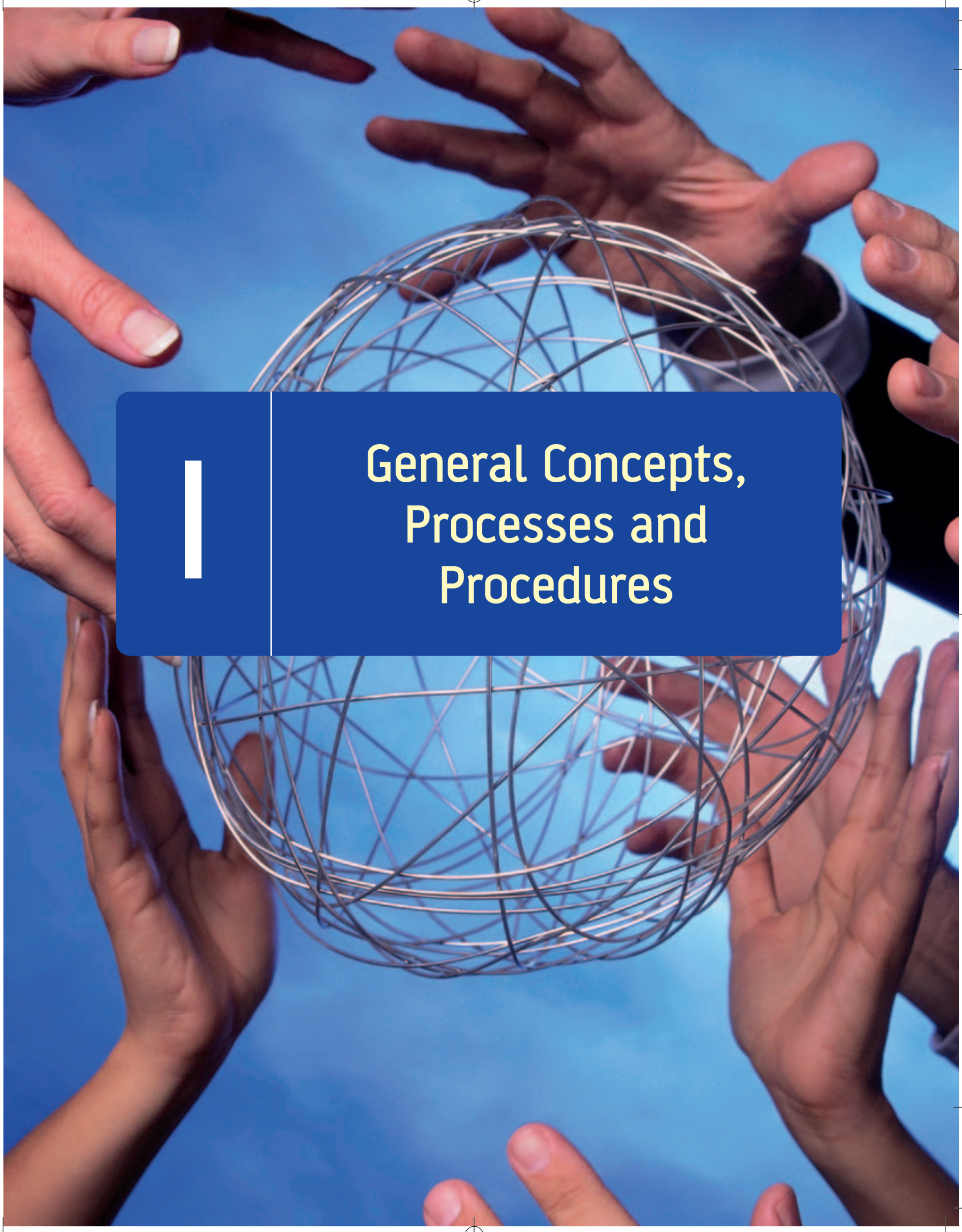


1 General Concepts, Processes and Procedures

1 Psychopathology: Concepts and Classification

ROUTE MAP OF THE CHAPTER

This first chapter introduces a number of basic issues concerned with the definition, explanation and classification of psychopathology. The first section describes how behaviour that was often labelled as 'mad' has been explained over the ages, and how our modern-day conceptions of 'madness' and psychopathology have developed. We then look at modern methods of explaining psychopathology and discuss a number of psychological approaches to explanation. The chapter then proceeds to a discussion of how psychopathology should be defined, and how we identify behaviour that is in need of support and treatment. Finally, we look at how psychopathology is classified, and review in detail the structure and pros and cons of the DSM method of classification.

Introduction

Am I crazy? I don't know what is wrong with me. I did have depression in the past and what I am going through doesn't feel a lot like what I had before. My moods change every 30 minutes at times. I have been like this for a while. I started out about once a week I would have a day where I was going from one extreme to the next. In the past few weeks it has gotten worse. It seems like my moods change for no reason at all. There are times that I will just lay down and cry for what appears to be no reason at all and then 2 hours later I will be happy. I find myself yelling at my son for stupid reasons and then shortly after I am fine again. I truly feel that I am going crazy and the more I think about it the worse I get. I am not sleeping or eating much and when I do eat I feel like I will be sick.

JOAN'S STORY

For the last ten months serving in Iraq I've told myself not to think about all that's going on around me. I've forced myself to go about my daily activities in some sort of normal manner. I knew that if I thought too much about the fact that mortars could hit me at any time. Or if I laid in bed every night knowing that a mortar could drop through the ceiling while I slept. Or if I focused too much on the randomness of death here, I'd go crazy.

And for the last ten months, I've managed to put these things out of my head for the most part. I've managed to try to live a normal life here while people die around me. But for some reason, since I got back from leave, I can't seem to shake the jitters, the nervousness, the just plain uneasiness I feel walking around or driving through the city streets.

Everywhere I walk I'm constantly thinking about where I'm going to go if a mortar lands. I'm always looking for the next bunker. When I leave the relative safety of the base, I'm constantly running scenarios through my head of the worst case situations.

There comes a point where living in fear is not living at all.

GREG'S STORY

When I was a child I regularly experienced dreams in which there was an awful buzzing noise, at the same time I could see what I can only describe as the needle from a machine such as a lie detector test drawing lines. I had a dream where an older alien cloaked in orange took me on a ship and told me things that I can't remember yet. He took me over an island (I think it was Australia), everything was dead and there was a mushroom cloud over it. Then there were 5 or 6 aliens, one was holding a clear ball. I knew that inside there was an embryo, they put it inside me. About one and a half weeks later I was confirmed pregnant. Then, when we were driving on the motorway, I seem to have lost 2 hours before seeing a brilliant flash above the car. I got pains in my left temple, behind my left eye and in my left cheekbone. There is a scar on my right leg which I can't explain. Some people think I'm crazy, but I know it happened.

BETTY'S STORY

I started using cocaine at thirteen. Before, I was using marijuana and alcohol and it didn't really work for me, so I wanted to step it up a level. I started using heroin when I was fifteen. I began using it to come down from cocaine and get some sleep. But I started liking the heroin high and started using it straight. Everyday, after awhile. Along with cocaine, I also began taking prescription drugs when I was thirteen. They were so easy to get. I never had to buy them or get them from a doctor. I would just get them from friends who had gone through their parent's medicine cabinet. I also thought that prescription drugs were 'safer' than other drugs. I figured that it was okay for people to take them, and if they were legal, I was fine. Like I said, prescription drugs were incredibly easy to get from friends, and it always seemed to be a last-minute thing. Heroin was also easy to get – all I had to do was go into town and buy it. My heroin use started spiralling out of control. I stopped going to school. I was leaving home for days at a time. My whole life revolved around getting and using drugs – I felt like I was going crazy.

ERICA'S STORY

Introduction

We begin this book with personal accounts from four very different individuals. Possibly the only common link between these four accounts is that they each use the word 'crazy' in relating their story. *Joan* questions whether she is going crazy, *Greg* tells us how he tries to prevent himself from going crazy, other people think *Betty* is crazy, and *Erica*'s life gets so out of control that she too felt like she was 'going crazy'. We tend to use words like 'crazy', 'madness' and 'insanity' regularly – as if we knew what we meant by those terms. However, we do tend to use these terms in a number of different circumstances – for example, (1) when someone's behaviour deviates from expected norms, (2) when we are unclear about the reasons for someone's actions, (3) when a behaviour seems to be irrational, or (4) when a behaviour or action appears to be maladaptive or harmful to the individual or others. You can try to see whether these different uses of the term 'crazy' or 'mad' apply to each of our personal accounts, but they probably still won't capture the full meaning of why each individual used the word 'crazy' in their vignettes. Trying to define our use of everyday words like 'crazy', 'madness' and 'insanity' leads us on to thinking about those areas of thinking and behaving that seem to deviate from normal or everyday modes of functioning. For psychologists, the study of these deviations from normal or everyday functioning is known as ***psychopathology***, and the branch of psychology responsible for understanding and treating psychopathology is known as ***clinical psychology***.

Psychopathology The study of deviations from normal or everyday functioning.

Clinical psychology The branch of psychology responsible for understanding and treating psychopathology.

Let's examine our four personal accounts a little more closely. *Joan* is distressed because she appears to have no control over her moods. She feels depressed; she shouts at her son, she feels sick when she eats. *Greg* feels anxious about the dangers of his daily life serving in Iraq. He feels nervous and jittery. *Betty* doesn't think she's crazy – but other people do. They think that her story about being abducted by aliens is a sign of psychosis or disordered thinking – she thinks it seems perfectly logical. Finally, *Erica*'s behaviour has become controlled by her need for drugs. She feels out of control and all other activities in her life – such as her education – are suffering severely because of this.

These four cases are all ones that are likely to be encountered by clinical psychologists. Although very different in their detail, they do all possess some commonalities that might help us to define what represents psychopathology. For example, (1) both *Joan* and *Greg* experience debilitating distress, (2) both *Joan* and *Erica* feel that important aspects of their life (such as their moods or cravings) are out of their control and they cannot cope, (3) both *Joan* and *Erica* find that their conditions have resulted in them failing to function properly in certain spheres of their life (e.g. as a mother or as a student), and (4) *Betty*'s life appears to be controlled by thoughts and memories which are probably not real. As we shall see later, these are all important aspects of psychopathology, and define to some extent what will be the subject matter of clinical practice.

However, deciding what are proper and appropriate examples of psychopathology is not easy. Just because someone's behaviour deviates from accepted norms or patterns does not mean he or she is suffering from a mental or psychiatric illness, and just because we might use the term 'crazy' to describe someone's behaviour does not mean that it is the product of disordered thinking. Similarly, we cannot attempt to define psychopathology on the basis that some 'normal' functioning (psychological, neurological or biological) has gone wrong. This is because (1) we are still some way from understanding the various processes that contribute to psychopathology, and (2) many forms of behaviour that require treatment by clinical psychologists are merely extreme forms of what we would call 'normal' or 'adaptive' behaviour. For example, we all worry and we all get depressed at some times, but these activities do not significantly interfere with our everyday living. However, for some other people, their experience of these activities may be so extreme as to cause them significant distress and to prevent them from undertaking normal daily living. Before we continue to discuss individual psychopathologies in detail, it is important to discuss how we define and classify psychopathology and mental health problems generally.

1.1 EXPLAINING PSYCHOPATHOLOGY

Throughout history, we have been willing to label behaviour as 'mad, 'crazy' or 'insane' if it appears unpredictable, irrational, harmful, or if it simply deviates from accepted contemporary social norms. Characters from history who have been labelled in such a way include the Roman Emperor Caligula, King George III, Vincent Van Gogh, King Saul of Israel and Virginia Woolf, to name just a few. But the term 'madness' does not imply a cause – it simply redescribes the behaviour as something that is odd. Views about what *causes* 'mad' behaviour have changed significantly over the course of history, and it is instructive to understand how the way we attribute the causes of mental health problems have developed over time. The following models provide some examples of how we attempt to *explain* psychopathology. We will begin by looking at a historical perspective on explaining psychopathology, which is known as demonic possession. We will then look at more contemporary models of explanation such as the ***medical model*** and ***psychological models***.

Medical model An explanation of psychopathology in terms of underlying biological or medical causes.

Psychological models Models which view psychopathology as caused primarily by psychological rather than biological processes.

1.1.1 Demonic Possession

Many forms of psychopathology are accompanied by what appear to be changes in the individual's personality, and these changes in personality or behaviour are some of the first symptoms that are noticed. The reserved person may become manic and outgoing, and the gregarious person withdrawn and sombre. They may start behaving in ways which mean they neglect important daily activities (such as parenting or going to work), or may be harmful to themselves or others. The fact that an individual's personality seems to have changed (and may do so very suddenly) has historically tended people towards describing those exhibiting symptoms of psychopathology as being 'possessed' in some way. That is, their behaviour has changed in such a way that their personality appears to have been taken over and replaced by the persona of someone or something else.

Explanations of psychopathology in terms of 'possession' have taken many forms over the course of history, and it is a form of explanation that has meant that many who have been suffering debilitating and distressing psychological problems have been persecuted and physically abused rather than offered the support and treatment they need. Many ancient civilizations, such as those in Egypt, China, Babylon and Greece, believed that those exhibiting symptoms of psychopathology were possessed by bad spirits (this is known as ***demonology***), and the only way to exorcise these bad spirits was with elaborate, ritualized ceremonies that frequently involved direct physical attacks on the sufferer's body in an attempt to force out the demons (e.g. through torture, flogging or starvation). Not surprisingly, such actions usually had the effect of increasing the distress and suffering of the victim.

Demonology The belief that those exhibiting symptoms of psychopathology are possessed by bad spirits.

Demonology survived as an explanation of psychopathology and mental health problems right up until the eighteenth century, when witchcraft and demonic possession were common explanations for psychopathology. This contrasts with the Middle Ages in England when individuals were often treated in a relatively civilized fashion. When someone exhibited symptoms typical of psychopathology, a 'lunacy trial' was held to determine the individual's sanity, and if the person was found to be insane, he or she was given the protection of the law (Neugebauer, 1979). Nevertheless, demonic possession is still a common explanation of psychopathology in some less developed areas of the world – especially where witchcraft and voodoo are still important features of the local culture such as Haiti and some areas of Western Africa (Desrosiers & Fleurose, 2002).

Plate 1.1
In June 2005, Sita Kisanga (above) was convicted with two other people of subjecting an 8-year-old girl in their care to a lengthy period of physical abuse because they believed she was possessed by evil spirits. Even today, many cultures still believe that unusual or bizarre behaviour that may be symptomatic of psychopathology is caused by spirit possession and direct physical abuse is often used on the sufferer in an attempt to drive out the supposed possessing spirit. The 8-year-old child in this case was beaten with a belt and a stiletto shoe, cut with a kitchen knife and had chilli peppers rubbed into her eyes. It is easy to understand how historically these kinds of beliefs merely exacerbated the distress experienced by those suffering psychopathology.

1.1.2 The Medical or Disease Model

As cultures develop, so too do the types of causes to which they attribute behaviour. In particular, as we began to understand some of the biological causes of physical disease and illness, then our conception of 'madness' moved very slowly towards treating it as a disease (hence the term 'mental illness'). The impetus for this change in conception came in the nineteenth century when it became apparent that many forms of behaviour typical of psychopathology were the result of physical illnesses, such as strokes or viral infections. For example, without proper treatment, the later stages of the sexually transmitted disease *syphilis* are characterized by the inability to coordinate muscle movements, paralysis, numbness, gradual blindness and dementia – and many of these symptoms caused radical changes in the individual's personality. The discovery that syphilis had a biological cause, and was also an important contributor to the mental disorder known as ***general paresis***, implied that many other examples of mental or psychological illness might also have medical or biological explanations. This became known as the ***somatogenic hypothesis***, which advocated that the causes or explanations of psychological problems could be found in physical or biological impairments.

General paresis A brain disease occurring as a late consequence of syphilis, characterized by dementia, progressive muscular weakness and paralysis.

Somatogenic hypothesis The hypothesis that the causes or explanations of psychological problems can be found in physical or biological impairments.

The medical model of psychopathology that was fostered by the somatogenic hypothesis was an important development because it introduced scientific thinking into our attempts to understand psychopathology, and shifted explanations away from those associated with cultural and religious beliefs. The medical model has given rise to a large body of scientific knowledge about psychopathology that is based on medicine. This profession is known as ***psychiatry***, and the primary approach of

Psychiatry A scientific method of treatment that is based on medicine, the primary approach of which is to identify the biological causes of psychopathology and treat them with medication or surgery.

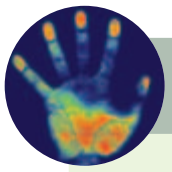
the medical model is to identify the biological causes of psychopathology and treat them with medication or surgery. As we shall see in later chapters, there are many explanations of psychopathology that allude to biological causes, and these attempt to explain symptoms in terms of such factors as brain abnormalities (e.g. in dementia, autism), biochemical imbalances (especially imbalances of brain neurotransmitters) (e.g. major depression, bipolar disorder, schizophrenia), genetic factors (e.g. learning disabilities, autism, schizophrenia), chromosome disorders (e.g. intellectual disabilities), congenital risk factors (such as maternal infections during pre-gnancy) (e.g. intellectual disorders, ADHD), abnormal physical development (e.g. autism), and the physical effects of pathological activities (e.g. the effect of hyperventilation in panic disorder), amongst others. However, while such biological factors may play a role in the aetiology of some psychopathologies, biological explanations are not the only way in which psychopathology can be explained, and nor is biological dysfunction necessarily a factor underlying all psychopathology. As we shall see later, it is often a person's experiences that are dysfunctional, not their biological substrates.

However, despite its obvious importance in developing a scientific view of psychopathology and providing some influential treatments, the medical model of psychopathology has some significant implications for the way we conceive mental health problems. First, an obvious implication is that it implies that medical or biological causes underlie psychopathology. This is by no means always the case, and bizarre behaviour can be developed by perfectly normal learning processes. For example, in Chapter 7 we describe the example of the schizophrenic sufferer who learned through perfectly normal learning processes to carry a broom around with her for 24 hours a day (see Focus Point 7.6). Similarly, children with autism or intellectual disabilities often learn disruptive, challenging or self-harming behaviours through normal learning processes that have nothing to do with their intellectual deficits (see Treatment in Practice Box 16.1). Furthermore, in contrast to the medical model, both psychodynamic and contemporary cognitive accounts of psychopathology argue that many psychological problems are the result of the individual acquiring dysfunctional ways of thinking and acting, and acquiring these characteristics through normal, functional learning processes. In this sense, it is not the individual or any part of their biology that is dysfunctional, it is the *experiences* they have had that are dysfunctional and have led to them thinking and acting in the way they do.

Secondly, the medical model adopts what is basically a reductionist approach by attempting to reduce the complex psychological and emotional features of psychopathology to simple biology. If you look at the personal accounts provided at the beginning of this chapter, it is arguable whether the phenomenology (i.e. the personal experience of psychopathology) or the complex cognitive factors involved in many psychological problems can be reduced to simple biological descriptions. Biological reductionism cannot easily encapsulate the distress felt by sufferers, nor can it easily explain the dysfunctional beliefs and forms of thinking that are characteristic of many psychopathologies.

Thirdly, as we have mentioned already, there is an implicit assumption in the medical model that psychopathology is caused by 'something not working properly'. For example, this type of explanation may allude to brain processes not functioning normally, brain or body biochemistry being imbalanced, or normal physical development being impaired. This 'something is broken and needs to be fixed' view of psychopathology is problematic for a number of reasons. (1) Rather than reflecting a dysfunction, psychopathology might just represent a more extreme form of normal behaviour. We all get anxious, we all worry and we all get depressed. Yet anxiety, worry and depression in their extreme forms provide the basis of many of the mental health problems we will cover in this book. If we take the example of worry, we can all testify to the fact that we worry about something at some time. However, for some of us it may become such a prevalent and regular activity that it becomes disabling, and may lead to a diagnosis of generalized anxiety disorder (GAD, see Chapter 4). Nevertheless, there is no reason to suppose that the cognitive mechanisms that generate the occasional worry bout in all of us are not the same ones that generate chronic worry in others (Davey, 2003). In this sense, psychopathology can be viewed as being on a dimension rather than being a discrete phenomenon that is separate from normal experience, and we will discuss this aspect of psychopathology in more detail in section 1.3. (2) By implying that psychopathology is caused by a normal process that is broken, imperfect or dysfunctional, the medical model may have an important influence on how we view people suffering from mental health problems, and indeed, how they might view themselves. (See Focus Point 1.1.) At the very least it can be stigmatizing to be labelled as someone who is biologically or psychologically imperfect, and people with mental health problems are often viewed as second-class citizens – even when their symptoms are really only more prominent and persistent versions of characteristics that we all possess. Client's Perspective 1.1 shows how different people's reactions can be to someone with a mental health problem, and how this can lead to loss of respect and consideration when they perceive that individual as no longer being a properly functioning member of society.

Even so, we cannot lay all the blame for the stigma attached to mental health problems at the feet of the medical model, and there are still attitudes within most societies that view symptoms of psychopathology as threatening and uncomfortable. Some sectors of the popular media bear some responsibility for propagating the stigma attached to mental health problems, and Focus Point 1.2 describes a recent example. Furthermore, studies have suggested that stigmatizing attitudes towards people with mental health problems are widespread and commonly held (Crisp, Gelder, Rix, Meltzer et al., 2000; Byrne, 1997; Heginbotham, 1998). In a survey of over 1,700 adults in the UK, Crisp et al. (2000) found that (1) the most commonly held belief was that people with mental health problems were dangerous – especially those with schizophrenia, alcoholism and drug dependency; (2) people believed that some mental health problems such as eating disorders and substance abuse were self-inflicted; and (3) respondents believed that people with mental health problems were generally hard to talk to. People tended to hold these negative beliefs regardless of their age, regardless of what knowledge they had of mental health problems, and regardless of whether they knew someone who had a mental health problem. The fact that such negative attitudes appear to be so entrenched suggests that campaigns to change these beliefs will have to be multifaceted, will



FOCUS POINT 1.1

'Creating' mental health problems through the medicalization of everyday problems of living

It is worth considering when an everyday 'problem in living' becomes something that should be categorized as a mental health problem. It is a fact of life that we all have to deal with difficult life situations. Sometimes these may make us anxious or depressed, sometimes we might feel as though we are 'unable to cope' with these difficulties. But they are still problems that almost everyone encounters. Many people have their own strategies for coping with these problems: some get help and support from friends and family, and in more severe cases perhaps seek help from their doctor or GP. However, at what point do problems of living cease to be everyday problems and become mental health problems? In particular, we must be wary about 'medicalizing' problems in daily living so that they become viewed as 'abnormal', symptoms of illness or disease, or even as characteristics of individuals who are 'ill' or in some way 'second class'.

Below are two useful examples of how everyday problems in living might become medicalized to the point where they are viewed as representing illness or disease rather than normal events of everyday living.

First, experiencing ***depression*** is the third most common reason for consulting a doctor or GP in the UK (Singleton, Bumpstead, O'Brien et al., 2001). In order for GPs to be able to provide treatment for such individuals, there is a tendency for them to overdiagnose mild or moderate depression (Middleton, Shaw, Hull & Feder, 2005). This may have contributed to the common view expressed by lay people that depression is a disease rather than a normal consequence of everyday life stress (Lauber, Falcato, Nordt & Rossler, 2003). If lay people already view depression as a disease or biological illness, and GPs are more than willing to diagnose it, then we run the risk of the medicalization of normal everyday negative emotions such as mild distress or even unhappiness (Shaw & Woodward, 2004).

Second, some clinical researchers have argued that the medical pharmaceutical industry in particular has attempted to manipulate women's beliefs about their sexuality in order to sell their products (Moynihan, 2006). Some drug companies claim that ***sexual desire problems*** affect up to 43 per cent of American women (Moynihan, 2003), and can be successfully treated with, for example, hormone patches. However, others claim that this figure is highly improbable and includes women who are quite happy with their reduced level of sexual interest (Bancroft, Loftus & Long, 2003). Tiefer (2006) lists a number of processes that have been used either wittingly or unwittingly in the past to medicalize what many see as normal sexual functioning – especially the normal lowering of sexual desire found in women during the menopause. These include:

1. taking a normal function and implying that there is something wrong with it and that it should be treated (e.g. implying that there is something abnormal about the female menopause, when it is a perfectly normal biological process);
2. imputing suffering that is not necessarily there (i.e. implying that individuals who lack sexual desire are 'suffering' as a result);
3. defining as large a proportion of the population as possible as suffering from the 'disease';
4. defining a condition as a 'deficiency', disease or disease of hormonal imbalance (e.g. implying that women experiencing the menopause have a 'deficiency' of sexual hormones); and
5. taking a common symptom that could mean anything and making it sound as if it is a sign of a serious disease (e.g. implying that lack of sexual desire is a symptom of underlying dysfunction).

While sexual dysfunctions are sometimes caused by medical conditions, lack of sexual desire and interest is itself often portrayed as a medical condition in need of treatment. Yet a reduction in sexual interest and desire can be a healthy and adaptive response to normal changes in body chemistry or a normal reaction to adverse life stressors or relationship changes. Medicalizing symptoms in this way leads to our viewing what are normal everyday symptoms and experiences as examples of dysfunction or psychopathology.

have to do more than just impart knowledge about mental health problems, and will need to challenge existing negative stereotypes especially as they are portrayed in the general media (Pinfold, Toulmin, Thornicroft, Huxley et al., 2003). Activity Box 1.1 provides an opportunity to assess your own awareness about mental health by seeing how well you can answer the 12 questions posed in this Mental Health Awareness Quiz.

Depression A mood disorder involving emotional, motivational, behavioural, physical and cognitive symptoms.

1.1.3 Psychological Models

By its very nature, the medical model tends us towards thinking of mental health problems as 'illness', and this can have quite important ramifications for how people suffering mental health problems might view themselves and their future. For example, Focus Point 1.1 describes how easy it is to

Sexual Offender Treatment Programme (SOTP) An integrated treatment for sexual offenders developed by the UK Home Office.

CLIENT'S PERSPECTIVE 1.1

A question of dignity – written by Louise from her own experience with depression

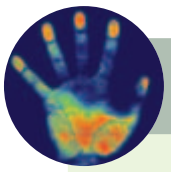
'During an episode of depression accompanied by anxiety, I shared my illness with a large number of people. In retrospect, now that the depression is lifting, I realize that this was a grave mistake, at least in light of the way society functions . . . What has occurred?

When I was deeply depressed, I noticed that some friends departed. I understand now that they could not cope with depression and withdrew. In a few cases the rejection was rude and cruel and those who had seemed to be friends were found not to be so. Other friends stayed and offered their help.

In some cases I became a "second-class citizen". I could be treated with a briskness and dismissive air that had never been present before. I could be rudely dismissed and ignored on special occasions. My presence was clearly thought to be potentially threatening. Perhaps I wouldn't be happy enough or introduce inappropriate topics. I had laid bare my weakness and others were not about to forget it. These people, like all human beings, probably thought that they were doing the right thing. They were saving others from my presence. They also probably thought that they were treating me as my merits deserved. I had permanently lost the respect and consideration that I had once received.

It is no wonder that people conceal serious illness, whether cancer, heart disease, or mental illness. Once exposed, these illnesses prove to be unforgettable to others. People never walk with the same dignity again. To some this weakness justifies treatment that shows no respect to the person as a human being. Somehow the person is seen to be responsible for the weakness and therefore appropriately blamed. The person has lost the right to be treated with honour. This honour is accorded only to those who are strong, healthy and successful.'

Source: www.mentalhealth.com/story/p52–dp11.hmtl



FOCUS POINT 1.2

The popular press can often present mental illness in a way which propagates the stigmas attached to mental illness. In September 2003, the ex-heavyweight champion boxer Frank Bruno was treated for depression at a psychiatric hospital. Unsympathetic coverage of his illness in the media was subsequently criticized by the mental health charity Sane (www.sane.org.uk).

The BBC News website reported that an early edition of the *Sun* newspaper carried the front page headline 'Bonkers Bruno Locked Up', which was later changed to 'Sad Bruno in Mental Home'.

Sane chief executive Marjorie Wallace said: 'It is both an insult to Mr Bruno and damaging to many thousands of people who endure mental illness to label him as "bonkers" or "a nutter" and having to be "put in a mental home" ' (news.bbc.co.uk/1/hi/uk/3130376.stm).

medicalize everyday emotions such as depression and low mood. When such experiences are seen as a condition that requires visits to a GP or treatment with drugs, they become viewed as pathological and no longer part of normal, everyday experience. Client's Perspective 1.2 provides an insight into how the medical model of mental health problems can cause sufferers to experience a lack of control over their condition, leading to a sense that they are victims of their condition and affecting their ability to view themselves as

ACTIVITY BOX 1.1

A Mental Health Awareness Quiz

See how many of the following questions you can answer correctly to test your own awareness of mental health issues.

1. Are mental health problems inherited?
2. Violence towards others is a symptom of which mental illness?
3. 35- to 50-year-olds show the highest incidence of suicide – True or False?
4. People who talk about suicide are not likely to go on to do it – True or False?
5. Men are more likely than women to attempt suicide – True or False?
6. What proportion of people are known to experience mental health problems? Is it (a) 1 in 8, (b) 1 in 4 or (c) 1 in 6?
7. What percentage of GP consultations are for mental health problems? Is it (a) 30%, (b) 50% or (c) 25%?
8. Drugs such as cannabis and ecstasy can increase the risk of panic attacks, anxiety disorders and psychotic episodes – True or False?
9. At what age are mental health problems most likely to occur?
10. In a MIND survey of people who currently have or have previously experienced a mental health problem:
    - **(a)** What percentage of these people said that they had been abused or harassed in public?
    - **(b)** What percentage of these people claim to have been harassed, intimidated or teased at work because of a psychiatric history?
11. Mental Health Media (a campaigning organization) has identified three major stereotypes of how people with a mental illness are portrayed by the media. One of these is sad and pitiable. What are the other two?

Answers

1. They can be, but not always.
2. None. Violence towards others is not on any diagnostic criteria. For every person killed by someone with a mental illness there are roughly 70 deaths on the road and 10 alcohol-related deaths. We are far more likely to be assaulted by someone we know, in our own homes, than by a random stranger with a mental illness. People with mental health problems are more likely to be victims than perpetrators of violence. Interestingly, approximately 70 per cent of media coverage links mental distress to violence.
3. False – the highest risk group is 18–25 years.
4. False – most people who commit suicide usually tell someone of their intentions within the prior 2 months.
5. False.
6. **(b)** 1 in 4. However, this is only the number of people we know about, who have sought help. The associated stigma means that many will be too embarrassed to seek help.
7. **(c)** 25% (source: National Service Framework for Mental Health, Department of Health).
8. True.
9. 16–25 years and over 65 years.
10. **(a)** 47%
    (b) 38%
11. **(a)** Comical and (b) violent to themselves and others. These stereotypes are found in fictional accounts and 'factual' reporting. This means that the key messages from the media are that if someone has a mental illness we should:
    - feel sorry for them
    - be afraid of them
    - laugh at them

50 per cent of people surveyed by Mind said that media coverage had a negative effect on their mental health. Effects included feeling more anxious or depressed and experiencing hostility from neighbours. A third of respondents said family or friends reacted to them differently because of recent media coverage.

Source: adapted from Student Psychological Health Project, Educational Development and Support Centre, University of Leicester (www.le.ac.uk/edsc/sphp) and 'Looniversity Challenge', a mental health awareness quiz provided by mental health awareness group Fifteen Training and Development, Brighton, UK

individuals with a fulfilling and productive future. Indeed, many individuals experience depressed mood and low self-esteem after receiving a psychiatric diagnosis and feel socially excluded (Warner, Taylor, Powers & Hyman, 1989; Farina, Gliha, Boudreau, Allen et al., 1971). At the very least, this implies that diagnosis and treatment should take place in a context that allows sufferers to fully understand their symptoms, to appreciate their own self-worth and social inclusion, and to discuss their symptoms within their own frame of reference – depending on whether individuals see their mental health problems primarily as medical, psychological or perhaps even spiritual (British Psychological Society, 2000).

Moving away from the medical model of psychopathology, some approaches to understanding and explaining mental health problems still see them as symptoms produced by an underlying cause that is psychological rather than biological or medical (what is known as the pathology model). Such approaches often view

CLIENT'S PERSPECTIVE 1.2

'Loss of control, whether truly lost or merely removed by others, and the attempt to re-establish that control have been central elements in my life since the age of 18. My argument is that the psychiatric system, as currently established, does too little to help people retain control of their lives through periods of emotional distress, and does far too much to frustrate their subsequent efforts to regain self-control. To live 18 years with a diagnosed illness is not incentive for a positive self-image. Illness is a one-way street, especially when the experts toss the concept of cure out of the window and congratulate themselves on candour. The idea of illness, of illness that can never go away, is not a dynamic, liberating force. Illness creates victims. While we harbour thoughts of emotional distress as some kind of deadly plague, it is not unrealistic to expect that many so-called victims will lead limited, powerless and unfulfilled lives.'

Peter Campbell (1996)

the cause of mental health problems as a perfectly normal and adaptive reaction to difficult or stressful life conditions (such as the psychoanalytic view that psychopathology is a consequence of perfectly normal psychodynamic processes that are attempting to deal with conflict). As such, psychological models of psychopathology tend to view mental health symptoms as normal reactions mediated by intact psychological or cognitive mechanisms, and not the result of processes that are 'broken' or malfunctioning.

The following sections describe in brief some of the main psychological approaches to understanding and explaining psychopathology.

1.1.3.1 The Psychoanalytical or Psychodynamic Model

This approach was first formulated and pioneered by the Viennese neurologist ***Sigmund Freud*** (1856–1939). He collaborated with the physician Josef Breuer in an attempt to understand the causes of mysterious physical symptoms such as hysteria and spontaneous paralysis – symptoms that appeared to have no obvious medical causes. Freud and Breuer first tried to use hypnosis as a means of understanding and treating these conditions, but during these cases clients often began talking about earlier traumatic experiences and highly stressful emotions. In many cases, simply talking about these repressed experiences and emotions under hypnosis led to an easing of symptoms. Freud built on these cases to develop his influential theory of ***psychoanalysis***, which was an attempt to explain both normal and abnormal psychological functioning in terms of how various psychological mechanisms help to defend against anxiety and depression by repressing memories and thoughts that may cause conflict and stress. Freud argued that three psychological forces shape an individual's personality and may also generate psychopathology. These are the id (instinctual needs), the ego (rational thinking) and the superego (moral standards).

Sigmund Freud An Austrian neurologist and psychiatrist who founded the psychoanalytic school of psychology.

Psychoanalysis An influential psychological model of psychopathology based on the theoretical works of Sigmund Freud.

The concept of the ***id*** was used to describe innate instinctual needs – especially sexual needs. He noted that from a very early age, children obtained pleasure from nursing, defecating, masturbating and other 'sexually' related activities and that many forms of behaviour were driven by the need to satisfy the needs of the id.

Id In psychoanalysis, the concept used to describe innate instinctual needs – especially sexual needs.

As we grow up, Freud argued that it becomes apparent to us that the environment itself will not satisfy all our instinctual needs, and we develop a separate part of our psychology known as the ***ego***. This is a rational part of the psyche that attempts to control the impulses of the id, and ***ego defence mechanisms*** develop by which the ego attempts to control unacceptable id impulses and reduce the anxiety that id impulses may arouse.

Ego In psychoanalysis, a rational part of the psyche that attempts to control the impulses of the id.

Ego defence mechanisms Means by which the ego attempts to control unacceptable id impulses and reduce the anxiety that id impulses may arouse.

The ***superego*** develops out of both the id and ego, and represents our attempts to integrate 'values' that we learn from our parents or society. Freud argued that we will often judge ourselves by the values that we assimilate, and if we think our behaviour does not meet the standards implicit in those values, we will feel guilty and stressed.

Superego In psychoanalysis, a development from both the id and ego which represents our attempts to integrate 'values' that we learn from our parents or society.

According to Freud, the id, ego and superego are often in conflict, and psychological health is maintained only when they are in balance. However, if these three factors are in conflict, then behaviour may begin to exhibit signs of psychopathology. Individuals attempt to control conflict between these factors and also reduce stress and conflict from external events by developing

Table 1.1 *Defence mechanisms in psychoanalytic theory*

Each of the Freudian defence mechanisms described below functions to reduce the amount of stress or conflict that might be caused by specific experiences.

Denial

The individual denies the source of the anxiety exists (e.g. I didn't fail my exam, it must be a mistake).

Repression

Suppressing bad memories, or even current thoughts that cause anxiety (e.g. repressing thoughts about liking someone because you are frightened that you may be rejected if you approach them).

Regression

Moving back to an earlier developmental stage (e.g. when highly stressed you abandon normal coping strategies and return to an early developmental stage, for example by smoking if you are fixated at the oral stage).

Reaction formation

Doing or thinking the opposite to how you feel (e.g. a person who is angry with their boss may go out of their way to be kind and courteous to them).

Projection

Ascribing unwanted impulses to someone else (e.g. the unfaithful husband who is extremely jealous of his wife might always suspect that she is being unfaithful).

Rationalization

Finding a rational explanation for something you've done wrong (e.g. you didn't fail the exam because you didn't study hard enough but because the questions were unfair).

Displacement

Moving an impulse from one object (target) to another (e.g. if you've been told off by your boss at work, you go home and shout at your partner or kick the dog).

Sublimation

Transforming impulses into something constructive (e.g. redecorating the bedroom when you're feeling angry about something).

Defence mechanisms In psychoanalysis, the means by which individuals attempt to control conflict between the id, ego and superego and also reduce stress and conflict from external events.

defence mechanisms. Table 1.1 describes some of these defence mechanisms together with some examples of how they are presumed to prevent the experience of stress and anxiety.

A further factor that Freud believed could cause psychopathology was the way in which children negotiated various ***stages of development*** from infancy to maturity. He defined a number of important stages through which childhood development progressed, and each of these stages was named after a body area or erogenous zone. If the child successfully negotiated each stage, then this led to personal growth and a psychologically healthy person. If, however, adjustment to a particular stage was not successful, then the individual would become fixated on that early stage of development. For example, Freud labelled the first 18 months of life as the ***oral stage*** because of the child's need for food from the mother. If the mother fails to satisfy these oral needs, the child may become fixated at this stage and in later life display 'oral stage characteristics' such as extreme dependence on others. Other stages of development include the anal stage (18 months to 3 years), the phallic stage (3 to 5 years), the latency stage (5–12 years) and the genital stage (12 years to adulthood).

Stages of development Progressive periods of development from infancy to maturity.

Oral stage According to Freud, the first 18 months of life based on the child's need for food from the mother. If the mother fails to satisfy these oral needs, the child may become fixated at this stage and in later life display 'oral stage characteristics' such as extreme dependence on others.

There is no doubt that the psychoanalytical model has been extremely influential, both in its attempts to provide explanations for psychopathology and in the treatments it has helped to develop. Psychoanalysis was arguably the first of the 'talking therapies' and as many as 20 per cent of modern practising clinical psychologists identify themselves, at least in part, with a psychoanalytical or psychodynamic approach to psychopathology (Prochaska & Norcross, 2003). Psychoanalysis was also the first approach to introduce a number of perspectives on psychopathology that are still important today, including (1) the view that psychopathology can have its origins in early experiences rather than being a manifestation of biological dysfunction, and (2) the possibility that psychopathology may often represent the operation of 'defence mechanisms' that reflect attempts by the individual to suppress stressful thoughts and memories (see, for example, cognitive theories of chronic worrying in Chapter 5 and theories of dissociative disorders in Chapter 13).

Theorists in the psychoanalytic tradition have elaborated on Freud's original theory, and we will see many examples of psychodynamic explanations applied to specific psychopathologies presented later in this book. However, psychoanalytic theory does have many shortcomings, and it is arguably no longer the explanation or treatment of choice for most psychological problems, nor is it a paradigm in which modern-day evidence-based researchers attempt to understand psychopathology. This is largely because the central concepts in psychoanalytic theory are hard to objectively define and measure. Because concepts such as the id, ego and superego are difficult to observe and measure, it is therefore difficult to conduct objective research on them to see if they are actually related to symptoms of psychopathology in the way that Freud and his associates describe (Erdelyi, 1992).

1.1.3.2 The Behavioural Model

Most psychological models have in common the view that psychopathology is caused by how we assimilate our experiences and how this is reflected in thinking and behaviour. The behavioural model adopts the broad view that many examples of psychopathology reflect our learned reactions to life experiences. That is, psychopathology can be explained as learned reactions to environmental experiences, and this approach was promoted primarily by the behaviourist school of psychology.

During the 1950s and 1960s, many clinical psychologists became disillusioned by psychoanalytic approaches to psychopathology and sought an approach that was more scientific and objective. They turned to that area of psychology known as ***learning theory***, and argued that just as adaptive behaviour can be acquired through learning, then so can many forms of dysfunctional behaviour. The two important principles of learning on which this approach was based are classical conditioning and operant conditioning. ***Classical conditioning*** represents the learning of an association between two stimuli, the first of which (the conditioned stimulus, CS) predicts the occurrence of the second (the unconditioned stimulus, UCS). The prototypical example of this form of learning is Pavlov's experiment in which a hungry dog learns to salivate to a bell (the CS) that predicts subsequent delivery of food (the UCS). This is represented schematically in Figure 1.1. In contrast, ***operant conditioning*** represents the learning of a specific behaviour or response because that behaviour has certain rewarding or reinforcing consequences. A prototypical example of operant conditioning is a hungry rat learning to press a lever to obtain food in an experimental chamber called a Skinner Box (see Figure 1.2).

Learning theory The body of knowledge encompassing principles of classical and operant conditioning (and which is frequently applied to explaining and treating psychopathology).

Classical conditioning The learning of an association between two stimuli, the first of which (the conditioned stimulus, CS) predicts the occurrence of the second (the unconditioned stimulus, UCS).

Operant conditioning The learning of a specific behaviour or response because that behaviour has certain rewarding or punishing consequences.

These two forms of learning have been used to explain a number of examples of psychopathology. For example, classical conditioning has been used to explain the acquisition of emotional disorders including many of those with anxiety-based symptoms (see Chapter 5). Some forms of specific phobias appear to be acquired when the sufferer experiences the phobic stimulus (the CS) in association with a traumatic event (the UCS). Such experiences might account for the acquisition of dog phobia (in which dogs have become associated with, for example, being bitten or chased), accident phobia (in which travelling in cars has become associated with being in a traumatic car accident) and dental phobia (when being at the dentist has become associated with a traumatic dental experience) (Davey, 1989; Kuch, 1997; Doogan & Thomas, 1992).

Classical conditioning processes have also been implicated in a number of other forms of psychopathology, including the acquisition of post-traumatic stress disorder (PTSD) (see Chapter 5), the acquisition of paraphilias (see Chapter 10) and substance dependency (see Chapter 8). Operant conditioning has been used extensively to explain why a range of psychopathology-relevant behaviours may have been acquired and maintained. Examples you will find in this book include learning approaches to understanding the acquisition of bizarre behaviours in schizophrenia (Ullman & Krasner, 1975), how the stress-reducing or stimulant effects of nicotine, alcohol and many illegal drugs may lead to substance dependency (e.g. Schachter, 1982), how hypochondriacal tendencies and somatoform disorders may be acquired when a child's illness symptoms are reinforced by attention from parents (Latimer, 1981) and how the disruptive, self-harming or challenging behaviour exhibited by individuals with intellectual

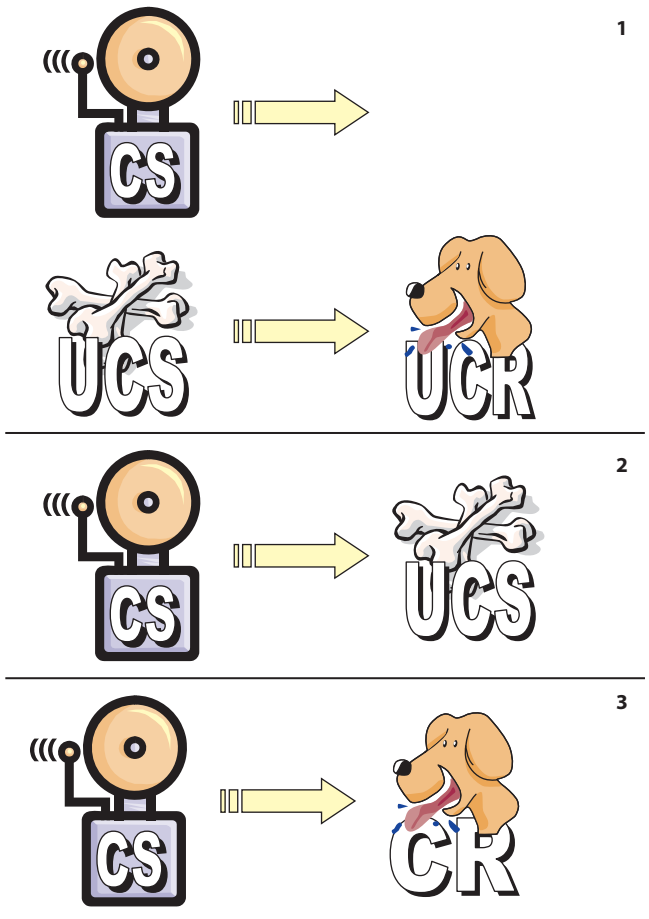


Figure 1.1 *Classical conditioning*
(1) Before conditioning takes place, Pavlov's dog salivates only to the presentation of food and not to the presentation of the bell; (2) pairing the bell with food then enables the dog to learn to predict food whenever it hears the bell, and (3) this results in the dog subsequently salivating whenever it hears the bell. This type of learning has frequently been used to explain psychopathology, and one such example is the acquisition of specific phobias where the phobic stimulus (the CS) elicits fear because it has been paired with some kind of trauma (the UCS) (see Figure 5.1).

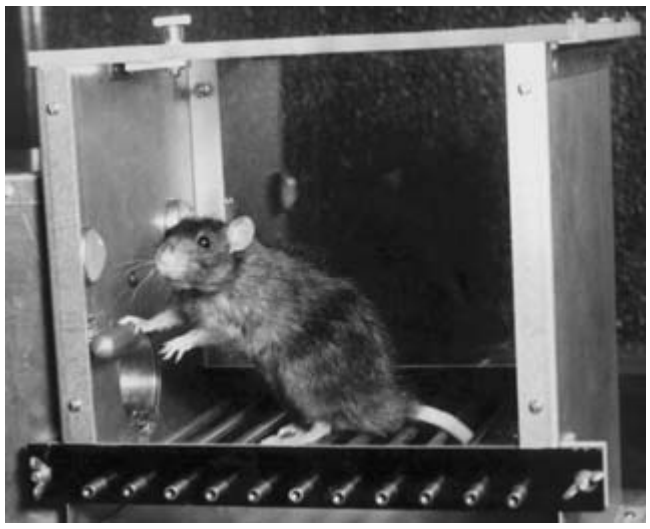


Figure 1.2 *Operant conditioning*
In operant conditioning, the rat learns to press the lever in this Skinner Box because it delivers food, and food acts to reinforce that behaviour so that it occurs more frequently in the future (known as operant reinforcement). Operant reinforcement has been used to explain how many behaviours that are typical of psychopathology are acquired and maintained. That is, many bizarre and disruptive behaviours may be acquired because they actually have positive or rewarding outcomes (see Focus Point 7.6 as an example).

Plate 1.2

or developmental disabilities may be maintained by attention from family and carers (Mazaleski, Iwata, Vollmer, Zarcone & Smith, 1993).

Behaviour therapy Therapies based mainly on the principles of classical and operant conditioning.

Behaviour modification A set of therapies based on the principles of operant conditioning.

The behavioural approach led to the development of important behavioural treatment methods, including ***behaviour therapy*** and ***behaviour modification***. For example, if psychopathology is learned through normal learning processes, then it should be possible to use those same learning processes to help the individual 'unlearn' any maladaptive behaviours or emotions. This view enabled the development of treatment methods based on classical conditioning principles (such as flooding, systematic desensitization and aversion therapy; see Chapter 8) and operant conditioning principles (e.g. functional analysis, token economies; see Chapter 7). Furthermore, learning principles could be used to alter psychopathology symptoms even if the original symptoms were not necessarily acquired through conditioning processes themselves, and so the behavioural approach to treatment had a broad appeal across a very wide range of symptoms and disorders.

As influential as the behavioural approach has been over the years, it too has some limitations. For example, many psychopathologies are complex and symptoms are acquired gradually over many years (e.g. obsessive-compulsive disorder, substance dependency, somatoform disorders, etc.). It would be almost impossible to trace the reinforcement history of such symptoms across time in an attempt to verify that reinforcement processes had shaped these psychopathologies. Secondly, learning paradigms may simply not represent the most ideal conceptual framework in which to describe and understand some quite complex psychopathologies. For example, many psychopathologies are characterized by a range of cognitive factors such as information processing biases, belief schemas and dysfunctional ways of thinking, and learning theory jargon is probably not the best framework in which to accurately and inclusively describe these phenomena. The cognitive approaches we will describe next are probably more suited to describing and explaining these aspects of psychopathology.

1.1.3.3 The Cognitive Model

Perhaps the most widely adopted current psychological model of psychopathology is the cognitive model, and one in four of all present-day clinical psychologists would describe their approach as cognitive (Prochaska & Norcross, 2003). Primarily, this approach considers psychopathology to be the result of individuals acquiring irrational beliefs, developing dysfunctional ways of thinking and processing information in biased ways. It was an approach first pioneered by Albert Ellis (1962) and Aaron Beck (1967). Albert Ellis argued that emotional distress (such as anxiety or depression) is caused primarily because people develop a set of irrational beliefs by which they need to judge their behaviour. Some people become anxious, for example, because they make unrealistic demands on themselves. The anxious individual may have developed unrealistic beliefs such as 'I must be loved by everyone', and the depressed individual may believe 'I am incapable of doing anything worthwhile'. Judging their behaviour against such 'dysfunctional' beliefs causes distress. Aaron Beck developed a highly successful cognitive therapy for depression based on the view that depressed individuals have developed unrealistic distortions in the way they perceive themselves, the world and their future (see Chapter 6).

For example, the cognitive approach argues that depression results from individuals having developed negative beliefs about themselves (e.g. 'I am worthless'), the world (e.g. 'bad things always happen') and their future (e.g. 'I am never going to achieve anything'), and these beliefs act to maintain depressive thinking.

The view that dysfunctional ways of thinking generate and maintain symptoms of psychopathology has been applied across a broad range of psychological problems, including both anxiety disorders and mood disorders, and has also been applied to the explanation of specific symptoms, such as paranoid thinking in schizophrenia (Morrison, 2001a), antisocial and impulsive behaviour in personality disorders (Young, Klosko & Weishaar, 2003), dysfunctional sexual behaviour in sex offenders and paedophiles (Ward, Hudson, Johnston & Marshall, 1997) and illness reporting in hypochondriasis and somatoform disorders (Warwick, 1995), to name but a few.

The cognitive approach has also been highly successful in generating an influential approach to treatment. If dysfunctional thoughts and beliefs maintain the symptoms of psychopathology, then these dysfunctional thoughts and beliefs can be identified, challenged and replaced by more functional cognitions. This has given rise to a broad-ranging therapeutic approach known as ***cognitive behaviour therapy (CBT)***, and many examples of the use of this approach will be encountered in this book.

Cognitive behaviour therapy (CBT) An intervention for changing both thoughts and behaviour. CBT represents an umbrella term for many different therapies that share the common aim of changing both cognitions and behaviour.

As successful as the cognitive approach seems to have been in recent years, it too has some limitations. For example, rather than being a cause of psychopathology, it has to be considered that dysfunctional thoughts and beliefs may themselves simply be just another symptom of psychopathology. For example, we have very little knowledge at present about how dysfunctional thoughts and beliefs develop. Are they the product of childhood experiences? Do they develop from the behavioural and emotional symptoms of psychopathology (i.e. do depressed people think they are worthless because of their feelings of depression)? Or are they merely *post hoc* constructions that function to help individuals rationalize the way they feel? These are all potentially fruitful areas for future research.

1.1.3.4 The Humanist-Existential Approach

Some approaches to psychopathology believe that insights into emotional and behavioural problems cannot be achieved unless individuals are able to gain insight into their lives from a broad range of perspectives. People not only acquire psychological conflicts and experience emotional distress, they also have the ability to acquire self-awareness, develop important values and a sense of meaning in life, and pursue freedom of choice. If these latter abilities are positively developed and encouraged, then conflict, emotional distress and psychopathology can often be resolved. This is the general approach adopted by humanistic and existential models of psychopathology, and the aim is to resolve psychological problems through insight, personal development and self-actualization.

Because such approaches are concerned primarily with insight and personal growth when dealing with psychopathology, they are interested less in the aetiology and origins of psychopathology than in ameliorating psychopathological symptoms through encouraging personal development. An influential example of the humanistic-existential approach is ***client-centred therapy***, developed by Carl Rogers (1951, 1987). This approach stresses the goodness of human nature and assumes that if individuals are unrestricted by fears and conflicts, they will develop into well-adjusted, happy individuals. The client-centred therapist will try to create a supportive climate in which the client is helped to acquire positive self-worth. The therapist will use ***empathy*** to help her to understand the client's feelings, and ***unconditional positive regard***, by which the therapist expresses her willingness to totally accept the client for who he or she is.

Client-centred therapy An approach to psychopathology stressing the goodness of human nature, assuming that if individuals are unrestricted by fears and conflicts, they will develop into well-adjusted, happy individuals.

Empathy An ability to understand and experience a client's own feelings and personal meanings, and a willingness to demonstrate unconditional positive regard for the client.

Unconditional positive regard Valuing clients for who they are without judging them.

As we said earlier, this type of approach to psychopathology does not put much emphasis on how psychopathology is acquired, but does try to eradicate psychopathology by moving the individual from one phenomenological perspective (e.g. one that contains fears and conflicts) to another (e.g. one that enables clients to view themselves as worthy, respected and achieving individuals). Approaches such as humanistic and existentialist ones are difficult to evaluate. For example, most controlled studies have indicated that clients undergoing client-centred therapy tend to fare no better than those undergoing non-therapeutic control treatments (Patterson, 2000; Greenberg, Watson & Lietaer, 1998). Similarly, exponents of existential therapies believe that experimental methodologies are inappropriate for estimating the effectiveness of such therapies, because experimental methods either dehumanize the individuals involved or are incapable of measuring the kinds of existential benefits that such approaches claim to bestow (Walsh & McElwain, 2002; May & Yalom, 1995). Nevertheless, such approaches to treatment are still accepted as having some value and are used at least in part by clinical psychologists, counselling psychologists and psychotherapists (see Table 1.2).

SELF-TEST QUESTIONS

- Why was demonic possession such a popular way of explaining psychopathology in historical times?
- What are the pros and cons of the medical model of psychopathology?
- Can you describe the basic concepts underlying psychoanalytic and psychodynamic approaches to psychopathology?
- What are the learning principles on which the behavioural approach to psychopathology is based?
- Who were the main founders of the cognitive approach to psychopathology, and what were their main contributions?
- How do humanistic-existential approaches to psychopathology differ from most of the others?

Table 1.2 *Mental health practitioners in the UK*

Title	*Description*
CHARTERED CLINICAL PSYCHOLOGIST	Anyone who has been awarded a degree in psychology (most in the UK are accredited by the *British Psychological Society*) can call himself or herself a psychologist. However, there are many different types of psychologists, and those who are qualified to offer therapy and undertake clinical assessments have undertaken an extra 3 years specialized training. The UK government is intending to introduce statutory regulation of psychologists in 2007, when the term 'clinical psychologist' will become a protected title that can be used only by those with accredited training.
PSYCHIATRIST	Psychiatrists are medically trained doctors who have undergone the normal medical training but have chosen to specialize in mental illness. Their approach to mental illness is primarily medical, but some do offer some forms of psychotherapy. They are the only practitioner group qualified to prescribe medication.
PSYCHOTHERAPIST	Psychotherapy is an umbrella term that covers almost all forms of therapy, but psychotherapists tend to specialize in only one type of therapy (e.g. psychodynamic, humanistic). Psychotherapists do not necessarily have a basic training in psychology. Many other professionals may also have training in psychotherapy, including clinical psychologists, psychiatrists, nurses and social workers.
COUNSELLOR	Counsellors are individuals who have been trained specifically in counselling skills, and may be skilled in the use of one or more forms of psychotherapy.
SOCIAL WORKER	This is a fully trained social worker who has received further training that enables him or her to undertake certain forms of psychotherapy.
OTHER MENTAL HEALTH PROFESSIONALS	Under the UK Mental Health Act, many other professionals have a role to play in providing mental health services and care. They include mental health nurses, community psychiatric nurses, approved social workers, occupational therapists and community support workers.

SECTION SUMMARY

1.1 Explaining Psychopathology

- Historical explanations of psychopathology often alluded to the fact that the individual had been 'possessed' in some way.
- The **medical model** attempts to explain psychopathology in terms of underlying biological or medical causes.
- **Psychological models** view psychopathology as caused primarily by psychological rather than biological processes.
- Influential psychological models of psychopathology include the **psychoanalytical model**, the **behavioural model**, the **cognitive model** and the **humanist-existential model**.

1.2 DEFINING PSYCHOPATHOLOGY

The models of psychopathology we have discussed in the previous sections represent different ways of trying to *explain* unusual or maladaptive behaviour, but they do not necessarily help us to *define* exactly what kinds of symptoms or behaviour should be considered as examples of psychopathology. In the personal accounts that we have included at the beginning of this chapter, it is not hard to believe that the experiences reported by *Joan*, *Greg* and even *Erica* are ones for which they would be happy to receive some structured help and support. Interestingly, even though her behaviour may seem the most bizarre of each of these introductory accounts, *Betty* is the one who doesn't believe she has a problem. So how do we define what is a problem that should be considered suitable for support and treatment, and what is not? Unlike medicine, we can't simply base our definitions on the existence

of a pathological cause. This is because we have already argued that psychological problems often do not have underlying physical or biological causes; and secondly, knowledge of the aetiology of many psychopathologies is still very much in its infancy, so we are not yet in a position to provide a classification of psychopathologies that is based on causal factors. This leads us to try to define psychopathology in ways that are independent of the possible causes of such problems – and, as we shall see, many attempts to do this have important ethical and practical implications. For example, most of us would find the murder of one human being by another an abhorrent act – yet, are all murderers mentally ill and suffering from a form of psychopathology that may need treatment?

The problems of defining psychopathology revolve not only around what criteria we use to define it, but also around what terminology we use. For example, numerous psychopathology courses and textbooks still use the title ***Abnormal Psychology***. Merely using this title implies that people suffering from mental health problems are in some way 'abnormal', either in the statistical or in the functional sense – neither of which is necessarily true because we have already suggested that many forms of psychopathology (1) are common rather than unusual (e.g. depression, worrying) and (2) do not imply that any biological or psychological system is malfunctioning. But the term 'abnormal' also has more important ramifications because it implies that those people suffering psychopathology are in some way 'not normal' or are inferior members of society. In this sense, the 'abnormal' label may affect our willingness to fully include such individuals in everyday activities and may lead to us treating such individuals with suspicion rather than respect (see Client's Perspectives 1.1 and 1.2, and Focus Point 1.2). Individuals with mental health problems have become increasingly vocal about how psychopathology and those who suffer from it are labelled and perceived by others. Examples of groups set up to communicate these views include ***service user groups*** (groups of individuals who are end users of the mental health services provided by, for example, government agencies such as the NHS) and organizations such as ***Mad Pride*** (www.ctono.freeserve.co.uk/), dedicated to changing the way in which society views people with mental health problems.

Abnormal psychology An alternative definition of psychopathology, albeit with negative connotations in regard to being 'not normal'.

Service user groups Groups of individuals who are end users of the mental health services provided by, for example, government agencies such as the NHS.

Mad Pride A UK organization dedicated to changing the way in which society views people with mental health problems.

So, when considering how to define psychopathology, we must consider not only whether a definition is useful in the scientific and professional sense, but also whether it provides a definition that will minimize the stigma experienced by sufferers, and facilitate the support they need to function as inclusive members of society. Let us bear this in mind as we look at some potential ways of identifying and defining psychopathology.

1.2.1 Deviation from the Statistical Norm

We can use statistical definitions to decide whether an activity ora psychological attribute deviates substantially from the ***statistical norm***, and in some areas of clinical psychology this is used as a means of deciding whether a particular disorder meets diagnostic criteria. For example, in the area of intellectual disability, if an IQ score is significantly below the norm of 100, this is currently used as one criterion for diagnosing mental retardation (see Chapter 16, Table 16.3). Figure 1.3 shows the distribution of IQ scores in a standard population, and this indicates that the percentage of individuals with IQ scores below 70 would be relatively rare (i.e. around 2.5–3 per cent of the population). However, there are at least two important problems with using deviations from statistical norms as indications of psychopathology. First, in the intellectual disability case, an IQ of less than 70 may be statistically rare, but rather than simply forcing the individual into a diagnostic category, a better approach would be to evaluate the specific needs of individuals with intellectual disabilities in a way that allows us to suggest strategies, services and supports that will optimize individual functioning. Secondly, as we can see from Figure 1.3, substantial deviation from the norm does not necessarily imply psychopathology because individuals with exceptionally high IQs are also statistically rare – yet we would not necessarily be willing to consider this group of individuals as candidates for psychological intervention.

Statistical norm The mean, average or modal example of a behaviour.

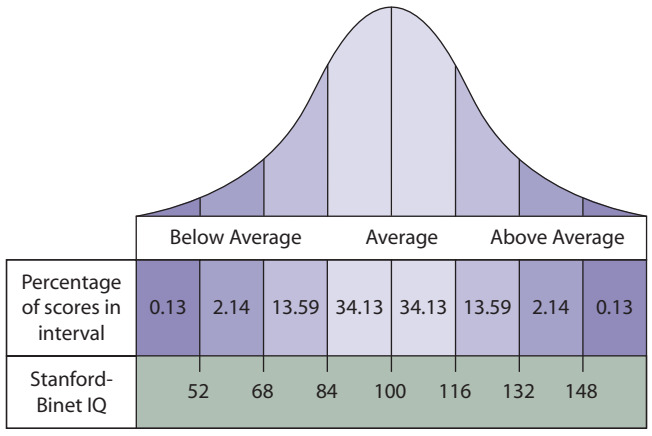


Figure 1.3
This figure represents a normal distribution curve for IQ scores. From this distribution it can be seen that 68 per cent of people score between 84 and 116 points, while only 2.27 per cent of people have an IQ score below 68 points. This graph suggests that around 2–3 per cent of the population will have IQs lower than the 70 points that is the diagnostic criterion for Mental Retardation. However, the problem for basing a definition of psychopathology on scores that deviate substantially from the norm is that high IQ also is very rare. Only 2.27 per cent of the population have an IQ score greater than 132 points.

1.2.2 Deviation from Social Norms

There is often a tendency within individual societies for the members of that society to label a behaviour or activity as indicative of psychopathology if it is far removed from what we consider to be the social norms for that culture. We assume (perhaps quite wrongly) that socially normal and acceptable behaviours have evolved to represent adaptive ways of behaving, and that anyone who deviates from these norms is exhibiting psychopathology. However, it is very difficult to use deviation from social norms as a way of defining psychopathology.

First, different cultures often differ significantly in what they consider to be socially normal and acceptable. For example, in the Soviet Union during the 1970s and 1980s, political dissidents who were active against the communist regime were regularly diagnosed with schizophrenia and incarcerated in psychiatric hospitals. At first we might think that this is a cynical method of political repression used to control dissent, but amongst many in the Soviet Union at the time it represented a genuine belief that anti-Soviet activity was indeed a manifestation of psychopathology (for example, anyone who wanted to protest against the perfect social system must be suffering from mental health problems!). Soviet psychiatrists even added to the official symptoms of schizophrenia by including '*reformist delusions*: a belief that an improvement in social conditions can be achieved only through the revision of people's attitudes, in accordance with the individual's own ideas for the transformation of reality', and '*litigation mania*: a conviction, which does not have any basis in fact, that the individual's own rights as a human being are being violated and flouted' (Goldacre, 2002). However, since the collapse of the Soviet system, few would suspect that these kinds of beliefs and activities are representative of psychopathology.

Second, it is difficult to use cultural norms to define psychopathology because cultural factors seem to significantly affect how psychopathology manifests itself. For example, (1) social and cultural factors will affect the vulnerability of an individual to causal factors (e.g. poor mental health is more prevalent in low-income countries) (Desjarlais, Eisenberg, Good & Kleinman, 1996). (2) Culture can produce 'culture-bound' symptoms of psychopathology which seem confined to specific cultures and can influence how stress, anxiety and depression manifest themselves. Two examples of such 'culture-bound' effects are described in Focus Point 1.3. These are known as ***Ataque de Nervios***, a form of panic disorder found in Latinos from the Caribbean (Salman, Liebowitz, Guarnaccia, Jusino et al., 1998), and ***Seizisman***, a state of psychological paralysis found in the Haitian community (Nicolas, DeSilva, Grey & Gonzalez-Eastep, 2006). Finally, (3) society or culture can influence the course of psychopathology; for example, schizophrenia in developing countries has a more favourable course and outcome than in developed countries (Weisman, 1997).

Ataque de Nervios A form of panic disorder found in Latinos from the Caribbean.

Seizisman A state of psychological paralysis found in the Haitian community.

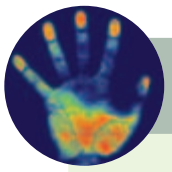
1.2.3 Maladaptive Behaviour

It is often tempting to define psychopathology in terms of whether it renders the individual incapable of adapting to what most of us would consider normal daily living. That is, whether a person can undertake and hold down a job, cope with the demands of being a parent, develop loving relationships or function socially. In its extreme form, maladaptive behaviour might involve behaving in a way that is a threat to the health and well-being of the individual and to others. It is certainly the case that current diagnostic criteria, such as DSM-IV-TR, do use deficits in social, occupational and educational functioning as one criterion for defining many psychological disorders, but it is by no means the only criterion by which those disorders are defined.

The problem with defining psychopathology solely in terms of maladaptive behaviour is also apparent when we discuss forms of behaviour that we might call maladaptive but that we would not necessarily want to label as psychopathological. The behaviour of many people convicted of murder or terrorist acts, for example, is maladaptive in the sense that it is harmful to others, but it is by no means the case that all murderers or terrorists commit their crimes because they have mental health problems (for an interesting contemporary example of this discussion, see Focus Point 12.1). On the other side of the coin, it can be argued that many forms of psychopathology may not be representative of maladaptive behaviour but instead serve a protective or adaptive function. For example, a case can be made for suggesting that specific phobias such as height phobia, water phobia, or snake and spider phobia are adaptive responses which protect us from exposure to potentially life-threatening situations (e.g. Seligman, 1971; see Chapter 5).

1.2.4 Distress and Impairment

Later in this chapter we will look at some of the ways in which psychologists and psychiatrists have attempted to classify psychopathology. In order to be diagnosed as a psychological disorder, one of the most common requirements is that the symptoms must cause 'clinically significant distress or impairment in social, academic or occupational functioning'. It is clearly the case that many individuals with severe symptoms of psychopathology do suffer considerable personal distress – often to the point of wanting to take their own lives. Defining psychopathology in terms of the degree of distress and impairment expressed by the sufferer is useful in a number of ways. First, it allows people to judge their own 'normality' rather than subjecting them to judgements about their 'normality' made by others in society such as psychologists or psychiatrists. Many people who are diagnosed with psychological disorders originally present themselves for treatment because of the distress and impairment caused by their symptoms, and to some degree this makes them judges of their own needs. Secondly, defining psychopathology in terms of the degree of distress and impairment experienced can be independent of the type of lifestyle chosen by the individual. This means we do not judge whether someone has a psychopathology purely on the basis of whether



FOCUS POINT 1.3

Psychopathology and culture

Psychopathology can manifest itself in different forms in different cultures, and this can lead to some disorders that are culture-specific (i.e. have a set of symptoms which are found only in that particular culture). Two such examples are *Ataque de Nervios*, which is an anxiety-based disorder found almost exclusively amongst Latinos from the Caribbean (Salman, Liebowitz, Guarnaccia, Jusino et al., 1998), and *Seizisman*, a state of psychological paralysis found in the Haitian community (Nicolas, DeSilva, Grey & Gonzalez-Eastep, 2006).

Ataque de Nervios

Its literal translation is 'attack of nerves', and symptoms include trembling, attacks of crying, screaming uncontrollably, and becoming verbally or physically aggressive. In some cases these primary symptoms are accompanied by fainting bouts, dissociative experiences and suicide attempts.

Research on *Ataque de Nervios* has begun to show that it is found predominantly in women, people over 45 years of age, and people from low socioeconomic backgrounds and disrupted marriages (Guarnaccia, De La Cancela & Carrillo, 1989). The symptoms appear to resemble many of those found in panic disorder, but with a coexisting affective disorder characterized by emotional lability and anger (Salman et al., 1998).

From this research, it appears that *Ataque de Nervios* may be a form of panic disorder brought on by stressful life events (such as economic or marital difficulties), but whose expression is determined by the social and cultural norms within that cultural group. In particular, Latino cultures place less emphasis on self-control and emotional restraint than other Western cultures, and so the distress of panic disorder in Latinos tends to be externalized in the form of screaming, uncontrolled behaviour and aggression. In contrast, in Western cultures the distress of panic disorder is usually coped with by adopting avoidance and withdrawal strategies – hence the common diagnosis of panic disorder with agoraphobia.

Seizisman

The term literally means 'seized-up-ness' and refers to a state of paralysis usually brought on by rage, anger or sadness, and in rare cases happiness. Events that can cause *Seizisman* include a traumatic event (such as receiving bad news), a family crisis and verbal insults from others. Individuals affected by the syndrome become completely dysfunctional, disorganized and confused, and unresponsive to their surroundings (Laguerre, 1981). The following quote illustrates how viewing traumatic events while working within a Haitian community that is attuned to the symptoms of this syndrome can actually given rise to these culture-bound symptoms:

> I remember over and over, when I was a UN Human Rights Monitor and I was down there in Port-au-Prince viewing cadaver after cadaver left by the Haitian army, people would say, 'Now go home and lie down or you will have *Seizisman*'. And I never really had a problem, you know? I never threw up or fainted no matter what I saw, but I started to feel 'stressed', which is an American illness defined in an American way. After viewing one particularly vile massacre scene, I went home and followed the cultural model I had been shown. I lay down, curled up, and went incommunicado. 'Ah-hah! *Seizisman*!' said the people of my household.
>
> (Nicola et al., 2006, p. 705)

he or she is perceived as productively contributing to society or not, but on the basis of how that person is able to cope with his or her lifestyle (e.g. we often tend to think of reclusive characters as eccentric oddballs, but they may be perfectly happy with their self-chosen lifestyle).

As attractive as this definition for defining psychopathology seems, it does have a number of difficulties. First, this approach does not provide any standards by which we should judge behaviour itself. For example, in our introductory personal accounts, *Betty*'s behaviour and thoughts do not entirely seem to be based in reality, and they could be manifestations of the thought-disordered behaviour that is sometimes characteristic of those developing schizophrenia (see Chapter 7). But *Betty* does not express any feelings of distress or impairment. Similarly, *Erica* does admit that her substance dependency is beginning to cause her some distress, but should we consider that a teenager's drug addiction is in need of treatment only if the individual expresses unhappiness about her situation?

Finally, psychopathology classification schemes include so-called 'disorders' in which diagnosis does not require the sufferer necessarily to report any personal distress or impairment. A good example of this is that group of disorders known as *personality disorders* (see Chapter 11). For example, individuals diagnosed with borderline personality disorder or antisocial personality disorder frequently exhibit behaviour that is impulsive, emotional, threatening and harmful to themselves and others. Yet they are rarely willing to admit that their behaviour is unusual or problematic.

SUMMARY

None of these individual ways of defining psychopathology is ideal. They may fail to include examples of behaviour that we intuitively believe are representative of mental health problems (the distress and impairment approach); they may include examples we intuitively feel are *not* examples of psychopathology (e.g. the statistical approach, the deviation from social norms approach); or they may represent forms of categorization that would lead us simply to impose stigmatizing labels on people rather then considering their individual needs (e.g. the statistical approach). In practice, classification schemes tend to use an amalgamation of all these approaches, with emphasis being placed on individual approaches depending on the nature of the symptoms and disorder being classified.

SELF-TEST QUESTIONS

- What are the problems with using the normal curve to define psychopathology?
- How do cultural factors make it difficult to define psychopathology in terms of deviations from social norms?
- What are the pros and cons of using maladaptive behaviour or distress and impairment as means of defining psychopathology?

SECTION SUMMARY

1.2 Defining Psychopathology

- Potential ways of defining psychopathology include **deviation from the statistical norm**, **deviation from social norms**, exhibiting **maladaptive behaviour** and experiencing **distress and impairment**.

1.3 CLASSIFYING PSYCHOPATHOLOGY

At this point you may be saying to yourself, 'why try to define and classify psychopathology at all?' Nevertheless, there are some good reasons for wanting to do this. First, as a social and biological science, psychology will want to try to understand the causes of mental health problems. This is important so that we can develop both effective treatments that address the root causes of psychopathology and prevention strategies designed to reduce the risk of individuals developing symptoms of psychopathology. Most sciences use classification to group phenomena into categories according to their similarities. Categorization and classification is thus an important first stage in the pursuit of knowledge about causes and aetiology, and it would be difficult to discuss aetiology in this book if there were not some form of classification that enabled us to understand how different causes relate to different symptoms. Secondly, classification is necessary if we are to organize services and support for sufferers effectively. For example, the needs of individuals with intellectual disabilities, major depression, an anxiety-based disorder or substance dependency are all very different and require different approaches and means of support and intervention. Thirdly, how do we decide if our interventions and support for sufferers have been effective unless we have some objective way of defining what constitute the symptoms of psychopathology? One important and objective way of determining whether an individual is responding to treatment is to see if there has been any improvement in objectively defined and measurable symptoms. Finally, whether we like it or not, modern-day society requires that we assess and classify people for a number of reasons, and this is also the case with psychopathology. For example, we might want to know whether a person is psychologically fit to stand trial for a criminal offence, whether a child has disabilities that will require special educational needs, or whether financial compensation or damages should be awarded to an individual because of psychological symptoms caused by the actions of others. All of these requirements of modern society necessitate a form of assessment and classification that can adequately and objectively deal with these kinds of issues.

1.3.1 The Development of Classification Systems

Arguably the first person to develop a comprehensive classification system for psychopathology was the German psychiatrist Emil Kraepelin (1883–1923). He suggested that psychopathology, like physical illness, could be classified into different and separate pathologies, each of which had a different cause and could be described by a distinct set of symptoms which he called a ***syndrome***. Kraepelin's work provided some hope that mental illness could be described and successfully treated in much the same way as other medical illnesses.

Syndrome A distinct set of symptoms.

Following on from Kraepelin's scheme, the first extensive system for classifying psychopathology was developed by the World Health Organization (WHO), who added psychological disorders to the ***International List of Causes of Death (ICD)*** in 1939. Despite this development, the mental disorders section in the ICD was not widely accepted, and in 1952 the ***American Psychiatric Association (APA)*** published

***International List of Causes of Death* (ICD)** The international standard diagnostic classification developed by the World Health Organization (WHO).

American Psychiatric Association (APA) A scientific and professional organization that represents psychiatry in the United States.

***Diagnostic and Statistical Manual* (DSM)**
An American Psychiatric Association handbook for mental health professionals that lists different categories of mental disorders and the criteria for diagnosing them.

its first ***Diagnostic and Statistical Manual (DSM)***. In 1968 the APA produced a second version of its diagnostic manual (DSM-II). In 1969, the WHO published a new classification system, which was more widely accepted, and in the UK a glossary of definitions was produced to accompany the WHO system (General Register Office, 1968). However, the WHO system was simply a listing of diagnostic categories, and while DSM-II and the British Glossary of Mental Disorders provided more information on which to base diagnoses, the actual practice of diagnosing psychopathology varied widely. In 1980, the APA produced a substantially revised and expanded DSM-III, which has come to be accepted as the most influential diagnostic system. The most recent version that is used in this book is DSM-IV-TR (TR means 'text revision'), published in 2000. APA task forces are already working on the next revision, DSM-V, which is due to be published in 2011. The ICD system is currently in its tenth edition (ICD-10), and most revisions of the DSM have been coordinated with the ICD to ensure some consistency of diagnosis across systems. For convenience and consistency, we will be using only the DSM diagnostic system in this book (see Cooper, 1994, for a guide to the ICD-10 classification system).

1.3.2 DSM-IV-TR

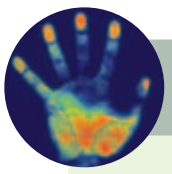
1.3.2.1 Defining and Diagnosing Psychopathology

Before attempting to classify psychopathology, it was necessary for DSM to define what it considers to be a mental disorder. As we have already seen in section 1.2, this is not a simple matter. However, DSM does make some attempt to rule out behaviours that are simply socially deviant as examples of psychopathology, and puts the emphasis on distress and disability as important defining characteristics. Focus Point 1.4 shows the relevant section from DSM-IV-TR that attempts to define what should be classified as a mental disorder. It is also important to try to define at this point what exactly the DSM system is designed to do. Wakefield (1997) argues that DSM has four basic objectives: (1) it must provide necessary and sufficient criteria for correct differential diagnosis; (2) it should provide a means of distinguishing 'true' psychopathology (in the medical sense) from non-disordered human conditions that are often labelled as 'problems in living'; (3) it should provide diagnostic criteria in a way that allows them to be applied systematically by different clinicians in different settings; and (4) the diagnostic criteria it provides should be theoretically neutral, in the sense that they do not favour one theoretical approach to psychopathology over another. Whether DSM can achieve these four objectives will be to some extent the measure of its success.

DSM-IV-TR also provides the following information: (1) *essential features* of the disorder (those that 'define' the disorder), (2) *associated features* (i.e. those that are usually, but not always, present), (3) *diagnostic criteria* (a list of symptoms that must be present for the patient to be given this diagnostic label) and (4) information on *differential diagnosis* (i.e. information on how to differentiate this disorder from other, similar disorders). Finally, as we mentioned earlier, an important feature of DSM is that it avoids any suggestion about the cause of a disorder unless the cause has been definitely established. This means that diagnosis is made almost entirely on the basis of observable behavioural symptoms rather than on any supposition about the underlying cause of the symptoms.

1.3.2.2 The Dimensions of Classification

DSM-IV-TR encourages clinicians to rate individuals on five separate dimensions, or axes, and these are listed in Table 1.3. Axes I and II cover the classification of psychopathology, with Axis I comprising the majority of common diagnostic categories such as anxiety disorders, depression, schizophrenia, etc. Axis II consists of personality disorders and intellectual disabilities, and covers psychopathologies that may be more chronic and long term. These disorders are separated onto two different axes to encourage



FOCUS POINT 1.4

The DSM-IV-TR definition of psychopathology

'In DSM-IV-TR, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g. political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual.'

(APA, 2000, pp. xxi–xxii)

Table 1.3 *The five dimensions of classification in DSM-IV-TR*

AXIS I	Clinical Disorders (e.g. anxiety disorders, mood disorders, schizophrenia and other psychotic disorders, etc.). Other conditions that may be a focus of clinical attention.
AXIS II	Personality Disorders (e.g. antisocial personality disorder, schizotypical personality disorder, etc.). Mental Retardation.
AXIS III	General Medical Conditions (e.g. infectious and parasitic diseases, diseases of the circulatory system, injury and poisoning, etc.).
AXIS IV	Psychosocial and Environmental problems (e.g. problems with primary support group, educational problems, economic problems).
AXIS V	Global Assessment of Functioning.

clinicians to explore the possibility that some shorter-term disorders (e.g. a diagnosed anxiety disorder) may also be concurrent with a longer-term disorder (such as a personality disorder). Axes III, IV and V are included so that the clinician can acquire a fuller appreciation of an individual's life situation. For example, a chronic physical illness, such as cancer or a cardiac disorder, may be a source of psychopathology symptoms (e.g. depression) and may affect what kinds of treatment interventions can be made. For example, it may be that certain forms of medication for depression should not be used if the client has a heart condition. In addition, Axis IV allows the clinician to note any psychosocial, environmental, financial or family factors that might be influencing psychopathology. Finally, Axis V allows the clinician to take a broader look at the client's level of psychological and social functioning, and assess the client's ability in the longer term to cope with any symptoms of psychopathology.

1.3.2.3 Problems with Classification

While DSM-IV-TR provides an objective and reliable set of criteria by which psychopathology symptoms can be diagnosed, it is in many senses imperfect.

First, we have already mentioned that it does not classify psychopathology according to its causes, but does so merely on the basis of symptoms. This can be problematic in a number of different ways. For example, psychopathologies that look the same on the surface may have different causes, and as a consequence require different forms of treatment. Also, diagnosis on the basis of symptoms gives the illusion of explanation, when it is nothing more than a redescription of the symptoms (Carson, 1996). So, to say that the client 'hears voices because she has schizophrenia' sounds like an explanation, but within DSM, schizophrenia is merely a collective term for the defining symptoms.

Second, simply using DSM criteria to label people with a disorder can be stigmatizing and harmful. We have already seen in section 1.2 that individuals with a psychopathology diagnosis tend to be viewed and treated differently within society. In addition, diagnostic labels actually encourage individuals to adopt a 'sick' role and can result in people adopting a long-term role as someone with what they perceive as a debilitating psychopathology (Scheff, 1975).

Thirdly, DSM diagnostic classification tends to define disorders as ***discrete entities*** (i.e. after being assessed, you will either be diagnosed with a disorder or you will not). However, much recent evidence has begun to suggest that psychopathology may be ***dimensional approach to classification*** rather than discrete (Krueger & Piasecki, 2002). That is, symptoms diagnosed as a disorder may just be more extreme versions of everyday behaviour. For example, at times we all worry about our own life problems – some more than others. In extreme cases this activity can become so regular and persistent that it will interfere with our daily living and may meet DSM-IV-TR criteria for diagnosis as a disorder (e.g. generalized anxiety disorder, GAD; see Chapter 5). In such circumstances, the cut-off point for defining an activity such as worrying as a disorder becomes relatively arbitrary.

Discrete entities The tendency to define individuals as either having a particular disorder or not.

Dimensional approach to classification The idea that symptoms diagnosed as a disorder may just be more extreme versions of everyday behaviour.

In an attempt to deal with this criticism, a clinical significance criterion was added to many diagnostic categories in DSM-IV-TR which requires that symptoms cause 'significant distress or impairment in social, occupational, or other important areas of functioning' (Spitzer & Wakefield, 1999). The purpose of this is to try to differentiate symptoms that reflect normal reactions to stress with which the individual may be able to cope from those that may require intervention and treatment to restore functioning. The fact that most psychopathology is dimensional rather than categorical is likely to be reflected in revisions in DSM-V and will enable disorders to be diagnosed at different levels of severity.

Fourthly, DSM conceptualizes psychopathology as a collection of hundreds of distinct categories of disorders, but what happens in practice provides quite a different picture. For example, the discrete, differentially defined disorders listed in DSM regularly co-occur. This is known as ***comorbidity***, where an individual client will often be diagnosed with two or more distinct disorders (e.g. an anxiety disorder such as obsessive-compulsive disorder and major depression). What is interesting is that comorbidity is so common that it is the norm rather than the exception. For example, surveys suggest that up to 79 per cent of individuals diagnosed with a disorder at some point during their lifetime will have a history of more than one disorder (Kessler, McGonagle, Zhao, Nelson et al., 1994).

Comorbidity The co-occurrence of two or more distinct disorders.

The frequency of comorbidity suggests that most disorders as defined by DSM may indeed not be independent discrete disorders but may represent symptoms of either ***hybrid disorders***

Hybrid disorders Disorders that contain elements of a number of different disorders.

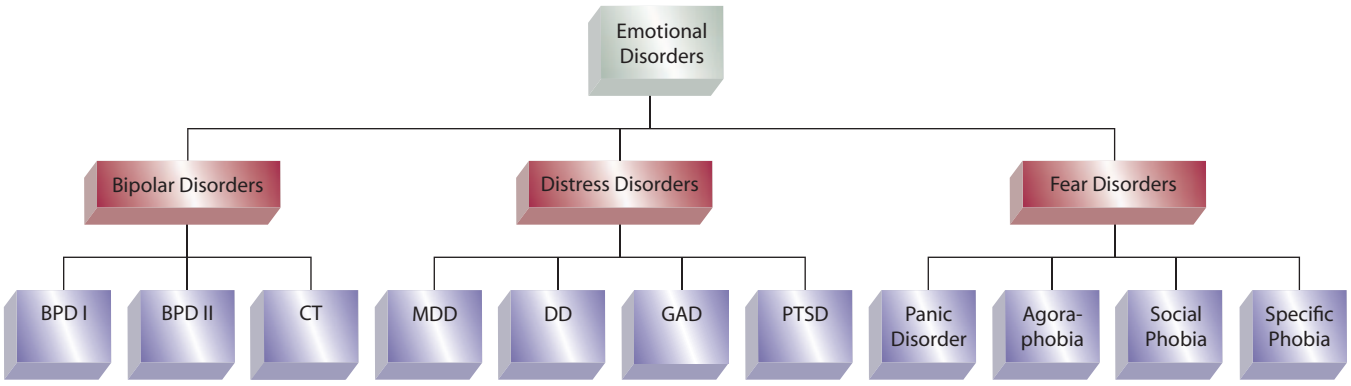


Figure 1.4
More detailed research on anxiety and depressive disorders can help reveal the way in which individual disorders are related and why many diagnosable disorders are frequently comorbid. This figure shows a proposed spectrum of emotional disorders which indicates how anxiety and depression may be related. For example, the fact that MDD and GAD are both classified as distress disorders provides some indication of why these two apparently different DSM disorders are frequently comorbid. Only the bottom line of the figure represents the individual disorders defined in DSM-IV-TR. BPD I = bipolar I disorder; BPD II = bipolar II disorder; CT = cyclothymia; MDD = major depressive disorder; DD = dysthymic disorder; GAD = generalized anxiety disorder; PTSD = post-traumatic stress disorder.

Source: Watson (2005).

(e.g. a disorder that contains elements of a number of different disorders) or a more broad-ranging *syndrome* or *disorder spectrum* that represents a higher-order categorical class of symptoms (Krueger, Watson & Barlow, 2005; Widiger & Samuel, 2005). An example of a hybrid disorder is ***mixed anxiety-depressive disorder***. Many people exhibit symptoms of both anxiety and depression, yet do not meet the threshold for either an anxiety or a depression diagnosis (Barlow & Campbell, 2000). Examples such as this suggest that because DSM defines disorders as numerous discrete entities, it fails to recognize cases where discrete symptoms, although individually not reaching a level significant enough for diagnosis, may collectively be causing considerable distress.

Mixed anxiety-depressive disorder
A hybrid disorder exhibiting symptoms of both anxiety and depression.

There is also a broader theoretical implication to the fact that comorbidity is so common. This is that psychopathology may occur in a spectrum that has a hierarchical structure rather than consisting merely of numerous discrete disorders. For example, Watson (2005) argues that anxiety and depression (which are both diagnosed as separate disorders in DSM-IV-TR) may both be members of a larger spectrum of emotional disorders. This is based on the facts that (1) 58 per cent of individuals with major depression also meet DSM criteria for a comorbid anxiety disorder (Kessler, Nelson, McGonagle, Liu et al., 1996), (2) various anxiety disorders are highly comorbid with each other (Brown, Campbell, Lehman, Grisham et al., 2001) and (3) depression and anxiety are together both highly comorbid with other psychopathologies, such as substance abuse, eating disorders, somatoform disorders and personality disorders (Mineka, Watson & Clark, 1998; Widiger & Clark, 2000).

Figure 1.4 provides a schematic representation of this proposed spectrum of emotional disorders, indicating its hierarchical structure and showing how individual disorders defined in DSM may only represent the bottom level of this hierarchy. Defining psychopathology in such hierarchical structures rather than as discrete independent entities has the benefit of explaining and predicting comorbidity and begins to provide some theoretical insight into how different symptoms may be related.

One final problem with DSM-IV-TR as it is currently constructed is that the diagnostic criteria often allow for extensive within-category heterogeneity (Krueger, Watson & Barlow, 2005). For example, the DSM diagnostic criteria for a personality disorder often specify that the individual must meet the criteria for only five of nine specified symptoms; thus, individuals who are diagnosed with a personality disorder may share no more than one common feature. In some cases (e.g. obsessive-compulsive personality disorder; see Chapter 11), it is theoretically possible for two different diagnosed cases to have no shared features at all. This means that there can be great variability in the symptoms displayed by different individuals diagnosed with the same disorder.

SUMMARY

While DSM-IV-TR is not ideal, it is the most comprehensive classification system we have available. While we have just listed a number of criticisms of DSM, we must also remember that classification in and of itself does have some advantages (see p. 00). We must also remember that DSM is an evolving classification system that takes into account criticisms of previous versions and develops to incorporate recent research. Thus, when DSM-V is published in 2011, it is likely to have attempted to address some of the problems with diagnosis that we have listed above.

SELF-TEST QUESTIONS

- Can you briefly describe the history of the development of psychopathology classification systems?
- What is the DSM classification system primarily designed to do?
- What are the five axes or dimensions of classification in DSM?
- DSM is not an ideal classification system. Can you describe at least four problems associated with this method of classification?

SECTION SUMMARY

1.3 Classifying Psychopathology

- The two most influential classification systems are the **American Psychiatric Association (APA)** ***Diagnostic and Statistical Manual*** and the **World Health Organization (WHO)** ***International List of Causes of Death*** **(ICD)**.
- Currently, the most widely adopted classification system is **DSM-IV-TR**.
- DSM-IV-TR encourages clinicians to rate clients on five separate **axes**.

1.4 GOOD PSYCHOLOGICAL HEALTH

So far in this chapter we have focused on psychopathology, mental health problems and diagnosable psychological disorders, but we must remember that it is often useful when defining psychopathology to view it in the context of what we would normally consider to be criteria for ***good psychological health***. Table 1.3 shows that Axis V of DSM-IV-TR attempts to measure the individual's current level of adaptive functioning in areas of social relationships, employment and use of leisure time. In most cases, good psychological health can be indicated by the presence of most of the following attributes: (1) an efficient perception of reality, (2) good self-knowledge and awareness of one's own feelings, (3) the ability to exercise voluntary control over behaviour, (4) good self-esteem and an appreciation of one's own worth, (5) an ability to form and maintain affectionate relationships with others and (6) productivity – a positive and planned approach to life. Table 1.4 shows the ***Global Assessment of Functioning Scale (GAF)*** that is used to assess adaptive functioning, and this acts as a measure of psychological health that can be contrasted with measures of psychopathology.

Good psychological health A measure of an individual's current level of adaptive functioning in areas of social relationships, employment and use of leisure time.

Global Assessment of Functioning Scale (GAF) A scale used to assess adaptive functioning which acts as a measure of psychological health that can be contrasted with measures of psychopathology.

Table 1.4 *The Global Assessment of Functioning (GAF) Scale*

Score	*Criteria*
100–91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
90–81	Absent or minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members).
71–80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational or school functioning (e.g. temporarily falling behind in schoolwork).
61–70	Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational or school functioning (e.g. occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
51–60	Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational or school functioning (e.g. no friends, conflicts with peers or co-workers).
41–50	Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).
31–40	Some impairment in reality testing or communication (e.g. speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgement, thinking or mood (e.g. depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).

Table 1.4 *(Cont'd)*

21–30	Behaviour is considerably influenced by delusions or hallucinations OR serious impairments in communication or judgement (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupations) OR inability to function in almost all areas (e.g. stays in bed all day, no job, home or friends).
11–20	Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g. smears faeces) OR gross impairment in communication (e.g. largely incoherent or mute).
1–10	Persistent danger of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal acts with clear expectation of death.
0	Inadequate information.

Source: taken from DSM-IV-TR (APA, 2000), p. 34.

SECTION SUMMARY

1.4 Good Psychological Health

- Criteria for good psychological health can be found in the **Global Assessment of Functioning Scale** (**GAF**).

1.5 CONCEPTUAL AND CLASSIFICATION ISSUES REVIEWED

This chapter has introduced the important conceptual and classification issues that surround psychopathology. We have discussed how methods of explaining psychopathology have developed over the ages and moved on to a more scientific basis with the advent of medical and psychological models of psychopathology. The medical model proved to be an important stepping stone towards objective explanations of psychopathology, but still has significant limitations, including the fact that it implies an underlying medical cause for psychopathology – which is not always true – and that psychopathology is caused by 'something biological or psychological not working properly' – again, an implication which is not always correct. The four main psychological approaches, psychodynamic, behavioural, cognitive and humanistic-existential, all provide a rather different means of explaining psychopathology, and all four approaches are still influential today.

Defining exactly what kinds of symptoms or behaviour should be considered as examples of psychopathology is also problematic. The four types of definition that we discussed (deviation from the statistical norm, deviation from social norms, maladaptive behaviour and distress and impairment) all have limitations. Some fail to cover examples of behaviour that we would intuitively believe to be representative of mental health problems, while others may cover examples that we intuitively feel are not examples of psychopathology, or they may represent forms of categorization that would lead us to impose stigmatizing labels on people suffering from psychopathology. In practice, classification schemes end up using an amalgamation of these different approaches to definition.

Finally, we discussed the pros and cons of classification schemes for psychopathology and how these schemes developed. The most commonly accepted form of classification is the APA *Diagnostic and Statistical Manual* (DSM), whose current version is DSM-IV-TR. This is the version we will be referring to throughout this text.

LEARNING OUTCOMES

When you have completed this chapter, you should be able to:

1. Compare and contrast approaches to the explanation of psychopathology, including historical approaches, the medical model and psychological models.
2. Discuss the pros and cons of a number of different approaches to defining psychopathology.
3. Describe the history of the development of psychopathology classification systems.
4. Compare and contrast the pros and cons of DSM as a means of classifying and diagnosing psychopathology.

KEY TERMS

Abnormal psychology *17*
American Psychiatric Association (APA) *20*
Ataque de Nervios *18*
Behaviour modification *14*
Behaviour therapy *14*
Behavioural model *00*
Classical conditioning *13*
Client-centred therapy *15*
Clinical psychology *5*
Cognitive behaviour therapy (CBT) *15*
Cognitive model *000*
Comorbidity *22*
Defence mechanisms *12*
Demonology *6*
Diagnostic and Statistical Manual (DSM) *21*
Dimensional approach to classification *22*
Discrete entities *22*
DSM-IV-TR *000*
Ego *11*
Ego defence mechanisms *11*
Empathy *15*
General paresis *000*
Global Assessment of Functioning Scale (GAF) *24*
Good psychological health *24*
Humanist-existentialist approach *000*
Hybrid disorders *22*
Id *11*
International List of Causes of Death (ICD) *20*
Learning theory *13*
Mad Pride *17*
Medical model *000*
Mixed anxiety-depressive disorder *23*
Operant conditioning *13*
Oral stage *12*
Psychiatry *000*
Psychoanalysis *11*
Psychological models *000*
Psychopathology *5*
Seizisman *18*
Service user groups *17*
Sigmund Freud *11*
Somatogenic hypothesis *000*
Stages of development *12*
Statistical norm *17*
Superego *11*
Syndrome *20*
Unconditional positive regard *15*

REVIEWS, THEORIES AND SEMINAL STUDIES

Links to Journal Articles

1.1 Explaining Psychopathology

Crisp, A.H., Gelder, M.G., Rix, S., Meltzer, H.I. & Rowlands, O.J. (2000). Stigmatization of people with mental illness. *British Journal of Psychiatry, 177*, 4–7.

1.2 Defining Psychopathology

British Psychological Society (2000). *Recent advances in understanding mental illness and psychotic experiences*. London: British Psychological Society.

Desrosiers, A. & Fleurose, S.S. (2002). Treating Haitian patients: Key cultural aspects. *American Journal of Psychotherapy, 56*, 508–521.

Nicolas, G., DeSilva, A.M., Grey, K.S. & Gonzalez-Eastep, D. (2006). Using a multicultural lens to understand illness among Haitians living in America. *Professional Psychology: Research and Practice, 37*, 702–707.

1.3 Classifying Psychopathology

Krueger, R.F. & Piasecki, T.M. (2002). Toward a dimensional and psychometrically informed approach to conceptualizing psychopathology. *Behaviour Research and Therapy, 40*, 485–499.

Krueger, R.F., Watson, D. & Barlow, D.H. (2005). Introduction to the special section: Towards a dimensionally based taxonomy of psychopathology. *Journal of Abnormal Psychology, 114*, 491–493.

McNally, R.J. (2001). On Wakefield's harmful dysfunction analysis of mental disorder. *Behaviour Research and Therapy, 39*, 309–314.

Wakefield, J.C. (1997). Diagnosing DSM-IV. Part I. DSM-IV and the concept of disorder. *Behaviour Research and Therapy, 35*, 633–649.

Watson, D. (2005). Rethinking the mood and anxiety disorders: A quantitative hierarchical model for DSM-V. *Journal of Abnormal Psychology, 114*, 522–536.

Widiger, T.A. & Samuel, D.B. (2005). Diagnostic categories or dimensions? A question for the Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition. *Journal of Abnormal Psychology, 114*, 494–504.

Texts for Further Reading

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: American Psychiatric Association.

Cave, S. (2002). *Classification and diagnosis of psychological abnormality*. Hove: Psychology Press.

Cooper, J.E. (1994). *Pocket guide to ICD-10 classification of mental and behavioural disorders*. New York: Churchill Livingstone.

Helzer, J.E. & Hudziak, J.J. (2002). *Defining psychopathology in the 21st Century: DSM-V and beyond*. Washington, DC: American Psychiatric Press.

Maj, M., Gaebel, W., Lopez-Ibor, J. & Sartorius, N. (Eds.) (2002). *Psychiatric diagnosis and classification*. New York: Wiley.

RESEARCH QUESTIONS

- Psychoanalytic and psychodynamic approaches to psychopathology are still very influential, but can the central concepts in this approach be objectively defined and measured as part of an attempt to assess the validity of the approach?
- Behavioural approaches often stress the important of reinforcement histories in psychopathology, but are there any objective and systematic ways in which reinforcement histories can be traced?
- Can the efficacy of humanistic-existentialist therapies ever be objectively measured and compared with the efficacy of other therapies?
- Can research on the causes of psychopathology provide a basis for the classification of psychopathology?
- How can psychopathology research contribute to an understanding of comorbidity?
- Can psychopathology research provide an insight into the way in which different diagnostic disorders are related?

CLINICAL ISSUES

1.1 Explaining Psychopathology

- Should clinical psychologists be looking for physical or biological impairments as the causes of psychopathology?
- Is 'bizarre' behaviour always a good indication of underlying psychopathology?
- Is psychopathology simply a more extreme form of normal behaviour?
- What do clinical psychologists need to do in order to challenge existing negative stereotypes of individuals with mental health problems?
- Depressed or low mood is often associated with receiving a psychiatric diagnosis. What can clinical practitioners do to minimize this?

1.2 Defining Psychopathology

- Psychopathology textbooks and courses still use the title 'Abnormal Psychology'. What effect might this title have on conceptions of psychopathology, and what can clinical practitioners do to influence the use of this and similar titles?
- How do cultural factors affect both our definition of psychopathology and our attempts at diagnosis?
- Is the presence of personal distress and impairment necessary for identifying symptoms as examples of psychopathology?

1.3 Classifying Psychopathology

- Do clinical psychologists need psychopathology classification systems in order to do their job properly?
- What are the basic functions of a classification scheme such as DSM?
- What are the problems for the practising clinician of using a diagnostic system that does not classify psychopathology according to its causes?
- Does giving clients a diagnostic label tend towards their adopting a 'sick role'?
- Should only individuals who have been diagnosed with a DSM-classified disorder be provided with access to structured treatment?
- Are the DSM diagnostic criteria so heterogeneous in some cases that it is possible to diagnose two people with the same disorder, although in fact they have no symptoms in common?