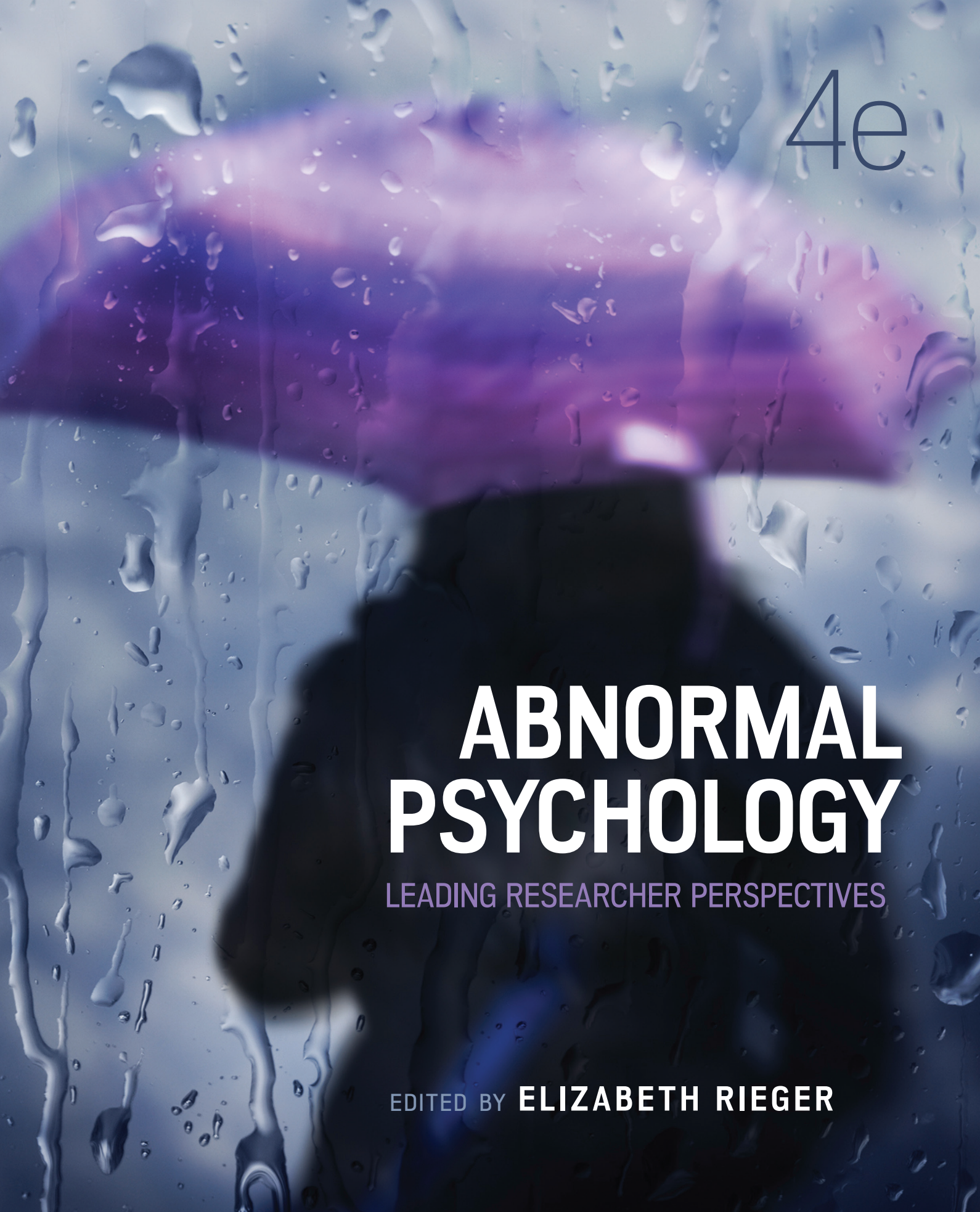
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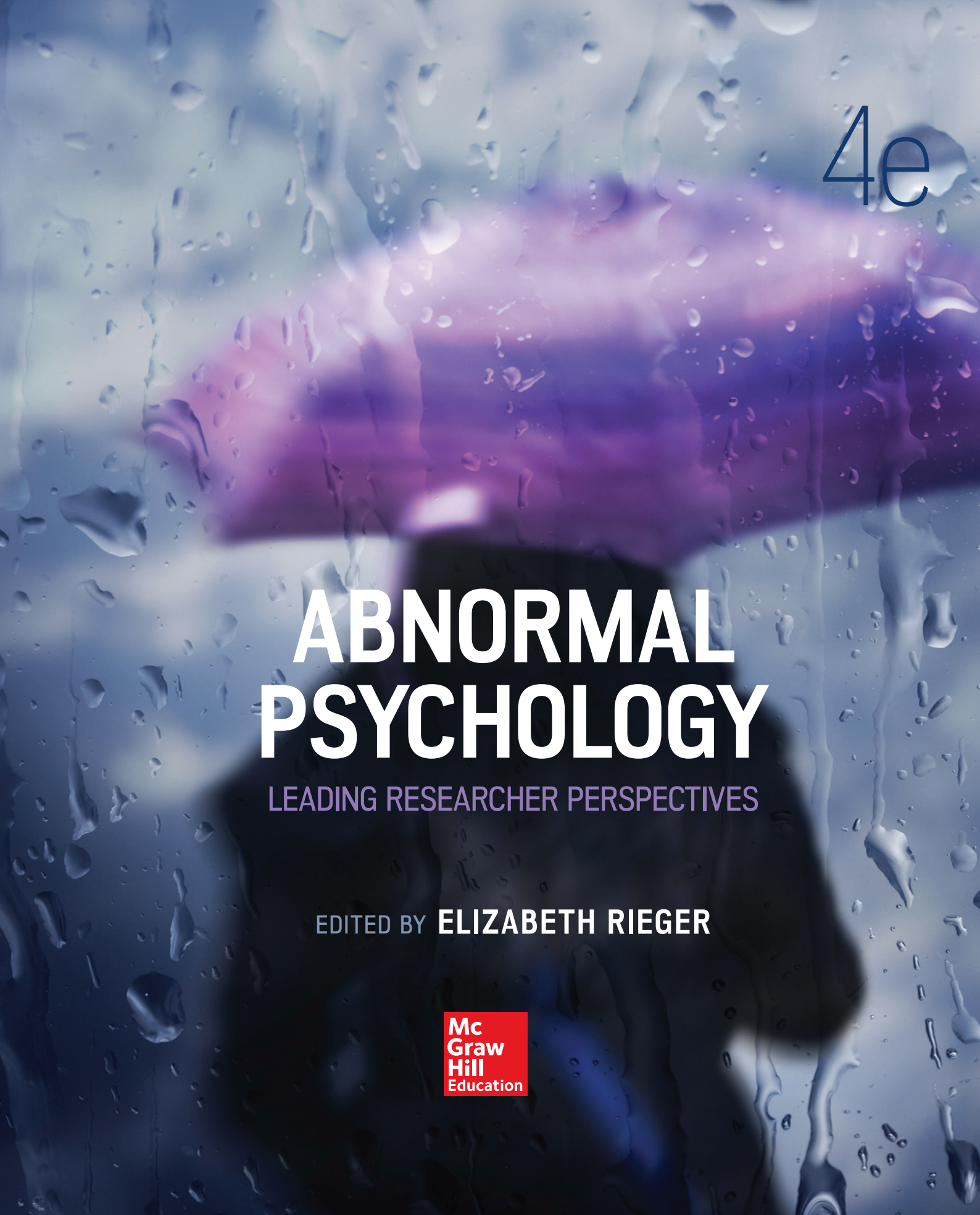
ABNORMAL PSYCHOLOGY
LEADING RESEARCHER PERSPECTIVES
EDITED BY ELIZABETH RIEGER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ABNORMAL PSYCHOLOGY
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EDITED BY ELIZABETH RIEGER
Mc Graw Hill Education

Dedication

In memory of Karl Rieger, my father—generous in his love and affirmation,
contagious in his exuberance for life,
unmatched in his courage.

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Contents in brief

Contents in full

Preface

The field of abnormal psychology is well served by several competent textbooks—so much so that in my first years of teaching in the area I was not immediately aware of the need for an innovative approach. Indeed, this impetus was initially provided through feedback from my students, who expressed their frustration with the lack of local content in the available texts, most of which were American, so that the content tended to distance them from, rather than more fully engage them with, the material. Having thus been encouraged to take a closer look at the range of available texts, I became aware of the additional need to have specialists presenting the current body of knowledge in their respective areas of expertise if students were to be provided with material that most accurately reflects contemporary theorising and research.

Both of these innovative aspects of the book—that is, the local content and reliance on specialist authors—require some elaboration. The local content is most obviously reflected in the selection of authors from Australia and New Zealand; the inclusion of research from this region when such studies constitute the best exemplars in the field; the presentation of topics of regional relevance; and the application of concepts using regional examples, most notably in the 'Australasian Focus' pieces that introduce each chapter. While these sections refer predominantly to Australian people and governmental policies, this material was selected so as to be highly recognisable and pertinent in the New Zealand context as well. Clearly, abnormal psychology is an international discipline, the knowledge base of which is informed by theoretical and empirical work worldwide. Yet, by presenting this information in a manner that is also sensitive to the reader's cultural context, this text aims to generate maximum relevance and hence interest and engagement on the part of the reader. Indeed, approximately 80 per cent of students in an undergraduate abnormal psychology course that I taught stated that they appreciated the inclusion of local content in the first edition of this book. We have sought to ensure that this local content remains highly current by, for example, including new Australasian Focus pieces at the beginning of each chapter in this fourth edition.

Aside from its Australian and New Zealand content, this book is noteworthy for the high calibre of its authors. The chapters have been written by eminent researchers and practitioners who continue to make a significant contribution to understanding the disorders in which they have expertise. As such, they are ideally placed to impart to the reader highly contemporary perspectives on the various disorders. While it is common practice for undergraduate students to be availed only of textbooks written by generalists, the use of specialist authors is intended to present readers with the most current scholarship from the time of their earliest engagement with the subject matter of abnormal psychology. Given our commitment to currency, we have introduced this fourth edition of the book only three years after the previous edition so that readers can be acquainted with the most recent research across the various domains of abnormal psychology, while also anticipating future challenges and innovations. Thus, while the book received its initial inspiration from students, its state-of-the-art approach aims, in turn, to inspire the next generation of leading researchers and clinicians by informing them of the limits of what is currently known and what remains to be understood in the field of abnormal psychology.

Elizabeth Rieger

About the editor

Photogragh by Scott Ogilvie

Elizabeth Rieger is an Associate Professor and clinical psychologist in the Research School of Psychology at the Australian National University where she conducts research, teaching and clinical work. In her research she specialises in eating disorders and obesity, having completed her PhD on anorexia nervosa at the University of Sydney and a postdoctoral fellowship at the Center for Eating and Weight Disorders of the University of California, San Diego and San Diego State University. She has published widely on both eating disorders and obesity, including the motivational, cognitive and interpersonal aspects of these conditions and their effective treatments.

As well as teaching undergraduate courses on abnormal psychology and health psychology, Elizabeth has taught postgraduate courses on eating and weight disorders, motivational interviewing, cognitive behaviour therapy and interpersonal psychotherapy. She has over 20 years of experience as a clinical psychologist, during which time she has worked in a diverse range of public and private settings.

Elizabeth is a member of the Eating Disorders Research Society, the Australia and New Zealand Academy for Eating Disorders, the College of Clinical Psychologists of the Australian Psychological Society and the Australian Clinical Psychology Association and is an editorial board member of the *Journal of Eating Disorders.*

Contributing authors

Maree Abbott is an Associate Professor in the School of Psychology at the University of Sydney and a practising clinical psychologist. She is the Director of Clinical Training for the postgraduate clinical psychology program and teaches in the areas of psychopathology and the assessment and treatment of adult psychological disorders, in addition to conducting clinical and research supervision. Prior to this appointment, Maree was based at Macquarie University as the Royce Abbey Postdoctoral Fellow. Her research focuses on further understanding the nature and treatment of child and adult anxiety disorders, particularly social phobia and generalised anxiety disorder. She has served on the Executive of the Australian Psychological Society College of Clinical Psychologists in New South Wales and currently chairs the Membership and Professional Standards Committee for the Australian Clinical Psychology Association.

Harjit Bagga is a Senior Clinical Psychologist at the Gender Clinic, Monash Health, in Melbourne. She has worked in public mental health (both state and federal government services) and private practice. Over the past 10 years, Harjit has developed a special interest in gender variance through her work at the Gender Clinic. Her research interests in this field include the role of sex hormones on brain function, prevalence, personality and psychometric assessment with adults. She has presented at several national and international gender conferences and contributed to research projects and publications examining the prevalence of gender dysphoria in Australia, quality of life in individuals attending the Gender Clinic and patient satisfaction with services. Harjit's work for this text was completed independently from her employment at Monash Health and does not necessarily reflect the views of Monash Health or its Gender Clinic.

Sarah Bendall is a Senior Research Fellow at Orygen: The National Centre of Excellence in Youth Mental Health and the Centre for Youth Mental Health, at the University of Melbourne. Her areas of research interest are trauma in first-episode psychosis and the development and trialling of new psychological therapies for recovery in early psychosis. She teaches psychological assessment of, and cognitive behaviour therapy for, psychosis within the postgraduate clinical psychology professional training program at the University of Melbourne. Sarah is the author of two psychological treatment manuals for early psychosis. She has practised as a clinical psychologist for over 20 years in a variety of settings including adult and adolescent outpatient mental health. She has supervised clinical psychologists for over 10 years and has provided training for treating trauma in those with first-episode psychosis nationally and internationally. She is the author of over 50 peer-reviewed journal articles and several book chapters.

Alex Blaszczynski is a Professor of Clinical Psychology and Director of the Gambling Treatment & Research Clinic at the School of Psychology, University of Sydney. He is a clinical psychologist with extensive experience in treating individuals with pathological gambling and other impulse control disorders. His research interests are directed towards the development of a conceptual pathway model of problem gambling, the role of the personality trait of impulsivity, treatment outcomes and their predictors, and the effectiveness of warning signs on electronic gaming machines as harm-minimisation strategies. Alex has investigated the association between pathological gambling and crime, and with co-authors has developed a model for casino self-exclusion. He is editor-in-chief of *International Gambling Studies,* has published more than 200 peer-reviewed journal articles, and has edited several books and book chapters on the topic of gambling.

Richard Bryant is a Scientia Professor of Psychology, Australian Research Council Laureate

Fellow, and Director of the Traumatic Stress Clinic at the University of New South Wales. His research has included conducting prospective studies of posttraumatic stress responses, developing the first assessment measures of acute stress disorder, implementing controlled treatment trials of acute stress disorder and investigating the biological and cognitive factors that influence psychological adaptation after trauma. Richard has published more than 380 peer-reviewed journal articles and co-authored the leading text on acute stress disorder. His assessment and treatment protocols are currently being employed by many civilian and military agencies around the world, including those coordinating mental health projects in the wake of terrorist and natural disaster events. Richard is a Fellow of the Australian Psychological Society and the Australian Academy of Social Sciences in Australia.

Phyllis Butow is a Professor, and National Health and Medical Research Council Senior Principal Research Fellow, in the School of Psychology, University of Sydney. She co-directs the Centre for Medical Psychology and Evidence-based Medicine (CeMPED) and chairs the Australian Psycho-Oncology Co-operative Research Group (PoCoG). Phyllis has worked for over 20 years in the area of psycho-oncology and has developed an international reputation in this field and the area of health communication. Phyllis has published more than 450 articles in peer-reviewed journals and her work has been translated into health communication modules for oncology professionals' guidelines and practice.

David Clarke is Professor of Psychological Medicine at Monash University. He works at the interface between psychiatry and physical medicine, as a consultation-liaison psychiatrist at Monash Medical Centre. He is Clinical Director of Consultation-Liaison and Primary Care Psychiatry at Monash Health in Melbourne and teaches psychiatry at undergraduate and postgraduate levels, with his main interests being depression and somatisation. David has been the recipient of a number of research grants from the National Health and Medical Research Council, with research focusing on the nature of distress and depression in the medically ill, demoralisation as a concept and a particular form of depression, the use of psychotherapy in the medically ill, and the nature of psychiatric presentations and pathways to care for people in the general medical and primary care settings. He has published more than 100 articles in scientific journals and regularly presents his work at conferences.

David H. Gleaves is Professor of Psychology (Clinical) at the University of South Australia in Adelaide. He has previously directed the clinical psychology programs at both the University of South Australia and the University of Canterbury, in New Zealand. He has worked in the areas of dissociative and eating disorders for approximately 30 years and has produced over 120 scholarly publications in these and related areas. He received both the Morton Prince Award for Scientific Achievement and the Pierre Janet Award for Writing Excellence from the International Society for the Study of Trauma & Dissociation. David is or has been a member of the editorial board of several journals including *Journal of Abnormal Psychology, Journal of Clinical Psychology, Journal of Child Sexual Abuse* and *Journal of Trauma & Dissociation.* He is also a registered clinical psychologist and a member of both the Australian Psychological Society's College of Clinical Psychologists and the American Psychological Association.

John Gleeson is a Professor of Psychology at the Australian Catholic University in Melbourne. Previously he held a joint appointment between the North Western Mental Health Program, a program of Melbourne Health, and the Psychology Department of the University of Melbourne. His research interests include cognitive behaviour therapy (CBT) for first-episode psychosis and psychological treatments for the complex behavioural problems associated with psychosis. He has taught psychological assessment and CBT within the postgraduate clinical psychology professional training program at the University of Melbourne. John edited the first treatment handbook of psychological interventions for early psychosis, which includes contributions from Europe, North America, Australia and Scandinavia. He has more than 10 years' experience in providing clinical supervision to clinical psychologists and has provided training workshops nationally and internationally on CBT for psychosis. Together with colleagues from Orygen: The National Centre of Excellence in Youth Mental Health and the University of Melbourne he has recently pioneered moderated online social therapy for first-episode psychosis.

Phillipa Hay is a Professor and Foundation Chair of Mental Health at the School of Medicine, Western Sydney University. She has been researching and working in the area of eating disorders for over two decades since completing her postgraduate training in psychiatry and has two higher research degrees in the area. She completed her DPhil under the supervision of Professor Christopher Fairburn at the University of Oxford. She has written more than 180 research articles and has been invited to present her research at meetings in the United States, Europe and South America. Phillipa is co-Editor-in-Chief of the *Journal of Eating Disorders,* a former President of the Australian and New Zealand Academy

for Eating Disorders and has served at a senior level on education and scientific committees of the Royal Australian and New Zealand College of Psychiatrists, Australian Medical Council and the international Academy for Eating Disorders. In 2015 she received the Lifetime Achievement Award from the Australia and New Zealand Academy for Eating Disorders.

Carol Hulbert is an Associate Professor in the School of Psychological Sciences at the University of Melbourne and also holds the position of Director of the Clinical Psychology Program. She is a clinical psychologist and clinical researcher with extensive experience in mental health services. She has worked as a clinician, manager and regional senior psychologist in public mental health. Carol's program development experience includes involvement in the setting up of the Early Psychosis Prevention and Intervention Centre and the establishment of the Spectrum Personality Disorder Service of Victoria. Her research interests include social cognition and social functioning in borderline personality disorder, the aetiology and psychological treatment of personality disorder, and the role of trauma in outcomes for early psychosis.

Martina Jovev is a psychologist at Orygen: The National Centre of Excellence in Youth Mental Health and a Research Fellow at Orygen Research Centre in Melbourne. Since completing her PhD, she has been an investigator on projects in borderline personality disorder in young people and has collaborated with leading researchers in the field of neuroimaging and youth mental health at the Melbourne Neuropsychiatry Centre and Orygen Research Centre to conduct pioneering work on the relationship between brain development and environment in risk for personality dysfunction in adolescence. Martina's previous research has examined the processing of psychosocial threat in young people with borderline personality disorder symptoms. She is also a co-investigator on several large clinical projects in the field of borderline personality disorder in young people, including a randomised controlled trial of cognitive analytic therapy, screening for the disorder in youth, and sexual and reproductive health among youth with the disorder. She has published multiple articles in the area of cognitive biases in borderline personality disorder and is a co-author on several papers published in prestigious international peer-reviewed journals, such as *Psychiatry Research: Neuroimaging* and *Journal of Clinical Psychiatry*. Martina has presented her work at numerous major national and international conferences, including the International Society for the Study of Personality Disorders Congress.

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Marita McCabe is Director, Institute for Health and Ageing at the Australian Catholic University in Melbourne. She has conducted research on a broad range of topics in the area of human sexuality for the past 30 years. In particular, she has studied the aetiology and treatment of sexual dysfunction. This research has involved the evaluation of cognitive behaviour therapy programs for male and female sexual dysfunction, which in recent years have been successfully converted to be delivered via the internet. Marita is on the editorial board of a number of journals and has supervised many doctoral students who have completed their theses in the area of human sexuality.

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Peter McEvoy is a teaching and research Professor of Clinical Psychology in the School of Psychology and Speech Pathology at Curtin University, and a Senior Clinical Psychologist at the Centre for Clinical Interventions, Perth. He previously worked at the Anxiety Disorders Clinic at St Vincent's Hospital in Sydney. Peter has extensive clinical experience providing evidence-supported group and individual treatments for emotional disorders. His research interests include treatment outcome evaluation, transdiagnostic approaches to conceptualising and treating emotional disorders, the use of imagery in psychotherapy, repetitive negative thinking, mechanisms of behavioural and cognitive change, and the epidemiology of mental disorders. Peter is an associate editor for the *Journal of Anxiety Disorders* and the *Journal of Experimental Psychopathology,* and teaches adult psychopathology and psychotherapy in the Master of Clinical Psychology program.

Catharine McNab is a Senior Clinical Psychologist in the Orygen Youth Health Clinical Program in Melbourne. Her clinical experience has focused on mental illness in adolescents and young adults, most recently in indicated prevention and early intervention for borderline personality disorder in young people. She consults with and provides training to medical and allied health staff about effective collaboration with young people with these difficulties, particularly in acute service settings. Her research interests include examining the experiences of families of people with early-onset mental illness and identifying what the consequences of appropriately supporting families might be, both for families and patients.

Ross G. Menzies is Associate Professor of Psychology in the discipline of Behavioural and Community Health Sciences at the University of Sydney. In 1991 he was appointed founding Director of the Anxiety Disorders Clinic, Faculty of Health Sciences, University of Sydney, a post he held for more than 20 years. He is the past NSW and National President of the Australian Association for Cognitive and Behaviour Therapy. He was the President and Convenor of the 2016 World Congress of Behavioural and Cognitive Therapies and is Editor of Australia's national cognitive behaviour therapy scientific journal, *Behaviour Change*. Ross holds numerous national competitive grants in the area of anxiety. He has produced more than 170 international journal papers, books and book chapters and is regularly invited to speak at conferences and leading universities and institutions around the world.

Philip B. Mitchell is Scientia Professor and Head of the School of Psychiatry at the University of New South Wales. His research and clinical interests are in bipolar disorder and depression, with particular focus on youth at high genetic risk of bipolar disorder, the molecular genetics of bipolar disorder, transcranial magnetic stimulation for depression, and the pharmacological and psychological treatment of bipolar disorder and depression. Philip has published (in conjunction with colleagues) more than 450 papers and chapters on these topics. In 2002 he was awarded the Senior Research Award of the Royal Australian and New Zealand College of Psychiatrists. In 2004 he received the Founders Medal of the Australasian Society for Psychiatry Research. In the 2010 Australia Day honours list he was appointed a Member of the Order of Australia. He is a Visiting Professor at Harbin Medical University in China and Guest Professor at Shanghai Jiao Tong University in China. He recently served as Chairman of the Australasian Society for Bipolar and Depressive Disorders.

Alina Morawska is the Deputy Director (Research) at the Parenting and Family Support Centre at the University of Queensland. Her research focuses on behavioural family intervention as a means of promoting positive family relationships, and the prevention and early intervention for young children at risk of developing behavioural and emotional problems. In particular, her focus is on improving the health and overall wellbeing of children and families. She completed her PhD in Clinical Psychology at the University of Queensland in 2004, for which she received the Australian Psychological Society's Excellent PhD Thesis in Psychology Award. She has published extensively in the field of parenting and family intervention and has received numerous grants to support her research. She is a Director of the Australian Association for Cognitive and Behaviour Therapy Ltd.

Greg Murray is a Professor of Psychology at Swinburne University in Melbourne. He has an international reputation for clinical psychology research, having published more than 120 peer-reviewed articles since taking out his PhD from the University of Melbourne in 2001. Expertscape ranks him in the top 1 per cent of researchers worldwide in the fields of bipolar disorders, circadian rhythms, personality and

affect. Greg authored the psychological aspects of the Royal Australian and New Zealand College of Psychiatrists mood disorder guidelines, and the Australian Psychological Society guidelines for treating bipolar disorder. He is Research Lead for an international network studying psychosocial issues in bipolar disorder, and a member of a National Institute of Mental Health working group on activation in mood disorders. Greg has won multiple individual awards for teaching, and provided professional development workshops for hundreds of psychologists and psychiatrists across Australia and overseas. He is a practising clinical psychologist, and was elected a Fellow of the Australian Psychological Society in 2013. Through 2016–2019, he is leading a trial funded by the National Health and Medical Research Council investigating a novel online intervention for bipolar disorder.

Richard O'Kearney is a Professor and Senior Research Fellow in the Research School of Psychology at the Australian National University. His research includes evaluation of interventions and prevention programs for depression in the community and schools, as well as work on the development of emotional regulation abilities in children and adolescents. He has published applied and basic research on obsessive-compulsive disorder and posttraumatic stress disorder. As a member of the Cochrane Collaboration, Richard has been actively involved in the dissemination of the evidence base for interventions in mental health and has authored and co-authored several systematic reviews. He also practises as a clinical psychologist in Canberra.

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Ken Pang is a Consultant Paediatrician at the Royal Children's Hospital in Melbourne and Clinician Scientist Fellow at the Murdoch Children's Research Institute. His clinical experience encompasses both paediatrics and child psychiatry, and his current work is focused on the care of transgender children and adolescents. His research background is in genetics and cell biology, and includes postdoctoral studies at Harvard University as a Fulbright Scholar and National Health and Medical Research Council RG Menzies Fellow. To date, he has published over 35 peer-reviewed papers (including in *Science, Genome Research* and *Molecular Psychiatry*) that have been cited more than 8000 times. More recently, motivated by a desire to improve the clinical outcomes of transgender children and adolescents, Ken's research has started to focus on questions related to transgender health.

Matthew Sanders is a Professor of Clinical Psychology and Director of the Parenting and Family Support Centre at the University of Queensland. He is also a consulting Professor at the University of Manchester, a visiting Professor at the University of South Carolina and holds adjunct Professorships at Glasgow Caledonian University and the University of Auckland. As the founder of the Triple P—Positive Parenting Program, he is considered a world leader in the development, implementation, evaluation and dissemination of population-based approaches to parenting and family interventions. Triple P is currently in use in many countries worldwide. Matthew's work has been widely recognised by his peers as reflected by a number of prestigious awards. In 2007, he received the Australian Psychological Society's President's Award for Distinguished Contribution to Psychology and in 2004 he received an International Collaborative Prevention Science award from the Society for Prevention Research in the United States. In 2007 he received a Trailblazers Award from the Parenting and Families Special Interest Group in the Association for Behavioural and Cognitive Therapy and in 2008 became a fellow of the New Zealand Psychological Society. He has also won a Distinguished Career Award from the Australian Association for Cognitive Behaviour Therapy, was named Honorary President of the Canadian Psychological Association (2009) and Queenslander of the Year (2007). In 2013, he was named one of the University of Queensland's top five innovators for his work with Triple P.

Marianna Szabó is a Senior Lecturer in the School of Psychology at the University of Sydney. She coordinates the undergraduate Abnormal Psychology course in the school and lectures on conceptual issues in classification and diagnosis, as

well as on the nature and causation of anxiety and depression in adults and youth. She also contributes to teaching abnormal psychology at different levels of training, from the first year Introductory Psychology course to postgraduate training. Marianna's research interests include examining basic diagnostic and conceptual issues in abnormal psychology, as well as further understanding the nature of child and adult anxiety and mood disorders, particularly generalised anxiety disorder and depression. She is a registered clinical psychologist in private practice and member of the Australian Psychological Society's College of Clinical Psychologists.

Robert Tait is a senior research fellow at the National Drug Research Institute, Faculty of Health Sciences, Curtin University. His research interests are in the areas of alcohol, tobacco and other drug use and in particular how these relate to mental health disorders. He has used administrative health data to assess the long-term relationships between substance use and mental health and to evaluate the effectiveness of interventions. Robert is also interested in the development of new interventions, in particular using internet-delivered programs. His work has included those in the general population, high-risk groups and clinical samples.

Stephen Touyz is Professor of Clinical Psychology and Clinical Professor in Psychiatry at the University of Sydney. He is also the executive Chair of the Centre for Eating and Dieting Disorders. He has written or edited six books and more than 270 research articles and book chapters on eating disorders and related topics. He is a Fellow of the Academy of Eating Disorders and the Australian Psychological Society and is a past President of the Eating Disorders Research Society. Stephen was the inaugural treasurer of the Australian and New Zealand Academy for Eating Disorders and a past executive member of the Eating Disorders Foundation. He is the Co-founding Editor of the *Journal of Eating Disorders* and a member of the editorial advisory boards of the *International Journal of Eating Disorders, European Eating Disorders Review* and *Advances in Eating Disorders: Theory, Research and Practice.* In 2012 he was presented with a Leadership in Research award by the prestigious Academy of Eating Disorders (International).

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Case matrix

CHAPTER	OPENING CASE STUDY	CHAPTER CASE STUDIES
1	Abnormal psychology: an Australasian focus	
2	Anxiety disorders: an Australasian focus	• Specific phobia • Panic disorder and agoraphobia • Social anxiety disorder • Generalised anxiety disorder
3	Obsessive-compulsive and related disorders: an Australasian focus	• Obsession with harming others • Contamination obsessions and compulsions
4	Trauma- and stressor-related disorders: an Australasian focus	• Posttraumatic stress disorder
5	Depressive disorders: an Australasian focus	• Anxiety and depression • The symptoms and treatment of major depressive disorder
6	Bipolar disorder: an Australasian focus	• First manic episode
7	Psychotic disorders: an Australasian focus	• The role of stress and trauma in psychosis onset • From prodromal phase to early recovery
8	Somatic symptom and dissociative disorders: an Australasian focus	• Somatic symptom disorder • The recovered memory/false memory debate • Dissociative identity disorder
9	Eating disorders: an Australasian focus	• Avoidant/restrictive food intake disorder (ARFID) • Anorexia nervosa • Bulimia nervosa • Binge eating disorder
10	Addictive disorders: an Australasian focus	• Severe alcohol use disorder • Cannabis withdrawal • Acute intoxication: synthetic cannabinoids • Stimulant-induced psychotic disorder • A behaviourally conditioned problem gambler • Cognitive therapy for a problem gambler
11	Sexual and relationship problems: an Australasian focus	• A male with hypoactive sexual desire disorder • A male with premature ejaculation • A female with sexual interest disorder and a male with erectile disorder
12	Gender dysphoria: an Australasian focus	• Jarc • Aubrey • Kelsey • Surajek • Naya
13	Personality disorders: an Australasian focus	• Personality disorder • Paranoid personality disorder • Antisocial personality disorder • Obsessive-compulsive personality disorder • Cognitive analytic therapy
14	Disorders of childhood: an Australasian focus	• Parent management training for oppositional defiant disorder • Cognitive-behavioural treatment for anxiety
15	Ageing and psychological disorders: an Australasian focus	• Anxiety • Driving
16	Health psychology: an Australasian focus	• A woman with cancer

What's new in this edition?

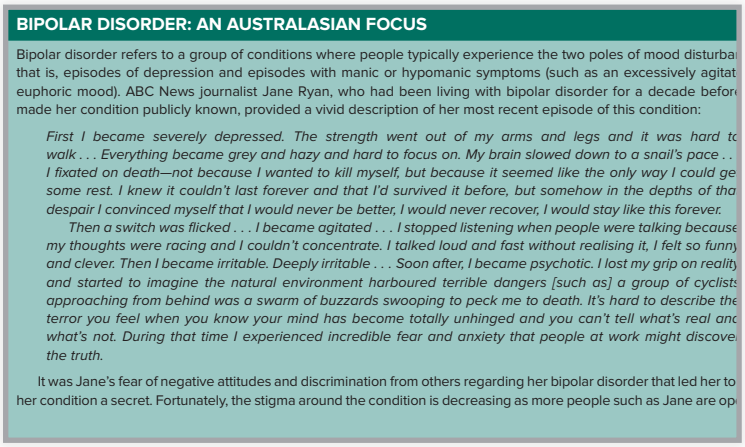
CHAPTER	MAJOR UPDATES
1 Conceptual issues in abnormal psychology	• New Australasian Focus piece • Updated research on topics such as the contributions and limitations of the biological perspective
2 Anxiety disorders	• New Australasian Focus piece • New case study on panic disorder and agoraphobia • Updated research on topics such as habituation and inhibitory learning, and CBT and generalised anxiety disorder
3 Obsessive-compulsive and related disorders	• New Australasian Focus piece • New case study on obsession with harming others • Updated research on topics such as OCD-related disorders, including hoarding disorder, body dysmorphic disorder, trichotillomania and excoriation disorder
4 Trauma- and stressor-related disorders	• New Australasian Focus piece • Updated case study on PTSD • Updated research on topics such as the prevalence and epidemiology of PTSD, and on prevention
5 Depressive disorders	• New Australasian Focus piece • New case study on anxiety and depression • Updated research on topics such as interpersonal psychotherapy and relapse prevention
6 Bipolar disorder	• New Australasian Focus piece • Updated research on topics such as the connection between bipolar disorder and creativity, and evidence-based psychological therapies and bipolar disorder
7 Psychotic disorders	• New Australasian Focus piece • New case study on the role of stress and trauma in psychosis onset • Updated research on topics such as vulnerability factors and delusions
8 Somatic symptom and dissociative disorders	• New Australasian Focus piece • Updated research on topics such as the diagnosis of somatic symptom and related disorders, and conversion disorder
9 Eating disorders	• New Australasian Focus piece • New case studies on avoidant/restrictive food intake disorder (ARFID), anorexia nervosa, bulimia nervosa and binge eating disorder • Updated research on topics such as the treatment of anorexia nervosa and binge eating disorder

CHAPTER	MAJOR UPDATES
10 Addictive disorders	• New Australasian Focus piece • New case studies on severe alcohol use disorder and acute intoxication: synthetic cannabinoids • Updated research on topics such as the diagnosis and prevalence of substance use disorders, and gambling disorder
11 Sexual and relationship problems	• Updated Australasian Focus piece • New case studies on hypoactive sexual desire disorder, and premature ejaculation • Updated research on topics such as the treatment of paraphilic disorders
12 Gender dsyphoria	• New chapter on gender dysphoria • Five case studies • Content covering the diagnosis, epidemiology, aetiology and treatment of gender dysphoria
13 Personality disorders	• New Australasian Focus piece • New case studies on personality disorder, and paranoid personality disorder • Updated research on topics such as the diagnosis of personality disorders, personality disorders across cultures, and cognitive analytic therapy
14 Disorders of childhood	• New Australasian Focus piece • New case study on cognitive behavioural treatment for anxiety • Updated research on topics such as the prevalence of mental disorders in childhood, and the diagnosis and epidemiology of oppositional defiant disorder
15 Ageing and psychological disorders	• New Australasian Focus piece • New case studies on anxiety and driving • Updated research on topics such as physical activity, disability and ageing, and executive functioning and ageing
16 Health psychology	• New Australasian Focus piece • Updated research on topics such as the health belief model and behaviour change interventions, and stress-response syndromes

Text at a glance - 4e

DEVELOPED FOR LOCAL STUDENTS BY LOCAL AUTHORS

Abnormal Psychology 4e has been developed by expert authors to help students studying in Australia and New Zealand engage with and apply the concepts and theories of abnormal psychology. Research by Australian and New Zealand academics and researchers, local statistics, case studies and examples are used throughout the book.



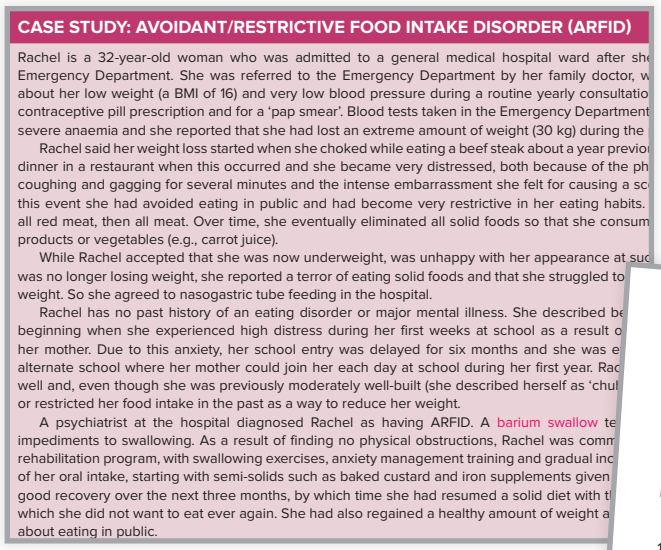
BIPOLAR DISORDER: AN AUSTRALASIAN FOCUS

Bipolar disorder refers to a group of conditions where people typically experience the two poles of mood disturba that is, episodes of depression and episodes with manic or hypomanic symptoms (such as an excessively agitat euphoric mood). ABC News journalist Jane Ryan, who had been living with bipolar disorder for a decade befor made her condition publicly known, provided a vivid description of her most recent episode of this condition:

First I became severely depressed. The strength went out of my arms and legs and it was hard to walk . . . Everything became grey and hazy and hard to focus on. My brain slowed down to a snail's pace . . I fixated on death—not because I wanted to kill myself, but because it seemed like the only way I could ge some rest. I knew it couldn't last forever and that I'd survived it before, but somehow in the depths of tha despair I convinced myself that I would never be better, I would never recover, I would stay like this forever.

Then a switch was flicked . . . I became agitated . . . I stopped listening when people were talking because my thoughts were racing and I couldn't concentrate. I talked loud and fast without realising it, I felt so funny and clever. Then I became irritable. Deeply irritable . . . Soon after, I became psychotic. I lost my grip on reality and started to imagine the natural environment harboured terrible dangers [such as] a group of cyclists approaching from behind was a swarm of buzzards swooping to peck me to death. It's hard to describe the terror you feel when you know your mind has become totally unhinged and you can't tell what's real and what's not. During that time I experienced incredible fear and anxiety that people at work might discover the truth.

It was Jane's fear of negative attitudes and discrimination from others regarding her bipolar disorder that led her to her condition a secret. Fortunately, the stigma around the condition is decreasing as more people such as Jane are op



CASE STUDY: AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID)

Rachel is a 32-year-old woman who was admitted to a general medical hospital ward after she Emergency Department. She was referred to the Emergency Department by her family doctor, w about her low weight (a BMI of 16) and very low blood pressure during a routine yearly consultatio contraceptive pill prescription and for a 'pap smear'. Blood tests taken in the Emergency Department severe anaemia and she reported that she had lost an extreme amount of weight (30 kg) during the

Rachel said her weight loss started when she choked while eating a beef steak about a year previo dinner in a restaurant when this occurred and she became very distressed, both because of the ph coughing and gagging for several minutes and the intense embarrassment she felt for causing a sc this event she had avoided eating in public and had become very restrictive in her eating habits. all red meat, then all meat. Over time, she eventually eliminated all solid foods so that she consum products or vegetables (e.g., carrot juice).

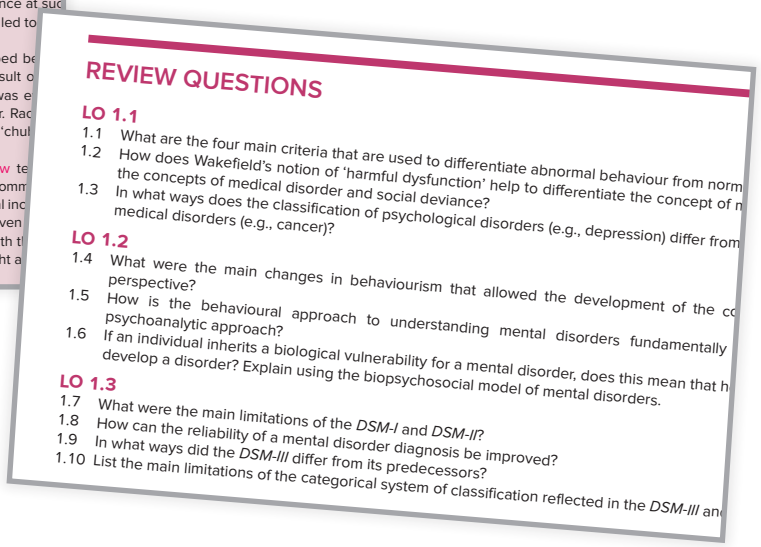
While Rachel accepted that she was now underweight, was unhappy with her appearance at suc was no longer losing weight, she reported a terror of eating solid foods and that she struggled to weight. So she agreed to nasogastric tube feeding in the hospital.

Rachel has no past history of an eating disorder or major mental illness. She described be beginning when she experienced high distress during her first weeks at school as a result o her mother. Due to this anxiety, her school entry was delayed for six months and she was e alternate school where her mother could join her each day at school during her first year. Rac well and, even though she was previously moderately well-built (she described herself as 'chul or restricted her food intake in the past as a way to reduce her weight.

A psychiatrist at the hospital diagnosed Rachel as having ARFID. A barium swallow te impediments to swallowing. As a result of finding no physical obstructions, Rachel was comm rehabilitation program, with swallowing exercises, anxiety management training and gradual inc of her oral intake, starting with semi-solids such as baked custard and iron supplements given good recovery over the next three months, by which time she had resumed a solid diet with t which she did not want to eat ever again. She had also regained a healthy amount of weight a about eating in public.

CRITICAL EXAMINATION

This text has been written to help students develop their critical thinking skills by providing tools within the text. Case study features provide an in-depth focus on topics from the chapter. When related to a specific disorder, the case studies cover the history, assessment and treatment of the subject involved. Review questions have been written to help students improve their critical thinking skills.



REVIEW QUESTIONS

LO 1.1

1.1 What are the four main criteria that are used to differentiate abnormal behaviour from norm

1.2 How does Wakefield's notion of 'harmful dysfunction' help to differentiate the concept of n the concepts of medical disorder and social deviance?

1.3 In what ways does the classification of psychological disorders (e.g., depression) differ from medical disorders (e.g., cancer)?

LO 1.2

1.4 What were the main changes in behaviourism that allowed the development of the co perspective?

1.5 How is the behavioural approach to understanding mental disorders fundamentally psychoanalytic approach?

1.6 If an individual inherits a biological vulnerability for a mental disorder, does this mean that h develop a disorder? Explain using the biopsychosocial model of mental disorders.

LO 1.3

1.7 What were the main limitations of the *DSM-I* and *DSM-II*?

1.8 How can the reliability of a mental disorder diagnosis be improved?

1.9 In what ways did the *DSM-III* differ from its predecessors?

1.10 List the main limitations of the categorical system of classification reflected in the *DSM-III* an

SUPPORTING STUDENT LEARNING

This book supports student reading and comprehension of material through a pedagogical framework that provides learning connections throughout the chapters. This framework uses each chapter's learning objectives (LO) to keep the core concepts in front of the student from the beginning to the end of the chapter and beyond. These learning objectives are tagged to sections in the chapter where students can find the information, as well as to the Review questions so students can check their understanding of key concepts. Key term definitions from the chapter are now provided as a margin definition on the page the term first appears and the end of chapter summary aids student revision and summarises core concepts before moving on to the next chapter.

CHAPTER OUTLINE

- Historical and current approaches to the diagnosis of bipolar disorder
- The epidemiology of bipolar disorder
- The aetiology of bipolar disorder
- The treatment of bipolar disorder
- Summary

LEARNING OBJECTIVES (LO)

6.1 Differentiate bipolar I disorder, bipolar II disorder and cyclothymic disorder.
6.2 Understand the epidemiological aspects of bipolar disorder.
6.3 Describe the possible causes of bipolar disorder.
6.4 Describe the medical and psychological interventions used to treat and prevent bipolar disorder.

BIPOLAR DISORDER: AN AUSTRALASIAN FOCUS

Bipolar disorder refers to a group of conditions where people typically experience the two poles of mood disturbance—that is, episodes of depression and episodes with manic or hypomanic symptoms (such as an excessively agitated or euphoric mood). ABC News journalist Jane Ryan, who had been living with bipolar disorder for a decade before she made her condition publicly known, provided a vivid description of her most recent episode of this condition:

First I became severely depressed. The strength went out of my arms and legs and it was hard to walk . . . Everything became grey and hazy and hard to focus on. My brain slowed down to a snail's pace . . . I fixated on death—not because I wanted to kill myself, but because it seemed like the only way I could get some rest. I knew it couldn't last forever and that I'd survived it before, but somehow in the depths of that despair I convinced myself that I would never be better, I would never recover, I would stay like this forever.

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can be traced back to classical Greek times. Throughout most of history, mania and depression were viewed as separate illnesses. However, a turning point for the contemporary view of bipolar disorder took place in the nineteenth century in France when Jean-Pierre Falret (1851) referred to the condition as '*la folie circulaire*' (the cycle of madness), thus describing a single entity involving the sequential change between mania and melancholia.

It was also during the late nineteenth century that Emil Kraepelin formally made the landmark distinction between 'manic depressive insanity' and other forms of severe mental illness, particularly 'dementia praecox' (an early term for schizophrenia). Kraepelin (1896) observed that patients with dementia praecox generally experienced ongoing symptoms of cognitive impairment and social withdrawal whereas manic-depressive patients tended to experience better functioning between episodes of mood disturbance. The next landmark occurrence in the classification of mood disorders was made by Karl Leonhard (1957), who argued that the term 'manic depressive insanity' was too inclusive. He coined the term bipolar disorder to refer to a condition where individuals experience both depressive and manic episodes, and distinguished this condition from one involving depressive episodes alone.

The treatments for bipolar disorder have changed dramatically, as illustrated by historical records of the lives of some great artists. For example, the composer Robert Schumann was struck down by manic-depressive psychosis and admitted to an asylum in the mid-1800s. He succumbed

bipolar disorder Mood disorder marked by manic/hypomanic episodes and depressive episodes (previously called manic-depression).

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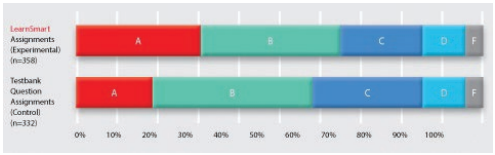

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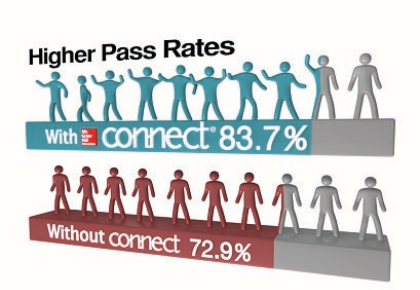

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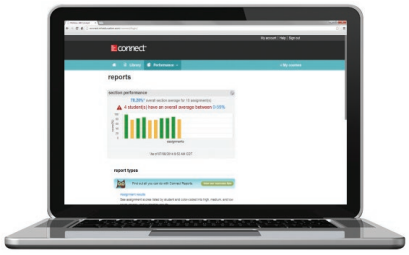

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CHAPTER 1

Conceptual issues in abnormal psychology

Marianna Szabó

CHAPTER OUTLINE

- **The definitions of abnormal behaviour and mental disorder**
- **Perspectives on the classification, causation and treatment of mental disorders**
- **The classification and diagnosis of mental disorders**
- **Summary**

LEARNING OBJECTIVES (LO)

1.1 Describe the difficulties inherent in defining abnormality and mental disorder.
1.2 Distinguish among the main theoretical approaches to understanding the classification, aetiology and treatment of mental disorders.
1.3 Evaluate the changes made in psychiatric classification over time.

ABNORMAL PSYCHOLOGY: AN AUSTRALASIAN FOCUS

In 1929, Henry Tasman Lovell, whose interest was in abnormal psychology, became the first Professor of Psychology in Australia at the University of Sydney. A more recent, yet also momentous, milestone for the field of abnormal psychology occurred in November 2006 when the Federal Government introduced the Better Access to Mental Health Care program, which, for the first time in Australia, allowed people to receive Medicare rebates for psychological treatment provided by trained mental health professionals. As a result of this program, access to psychological services is now available to people who would not otherwise be able to afford it. The introduction of the Better Access initiative signalled a significant recognition of the effectiveness of psychological treatments.

A 2017 report by the Australian Psychological Society entitled 'Ten Years of Better Access' provides a review of the first decade of the Better Access program (Littlefield, 2017). The report highlights the program's success in providing accessible, effective and affordable treatment for psychological problems to many Australians. For example, by 2013 psychological services provided through Better Access had been accessed by more than three million people. In addition, while only 35 per cent of Australians with mental disorders sought treatment prior to the introduction of Better Access, this rate had increased to 46 per cent by 2010. Researchers attributed this increase in the treatment rate to the availability of affordable psychological services through the Medicare system, and the de-stigmatisation of help-seeking for mental health encouraged by this system (Pirkis, Harris, Hall, & Ftanou, 2011). A client satisfaction survey of more than 2000 clients indicated that psychological treatment provided through Better Access resulted in significant or very significant improvement for 91 per cent of clients, thus supporting the program's effectiveness.

Nevertheless, the 'Ten Years of Better Access' report also highlights important limitations and challenges associated with the program. For instance, it was announced in the 2011–2012 Federal Budget that the number of Medicare-supported psychological consultations would be reduced from a possible maximum of 18 to 10 sessions per calendar year.

continued

Unfortunately, this number of sessions is inadequate to treat many psychological disorders. A study investigating mental health outcomes found that among individuals receiving psychological treatment, 65 per cent continued to have severe symptoms after 10 treatment sessions, but that only 22 per cent continued to report severe symptoms after receiving up to 18 sessions (see Littlefield, 2013). As many individuals do not improve sufficiently after receiving the 10 treatment sessions available under Better Access, psychologists and clients alike experience difficulty in achieving adequate client care. Among the less than optimal options available to psychologists and their clients when the maximum 10 sessions per year has been reached are: postponing further treatment until the following year, when the client can once again access Medicare-supported sessions; extending the interval between sessions so that treatment can be available for a longer period of time, even though more frequent sessions might be beneficial; or receiving treatment from a public mental health service, which often entails long waiting periods.

As well as summarising some of the key achievements and difficulties of Better Access to date, the 'Ten Years of Better Access' report also highlights future potential challenges for the program. Among these is the Federal Government's proposal to limit access to Better Access to those with moderately severe mental disorders, while directing those with milder and more severe disorders to other programs. However, these alternative programs raise concerns about those with milder disorders having services delivered by inadequately trained practitioners and about those with more severe and complex disorders receiving sufficient funds to meet their needs. The ability to address the mental health needs of all groups in society therefore remains a significant challenge.

COURTESY THE UNIVERSITY OF SYDNEY ARCHIVES

Henry Tasman (Tassie) Lovell (pictured with his son) was the first Professor of Psychology in Australia, taking up his position in the Department of Psychology at the University of Sydney in 1929.

This chapter traces the development of abnormal psychology and the mental health professions from their beginnings to the present and looks at possible future directions. Abnormal psychology is commonly defined as the field of psychology that aims to understand and modify abnormal behaviours. Most of the field of abnormal psychology today, however, is concerned only with a special subset of abnormal behaviours, a subset labelled 'mental disorders' or 'psychological disorders'. Indeed, most of the following chapters focus upon a specific category of mental/psychological disorder. The present chapter serves as an introduction to some of the fundamental concepts of abnormal psychology. First, definitions of abnormality and mental disorder will be discussed. The bulk of the chapter will focus on the main theoretical perspectives that have shaped current knowledge in abnormal psychology. In this section, the biological perspective (the oldest and currently dominant approach to understanding mental disorders) will be contrasted with various psychological perspectives to underline the differences in their approaches to the conceptualisation, classification, explanation and treatment of mental disorders. The chapter will end with a description of one of the major systems for diagnosing mental disorders, and a consideration of the directions for future developments in the field of psychiatric classification.

LO 1.1 The definitions of abnormal behaviour and mental disorder

Abnormality

Although the distinction between 'normal' and 'abnormal' behaviours seems intuitively clear to most people, a more careful consideration reveals that this distinction is often difficult to make. Although no clear rules have yet been identified to differentiate normality and abnormality, several elements

have been proposed. The most common ones are statistical rarity and the 'three Ds': deviance, distress and dysfunction.

STATISTICAL RARITY

Statistical rarity is one criterion that has been used to define abnormality. Individuals who possess a characteristic that is rarely found in society can be said to be abnormal, in the sense that they deviate from the average to a large extent. This element of abnormality, of course, can include positive deviations as well. So, according to this definition, people who are known for their musical or scientific genius, for example, can be considered abnormal. Clearly, the field of abnormal psychology cannot be defined on the basis of statistical rarity alone, otherwise individuals such as Wolfgang Amadeus Mozart or Albert Einstein would be prime candidates for treatment!

DAL

The definition of abnormality often includes an element of statistical rarity. However, individuals whose statistically rare characteristics or abilities (such as those of a concert pianist or an Olympic athlete) are positively evaluated by society would not be described as abnormal.

DEVIANCE OR NORM VIOLATION

Unlike the criterion of statistical rarity, the criterion of 'deviance' includes a value component. According to this criterion, a behaviour is considered to be abnormal if it is negatively evaluated by society. The 'abnormal' abilities of famous musicians, sportspeople or scientists are positively valued by society and thus would not be defined as abnormal according to this criterion. On the other hand, being unable to socialise because of extreme anxiety, avoiding all forms of public transport, hearing voices, physically assaulting one's spouse, or making a living by armed robbery are generally seen as violating social expectations.

While adding the element of norm violation to statistical rarity can give a more precise definition of abnormality, it still leaves a very broad class of behaviours for abnormal psychology to be concerned with. Norm-violating behaviours encompass a diverse range of behaviours. These may include instances of harmless eccentricity and serious criminal acts, as well as instances of mental disorder. Moreover, using norm violation as a sole requirement to define abnormality can be dangerous as it can be used to oppress any non-conformist behaviours. For example, homosexuality and a range of other sexual behaviours such as masturbation were seen as both statistically rare and unacceptable by society only a few decades ago. Therefore, people engaging in these behaviours were viewed as in need of either punishment or treatment (Szasz, 1961).

DISTRESS

A third important element in defining abnormality, which is sometimes used to differentiate the field of abnormal psychology from that of forensic psychology or criminology, is that the abnormal behaviour causes distress to the person. At first sight, this would appear to be a necessary element in defining psychological abnormality. In addition, this element allows the individual to self-define their behaviours as abnormal or not, rather than allowing society at large to make that decision. People who are happy and content with their lives tend to consider themselves normal, while those who are distressed by their own thoughts, feelings or behaviours tend to seek treatment.

Unfortunately, this element also has its limitations and dangers in attempting to define abnormality. On the one hand, some individuals cause themselves a great deal of personal suffering, for example, by starving themselves to near death for religious, political or other reasons. Should these individuals (e.g., great national leaders such as Mahatma Gandhi) be considered abnormal and requiring treatment? On the other hand, many people whose behaviours come to the attention of mental health professionals do not experience distress. For example, one of the defining features of a manic episode in bipolar

disorder (as discussed in Chapter 6) is abnormally elevated mood, self-esteem and creativity, all of which are experienced as very pleasant by the individual.

DYSFUNCTION

maladaptive Behaviour that interferes with a person's ability to meet the requirements of everyday life.

The fourth element in defining abnormality asks whether the behaviour is dysfunctional or maladaptive. In other words, does the behaviour interfere with the person's ability to meet the requirements of everyday life? For instance, is s/he able to have a job, a family, a social network and a necessary level of financial security? This element is widely accepted among mental health professionals as crucial in defining abnormality and is often incorporated in the diagnostic criteria for the various mental disorders. So, the person who experiences a manic episode with abnormally elevated mood, self-esteem and creativity may not be distressed but may be making decisions that interfere with his/her ability to function effectively in everyday life. During manic episodes, individuals often make risky financial investments or engage in sexual or aggressive behaviours that they would normally see as foolhardy and dangerous. In that sense, the behaviour is maladaptive or dysfunctional. On the other hand, according to the dysfunction criterion, a person with an extreme snake phobia who never leaves the city would not be considered abnormal because his/her fear of snakes does not interfere with the ability to meet the requirements of everyday life.

The maladaptiveness criterion is highly practical and liberal in that it can accommodate an individual's life circumstances (as in the case of the urban-dwelling person with a fear of snakes). However, it also has its limitations. Most importantly, it greatly overlaps with the concept of norm violation: how functional an individual is considered to be is often based on how well s/he meets social expectations. It is a social expectation that individuals should have a job, a family, financial security and a social network, and not to do so is seen as dysfunctional. As such, this criterion suffers from the same limitation as the criterion of norm violation: it may be the social expectations that are wrong rather than the individual's failure to adapt to these.

A commonly cited illustration of how a particular society's values influence the idea of what is dysfunctional is the mental disorder drapetomania (Szasz, 1971; Wakefield, 1992). Drapetomania was described by Dr Samuel Cartwright in 1851 as a mental disorder. It was used to describe African American slaves who repeatedly attempted to run away from slavery, even though running away resulted in severe punishment for those who were caught. So, this behaviour was thought to be causing distress to the individual (as it elicited punishment), as well as being 'dysfunctional' (as it was inconsistent with what was thought to be the normal function of African Americans in society, that is, to be a slave). Therefore, running away was seen as a type of insanity requiring treatment.

Clearly, neither rarity, norm violation, distress or dysfunction on its own is sufficient or necessary for the definition of abnormality. Therefore, a common approach is to consider all of these elements together: it is the accumulation of these elements that assists in defining behaviour as abnormal. Nevertheless, it is important to remember that each of the criteria suffers from being closely tied with societal norms and expectations that change over time and cultures. No clear, universally accepted definition of 'abnormality' has yet been established.

Mental disorder

The field of abnormal psychology concerns itself with a wide range of behaviours that are considered 'abnormal'. However, not all of them are currently defined as mental disorders. For example, much research effort has been focused on understanding the reasons behind domestic violence or the eating behaviours leading to obesity. Yet neither domestic violence nor obesity is currently classified as a mental disorder.

Unfortunately, similar to the concept of abnormality, a precise definition of the general concept of mental disorder continues to be elusive. Several theorists have offered their views on how to differentiate mental from physical disorders (Brülde & Radovic, 2006), while others have concentrated on attempting to clearly define the concepts of disease, illness and disorder (Wakefield, 1992).

One of the most contentious issues has been whether disease, illness and disorder are purely factual, medical terms, or whether they are purely value judgments based on social norms.

The label 'mental disorder' in its most common usage today implies that the abnormal behaviour is not only statistically rare, unacceptable to society, causes distress and/or is maladaptive, but that it also stems from an underlying dysfunction or illness. For example, the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) defines mental disorder as follows:

> *A mental disorder is a syndrome characterized by* clinically significant *disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.*
>
> American Psychiatric Association (APA), 2013, p. 20

clinically significant Meaning the disorder causes substantial impairment in social, occupational or other areas of functioning.

Each specific mental disorder identified in the *DSM* must meet this general definition.

Wakefield (1992; 1999) proposes that the concept of mental disorder, as stated in the *DSM,* involves both a factual component (there is an underlying dysfunction) and a value component (it is seen by society as harmful). The factual component specifies that there is an internal dysfunction present: that a psychological mechanism has failed to carry out its natural evolutionary function. For example, the evolutionary function of anxiety may be to warn the individual of objective danger. When anxiety occurs in the absence of objective danger, this psychological mechanism has failed to perform its natural function. Therefore, the individual's fear of harmless objects can be said to occur as a result of an internal dysfunction. It is important to note that the meaning of the term 'dysfunction' in Wakefield's approach is different from its usage in relation to the 'three Ds' above, where it refers to an individual's inability to carry out his/her social roles.

The 'internal dysfunction' specification helps demarcate instances of mental disorder from instances of social deviance, non-conformity or crime. For example, individuals who go on hunger strikes and starve themselves for political reasons do not do so as a result of an internal dysfunction but as a means of effecting social change. On the other hand, individuals with anorexia nervosa may be said to severely limit their food intake as a result of an internal psychological dysfunction: the internal mechanisms that contribute to maintaining a minimum healthy weight do not perform their natural function. Similarly, individuals who carry out violent, illegal or otherwise antisocial acts may do so as a result of an internal dysfunction (e.g., a lack of impulse control or an inability to feel empathy for others) and thus they may qualify for the diagnosis of a mental disorder (in this case, antisocial personality disorder). Some of these individuals, however, may engage in such acts as a result of belonging to a gang so as to protect themselves in a violent neighbourhood or simply because they find it easier and more acceptable to earn a living by illegal means. Such cases would not qualify for a diagnosis of mental disorder as no internal dysfunction is present.

However, according to Wakefield's approach, for a behaviour resulting from an internal dysfunction to qualify as a mental disorder it needs an additional value component: it needs to be causing harm to the individual. So, hallucinating that results from an internal dysfunction is not necessarily seen as a disorder in societies where hallucinating is evaluated positively, perhaps as a sign of psychic abilities. In these societies, hallucinating causes no harm or social disadvantage to the person.

According to Wakefield's analysis, therefore, mental disorders are best conceptualised as lying somewhere between the concept of physical disorder, which involves mainly a factual component (e.g., having a broken leg or a viral infection are facts that exist in nature, independent of any evaluations) and the concept of social deviance, which involves mainly a value component (e.g., being a nudist, taking recreational drugs, living in a commune or running away from slavery can be considered

instances of social deviance, as they are evaluated as right or wrong in relation to changing social norms). The concept of mental disorder involves a bit of both.

Wakefield's conceptualisation of mental disorder has received several criticisms, most of which concentrate on the difficulty in ascertaining the normal evolutionary function of psychological processes and the consequent difficulty in identifying when such processes are not carrying out their functions (Lilienfeld & Marino, 1995; McNally, 2001). For example, while the function of anxiety is likely to be to warn the organism of impending danger, the possible evolutionary function of sadness is the subject of ongoing debate. It is difficult, therefore, to offer a conceptualisation of major depression in terms similar to that of anxiety disorders. Further, some cognitive abilities, such as reading, have been acquired too recently in human history to be regarded as natural functions designed by evolution. According to an evolutionary analysis, therefore, reading disabilities such as dyslexia could not be classified as a disorder. Although Wakefield's analysis and the subsequent responses to it have made important contributions, the ongoing debate regarding the most appropriate definition of mental disorder continues to pose a fundamental conceptual challenge to the field of abnormal psychology (Rounsaville et al., 2002).

LO 1.2 Perspectives on the classification, causation and treatment of mental disorders

To appreciate how the understanding of mental disorders has developed to its current stage and in what directions it may be developing in the future, an introduction to the main theoretical perspectives for mental disorders is needed. These perspectives propose different conceptualisations of what a mental disorder is, how many and what kinds of different mental disorders there are, what their primary causes may be, and what the best treatments are.

The discussion will begin with the currently dominant (and oldest) biological/medical perspective, followed by the main psychological perspectives, the sociocultural perspective and the integration of these various perspectives in the biopsychosocial model. Such integration emphasises that the various perspectives on mental disorders are not mutually exclusive. There is not *one* right way of explaining mental disorders. Rather, the various perspectives emphasise different levels of explanation and are best seen as complementing, rather than competing with, each other.

The biological perspective

HISTORICAL BACKGROUND OF THE BIOLOGICAL PERSPECTIVE

Before the emergence of psychoanalytic thinking and behaviourism in the early twentieth century, the concept of mental illness was virtually identical with the concepts of madness or insanity. These terms were applied to individuals with extremely severe disturbances involving hallucinations and delusions, or severe disorganisation of speech, affect (emotion), thinking or behaviour. Most of these symptoms would today be summarised under the term 'psychosis' (as discussed in Chapter 7), while others might resemble dementia (as discussed in Chapter 15).

affect Experience of feeling or emotion.

Patients who displayed such severe disturbances were treated in mental asylums by 'mad doctors' or 'alienists', the forerunners of today's psychiatrists. Until the early nineteenth century, a large proportion of those treating the mentally ill were not even medically trained, let alone specialists in the study of mental illness—some were general physicians or surgeons, but others were simply charlatans. Madness was seen as a state that anyone could recognise, and often it was left to local magistrates to certify a person's sanity or lack thereof (Routh, 1998).

dementia Neurological disorder in which a gradual decline of intellectual functioning occurs.

Psychiatry became recognised as a legitimate speciality within medicine only about 150 years ago (Barton, 1987). The forerunner of the American Psychiatric Association—the Association of Medical Superintendents of American Institutions for the Insane—was established in 1844. The *American*

Journal of Insanity, later called the *American Journal of Psychiatry,* was also first published in 1844, and remains one of the leading journals in psychiatry to this day. By the end of the nineteenth century, most of those treating mentally ill people were medically trained physicians who believed that symptoms of madness arose from underlying biological diseases affecting the brain or the nervous system.

CLASSIFICATION AND CAUSATION FROM THE BIOLOGICAL PERSPECTIVE

> *There is only one kind of mental disease, we call it insanity.*
>
> Heinrich Neumann, 1859, cited in Hecker, 1871/2004, p. 351

Prior to the twentieth century, the symptoms of the various mental disorders (as currently defined) were not usually seen as indicators of separate disorders. Instead, many doctors in the nineteenth century agreed with Heinrich Neumann, believing insanity to be a single disease that progressed from one major symptom to another over time, with the symptoms becoming increasingly severe. Thus, the first symptom of insanity was thought to be depression, followed by agitation, then confusion, paranoia and finally dementia (Misbach & Stam, 2006).

Others, however, believed that there were in fact several different mental diseases. The basis for this belief was the observation that some individuals displayed groups of symptoms (called syndromes) that others did not, or that people with certain types of symptoms got better while others with different symptoms got worse, or that some symptoms began early in life and others began later, or that some symptoms were more often seen in men while others were more often seen in women. The ultimate aim of such observations was to identify symptoms that clustered together to form syndromes because they had a common cause. Once the causal agents underlying these symptom clusters were identified, it was hoped that it would become possible to discover an effective treatment that targeted those underlying causes. In other words, the ultimate aim of psychiatric classification was, and still is, to describe symptom clusters that have common causes and respond to common treatments. Such symptom clusters are then labelled as 'disorders' or 'diseases'.

syndrome
Set of symptoms that tend to occur together.

An example of a similar process in the history of physical illnesses pertains to the treatment of 'the fevers'. Such treatment had limited success. This was partly because people did not understand that a high fever was not a disease in its own right, but that it could be a symptom of a diverse range of disorders, caused by a diverse range of underlying pathologies that were unknown at the time. However, once doctors noticed that some fevers were accompanied by red spots on the body, while others were accompanied by abdominal pain, they were in a position to describe two different syndromes or categories of illness (e.g., measles and appendicitis, respectively). They could then begin to look for the specific causes and treatments of these different illnesses.

Unfortunately, the causes of most diseases were unknown for much of human history so that classification of illnesses into separate categories was often based on *hypothesised* causes. The earliest known attempt at such classification was offered by the ancient Greek physician Hippocrates (c. 460–377 BCE), who is often referred to as the father of modern medicine given his emphasis on natural (rather than supernatural) causation. He hypothesised that mental and physical health required the balance of four 'humours' or fluids in the body: blood, yellow bile (choler), black bile (melancholer) and phlegm. Too much of any of these was believed to result in certain personality types, such as a melancholic or depressed personality arising from excessive black bile. An extreme imbalance of the humours was thought to result in mental illness.

Another mental illness identified at the time was 'hysteria', which was thought to be caused by a detached womb wandering in the body (and which, therefore, by definition, could afflict only women). About 2000 years later, in the sixteenth century, the famous Swiss physician Paracelsus proposed that there were three classes of mental illnesses: vesania, thought to be caused by poisons; lunacy, believed to be influenced by phases of the moon; and insanity, a disease believed to be caused by heredity (Charney et al., 2002). Unfortunately, because the assumed causation underlying these proposed disorders was manifestly wrong, the treatments targeting the presumed causes also had limited success.

However, by the end of the nineteenth century the medical profession was optimistic that it was only a matter of time before the biological causes of mental illnesses would be precisely known. A number of important scientific discoveries gave impetus to this optimism. Foremost among these were Louis Pasteur's germ theory of diseases, which stated that tiny creatures, invisible to the naked eye, could invade the body and cause illness. This seemingly strange idea received empirical support in the late nineteenth century and was followed by the discovery of various bacterial microorganisms.

Concerning mental illness specifically, one of the most important early discoveries within the biological perspective was the identification of the cause of a mysterious mental illness: 'general paralysis of the insane', also known as general paresis (Routh, 1998). In many respects, general paresis was similar to other types of 'insanity': it included bizarre behaviours, persecutory delusions and hallucinations. However, it had a steadily deteriorating course, while most other types of insanity tended to remain stable. Patients with general paresis almost invariably got worse, eventually becoming paralysed and dying within about five years of disease onset.

This suggested that general paresis might be a specific disease category with its own causation and treatment, different from other types of insanity. Additional descriptive information was then used to hypothesise about and test various ideas about causation. As the condition was observed more often in men, especially in sailors, it was initially thought that smoking, drinking alcohol or being in contact with sea water might cause the illness. Experimental studies were conducted to discover the biological disease process underlying the syndrome.

To test one hypothesis, in 1897 Richard von Krafft-Ebing, a German neurologist, injected discharge from syphilitic sores into patients suffering from general paresis. None of the patients developed symptoms of syphilis, suggesting that they were already infected. This finding gave support to the notion that general paresis might be caused by syphilis. Indeed, the bacterium *Treponema pallidum* was discovered as the causal agent of syphilis in 1905 and it was found in the brains of patients with general paresis in 1913, confirming the hypothesis. On the basis of this underlying biological causation, the syndrome general paresis was identified as a part of the last stage of syphilis, rather than being a separate category of mental illness with its own specific cause. Of course, after the invention of antibiotics, it also became possible to treat it.

electroconvulsive therapy (ECT) Treatment for mood disorders that involves the induction of a brain seizure by passing an electrical current through the patient's brain while s/he is anaesthetised.

Other important discoveries at the time included the identification of associations between certain syndromes and localised damage to the brain. The French physician Pierre P. Broca (1824–1880) identified the area of the brain damaged in patients with expressive aphasia (an inability to produce meaningful speech) and Carl Wernicke (1848–1905) later found damage in a different part of the brain associated with receptive aphasia (an inability to understand speech).

Following such discoveries, the idea that all mental disorders were caused by biological factors became increasingly accepted. Many doctors believed that all mental disturbances would eventually be identified as having a biological origin, for instance, in the form of some bacterial or viral infection, contact with toxic agents or structural brain abnormality.

psychosurgery Biological treatment (such as lobotomy) for a psychological disorder in which a neurosurgeon attempts to destroy small areas of the brain thought to be involved in producing the patient's symptoms.

An enduring contribution to the classification of mental disorders at this time was made by the German psychiatrist Emil Kraepelin (1856–1926), one of the most influential thinkers to challenge the single-disease concept of insanity in the nineteenth century. In the first edition of his great work of psychiatric classification, the *Compendium of Psychiatry* in 1883, he initially distinguished two main mental illnesses: manic-depressive psychosis and dementia praecox. These historical definitions are close to today's concepts of bipolar disorder and schizophrenia, respectively. After a further 30 years of work, in the final edition of his *Compendium* published in 1915, Kraepelin distinguished 13 categories of mental illness.

A crucial feature of Kraepelin's classification system was that mental illnesses were either categorised according to their *known* causes (e.g., intoxication psychosis or infectious psychosis) or remained at the level of description (e.g., manic-depressive insanity or dementia praecox). Kraepelin expected that biological causes would eventually be identified for each mental illness. Where such