of a disorder. Many people are far from the average in their behaviour, but few would be considered disordered. We might call them talented or eccentric. Many artists, performers, and athletes fall into this category. For example, it's not normal to wear a dress made entirely out of meat, but when Lady Gaga wore one to an awards show it only enhanced her celebrity. The late novelist J. D. Salinger, who wrote *The Catcher in the Rye*, retreated to a small town in New Hampshire and refused to see any outsiders for years, but he continued to write. Some rock singers wear outrageous costume on stage. These people are well paid and seem to enjoy their careers. In most cases, the more productive you are in the eyes of society, the more eccentricities society will tolerate. Therefore, "deviating from the average" doesn't work very well as a definition.

Another view is that your behaviour is abnormal if you are violating social norms in your culture. This view is very useful in considering important cultural differences in psychological disorders. For example, to enter a trance state and believe you are possessed would point to a psychological disorder in most Western cultures, but in many other societies the behaviour is accepted and expected.

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

An informative example of this view is provided by prominent neuroscientist Robert Sapolsky (2002), who worked closely with the Masai tribe in East Africa. One day Sapolsky's Masai friend Rhoda asked him to bring his jeep as quickly as possible to the Masai village, where a woman had been acting very aggressively and had been hearing voices. The woman had actually killed a goat with her own hands. Sapolsky and several Masai were able to subdue her and transport her to a local health centre. Realizing that this was an opportunity to learn more of the Masai's view of psychological disorders, Sapolsky had the following discussion:

> "So Rhoda," I began laconically, "what do you suppose was wrong with that woman?"
>
> She looked at me as if I was mad.
>
> "She is crazy."
>
> "But how can you tell?"
>
> "She's crazy. Can't you just see from how she acts?"
>
> "But how do you decide that she is crazy? What did she do?"
>
> "She killed that goat."
>
> "Oh," I said with anthropological detachment, "but Masai kill goats all the time."
>
> She looked at me as if I were an idiot. "Only the men kill goats," she said.
>
> "Well, how else do you know that she is crazy?"
>
> "She hears voices."
>
> Again, I made a pain of myself. "Oh, but the Masai hear voices sometimes." (At ceremonies before long cattle drives, the Masai trance-dance and claim to hear voices.) And in one sentence, Rhoda summed up half of what anyone needs to know about cross-cultural psychiatry. "But she hears voices at the wrong time." (2002, p. 138)

ake1150/Fotolia LLC

▲ Some religious behaviours may seem unusual to us but are culturally or individually appropriate.

Social standards associated with what is *normal* have been misused. Consider, for example, the practice of committing political dissidents to mental institutions, which was common in the former Soviet Union before the fall of Communism. Although such dissident behaviour clearly violates social norms, it should not alone be cause for commitment.

In a very thoughtful analysis of the matter, Wakefield (1992, 1999) uses the shorthand definition "harmful dysfunction." According to Wakefield, a psychological disorder is caused by a failure of one or more mechanisms to perform their evolved function and the dysfunction produces harm or distress. The advantage of Wakefield's notion is that it provides a potentially objective or scientific view of dysfunction (it requires an objective analysis of the structure and function of the relevant psychological mechanisms, and how it is broken), along with allowing a subjective or culturally bound consideration of harm and distress (what is considered harmful in one culture may not be so in another). For example, to determine if Jody's condition of fainting when seeing or thinking about blood is a psychological disorder, psychologists would need to understand the functioning of the mechanisms designed to deal with reactions to sight of injury and blood in people in general, if such mechanisms exist. We could hypothesize that being exposed to blood and injuries signals danger and would trigger adaptive self-protective responses (e.g., getting away from danger, avoiding pathogens). The common reaction of feeling queasy at the sign of blood might motivate these protective responses. Fainting, however, might be an exaggerated reaction, and therefore can be considered dysfunctional if it led to poor outcomes in our ancestral environment, such as being more vulnerable to attackers or predators (in the terms of natural selection, if it led to poorer survival and reproduction compared with alternative, more typical responses in the environment in which we evolved). And with regard to the harm criterion, in our culture, fainting at the sign of blood and avoidance of any blood-related cues would be considered harmful in most situations.

A related concept that is also useful when considering the definition of psychological disorder is to determine whether the behaviour is beyond the individual's control (something he or she doesn't want to do or feel; Widiger & Sankis, 2000). Variants of these approaches are most often used in current diagnostic practice, as outlined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*, American Psychiatric Association, 2013), which contains the current listing of criteria for psychological disorders. The *DSM-5* acknowledges that it is difficult to provide a clear and encompassing definition of psychological disorders, and offers a definition that is quite similar to the one we provided earlier. These approaches guide our thinking in this book.

AN ACCEPTED DEFINITION?

It is difficult to define "normal" and "abnormal" (Lilienfeld & Marino, 1995, 1999; Spitzer, 1999)—and the debate continues (Blashfield et al., 2014; McNally, 2011; Stein et al., 2010; Wakefield, 2003, 2009; Zachar & Kendler, 2014). The most widely accepted definition used in the *DSM-5* describes behavioural, psychological, or biological dysfunctions that are unexpected in their cultural context and associated with present distress and impairment in functioning, or increased risk of suffering, death, pain, or impairment. This definition can be useful across cultures and subcultures if we pay careful attention to what is functional or dysfunctional (or out of control) in a given society. But it is never easy to decide what represents dysfunction, and some scholars have argued persuasively that the health professions will never be able to satisfactorily define *disease* or *disorder* (e.g., Lilienfeld & Marino, 1995, 1999; Zachar & Kendler, 2014). Perhaps the best we can do is consider how the apparent disease or disorder matches a "typical" profile of a disorder—for example, major depression or schizophrenia—when most or all symptoms that experts agree are part of the disorder are present. We call this typical profile a *prototype*, and, as described in Chapter 3, the diagnostic criteria from *DSM-5* found throughout this book are all prototypes. This means that the patient may have only some features or symptoms of the disorder (a minimum number) and still meet the criteria for the disorder because his or her set of symptoms is close to the prototype. This concept is described more fully in Chapter 3, where the diagnosis of psychological disorder is discussed. Wakefield's notion of harmful dysfunction is likely to guide research on psychological disorders, but it is not clear when or how it will be applied in clinical practice.

Some controversial figures, such as Thomas Szasz and George Albee, are highly critical of medical diagnoses being used in the case of psychological disorders. In 1960, Szasz advanced his position that mental illness is a myth and that the practice of labelling mental illnesses should be abolished. For example, Szasz (1960) argued that a fundamental difference exists between the use of diagnoses for physical diseases and their use in mental illnesses. The former uses objective criteria (e.g., results of blood tests), but for mental illness, subjective judgments are required. Albee (1998, 2000) has argued that the biggest mistake made by the clinical psychology profession was uncritically accepting the concept of "mental disease" and using the medical model and associated diagnoses (e.g., the *DSM* system) in conceptualizing abnormal behaviour. Even among the many proponents of the *DSM* system, disagreement continues about how to define the concept of "disorder."

As a challenge, take the problem of defining abnormal behaviour a step further and consider this: What if Jody passed out repeatedly but regained consciousness so quickly that neither his classmates nor his teachers even noticed? Furthermore, what if Jody continued to get good grades? Would fainting all the time at the mere thought of blood be a disorder? Would it be impairing? Dysfunctional? Distressing? How would the notion of harmful dysfunction handle that situation? What do you think?

THE SCIENCE OF PSYCHOPATHOLOGY

Psychopathology is the scientific study of psychological disorders. Within this field are specially trained professionals, including clinical and counselling psychologists, psychiatrists, psychiatric social workers, psychiatric nurses, marriage and family therapists, sex therapists, and mental health counsellors. Clinical psychologists typically receive a Ph.D. (Doctor of Philosophy) following a course of graduate-level study that lasts six to seven years. This education prepares them to conduct research into the causes and treatment of psychological disorders and to assess, diagnose, and treat these disorders. Instead of a Ph.D., clinical psychologists sometimes receive a Psy.D. (Doctor of Psychology) degree for which the training is similar to the Ph.D. but with more emphasis on clinical practice and less on research training.

In Canada, regulation of the psychology profession is under the jurisdiction of the provinces and territories. Depending on the jurisdiction, a psychologist may have either a doctoral or a master's degree. For example, in Ontario, professional psychologists are regulated by the College of Psychologists of Ontario, as outlined in the Regulated Health Professions Act (1991). Largely to protect the public, but also in the interest of the profession, only those who are licensed or registered with their provincial or territorial board or college are permitted to call themselves psychologists (e.g., in advertising)—with the exception of university professors in psychology. The labels *psychotherapist* and *therapist* are not regulated in most provinces and territories. Thus, in Canada, the label of *psychologist* conveys information about the training and qualifications of the professional, whereas the label of *psychotherapist* does not always (as of 2015, Ontario has a new College of Registered Psychotherapists). In addition, the terms *therapist* and *psychotherapist* are not specific to a particular profession. For example, a social worker, a psychologist, a nurse, and a psychiatrist can all refer to themselves as psychotherapists if they provide therapy services to members of the public around psychological issues.

Psychologists with other specialty training, such as experimental and social psychologists, concentrate on investigating the basic determinants of behaviour but do not assess or treat psychological disorders. Although a great deal of overlap exists, *counselling psychologists* (who can receive a Ph.D., Psy.D., or Ed.D.—Doctor of Education, or a master's degree in education or counselling) tend to study and treat adjustment and vocational issues encountered by relatively healthy individuals, whereas clinical psychologists usually concentrate on more severe psychological disorders.

Psychiatrists first earn an M.D. in medical school and then specialize in psychiatry during a four-year residency training program. Psychiatrists also investigate the nature and causes of psychological disorders, often from a biological point of view, make diagnoses, and offer treatments. Many psychiatrists emphasize drugs or other biological treatments, although many use psychosocial treatments as well.

Psychiatric social workers typically earn a master's degree in social work as they develop expertise in collecting information relevant to the social and family situation of the individual with a psychological disorder. Social workers also treat disorders, often concentrating on family problems associated with them. *Psychiatric nurses* have advanced degrees, such as a master's or a Ph.D., and specialize in the care and treatment of patients with psychological disorders, usually in hospitals as part of a treatment team. Finally, *marriage and family therapists* and *mental health counsellors* typically spend one to two years earning a master's degree and provide clinical services in hospitals or clinics, usually under the supervision of a doctoral-level clinician. Sex therapists have specialized training, often in the context of a graduate degree. Table 1.1 shows the number of each major category of mental health professionals currently practising in Canada.

Courtesy of John Hunsley

▲ University of Ottawa psychologist John Hunsley has written extensively on incorporating evidence into clinical practice.

THE SCIENTIST-PRACTITIONER

The most important recent development in the history of psychopathology is the adoption of scientific methods to learn more about the nature of psychological disorders, their causes, and their treatment. Many mental health professionals take a scientific approach to their clinical work and are therefore referred to as **scientist-practitioners**. Mental health practitioners may function as scientist-practitioners at least one of three ways (see ■ Figure 1.1). First, they may keep up with the latest scientific developments in their field and therefore use the best empirically supported diagnostic and treatment procedures. In this sense, they are consumers of the science of psychopathology to the advantage of their patients. This approach is now often called *evidence-based practice* (Hunsley, 2007; Hunsley & Lee, 2007). Second, scientist-practitioners evaluate their own assessments or treatment procedures to see whether they work and to generate new knowledge, an approach called *practice-based evidence* (Wampold & Imel, 2015).

TABLE 1.1 | Mental Health Professionals Practising in Canada, 2016

Profession	Number Currently Practising (per 100 000 in parentheses)
Psychiatrists	5 214 (14)
Psychologists	17 493 (49)
Psychiatric nurses (BC, AB, SK, MB, YT)	5 863 (52)
Social workers	52 283 (146)

Sources: *Supply, Distribution and Migration of Physicians in Canada, 2016: Methodological Notes*, by Institute of Health Information, 2017; *Canada's Health Care Providers: Provincial Profiles, 2007 to 2016—Data Tables,* by Canadian Institute of Health Information, 2017 (https://secure.cihi.ca/estore/productSeries.htm?pc=PCC314); *Health Workforce Database, 2016: Methodology Guide*, by Canadian Institute of Health Information, 2017.

They are accountable not only to their patients but also to the government agencies and insurance companies that pay for the treatments, so they must demonstrate clearly whether their treatments are effective or not. Third, scientist-practitioners might conduct research, often in clinics or hospitals, that produces new information about disorders or their treatment. This research helps suppress the fads that plague our field. For example, new "miracle cures" for psychological disorders that are reported several times a year in the popular media would not be used by a scientist-practitioner who did not have sound scientific data showing that they work. Such data flow from research that attempts three basic things: to describe psychological disorders, to determine their causes, and to treat them (see ■ Figure 1.2). These three categories compose an organizational structure that recurs throughout this book and is formally evident in the discussions of specific disorders beginning in Chapter 5. A general overview of the categories now will give you a clearer perspective on our efforts to understand abnormality.

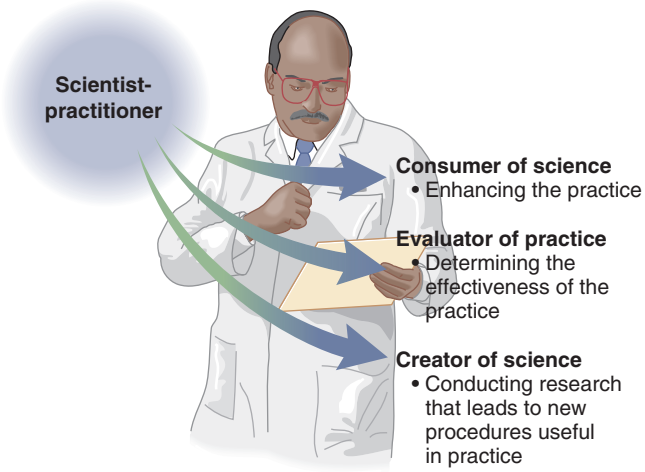


FIGURE 1.1 | Functioning as a scientist-practitioner.

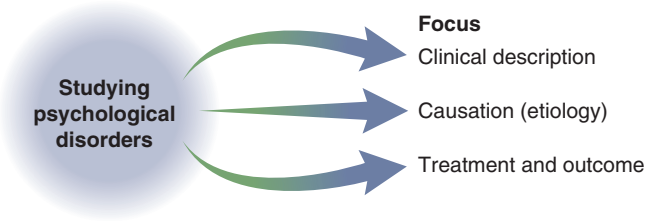


FIGURE 1.2 | Three major categories compose the study and discussion of psychological disorders.

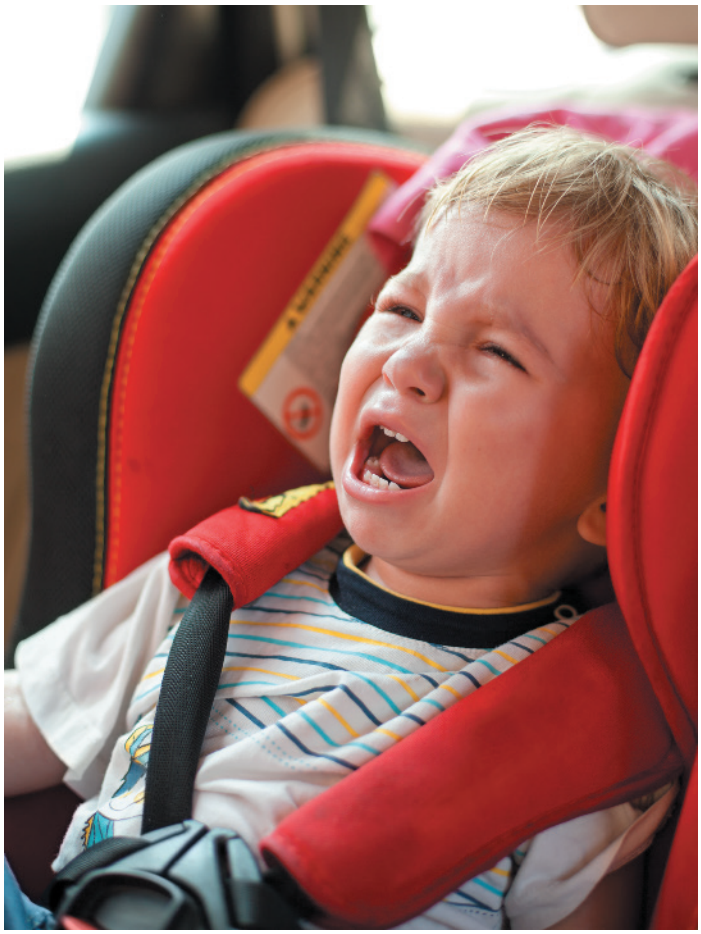
CLINICAL DESCRIPTION

In hospitals and clinics we often say that a patient "presents" with a specific problem or set of problems, or we discuss the **presenting problem**. *Presents* is a traditional shorthand way of indicating why the person came to the clinic. Describing Jody's presenting problem is the first step in determining his **clinical description**, which represents the unique combination of behaviours, thoughts, and feelings that make up a specific disorder. The word *clinical* refers both to the types of problems or disorders you would find in a clinic or hospital and to the activities connected with assessment and treatment. Throughout this text are excerpts from many individual cases, most of them from our personal files.

Clearly, one important function of the clinical description is to specify what makes the disorder different from normal behaviour or from other disorders. Statistical data may also be relevant. For example, how many people in the population as a whole have the disorder? This figure is called the **prevalence** of the disorder. How many people in the population have ever had the disorder (**lifetime prevalence**)? Statistics on how many new cases occur during a given period, such as a year, represent the **incidence** of the disorder. Other statistics include the *sex ratio*—that is, what proportion of males and females have the disorder—and the typical *age of onset*, which often differs from one disorder to another.

In addition to having different symptoms, a different age of onset, and possibly a different sex ratio and prevalence, most disorders follow a somewhat individual pattern, or **course**. For example, some disorders, such as schizophrenia (Chapter 14), follow a *chronic course*, meaning that they tend to last a long time, sometimes a whole lifetime. Other disorders, like mood disorders (Chapter 8), follow an *episodic course* in which the individual is likely to recover within a few months, only to have a recurrence of the disorder later. Still other disorders may have a *time-limited course*, like some sleep disorders (Chapter 10), meaning the disorder will improve without treatment in a relatively short period with little or no risk of recurrence.

Closely related to differences in the course of disorders are differences in onset. Some disorders have an *acute onset*, meaning that they begin suddenly; others develop gradually over an extended time, which is sometimes called an *insidious onset*. It is important to know the typical course of a disorder so that we know what to expect and how best to deal with the problem. The anticipated course is an important part of the clinical description. For example, if someone has a mild disorder with acute onset that we know is time limited, we might advise the individual to forgo expensive treatment because the problem will resolve soon enough, like a common cold. However, if the disorder is likely to last a long time (become chronic), the individual might want to seek treatment and take other appropriate steps. The anticipated course of a disorder is called the **prognosis**. So we might say, "the prognosis is good," meaning the individual will probably recover, or "the prognosis is guarded," meaning the probable outcome doesn't look good.



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

The patient's age may be a very important part of the clinical description. A specific psychological disorder occurring in childhood may present very differently from the same disorder in adulthood or old age. Children experiencing severe anxiety and panic often assume that they are physically ill because they have difficulty understanding there is nothing physically wrong. Because their thoughts and feelings are different from those experienced by adults with anxiety and panic, children are often misdiagnosed and treated for a medical disorder.

CAUSATION, TREATMENT, AND OUTCOMES

Etiology, or the study of origins, has to do with why a disorder begins (what causes it) and includes biological, psychological, and social dimensions. Because the etiology of psychological disorders is so important to this field, we devote an entire chapter to it (Chapter 2). Treatment is often important to the study of psychological disorders. If a new drug or psychosocial treatment

is successful in treating a disorder, it may give us some hints about the nature of the disorder and its causes. For example, if a drug with a specific known effect within the nervous system alleviates a certain psychological disorder, we know that something in that part of the nervous system might be either causing the disorder or helping to maintain it. Similarly, if a psychosocial treatment designed to help clients regain a sense of control over their lives is effective with a certain disorder, a diminished sense of control may be an important psychological component of the disorder itself.

Concept Check 1.1

A clinical description includes the unique combination of behaviours, thoughts, and feelings that compose a given psychological disorder. Match the following words that are used in clinical descriptions with their corresponding examples: (a) presenting problem, (b) prevalence, (c) incidence, (d) prognosis, (e) course, and (f) etiology.

1. Maria should recover quickly with no intervention necessary. Without treatment, David will deteriorate rapidly. _____
2. Three new cases of bulimia have been reported in this county during the past month and only one in the next county. _____
3. Elizabeth visited the campus mental health centre because of her increasing feelings of guilt and anxiety. _____
4. Biological, psychological, and social influences all contribute to a variety of disorders. _____
5. The pattern a disorder follows can be chronic, time limited, or episodic. _____
6. How many people in the population as a whole have obsessive-compulsive disorder? _____

As we see in the next chapter, psychology is never that simple. This is because the effect does not necessarily imply the cause. To use a common example, you might take an Aspirin to relieve a tension headache that you developed during a gruelling day of taking exams. If you then feel better, it does not mean the headache was caused by a lack of Aspirin in the first place. Nevertheless, many people seek treatment for psychological disorders, and treatment can provide interesting hints about the nature of the disorder.

In the past, textbooks emphasized treatment approaches in a very general sense, with little attention to the disorder being treated. For example, a mental health professional might be thoroughly trained in a single theoretical approach, such as psychoanalysis or behaviour therapy (both described later in the chapter), and then use that approach on every disorder. More recently, as our science has advanced, we have developed specific effective treatments that do not always adhere neatly to one theoretical approach but that have grown out of a deeper understanding of the disorder in question. For this reason, this book does not have separate chapters on such types of treatment approaches as psychodynamic, cognitive behavioural, or humanistic. Rather, the latest and most effective drug and psychological treatments are described in the context of specific disorders, in keeping with our integrative multidimensional perspective and evidence-based approach.

We now survey many early attempts to *describe* and *treat* abnormal behaviour, and more still to comprehend its *causes*, which will give you a better perspective on current approaches. In Chapter 2, we examine contemporary views of causation and treatment. In Chapter 3, we discuss efforts to describe, or classify, abnormal behaviour. In Chapter 4, we review research methods—our systematic efforts to discover the truths underlying description, cause, and treatment that allow us to function as scientist-practitioners. In Chapters 5 through 16, we examine specific disorders; our discussion is organized in each case in the now familiar triad of description, cause, and treatment. Finally, in Chapter 17 we examine legal, professional, and ethical issues that are relevant to psychological disorders and their treatment in Canada today. The Online Chapter tackles issues related to stress, pain, and, health. But first, let us turn to the past.

For thousands of years, humans have tried to explain and control problematic behaviour. But our efforts always derive from the theories or models of behaviour that are popular at the time. The purpose of these models is to explain why someone is "acting like that." Three major models that have guided us date back to the beginnings of civilization.

Humans have always supposed that certain agents outside our bodies and environment influence our behaviour, thinking, and emotions. These agents, which might be divinities, demons, spirits, or other phenomena such as magnetic fields or the moon or the stars, are the driving forces behind the *supernatural model*. In addition, since ancient Greece, the mind has often been called the *soul* or the *psyche* and considered separate from the body. Although many have thought that the mind can influence the body and, in turn, the body can influence the mind, most philosophers looked for causes of abnormal behaviour in one or the other. This split gave rise to two traditions of thought about abnormal behaviour, summarized as the *biological model* and the *psychological model*.

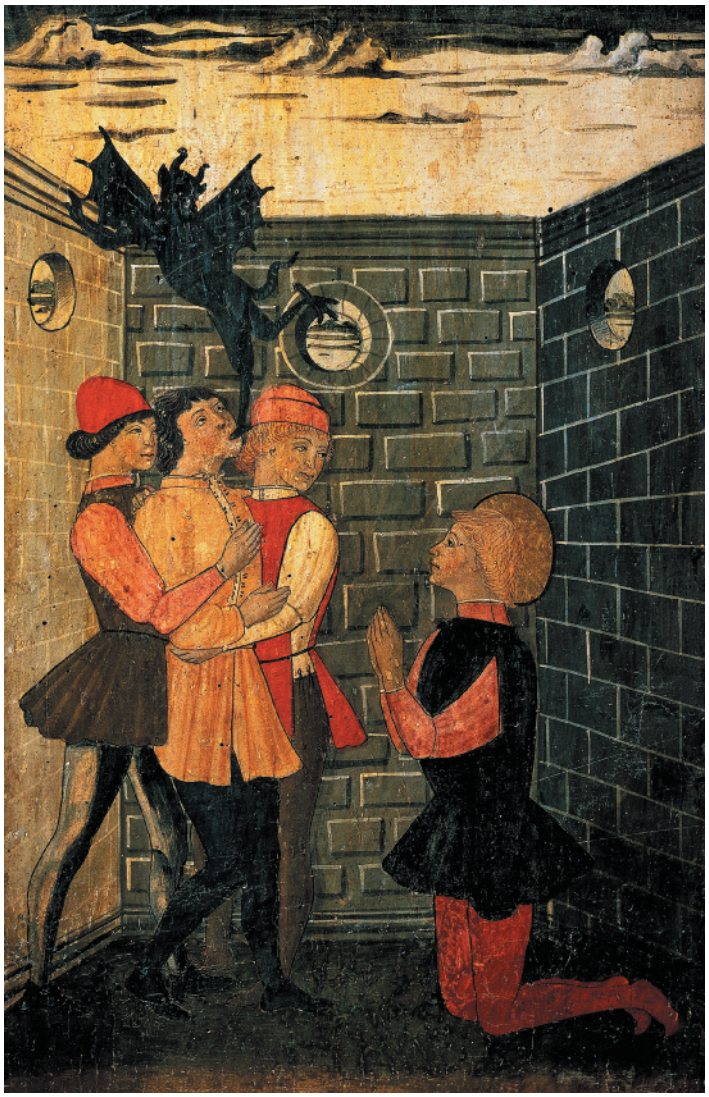
These three models—the supernatural, the biological, and the psychological—are very old but still in use today.

THE SUPERNATURAL TRADITION

For much of our recorded history, deviant behaviour has been considered a reflection of the battle between good and evil. When confronted with unexplainable behaviour and by suffering and upheaval, people perceived evil.

DEMONS AND WITCHES

One strong current of opinion put the causes and treatment of psychological disorders squarely in the realm of the supernatural. During the last quarter of the 14th century, religious and lay authorities supported these popular superstitions, and society as a whole began to believe in the reality and power of demons and witches. The Catholic Church had split, and a second centre, complete with a pope, emerged in the south of France to compete with Rome.



DEA PICTURE LIBRARY/Getty Images

▲ During the Middle Ages, individuals with psychological disorders were sometimes thought to be possessed by evil spirits that had to be exorcised through rituals.

In reaction to this schism, the Roman church fought back against the evil in the world that must have been behind this heresy.

People turned increasingly to magic and sorcery to solve their problems. During these turbulent times, the bizarre behaviour of people afflicted with psychological disorders was seen as the work of the devil and witches. It followed that individuals possessed by evil spirits were probably responsible for any misfortune experienced by the townspeople, which inspired drastic action against the possessed. Treatments included *exorcism*, in which various religious rituals were performed to rid the victim of evil spirits. Other approaches included shaving the pattern of a cross in the victims' hair and securing them to a wall near the front of a church so that they might benefit from hearing mass.

The conviction that sorcery and witches were causes of madness and other evils continued into the 15th century. Evil continued to be blamed for unexplainable behaviour, even after the European founding of the New World, as evidenced by the Salem witch trials in the 17th century, which resulted in the hanging deaths of 20 women.

STRESS AND MELANCHOLY

An equally strong opinion, even during this period, reflected the enlightened view that insanity was a natural phenomenon, caused by mental or emotional stress, and that it was curable. Mental depression and anxiety were recognized as illnesses, although symptoms such as despair and lethargy were often identified by the church with the sin of *acedia*, or sloth. Common treatments were rest, sleep, and a healthy and happy environment. Other treatments included baths, ointments, and various potions. Indeed, during the 14th and 15th centuries, people with mental illnesses, along with people who had physical deformities or disabilities, were often moved from house to house in medieval villages, as neighbours took turns caring for them. We now know that this medieval practice of keeping people who have psychological disturbances in their own community is beneficial.

One of the chief advisers to the king of France Charles V, a bishop and philosopher named Nicholas Oresme, also suggested that the disease of melancholy (depression), rather than demons, was the source of some bizarre behaviour. Oresme pointed out that much of the evidence for the existence of sorcery and witchcraft, particularly among people with psychological disorders, was obtained from people who were tortured and who, quite understandably, would confess to anything.

These conflicting crosscurrents of natural and supernatural explanations for mental disorders are represented more or less strongly in various historical works, depending on the sources consulted by historians. Some assume that demonic influences were the predominant explanations of abnormal behaviour during the Middle Ages (e.g., Zilboorg & Henry, 1941); others believe the supernatural had little or no influence. As we see in the handling of the severe psychological disorder experienced by King Charles VI of France in the late 14th century, both influences were strong, sometimes alternating in the treatment of the same case.

CHARLES VI | *The Mad King*

In the summer of 1392, King Charles VI of France was under a great deal of stress, in part because of the division of the Catholic Church. As he rode with his army to the province of Brittany, a nearby aide dropped his lance with a loud clatter and the king, thinking he was under attack, turned on his own army, killing several prominent knights before being subdued from behind. The army immediately marched back to Paris. The king's lieutenants and advisers concluded that he was mad.

During the following years, at his worst the king hid in a corner of his castle, believing he was made of glass, or roamed the corridors howling like a wolf. At other times he couldn't remember who or what he was. He became fearful and enraged whenever he saw his own royal coat of arms and would try to destroy it if it were brought near him.

The people of Paris were devastated by their leader's apparent madness. Some thought it reflected God's anger, because the king had failed to take up arms to end the schism in the Catholic Church; others thought it was God's warning against taking up arms; still others thought it was