Part I

Introducing Psychopathology: Concepts, Procedures and Practices

1 An Introduction to Psychopathology: Concepts, Paradigms & Stigma
2 Classification & Assessment in Clinical Psychology
3 Research Methods in Clinical Psychology
4 Treating Psychopathology
5 Clinical Practice
An Introduction to Psychopathology: Concepts, Paradigms and Stigma

This first chapter introduces the reader to a number of basic issues concerned with the definition and explanation of psychopathology – including the issue of ‘stigma’ that is often an outcome of how psychopathology is conceptualized and portrayed. The first section describes a brief history of how mental health problems have been conceived and treated. This is followed, in the second section, by a discussion of how psychopathology can be defined, and how we identify behaviour that is in need of support and treatment. The third section describes some of the most common explanatory approaches that have been developed to help us understand psychopathology, and these approaches are ones that the reader will encounter frequently throughout this book. Finally, the fourth section takes a close look at mental health stigma, how it is manifested, why it is important, and how stigma can be dealt with.

ROUTE MAP OF THE CHAPTER

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CHAPTER OUTLINE

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LEARNING OUTCOMES

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

1. Discuss the pros and cons of a number of different approaches to defining psychopathology.
2. Describe important developments in the history of our understanding and response to mental health problems.
3. Describe and evaluate the nature and causes of mental health stigma.
4. Compare and contrast approaches to the explanation of psychopathology, including historical approaches, the medical model and psychological models.

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 past 10 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 past 10 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 five or six aliens, and 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
**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 seeing 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 they each 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 are known as **psychopathology**, and the branch of psychology responsible for understanding and treating psychopathology is known as **clinical psychology**.

*Erica’s Story*

I started using cocaine at 13. 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 15. 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. Every day, after a while. Along with cocaine, I also began taking prescription drugs when I was 13. 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 parents’ 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.

Let’s examine our four personal accounts a little closer. *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 and 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 *Erica* 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 delusional and 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 they are 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 the way we define psychopathology has evolved over time, and ways in which we can define and classify psychopathology and mental health problems generally.

### 1.1 A BRIEF HISTORY OF 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. An historical perspective on psychopathology and ‘madness’ is important because it helps us to understand how our views of the causes of mental health problems have changed and developed over time, and it also helps us to understand how approaches to treating and dealing with mental health problems have changed. We will begin by looking at an historical perspective on explaining psychopathology, which is known as demonic possession. We will then describe how the medical model of psychopathology developed, and finish with a discussion of the transition from asylums to community care.

#### 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 that 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.

In Western societies, demonology survived as an explanation of mental health problems right up until the 18th 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, they were 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). The continued adoption of demonic possession
as an explanation of mental health problems (especially in relation to psychotic symptoms) is often linked to local religious beliefs (Ng, 2007; Hanwella, de Silva, Yoosuf, Karunaratne & de Silva, 2012), and may often be accompanied by exorcism as an attempted treatment – even in individuals with a known history of diagnosed psychotic symptoms (e.g. Tajima-Pozo, Zambrano-Enriquez, de Anta, Moron, Carrasco, Lopez-Ibor et al., 2011).

SPIRIT POSSESSION AS A TRAUMA-RELATED PHENOMENON IN UGANDAN CHILD SOLDIERS

Even today, many cultures still believe that unusual behaviour that may be symptomatic of psychopathology is caused by spirit possession – especially in some less developed areas of the world where such beliefs are still important features of the local culture. Interestingly, beliefs about spirit possession are not simply used to try and explain the effects of psychopathology-related experiences, but are also regularly used to control and coerce individuals.

Neuner, Pfeiffer, Schauer-Kaiser, Odenwald et al. (2012) carried out a study investigating the prevalence of cen, a local variant of spirit possession, in youths aged between 12 and 25 years in war-affected regions of northern Uganda. They compared youths who had been abducted and forced to fight as child soldiers in the so-called Lord’s Resistance Army – a group that has waged a long and brutal campaign to overthrow the government of Uganda – with youths who had never been abducted.

Cen is a form of spirit possession where the ‘ghost of a deceased person visits the affected individual and replaces his or her identity’. The table below shows that reporting of spirit possession is significantly higher in former abducted child soldiers than in non-abductees. They also found that reports of spirit possession were related to trauma exposure (such as sexual assault and being forced to kill), to psychological distress, and to higher rates of suicide and post-traumatic stress disorder.

Neuner, Pfeiffer, Schauer-Kaiser, Odenwald et al. (2012) conclude that in many of the areas of the world where beliefs about spirit possession are widely held, such beliefs are a standard consequence of psychological trauma and may be a way of explaining the dissociative symptoms that often accompany intense traumatic experiences (see Chapter 14). These beliefs about spirit possession can then be used by various local agencies to manipulate the behaviour of individuals – even to the extent of coercing them into acts of extreme brutality.

<table>
<thead>
<tr>
<th>Characteristics of spirit possession (%)</th>
<th>Total</th>
<th>Abductees</th>
<th>Non-abductees</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the past 4 weeks, were you haunted by ghosts of a deceased person?</td>
<td>14.4</td>
<td>21.3</td>
<td>9.2</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Within the past 4 weeks, did these spirits enter your body and replace your inner self?</td>
<td>10.3</td>
<td>17.3</td>
<td>5.2</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Within the past 4 weeks, during the time the spirit possessed you, did you show behaviour or make movements that were not under your control, but controlled by the spirit?</td>
<td>9.0</td>
<td>15.4</td>
<td>3.9</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Within the past 4 weeks, did it occur that you had lack of memory for parts of the time or the whole time the spirit possessed you?</td>
<td>15.1</td>
<td>23.6</td>
<td>8.8</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Did you ever seek help because ghosts haunted you?</td>
<td>15.1</td>
<td>23.6</td>
<td>8.8</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Four or more characteristics (high spirit possession)</td>
<td>8.2</td>
<td>14.3</td>
<td>3.7</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

1.1.2 The Medical or Disease Model

As cultures develop, then so too do the types of causes that they attribute behaviour to. 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 19th 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 cause 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.

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, and this profession is known as psychiatry. The primary approach of 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 attempts 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 pregnancy) (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 important implications for the way we conceive mental health problems. Firstly, 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 8 we describe the example of the schizophrenia sufferer who learnt through perfectly normal learning processes to carry a broom around with them for 24 hours a day (see Focus Point 8.5). 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 17.1). 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. In addition, complex mental health problems are often not just biological or even simply reducible to psychological...
problems and processes, they are influenced by the socio-economic situation in which the individual lives, their potential for employment and education, and the support they are given that will provide hope for recovery and support for social inclusion (this broad ranging approach to understanding and treating mental health problems is known as the recovery model, and is discussed in more detail in section 5.3.3). All of these factors arguably contribute to a full understanding and explanation of psychopathology.

Finally, 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 couple of reasons. First, 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 form 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 6). Nevertheless, there is no reason to suppose that the cognitive mechanisms that generate the occasional bout of worrying 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. There is accumulating evidence that important psychopathology symptoms are on a dimension from normal to distressing, rather than being qualitatively distinct (e.g. Haslam, Williams, Kyrios, McKay & Taylor, 2005; Olatunji, Williams, Haslam, Abramowitz & Tolin, 2008). A second reason this view is problematic is that, 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. At the very least it can be stigmatising 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.

### 1.1.3 From Asylums to Community Care

Prior to the 18th century, hospitals and asylums were few and far between, and those that were established were often devoted to very specific and often highly infectious illnesses (such as leprosy). ‘Madness’ was considered to be a local or domestic problem, and individuals suffering mental health problems would either be cared for by their families or by their local parish authorities. However, as many traditional infectious diseases became less common, many hospitals for these diseases were converted into asylums for the confinement of individuals with mental health problems.

Because there was no coordinated government response to mental health issues until the 19th century, individual privately funded hospitals or ‘madhouses’ began to appear prior to this time, and the most famous of these was the Bethlem Hospital in Moorfields, London, which in 1676 had a capacity for 100 inmates (Porter, 2006). Life in these asylums was often cruel and inhumane, and because ‘madhouses’ were essentially businesses established for financial profit, many expanded to take more and more sufferers in conditions that were not subject to inspection under the relevant legislation of the time (MacKenzie, 1992). Any medical treatments provided were usually crude and often painful (e.g. drawing copious quantities of blood from the brain, hot and cold baths, mercury pills, or administration of the opiate laudanum to pacify inmates), and the nature of the inmates often expanded to include not just those with mental health problems, but paupers and individuals from poor backgrounds – especially young pregnant women, who were considered to be ‘wayward’ or ‘morally degenerate’. This growing hotchpotch of inmates in 18th- and 19th-century asylums gave rise to ad hoc approaches to mental health care that were based around combating moral degeneration and ‘social weakness’, and such approaches probably represent the roots of the modern-day stigma that is associated with mental health problems. Indeed, in Victorian times, the public could buy tickets to view the inmates of asylums, a process that will have increased the conception that individuals with mental health problems were objects of curiosity excluded from everyday society.

However, in the 19th century there was a gradual movement towards more humane treatments for individuals in asylums, and these developments were led by a number of important reforming pioneers. Philippe Pinel (1745–1826) is often considered to be the first to...
introduce more humane treatments during his time as the superintendent of the Bicêtre Hospital in Paris. He began by removing the chains and restraints that had previously been standard ways of shackling inmates, and started to treat these inmates as sick human beings rather than animals. Further enlightened approaches to the treatment of asylum inmates were pioneered in the USA by Benjamin Rush of Philadelphia, and by the Quaker movement in the UK. The latter developed an approach known as moral treatment, which abandoned contemporary medical approaches in favour of understanding, hope, moral responsibility, and occupational therapy (Digby, 1985).

Even into the 20th century and up until the 1970s in both the UK and the USA, hospitalization was usually the norm for individuals with severe mental health problems, and lifelong hospitalization was not uncommon for individuals with chronic symptoms. However, it became clear that custodial care of this kind was neither economically viable nor was it providing an environment in which patients had an opportunity to improve. Because of the growing numbers of in-patients diagnosed with mental health problems, the burden of care came to rest more and more on nurses and attendants who, because of lack of training and experience, would resort simply to restraint as the main form of intervention. This would often lead to deterioration in symptoms, with patients developing what was called social breakdown syndrome, consisting of confrontational and challenging behaviour, physical aggressiveness, and a lack of interest in personal welfare and hygiene (Gruenberg, 1980).

Between 1950 and 1970, these limitations of hospitalization were being recognized and there was some attempt to structure the hospital environment for patients. The first attempts were known as milieu therapies, which were the first attempts to create a therapeutic community on the ward which would develop productivity, independence, responsibility and feelings of self-respect. This included mutual respect between staff and patients, and the opportunity for patients to become involved in vocational and recreational activities. Patients exposed to milieu therapy were more likely to be discharged from hospital sooner and less likely to relapse than patients who had undergone traditional custodial care (Paul & Lentz, 1977; Cumming & Cumming, 1962). A further therapeutic refinement of the hospital environment came with the development of token economy programmes (Ayllon & Azrin, 1968). These were programmes based on operant reinforcement, where patients would receive tokens (rewards) for exhibiting desired behaviours. These desired behaviours would usually include social and self-help behaviours (e.g. communicating coherently to a nurse or other patient, or washing or combing hair), and tokens could subsequently be exchanged for a variety of rewards such as chocolate, cigarettes and hospital privileges. A number of studies have demonstrated that token economies can have significant therapeutic gains. For example, Gripp & Magaro (1971) showed that patients in a token economy ward improved significantly more than patients in a traditional ward, and Gershone, Errickson, Mitchell & Paulson (1977) found that patients in a token economy ward were better groomed, spent more time in activities and less time in bed, and made fewer disturbing comments than patients on a traditional ward. Patients on token economy schemes also earn discharge significantly sooner than patients who are not on such a scheme or have been involved in a milieu therapy programme (Hofmeister, Schneckenbach & Clayton, 1979; Paul & Lentz, 1977). However, despite the apparent success of token economies, their use in the hospital setting has been in serious decline since the early 1980s (Dickerson, Tennhula & Green-Paden, 2005). There are a number of reasons for this decline, and they are discussed in Focus Point 1.2.

Since the 1970s treatment and care of individuals diagnosed with severe mental health problems has moved away from long-term hospitalization to various forms of community care. However, the psychiatric hospital is still an important part of the treatment picture for those displaying severe and distressing symptoms – especially since it will often be the environment in which treatment takes place for an individual’s first acute experience (e.g. a first psychotic episode). However, length of stay in hospital for individuals has been significantly reduced as a
Despite its apparent therapeutic advantages, recent surveys indicate that the use of ‘token economies’ in clinical settings is in serious decline (Corrigan, 1995; Hall & Baker, 1973; Boudewyns, Fry & Nightengale, 1986; Dickerson, Tenhula & Green-Paden, 2005). A number of reasons have been put forward for this decline.

- There are legal and ethical issues that need to be considered. This is especially so when decisions have to be made about who will participate in token economies, for how long, and what will be made available as positive reinforcers. Legislation over the past 25 years has sought to protect patients’ rights, and treatment staff are severely constrained with regard to the use of more basic items as reinforcers (Glynn, 1990) – especially when patients now have a legal right to their own personal property and humane treatment, including comfortable bed, chair, bedside table, nutritious meals, cheerful furnishings, and suchlike.

- One of the major challenges for token economies has been maintenance and generalization of therapeutic effects. To the extent that patients can obtain reinforcers outside the programme and avoid punishment by exiting from the programme, the therapeutic benefit of token economies becomes less useful (Glynn, 1990). It is true that some studies have shown that behaviours targeted for improvement in a token economy scheme return to low baseline levels outside of the program (e.g. Ayllon & Azrin, 1968; Walker & Buckley, 1968). However, there are other studies that have shown positive effects of maintenance and generalization (Banzett, Liberman & Moore, 1984). Nevertheless, it should be pointed out that generalization is not a passive process, and clinicians must actively build into the programme strategies that transfer positive effects to settings outside the treatment scheme (Stokes & Baer, 1977; Stokes & Osnes, 1988).

- Some other proponents of the token economy have argued that its decline has been the result of unfounded misconceptions about the nature and efficacy of such programmes (e.g. Corrigan, 1995). These include such misconceptions as token economies not being therapeutically effective, their benefits do not generalize, they do not provide individualized treatment, they are abusive and coercive, and they are not practical to implement in the context of present-day attempts to treat patients in the community. Corrigan (1995) argues that these are all unfounded, and that the token economy remains an important and valuable tool for the management of patients and staff in treatment settings.

Janey describes her first experience of a psychiatric ward after exhibiting psychotic symptoms in 1985. She then describes her experiences on being readmitted to the same ward after relapse in 2000.

**1985**

‘The ward was supposed to be for 24 people but it was my bad luck that they were decorating one of the other wards and we had four extra beds squashed into various corners. The whole area smelled of smoke, floor cleaner and urine – in that order. I was given a bed – one of five in a four-person room – and introduced to my two neighbours. A nurse went through my things, listing my valuables and in the end confiscating my birth control pills. I argued about that too because I didn’t see how oestrogen and progesterone could be seen as dangerous.

The other patients terrified me; some seemed to have strange glassy-eyed expressions or shambling walks. There were people pacing the ward in silence, someone smashed a guitar against the wall, another person wet the floor. One of my room-mates, an oldish, sleepy-looking woman called Amy, told me that she had entered ‘The Brain of Britain’ programme in the past but frankly, I didn’t believe her. And there was a young man in a wheelchair, who, I was informed, had jumped off a building. Most people were smoking heavily.

I ate someone else’s dinner (they were on leave) because food was ordered two days ahead and I had yet to fill in menus. Then I retreated onto my bed to hide and to try to read – desperately attempting to act normal so I could go home as soon as possible. Fortunately, my husband came and he took me home as soon as possible. I was given a bed – one of five in a four-person room – and introduced to my two neighbours. The Christmas decorations were put up – paper chains and plastic baubles only. Later another man in black leather silently and inexplicably held my hand while we were watching TV.”

**2000**

‘Of course the building hasn’t changed and, although there have obviously been several facelifts within the ward, it still has that lived-in look, with splodges of something-or-other on the floor and walls. The internal structure of the place has changed a little, so the nurses have a big room, as compared with a little one (6 years ago) and a nursing station (15 years ago). I didn’t walk into a sea of smoke this time, all smoking has been confined to one room. We have carpet in the corridor and there are more single rooms too. But other than that, the basic cubicule with bed, wardrobe and locker are the same. Drug times, ward rounds and that sort of thing seem immutable, set in stone. Unfortunately, even some of the patients have stayed the same – though I suppose they can say that of me.

The rules of the ward are stricter, with notices pinned up to remind us of them. ‘No visitors until four o’clock,’ ‘no mobile phones,’ ‘no smoking except in the smoking room,’ ‘drug and alcohol use will result in the police being called,’ and so on. And good behaviour is enforced with a ‘sin bin,’ the seclusion room (I was threatened with seclusion for kicking the door in a moment’s temper.) Surprisingly, all of this makes for a more relaxed, less dog-eat-dog atmosphere.

There is a mission statement on the wall by the new and bigger nurses’ room now. It contains lots of long words like ‘integrity,’ ‘confidentiality’ and ‘valuing individuals’ – the shortest is ‘caring.’ I guess this is a response to hospitals’ trust and The Patients’ Charter, though I’m not sure that practically it makes any difference at all. Observation levels are more relaxed: the hell of having a nurse with you all the time – even in the loo – seems to have disappeared. The food is still bad, with little green vegetables.
A tenfold decrease in the number of people being treated in hospital for mental health problems (Torrey, 2001). Assertive community treatment programmes help people recovering from psychotic episodes with their medication regimes, psychotherapy, assistance in dealing with everyday life and its stressors, guidance on making decisions, residential supervision and vocational training (Bebbington, Johnson & Thornicroft, 2002). In the UK, assertive outreach is a way of working with groups of individuals with severe mental health problems who do not effectively engage with mental health services. Assertive outreach staff would expect to meet their clients in their own environments, whether that is a home, café, park or street, and the aim is to build a long-term relationship between the client and mental health services.

The queue for medication still takes time to get through, and ECT is still done on Tuesday and Friday. Sadly, the suicide of those with a mental health problem has not changed at all. During my three weeks in the ward, one of my fellow patients found a way to kill himself.

Once more I'm back out in the community, trying to sort my life and planning not to have to go into hospital again.‘

Source: Adapted from http://www.schizophrenia.co.uk/treatment/treatment_articles/treatment.

**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?
- How has care for people with mental health problems developed from the times of asylums to the present day?

**SECTION SUMMARY**

### 1.1 A BRIEF HISTORY OF PSYCHOPATHOLOGY

This section has provided an historical perspective on the way in which people have attempted to understand and explain mental health problems, and also describes how people with mental health problems have been treated over the centuries. Today, most models of mental health provision espouse compassion, support, understanding, and empowerment for individuals suffering mental health problems (Repper & Perkins, 2006), but it has been a long journey to get to this point. It has required us to understand that individuals with mental health problems are not ‘possessed’, they do not need to have ‘demons’ exorcised or driven from their bodies by physical force, they do not need to be incarcerated in asylums, and nor do they need life-long custodial care in psychiatric institutions. However, while most of the physical constraints and impositions imposed on individuals with mental health problems have been lifted, attitudes to mental health problems have been slower to evolve, and the stigma and discrimination associated with mental health problems remain a significant issue in need of resolution (see section 1.4).

The key points are:

- Historical explanations of psychopathology such as ‘demonic possession’ 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.
- Historically individuals with mental health problems were often locked away in asylums or given lifelong custodial care in psychiatric hospitals.
- Current models of mental health care espouse compassion, support, understanding, and empowerment.
1.2 DEFINING PSYCHOPATHOLOGY

The personal accounts at the beginning of this chapter have been chosen to represent rather different and contrasting examples of mental health problems. However, 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 etiology 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.

The problems of defining psychopathology not only revolve around what criteria we use to define psychopathology, but also what terminology we use. For example, there are still numerous psychopathology courses and text books that 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 the functional sense. 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 section 1.4 for a fuller account of mental health stigma and how this affects people suffering with mental health problems). Individuals with mental health problems have become increasingly vocal about how psychopathology and those who suffer from it are labelled and perceived by others, and 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), charitable organizations that champion the rights of mental health service users, such as Rethink (www.rethink.org), and ‘Time to Change’, a national UK programme aiming to promote awareness of mental health problems and to combat stigma and discrimination (www.time-to-change.org.uk).

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 or a psychological attribute deviates substantially from the statistical norm, and in some areas of clinical psychology this has been 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 has been used in the past as one criterion for diagnosing intellectual disability (see Table 17.3). Figure 1.1 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 2–3 per cent of the population). However, there are at least two important problems with using deviations from statistical norms as indications of psychopathology. Firstly, 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 1.1, 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. We might feel that adopting a definition of psychopathology that is statistically based
FIGURE 1.1 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 intellectual development disorder. 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 and Political 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 they 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, or even violations of 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 (surely, 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, and these are known as Ataque de Nervios, a form of panic disorder found in Latinos from the Caribbean (Salman, Liebowitz, Guariglia, Jusino, Garfinkel et al., 1998), and Seizisman, a state of psychological paralysis found in the Haitian community (Nicolas, De Silva, Grey & Gonzalez-Eastep, 2006)), and (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).

1.2.3 Maladaptive Behaviour and Harmful Dysfunction

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
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 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, those over 45 years of age, and those from low socio-economic backgrounds and disrupted marriages (Guarnaccia et al., 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 name 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 give 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.


down a job, can cope with the demands of being a parent, develop loving relationships, and 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-5, 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 we would not necessarily want to label as psychopathology. 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. 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, snake and spider phobia are adaptive responses which protect us from exposure to potentially life-threatening situations (e.g. Seligman, 1971; see Chapter 6).

A similar approach is to assume that mental health problems can be defined as harmful dysfunction (Wakefield, 1997). This view assumes that psychopathology is defined by the ‘dysfunction’ of a normal process that has the consequence of being in some way harmful. For example, ‘hearing voices’ during episodes of psychosis may be caused by the brain’s inability to turn off unwanted thoughts, and these may give rise to potentially harmful consequences such as extreme paranoia. The problem with this type of definition is that we still know very little about the brain mechanisms that generate psychopathology symptoms, so it is very difficult to know what ‘normal’ process might be dysfunctioning. In addition, there are now a number of taxometric studies suggesting that many common mental health problems are best considered as dimensional rather than categorical (e.g. Haslam, Williams, Kyrios, McKay & Taylor, 2005; Olatunji, Williams, Haslam, Abramowitz & Tolin, 2008). That is, distressing mental health symptoms are just more extreme versions of normal emotions and behaviours, and are not in any way as qualitatively different from normal behaviour as the harmful dysfunction model would imply.

### 1.2.4 Distress and Disability

Later in this chapter we will look at some of the ways in which psychologists and psychiatrists have attempted to classify psychopathology, and 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. Firstly, it allows people to judge their own ‘normality’ rather than subjecting them to judgments 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 they are perceived as productively contributing to society or not, or whether they actively violate social norms, but on the basis of how they are able to cope with their lifestyle.

As attractive as this definition for defining psychopathology seems, it does have a number of difficulties. Firstly, 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 experiencing psychotic episodes (see Chapter 8). But Betty does not express any feelings of distress or impairment. Similarly, in Erica’s story she 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 they express unhappiness about their situation? Finally, psychopathology classification schemes do include so-called ‘disorders’ in which diagnosis does not require that the sufferer necessarily reports any personal distress or impairment. A good example of this is that group of disorders known as personality disorders (see Chapter 12). 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 often unwilling to admit that their behaviour is unusual or problematic.

### 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?
1.3 EXPLANATORY APPROACHES TO PSYCHOPATHOLOGY

Despite the fact that symptoms of mental health problems seemed baffling to many people, there was still a strong desire to understand psychopathology, to describe its causes, and, as a consequence, to develop effective interventions. Section 1.1 described some of the important milestones in the history of psychopathology, and how an understanding of mental health problems has evolved from the level of primitive beliefs, through an application of medical knowledge, to current models of care. This section will now introduce you to the main contemporary explanatory approaches to psychopathology, and these are ones that you will encounter regularly in the following chapters.

At this point it is important to understand what an explanatory paradigm is, and why we can explain mental health problems in many different ways within a number of different paradigms. Firstly, human beings are multifaceted organisms; they consist of a genetically propagated biological substrate which serves as a basis for behaviour and a whole range of psychological processes, such as thinking, learning, remembering, perceiving, and so on. These genetic, biological, behavioural and psychological processes are interdependent and together make up our conception of the complete thinking and behaving human being. But genetic, biological, behavioural and psychological processes can also be studied independently; they have their own language of description, and researchers may be skilled in studying people only within one of these basic paradigms.

Secondly, this view also applies to psychopathology. For example, symptoms of psychosis might be explained genetically (in terms of the inheritance of genes that give rise to a predisposition for these symptoms), biologically (in terms of abnormalities in brain function that generate symptoms), behaviourally (in terms of how symptomatic behaviours are learnt through experience), and psychologically (in terms of how symptoms might be generated by dysfunctional ways of thinking). In many cases, a specific psychopathology can be explained at all these different levels. Furthermore, these explanations within different paradigms are not mutually exclusive – they supplement each other and provide a fuller, richer understanding of that psychopathology.

The following sections introduce you to some examples of these different paradigms and how they each contribute to our broad understanding of psychopathology.

1.3.1 Biological Models

Genetics and neuroscience are two of the most important biological paradigms through which researchers attempt to understand psychopathology. The discipline of genetics provides us with a variety of techniques that allow an assessment of whether psychopathology symptoms are inherited or not, and neuroscience techniques allow us to determine whether psychopathology symptoms are associated with abnormalities or differences in brain or central nervous system functioning.

Genetics

*Genetics* is a fast growing and important branch of science, and collaborations such as the Human Genetics

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**SECTION SUMMARY**

### 1.2 DEFINING PSYCHOPATHOLOGY

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 categorisation that would lead us simply to imposing stigmatising labels on people rather than 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.

To sum up:

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

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**Paradigm** The study of heredity and the variation of inherited characteristics.
Genome Project are attempting to identify those genes that may be responsible for human characteristics, disorders and diseases (Collins & McKusick, 2001). People are biological organisms who come into the world with a biological substructure that will be significantly determined by the genes they have inherited from their ancestors. It is therefore almost a truism to say that behaviour – and mental health problems too – will therefore have at least some genetic component. In some cases the genetic component may be extremely influential (e.g. in Huntington’s disease – see Focus Box 1.4); in others it may be a necessary component but may not always be sufficient to trigger a mental health problem; in still other cases the genetic component may be relatively nonspecific and less important to the development of a mental health problem than the experiences that an individual may have during their lifetime.

The way in which genetics might influence psychopathology can be studied in a variety of ways:

1. By studying psychopathology symptoms across different family members who may differ in the extent to which they are genetically related to each other. These studies are known as concordance studies, where the probability of symptoms occurring can be related to the degree to which different family members share genes in common.

2. Twin studies compare the probability with which monozygotic (MZ) and dizygotic (DZ) twins both develop psychopathology symptoms. MZ twins share 100 per cent of their genetic material, whereas DZ twins share only 50 per cent of their genes, so a genetic explanation of psychopathology would predict that there would be greater concordance.

**FOCUS POINT 1.4**

Huntington’s disease is a degenerative neurological condition that can often give rise to dementia, and it is caused by a dominant mutation in a gene on the fourth chromosome. Each person has two copies of this gene (each one called an allele), one inherited from each parent. In the case of Huntington’s disease an individual only needs one copy of the mutant allele to develop the disease. Parents randomly give one of their two alleles to their offspring, so a child of a parent who has Huntington’s disease has a 50 per cent chance of inheriting the mutant version of the gene from their parent. A grandchild of a person with Huntington’s disease has a 25 per cent chance of inheriting the mutant gene and so developing the disease.

The gene for Huntington’s disease is dominant, and so the disease can be inherited even if only one parent has the mutant gene. In this case, inheriting the mutant gene is the primary factor in the affected individual developing the disease. In other mental health problems where genetic factors have been found to be important (e.g. schizophrenia), inheritance is only one of a number of factors that has been found to contribute to the development of symptoms, and this has led researchers to advocate a diathesis–stress model in which inherited factors provide a vulnerability to develop symptoms, but these symptoms do not appear unless the individual encounters stressful life experiences.
in the diagnosis of a mental health problem in MZ than in DZ twins (see Chapter 8 for some examples of this approach).

3. Because both families and twins are likely to share similar environments as well as genes, interpretation of family and twin studies can be difficult. However, many of these difficulties of interpretation can be overcome by studying the offspring of MZ and DZ twins rather than the twins themselves (Gottesman & Bertelsen, 1989). If one MZ twin develops psychopathology symptoms and the other does not, any genetic element in symptoms should still show up in the children of either of the two MZ twins. That is, the children of the MZ twins should still exhibit similar rates of risk for the psychopathology (because they have inherited the same predisposition) – even though one of their parents developed the symptoms and the other did not.

However, in the vast majority of psychopathologies we will describe in this book, people do not solely inherit a mental health problem through their genes, a mental health problem develops because of an interaction between a genetic predisposition and our interactions with the environment (Shenk, 2010). This is basically what is known as a diathesis–stress model of psychopathology, where ‘diathesis’ refers to an inherited predisposition and ‘stress’ refers to a variety of experiences that may trigger the inherited predisposition (this is a model that is particularly important in the case of Huntington’s disease described in Focus Point 1.4, the heritability of Huntington’s symptoms is very close to 1 because if you inherit the dominant gene for this disorder, that is sufficient to ensure that the individual will develop the disease.

Not only do genetic approaches to psychopathology attempt to estimate the heritability of individual disorders, the area of molecular genetics also seeks to identify individual genes that may be involved in transmitting psychopathology symptoms. One method of identifying individual genes that has been particularly applied to psychopathology is genetic linkage analysis. Linkage analysis works by comparing the inheritance of characteristics for which gene location is known (e.g. eye colour) with the inheritance of psychopathology symptoms. For example, if the inheritance of eye colour follows the same pattern within a family as particular psychopathology symptoms, then it can reasonably be concluded that the gene controlling the psychopathology symptoms can probably be found on the same chromosome as the gene controlling eye colour. While such methods are extremely valuable, it should be pointed out that it is very rare that psychopathology symptoms can be traced to an individual gene, and very often symptoms are associated with multiple genes, which testifies to the complex and often heterogeneous nature of mental health problems (e.g. Badner & Gershon, 2002; Levinson, Lewis & Wise, 2002; Faraone, Doyle, Lasky-Su, Sklar, D’Angelo et al., 2007). In addition, an alternative means of identifying psychopathology-relevant genes is to use non-human animals. For example, researchers can manipulate specific genes in animals with some accuracy, and in mice studies can even delete individual genes. This then enables the researcher to determine whether that gene is linked to any changes in the animal’s behaviour that might be indicative of psychopathology (e.g. by observing more anxious behaviour) (Gross, Zhuang, Stark, Ramboz et al., 2002).

Finally, one new area of genetics highly relevant to psychopathology is epigenetics. We know that aspects of psychopathology and mental health can be influenced by genetics and hereditary factors, and we also know that personal experiences can also influence psychopathology. However, recent research in the developing area of epigenetics suggests that the way that parents behaved or what they ate can also affect the subsequent behaviour of their offspring by influencing their offspring’s genetic heritage, either by changing the nature of their DNA or triggering or inhibiting the expression of genes that may represent risk factors for psychopathology. Similarly, the early experiences of an individual may either trigger or inhibit the expression of genes they may possess that make them vulnerable to mental health problems such as anxiety or depression, and in this way there can be a direct interaction between environmental factors and inherited factors. For example, early life stress can enable the expression of genes that control the neuroendocrinology of post-traumatic
stress disorder (PTSD), which then puts such individuals at higher risk of developing PTSD after highly traumatic life experiences (Yehuda, Flory, Pratchett, Buxbaum et al., 2010). This has important implications for our understanding of how mental health problems develop and the aetiology of those disorders (Kofink, Boks, Timmers & Kas, 2013).

**Neuroscience**

The neuroscience paradigm seeks an understanding of psychopathology by identifying aspects of the individual’s biology that may contribute to symptoms. The main focus of this paradigm is on brain structure and function, although the broader activity of the neuroendocrine system has also been implicated in some psychopathology symptoms, especially mood disorders (the neuroendocrine system involves interactions between the brain and the endocrine system that produces hormone secretions in the body).

**Brain structure and function**  
The brain is the organ that controls and organizes most of a person’s behaviour – including their actions and their thoughts, so it is not surprising that the brain has been a focus for attempting to understand psychopathology. The brain is divided into two mirror-image hemispheres that are connected by a set of nerve fibres called the corpus callosum.

The outer convoluted area of the brain is known as the cerebral cortex, and the large troughs in the convolutions are called fissures (see Figure 1.2a). The lateral and central fissures divide the cerebral cortex into four lobes: the frontal, occipital, temporal and parietal lobes, and these areas serve various specific functions. The occipital lobe is the area for visual perception, the temporal lobe is considered to be a focus for memory processes, and the parietal lobe is associated with visuomotor coordination (Kolb & Whishaw, 2009). However, the frontal lobes are especially important, and are the areas of the brain that are considered to make us uniquely human. The frontal lobes are known to be important in executive functions such as planning and decision making, error correction and troubleshooting, novel situations, and inhibiting habitual and impulsive responses (Norman & Shallice, 1980). Given the important functions of the frontal lobes, it is an area of the brain where deficits or abnormalities have been implicated in many types of psychopathology, including attention disorders, perseveration and stereotyped behaviour patterns, lack of drive and motivation, inability to plan ahead, and apathy and emotional blunting. Alternatively, because the frontal lobes also control response inhibition, deficits in this area can also be associated with impulsivity, euphoria, and aggressive behaviour – especially in relation to personality disorders (Brower & Price, 2001; Meyers, Berman, Scheibel & Hayman, 1992).

A further set of brain areas that are often implicated in psychopathology are collectively known as the limbic system. The limbic system comprises the hippocampus, mammillary body, amygdala, hypothalamus, fornix and thalamus. It is situated beneath the cerebral cortex (see Figure 1.2b) and is thought to be critically involved in emotion and learning. For example, the hippocampus is involved in spatial learning and the amygdala is an important region coordinating attention to emotionally relevant stimuli (e.g. threatening or fear-relevant stimuli). Because of its function in regulating emotional responses, the amygdala is an important brain structure in understanding many aspects of psychopathology. It is involved in the formation and storage of emotion-relevant stimuli and provides feedback to the thalamus that results in appropriate motor action (Del Casale, Ferracuti, Rapinesi, Serata et al., 2012). Because of this role, the amygdala is important in activating phobic fear (Ahs, Pissiota, Michelgard, Frans, Furmark et al., 2009), and depressed individuals show more activity in the amygdala when viewing emotional stimuli than non-depressed individuals (Sheline, Barch, Donnelly, Ollinger et al., 2001).

**Brain neurotransmitters**  
These are the chemicals that help neurones to communicate with each other and thus are essential components of the mechanisms that regulate efficient and effective brain functioning. During synaptic transmission, neurones release a neurotransmitter that crosses the synapse and interacts with receptors on neighbouring neurones, and most neurotransmitters relay, amplify and modify

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**cerebral cortex**  
The outer, convoluted area of the brain.

**corpus callosum**  
A set of nerve fibres which connects the two mirror-image hemispheres of the brain.

**occipital lobe**  
Brain area associated with visual perception.

**temporal lobe**  
The areas of the brain that lie at the side of the head behind the temples and which are involved in hearing, memory, emotion, language, illusions, tastes and smells.

**parietal lobe**  
Brain region associated with visuomotor coordination.

**frontal lobe**  
One of four parts of the cerebrum that control voluntary movement, verbal expressions, problem solving, will power and planning.

**limbic system**  
A brain system comprising the hippocampus, mammillary body, amygdala, hypothalamus, fornix and thalamus. It is situated beneath the cerebral cortex and is thought to be critically involved in emotion and learning.

**hippocampus**  
A part of the brain which is involved in spatial learning.

**amygdala**  
The region of the brain responsible for coordinating and initiating responses to fear.
signals between neurones (see Figure 1.3). There are many different types of brain neurotransmitters that can be grouped according to either their chemical structure or to their function, and a number of different neurotransmitters have been implicated in psychopathology symptoms. It is clear that biological explanations of psychopathology will be highly relevant. They will tell us whether all or
some of the symptoms of a mental health problem are inherited or not; they will also provide us with information about whether abnormalities in brain function or neurotransmitter activity are associated with psychopathology. There are some clear advantages to the biological approach – especially in terms of treatments. One prominent example is that if we can identify associations between psychopathology and imbalances in neurotransmitters, then we can develop pharmaceutical products that might resolve this imbalance – and this has been particularly the case with mood disorders and psychotic symptoms. However, mental health problems cannot always be reduced simply to biological descriptions, and a full understanding of the causes and experience of mental health problems will require description and explanation at other levels (e.g. how a person’s experiences influence their thoughts and behaviour, how their interpretation of events affects their emotions, and how distress is experienced and manifested). We will discuss some of these alternative – but complimentary – paradigms below.

### 1.3.2 Psychological Models

Moving away from the biological model of psychopathology, some approaches to understanding and explaining mental health problems still see mental health problems as symptoms produced by an underlying cause (what is known as the pathology model), but hold that the causes are psychological rather than biological or medical. These approaches often view the cause 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 abnormal, ‘broken’ or malfunctioning.

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

**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 which 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).

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.

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.

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 these values that we assimilate and if we think our behaviour does not meet the standards implicit in these values we will feel guilty and stressed.

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 **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 how 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.

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 6 and theories of dissociative disorders in Chapter 14). 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

### TABLE 1.1 Defence mechanisms in psychoanalytic theory

<table>
<thead>
<tr>
<th>Defence Mechanism</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td>The individual denies the source of the anxiety exists (e.g. I didn’t fail my exam, it must be a mistake).</td>
</tr>
<tr>
<td>Repression</td>
<td>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).</td>
</tr>
<tr>
<td>Regression</td>
<td>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 instance, by smoking if you are fixated at the oral stage).</td>
</tr>
<tr>
<td>Reaction Formation</td>
<td>Doing or thinking the opposite to how you feel (e.g. the person who is angry with their boss may go out of their way to be kind and courteous to them).</td>
</tr>
<tr>
<td>Projection</td>
<td>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).</td>
</tr>
<tr>
<td>Rationalization</td>
<td>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).</td>
</tr>
<tr>
<td>Displacement</td>
<td>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).</td>
</tr>
<tr>
<td>Sublimation</td>
<td>Transforming impulses into something constructive (e.g. redecorating the bedroom when you’re feeling angry about something).</td>
</tr>
</tbody>
</table>

Each of the Freudian defence mechanisms described above function to reduce the amount of stress or conflict that might be caused by specific experiences.
symptoms of psychopathology in the way that Freud and his associates describe (Erdelyi, 1992).

**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 learnt reactions to life experiences. That is, psychopathology can be explained as learnt 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), and this is represented schematically in Figure 1.4. In contrast, **operant conditioning** represents the learning of a specific behaviour or response because that behaviour has

![Diagram of classical conditioning](image)

**FIGURE 1.4 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 6.2).
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 Photo 1.2).

These two forms of learning have been used to explain a number of examples of psychopathology. For instance, classical conditioning has been used to explain the acquisition of emotional disorders including many of those with anxiety-based symptoms (see Chapter 6). For example, 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), and such experiences might account for the acquisition of dog phobia (in which dogs have become associated with, for example, being bitten or chased by a dog), 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 6), the acquisition of paraphilias (see Chapter 11), and substance dependency (see Chapter 9). 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 or developmental disabilities may be maintained by attention from family and carers (Mazaleski et al., 1993).

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 desensitisation, aversion therapy: see Chapter 4) and operant conditioning principles (e.g. functional analysis, token economies: see section 1.1.3 and Chapter 17). 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 dependence, somatoform disorders, and so on). 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. In addition, 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.

**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 by 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 belief 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 7). For example, the cognitive approach argues that depression results from the depressed individual 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, 2001), 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.

As successful as the cognitive approach seems to have been in recent years, it too also 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 the individual rationalize the way they feel? These are all potentially fruitful areas for future research.

**The humanist–existential approach**

Some approaches to psychopathology believe that insights into emotional and behavioural problems cannot be achieved unless the individual is 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-actualisation.

Because such approaches are interested primarily in insight and personal growth when dealing with psychopathology, they are relatively uninterested in aetiology and the origins of psychopathology, but more interested in ameliorating symptoms of psychopathology through encouraging personal development. An influential example of the is **humanistic-existentialist 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 them understand the client’s feelings and unconditional positive regard, by which the therapist expresses their willingness to totally accept the client for who he or she is.
As we said earlier, this type of approach to psychopathology does not put too much emphasis on how psychopathology was 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 the client to view themself as a worthy, respected and achieving individual). 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 fair 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 such 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 still used at least in part by clinical psychologists, counselling psychologists and psychotherapists.

**SELF-TEST QUESTIONS**

- What are the main approaches to understanding psychopathology that are advocated by the biological approach?
- 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?

**SECTION SUMMARY**

1.3 EXPLANATORY APPROACHES TO PSYCHOPATHOLOGY

The four psychological paradigms we have discussed in this section have tended to evolve historically from explanatory paradigms that have represented different ‘schools’ of psychology generally, but all have a relevant place in explaining psychopathology – either at different levels of explanation (e.g. cognitive vs. behavioural), or using different philosophical approaches to explaining human behaviour and psychopathology (e.g. the hypothetical constructs developed by the psychoanalytical approach vs. the learning paradigm developed by behaviourist approaches). In addition to pure psychological paradigms, clinical psychologists are continually developing new ways of conceptualising and studying the factors that influence the development of mental health problems, and one approach of growing importance is to consider how sociocultural factors might affect the acquisition of psychopathology. Some examples of this latter approach are discussed in Focus Point 1.5.

The key points are:

- **Psychological models** view psychopathology as caused primarily by psychological rather than biological processes.
- Influential psychological models of psychopathology include biological models, the psychoanalytical model, the behavioural model, and the humanist–existential model.
- Biological models attempt to explain psychopathology in terms of processes such as genetics and brain structure and function.
- Psychoanalytical models attempt to discuss psychopathology in terms of the psychological mechanisms that help to defend against anxiety and depression.
- Behavioural models use processes of learning such as classical conditioning and operant conditioning to understand how psychopathology might be acquired.
- The cognitive model considers psychopathology to be the result of individuals acquiring irrational beliefs, developing dysfunctional ways of thinking, and processing information in biased ways.
- The humanist–existential approach attempts to help the individual to gain insight into their lives from a broad range of perspectives and develop a sense of meaning in life.
SOCIOCULTURAL FACTORS AND PSYCHOPATHOLOGY

There is a growing realization that sociocultural factors can influence both the acquisition of mental health problems and the way that psychopathology is expressed. These factors include gender, culture, ethnicity and socioeconomic factors such as poverty and deprivation, and we will discuss some examples of these here.

GENDER

Your gender is likely to be a significant factor in whether you are likely to develop a particular mental health problem. For example, the prevalence of major depression is twice as high in women as it is in men, women are significantly more likely to develop anxiety-based problems such as social anxiety disorder, panic disorder or general anxiety disorder (see Chapter 6), and women are also significantly more likely to develop eating disorders such as anorexia nervosa or bulimia nervosa (see Chapter 10). Alternatively, males are more likely to develop conduct disorders, attention deficit hyperactivity disorder (ADHD) (see Chapter 16), and antisocial personality disorder (Chapter 12). How gender differentially affects the acquisition of these various disorders is far from clear, and could be linked to gender-based biological differences (e.g. men appear to possess a gene that imparts risk for alcohol abuse and dependence, and this can be passed on to their sons; Chapter 9), to factors associated with the gender roles that males and females adopt in different societies (e.g. women's roles in society may be more stressful than men's and so increase the risk of mental health problems), or differences in gender-based coping practices (e.g. women ruminate more than men, while men frequently react to stress by distracting themselves; Just & Alloy, 1997). An interesting discussion of the role of gender in risk for major depression is provided in Activity 7.1.

CULTURE

The culture in which you live can also be a factor that will determine whether you develop a particular mental health problem and also how that problem will manifest itself. For example, prevalence rates for many common mental health problems differ significantly across the world. In the case of major depression, prevalence rates can vary between 1.5 per cent and 19 per cent (Weissman, Bland, Canino, Faravelli et al., 1996), and may be affected by the stigma associated with reporting symptoms, cultural differences in diagnosing symptoms, and depression being expressed in more physical terms in some societies (called somatisation) (Patten, 2003; Compton et al., 1991). Eating disorders are another example where prevalence rates are higher in most Western cultures, but may only be rarely reported in less socio-economically developed societies (Keel & Klump, 2003). Finally, some combinations of mental health problems may be found only in certain specific cultures, and be examples of the culturally specific ways in which stress and trauma are manifested. Two specific examples of this are provided in Focus Point 1.3.

ETHNICITY

The frequency of diagnosis of many mental health problems also differs across different ethnicities. For example, schizophrenia is more frequently diagnosed in individuals of African descent than white European origin. Conversely, specific types of eating disorders – such as anorexia nervosa – are found more commonly in white women than black women (Lovejoy, 2001). In some of these cases, there may be a genetic component (e.g. individuals of Asian descent inherit a gene which makes drinking large amounts of alcohol aversive, and so makes them less likely to develop alcohol dependency and abuse problems; Wall et al., 2001), but equally it may be the case that diagnostic criteria are either unwittingly or unwittingly applied differently to people from different ethnic backgrounds (e.g. it is caused by a cultural bias in assessment – see section 2.2.6). For example, black Americans have a higher rate of diagnosis of disorders such as schizophrenia and alcoholism, whereas white Americans are more likely to be given the less stigmatising diagnosis of major depression (Garb, 1997), and such differential effects may reflect differential diagnoses driven by implicit racial and ethnic stereotyping.

POVERTY

Finally, the socio-economic conditions in which an individual is either raised or lives in is an important contributor to the development of psychopathology. Obvious examples include the development of conduct disorders, some personality disorders such as antisocial personality disorder, and substance abuse and dependency problems. However, poverty is also a risk factor for the development of many common mental health problems such as anxiety and depression, possibly because of the additional stressors and traumas that accompany poverty, unemployment, standard accommodation, and neglect (Evans & Kim, 2012). Indeed, so specific are many of the stressors that afflict people living in poverty that it may be necessary to develop interventions that are tailored to the specific sociocultural experiences of low-income families (Goodman et al., 2013).
1.4 MENTAL HEALTH AND STIGMA

There are still attitudes within most societies that view symptoms of psychopathology as threatening and uncomfortable, and these attitudes frequently foster stigma and discrimination towards people with mental health problems. Reactions to people often change when they suffer a mental health problem, and this leads to loss of respect and consideration. Such reactions are common when people are brave enough to admit they have a mental health problem, and they can often lead on to various forms of exclusion or discrimination – either within social circles or within the workplace. In the following sections we will look at five key questions: (1) what is mental health stigma?; (2) who holds stigmatising beliefs and attitudes?; (3) what factors cause stigma?; (4) why does stigma matter?; and (5) how can we eliminate stigma?

1.4.1 What Is Mental Health Stigma?

Mental health stigma can be divided into two distinct types. The first, social stigma, is characterized by prejudicial attitudes and discriminating behaviour directed towards individuals with mental health problems as a result of the psychiatric label they have been given. In contrast, perceived stigma or self-stigma is the internalizing by the mental health sufferer of their perceptions of discrimination. This can significantly affect feelings of shame and lead to poorer treatment outcomes.

Social stigma Stigma characterized by prejudicial attitudes and discriminating behaviour directed towards individuals with mental health problems as a result of the psychiatric label they have been given.

Perceived stigma/self-stigma The internalising by the mental health sufferer of their perceptions of discrimination. This can significantly affect feelings of shame and lead to poorer treatment outcomes. See also Mental health stigma.

Mental health stigma Mental health stigma can be divided into two distinct types: social stigma is characterized by prejudicial attitudes and discriminating behaviour directed towards individuals with mental health problems as a result of the psychiatric label they have been given. In contrast, perceived stigma or self-stigma is the internalizing by the mental health sufferer of their perceptions of discrimination. This can significantly affect feelings of shame and lead to poorer treatment outcomes.

1.4.2 Who Holds Stigmatizing Beliefs about Mental Health Problems?

Perhaps surprisingly, stigmatising beliefs about individuals with mental health problems are held by a broad range of individuals within society, regardless of whether they know someone with a mental health problem, have a family member with a mental health problem, or have a good knowledge and experience of mental health problems (Crisp et al., 2000; Moses, 2010; Wallace, 2010). For example, Moses (2010) found that stigma directed at adolescents with mental health problems came from family members, peers and teachers. Forty-six per cent of these adolescents described experiencing stigmatisation by family members in the form of unwarranted assumptions (e.g. the sufferer was being manipulative), distrust, avoidance, pity and gossip; 62 per cent experienced stigma from peers, which often led to friendship losses and social rejection (Connolly, Geller, Marton & Kutcher, 1992); and 35 per cent reported stigma perpetrated by teachers and school staff, who expressed fear, dislike, avoidance, and underestimation of abilities. Mental health stigma is even widespread in the medical profession, at least in part because it is given a low priority during the training of physicians and GPs (Wallace, 2010).

1.4.3 What Factors Cause Stigma?

The social stigma associated with mental health problems almost certainly has multiple causes. We’ve seen in the section on historical perspectives that throughout history people with mental health problems have been treated differently, excluded and even brutalized. This treatment may come from the misguided views that people with mental health problems may be more violent or unpredictable than people without such problems, or somehow just ‘different’, but none of these beliefs has any basis in fact (see e.g. Swanson, Holzer, Ganju & Jono,
Similarly, early beliefs about the causes of mental health problems, such as demonic or spirit possession, were ‘explanations’ that would almost certainly give rise to reactions of caution, fear and discrimination. Even the medical model of mental health problems is itself an unwitting source of stigmatising beliefs. Firstly, the medical model implies that mental health problems are on a par with physical illnesses and may result from medical or physical dysfunction in some way (when many may not be simply reducible to biological or medical causes). This itself implies that people with mental health problems are in some way ‘different’ from ‘normally’ functioning individuals. Secondly, the medical model implies diagnosis, and diagnosis implies a label that is applied to a ‘patient’. That label may well be associated with undesirable attributes (e.g. ‘mad’ people cannot function properly in society, or can sometimes be violent), and this again will perpetuate the view that people with mental health problems are different and should be treated with caution.

**FOCUS POINT 1.6**

*‘CREATING’ MENTAL HEALTH PROBLEMS THROUGH THE MEDICALISATION 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 ‘medicalising’ 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 et al., 2001), and in order for GPs to be able to provide treatment for such individuals, there is a tendency for them to **over diagnose** mild or moderate depression (Middleton et al., 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 et al., 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 ‘medicalisation’ 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 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 as a normal reaction to adverse life stressors or relationship changes. ‘Medicalising’ symptoms in this way leads to us viewing what are normal everyday symptoms and experiences as examples of dysfunction or psychopathology.
We will discuss ways in which stigma can be addressed below, but it must also be acknowledged here that the media regularly play a role in perpetuating stigmatising stereotypes of people with mental health problems. The popular press is a branch of the media that is frequently criticized for perpetuating these stereotypes, and a particular example of this is provided in Focus Point 1.7. Blame can also be levelled at the entertainment media. For example, cinematic depictions of schizophrenia are often stereotypic and characterized by misinformation about symptoms, causes and treatment. In an analysis of English-language movies released between 1990 and 2010 that depicted at least one character with schizophrenia, Owen (2012) found that most schizophrenic characters displayed violent behaviour, one-third of these violent characters engaged in homicidal behaviour, and a quarter committed suicide. This suggests that negative portrayals of schizophrenia in contemporary movies are common and are sure to reinforce biased beliefs and stigmatising attitudes towards people with mental health problems. While the media may be getting better at increasing their portrayal of anti-stigmatising material over recent years, studies suggest that there has been no proportional decrease in the news media’s publication of stigmatising articles, suggesting that the media are still a significant source of stigma-relevant misinformation (Thornicroft, Goulden, Shefer, Rhydderch et al., 2013).

1.4.4 Why Does Stigma Matter?

Stigma embraces both prejudicial attitudes and discriminating behaviour towards individuals with mental health problems, and the social effects of this include exclusion, poor social support, poorer subjective quality of life, and low self-esteem (Livingston & Boyd, 2010). As well as its effect on the quality of daily living, stigma also has a detrimental effect on treatment outcomes, and so hinders efficient and effective recovery from mental health problems (Perlick, Rosenheck, Clarkin, Sirey et al., 2001). In particular, self-stigma is correlated with poorer vocational outcomes (employment success) and increased social isolation (Yanos, Roe & Lysaker, 2010). These factors alone represent significant reasons for attempting to eradicate mental health stigma and ensure that social inclusion is facilitated and recovery can be efficiently achieved.

1.4.5 How Can We Eliminate Stigma?

We now have a good knowledge of what mental health stigma is and how it affects sufferers, both in terms of their role in society and their route to recovery. It is not surprising, then, that attention has most recently turned to developing ways in which stigma and discrimination can be reduced. As we have already described, people tend to hold these negative beliefs about mental health problems regardless of their age, regardless of what knowledge they have of mental health problems, and regardless of whether they know someone who has 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 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). In the UK, the Time to Change campaign is one of the biggest programmes attempting to address mental health stigma and is supported both by charities and mental health service providers (www.time-to-change.org.uk). This programme provides blogs, videos, TV advertisements, and promotional events to help raise awareness of mental health stigma and the detrimental effect this has on mental health sufferers. However, raising awareness of mental health problems simply by providing information about these problems may not be a simple solution — especially since individuals who are most knowledgeable about mental health problems (e.g. psychiatrists, mental health nurses) regularly hold strong
stigmatising beliefs about mental health themselves! (Schlosberg, 1993; Caldwell & Jorm, 2001). As a consequence, attention has turned towards some methods identified in the social psychology literature for improving intergroup relations and reducing prejudice (Brown, 2010). These methods aim at promoting events to encourage mass participation social contact between individuals with and without mental health problems and to facilitate positive intergroup contact and disclosure of mental health problems (one example is the Time to Change Roadshow, which sets up events in prominent town centre locations with high footfall). Analysis of these kinds of intergroup events suggests that they (1) improve attitudes towards people with mental health problems, (2) increase future willingness to disclose mental health problems, and (3) promote behaviours associated with anti-stigma engagement (Evans-Lacko, London, Japhet, Rusch et al., 2012; Thornicroft, Brohan, Kassam & Lewis-Holmes, 2008). A fuller evidence-based evaluation of the Time to Change initiative can be found in a special issue dedicated to this topic in the British Journal of Psychiatry (vol. 202, issue s55, April 2013).

**SELF-TEST QUESTIONS**

- Describe the main characteristics of mental health stigma.
- What kinds of interventions have been developed to try to reduce mental health stigma?

**SECTION SUMMARY**

### 1.4 MENTAL HEALTH AND STIGMA

Hopefully, this section has introduced you to the complex nature of mental health stigma and the effects it has on both the daily lives and recovery of individuals suffering from mental health problems. We have discussed how mental health stigma manifests itself, the effect it has on social inclusion, self-esteem, quality of life and recovery. We ended by describing the development of multifaceted programmes to combat mental health stigma and discrimination.

The key points are:

- **Social stigma** is characterized by prejudicial attitudes and discriminating behaviour directed towards individuals with mental health problems.
- Stigmatising beliefs about people with mental health are held by a broad range of individuals within society, including family members, peers, teachers, and members of the medical profession.
- The popular media often play a role in perpetuating stigmatising stereotypes of people with mental health problems.
- Stigma has a detrimental effect on treatment outcome for people with mental health problems.
- Stigma can be addressed by adopting methods described in the social psychology literature for improving intergroup relations.

### 1.5 CONCEPTS, PARADIGMS AND STIGMA REVISITED

This chapter has introduced the reader to the important concepts and paradigms that surround psychopathology. We have set the scene with a brief history of psychopathology, looking at traditional ways in which people have tried to understand and explain mental health problems and how people with mental health problems have been treated. This has given us a backdrop by which to discuss the many contemporary ways in which psychopathology can be defined and the explanatory paradigms that are used in modern day scientific study of psychopathology. 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, others may cover examples that we intuitively feel are not examples of psychopathology, or they may represent forms of categorisation that would lead us to imposing stigmatising labels on people suffering from psychopathology. In practice, classification schemes end up using an amalgamation of these different approaches to definition, and we will discuss some of these issues in Chapter 2. Finally, this chapter has introduced the notion of mental health stigma, described what it is and how it affects individuals with mental health problems. Stigma and discrimination are currently important targets for change, and programmes designed to challenge stigma are a significant part of most mental health services.

To access the online resources for this chapter go to www.wiley-psychopathology.com/ch1

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