1 An Introduction to Psychopathology: Concepts, Paradigms, and Stigma

ROUTE MAP OF THE CHAPTER

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 can often be an outcome of how psychopathology is conceptualised and portrayed. The first section describes a brief history of how mental health problems have been conceived and treated 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.

CHAPTER OUTLINE

Psychopathology: Research, Assessment, and Treatment in Clinical Psychology, Third Edition. Graham Davey.

Companion website: www.wiley.com/go/davey/psychopathology3e

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

Ten years ago after a pub brawl I was beaten and left for dead outside a pub. Following the attack, my physical recovery from a broken collarbone and broken ribs was slow. From that day on, I lost my confidence and was scared of going out in case I was attacked again as the attackers were never caught; scared that I would lose my rag and end up in prison. I started getting panic attacks and getting easily upset by noise, spending most of the time in my room on my own. I was unable to stop thinking about the beating and it played in my mind almost constantly like a film. Sometimes, I went crazy, I lost the sense of where I was and it felt like the assault was happening all over again—the footsteps behind me, the whack on my head, the sense of falling on my face thinking 'This is it, I'm in for it'. I started smoking cannabis because that was the only way to numb my feelings and get me to sleep but I woke soon after with nightmares of being chased and would wake up shouting and soaked in sweat.

Ten years on and little has changed. I'm stuck in a rut and don't know how to get out. My life is worthless. I'm a failure for letting this get on top of me.

Adapted from Davey GCL, Lake N & Whittington A (2015) Clinical Psychology. Routledge

Peter's Story

I found it hard at secondary school to make friends and not having a lot of money meant I was singled out. While it wasn't physical, mainly name calling and being spat at, it reinforced the feeling that I didn't deserve to be here. By now I was hearing 'inside' voices in my head telling me I was useless, shouting words like 'Bitch!' and 'Die!'. I was having severe mood swings. I thought about self-harming and became controlling about my food intake. At age 14 I started taking drugs and drinking alcohol. Between 14 and 21 I had a cannabis and cocaine addiction which I overcame. At age 24 I was planning my suicide when my father died. Within 3 days I was having extreme audio and visual hallucinations such as whispering and people calling my name and seeing deceased people, dead bodies and shadows as well as everyday objects. People also transformed into other people in front of me leading me to believe they were possessed by the dead. I also heard menacing voices issuing commands. I experienced strange smells, tasting poison in my food and on one occasion felt someone stroking my hair. It sounds crazy, but I thought that my mind was being controlled, that I could communicate with the dead and that, because of this, the government was spying on me and plotting to kill me.

Adapted from Davey GCL, Lake N & Whittington A (2015) Clinical Psychology. Routledge

Jo'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 thirteen. They were so easy to get. I never had to buy them or get them from a doctor. I would just get them from friends who had gone through their parent's medicine cabinet. I also thought that prescription drugs were "safer" than other drugs. I figured that it was okay for people to take them, and if they were legal, I was fine. Like I said, prescription drugs were incredibly easy to get from friends, and it always seemed to be a last-minute thing. Heroin was also easy to get—all I had to do was go into town and buy it. My heroin use started spiraling out of control. I stopped going to school. I was leaving home for days at a time. My whole life revolved around getting and using drugs—I felt like I was going crazy.

Erica's Story

Introduction

We begin this book with personal accounts from four very different individuals. Possibly the only common link between these four accounts is that they each use the word 'crazy' in relating their story. *Joan* questions whether she is going crazy, *Peter* feels he's going crazy as he relives the trauma he experienced, *Jo* experienced auditory and visual hallucinations that in retrospect seem 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, (a) when someone's behaviour deviates from expected norms, (b) when we are unclear about the reasons for someone's actions, (c) when a behaviour seems to be irrational, or (d) 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 and cause distress to those exhibiting these behaviours. For psychologists the study of these phenomena is known as **psychopathology**, and the branch of psychology responsible for understanding and treating psychopathology is known as **clinical psychology**.

psychopathology The in-depth study of mental health problems.

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

But before we go any further, let's quickly unpack what is meant by the term psychopathology. A traditional definition of psychopathology based on the linguistic origins of the term is that it is 'the scientific study of mental disorders'—a definition that harks back to the days when the medical or illness model of mental health problems was the most influential. But as we'll see in this chapter, in current usage the term psychopathology has a much broader meaning covering the in-depth study of mental health problems generally, and many contemporary approaches to mental health problems do not conceive of them as disorders or illnesses but as the product of perfectly healthy psychological processes in response to stressful or extreme life experiences. In this way, psychopathology has become a term that describes a general scientific approach that embraces attempts to understand the causes of mental health problems, how we should classify them, and how we can successfully fix them. If you're interested in how the nature of mental health terms can change over time, see the descriptions of 'concept creep' in clinical psychology terminology discussed by Haslam (2016) and McGrath, Randall-Dzerdz, Wheeler, Murphy, & Haslam (2019).

With this broader, eclectic meaning of psychopathology in mind, let's examine our four personal accounts a little closer. In each case, the individual finds what is happening to them distressing, and to some extent out of their control. *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. *Peter* is plagued by continually reliving the horrors of a traumatic assault and feels his life is now stuck in a rut and is worthless. In response to severe bullying at school and then the death of her father, *Jo* developed unusual ways of interpreting events around her, hearing voices and experiencing visual hallucinations—interpretations of the world that many other people might label as crazy. 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 a

mental health problem. For example, (a) both *Joan* and *Peter* experience debilitating distress, (b) 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, (c) 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 (d) *Jo*'s life appears to be controlled by interpretations of the world that are extreme 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 health problem, 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, as we alluded to earlier, we cannot attempt to define psychopathology on the basis that some 'normal' functioning (psychological, neurological, or biological) has gone wrong. This is because (a) we are still some way from understanding the various processes that contribute to mental health problems, and (b) 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 in most cases these activities do not significantly interfere with our everyday living. However, for some other people, their experience of these activities may be so extreme or so chronic as to cause them significant distress and prevent them from undertaking normal daily activities such as looking after a family or earning a living (Focus Point 1.1).

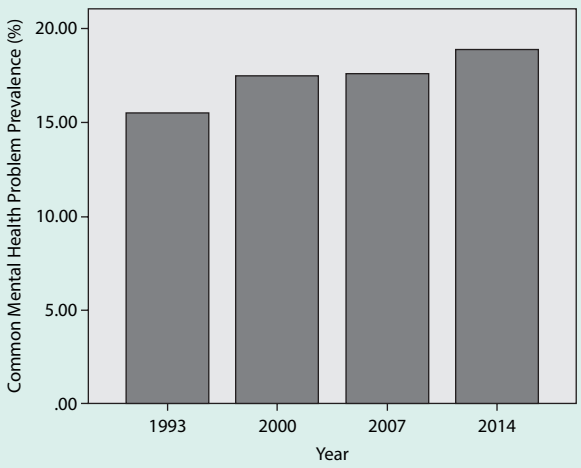
FOCUS POINT 1.1

IS THERE A MODERN-DAY MENTAL HEALTH EPIDEMIC?

There has been a general concern in recent decades that the prevalence of mental health problems is increasing, to almost epidemic proportions. This concern has been expressed in the media generally (https://www.bbc.co.uk/news/health-41125009), by blogging health journalists (https://www.thenational.ae/lifestyle/wellbeing/the-fear-factor-1.640564), by heads of mental health agencies (e.g., https://www.telegraph.co.uk/health-fitness/mind/mental-health-crisis-among-children-selfie-culture-sees-cases/), and by health practitioners and researchers (Davey, 2018a; The Lancet, 2018b).

But is there an epidemic? Well it's very hard to find longitudinal data to confirm this. In part this is because reliable data on prevalence rates has been patchy over the last 3–4 decades, and when data are reported they are often reported in different ways using different methods of data collection.

The Adult Psychiatric Morbidity Survey carried out in England by the National Health Service (NHS) uses validated mental health screening and assessment tools to gauge the level of mental health problems in a sample of the general population, and this survey provides prevalence data for years 1993, 2000, 2007, and 2014 (NHS Digital, 2016). Key findings suggest that between 2007 and 2014, the number of adults aged 16–74 years accessing mental health treatment in the UK with conditions such as anxiety or depression had increased significantly from 24% to 39%. In addition, in 2014 around one in six adults met the criteria for a common mental health problem such as anxiety or depression, and this number has increased modestly over the 4 years of sampling since 1993—but these increases are probably not statistically significant (Spiers et al., 2016). However, what these figures do suggest is that while there may not be a substantial increase in diagnosable common mental health problems, there does appear to be a sizable increase in the number of people accessing mental health services for these conditions.



Prevalence of common mental health problems (anxiety or depression) in England between 1993 and 2014 (data from NHS Digital, 2016).

Similarly, the picture on more severe diagnosable mental health problems such as schizophrenia, autism, and eating disorders does not obviously indicate a growing mental health epidemic. The following table shows data on the global prevalence of mental health problems as collected by the Global Burden of Disease 2017 study (The Lancet, 2018a). To be sure, this indicates that a significant number of people worldwide (970.8 million) are suffering from a diagnosable mental health problem, and on current population figures that

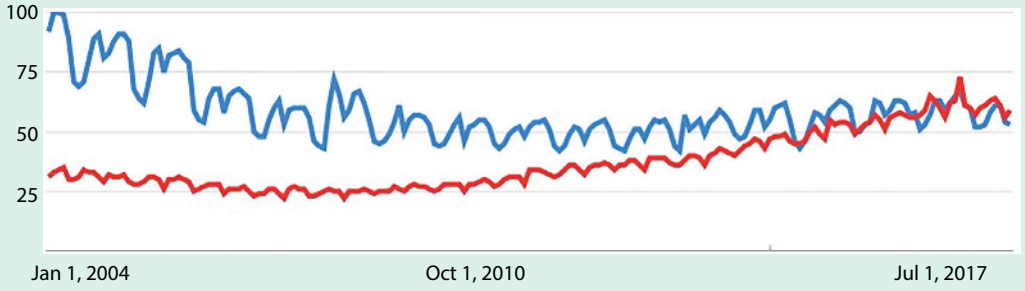
amounts to one in seven people globally (14.2%). But a comparison of figures between 1990 and 2017 suggests a small decrease in reported mental health problems in both males (−2.1%) and females (−3.0%) over this time. This evidence for a relative stability of mental health problems over time is also supported by systematic reviews and meta-analyses, which suggest at best only a modest increase in the prevalence of mental health problems since at least the 1970s (Richter, Wall, Bruen, & Whittington, 2019).

Global Prevalence of Mental Health Problems 2017 (The Lancet, 2018a)

Mental Health Problem	Prevalence (million)
All mental health problems	970.8
Anxiety disorders	284.3
Depressive disorders	264.4
Substance use disorders	175.5
Bipolar disorder	45.5
Autism spectrum disorders	31.1
Schizophrenia	19.7
Eating disorders	15.8

So what is driving talk of a mental health epidemic? Perhaps people are becoming more aware of the immense scale of existing levels of mental health problems (the NHS Psychiatric Morbidity Survey for 2014 suggests that one in six people in the UK will be suffering a diagnosable common mental health problem at any one time (NHS Digital, 2016). People may also be growing more aware of when they themselves are suffering mental health symptoms. They may be more able to identify these symptoms and have a better knowledge of how to access mental health services for treatment.

In addition, there may be a real growth of mental health problems in specific demographic groups and a growth in numbers of individuals experiencing only specific conditions. For example, there may be a growing recognition of mental health problems in children and adolescents—especially common mental health problems such as anxiety, depression, and self-harm (e.g., Creswell, Waite, & Cooper, 2013), and the number of young people experiencing severe emotional disorders in England has increased from 3.9% in 2004 to 5.8% in 2017 (NHS Digital, 2017). Also, the 2017 Global Burden of Disease study indicates that anxiety has overtaken depression as the predominant mental health condition globally—the 'silent epidemic' may have eclipsed the 'black dog' (Davey, 2018a). The following figure shows the Google trends results on searches for 'depression' (blue line) and 'anxiety' (red line) over the years from 2004 to 2019, indicating that there has been a relative increase in interest in the term 'anxiety' relative to 'depression' during this time.



Before we continue to discuss individual mental health problems in detail, it is important to discuss how the way we define these problems has evolved over time.

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 re-describes the behaviour as something that is unusual. 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. We begin by looking at an historical perspective on explaining psychopathology, which is known as **demonic possession**. We then describe how the **medical model** of

demonic possession Historical explanations of psychopathology such as 'demonic possession' often alluded to the fact that the individual had been 'possessed' in some way.

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

asylums In previous centuries asylums were hospices converted for the confinement of individuals with mental health problems.

community care Care that is provided outside a hospital setting.

psychopathology developed and finish with a discussion of the transition from **asylums** to **community care**.

demonic possession Historical explanations of psychopathology such as 'demonic possession' often alluded to the fact that the individual had been 'possessed' in some way.

1.1.1 Demonic Possession

Many forms of psychopathology are accompanied by what appear to be changes in the individuals' 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 in some cases 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 **demonic possession**), and the only way to exorcise these bad spirits was with elaborate ritualised 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 eighteenth century, when witchcraft and demonic possession were common explanations for psychopathology, and analyses of examples of demonic possession from the Middle Ages have identified symptoms of psychosis, mood disorders, neurosis, and personality disorders in those believed to be possessed (Forcén & Forcén, 2014). Today, 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 (Hanwella, de Silva, Yoosuf, Karunaratne, & de Silva, 2012; Ng, 2007), 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 et al., 2011) (Focus Point 1.2).

FOCUS POINT 1.2

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 to explain the effects of psychopathology-related experiences, but are also regularly used to control and coerce individuals.

Neuner 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 had 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 is believed to visit the affected individual and replaces his or her identity'. Neuner and colleagues found 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 (PTSD).

Neuner et al. (2012) concluded 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.

1.1.2 The Medical or Disease Model

As cultures develop, then so too do the types of causes that they attribute behaviour to. By the middle of the seventeenth century, religious, spiritual, and superstitious explanations of psychopathology were being replaced by more objective, medical explanations as a consequence of the new empirical scientific methods being pioneered across Europe by thinkers and scientists such as Isaac Newton, René Descartes, and Galileo. In particular, the body-mind dualism of René Descartes introduced some significant reorientations in the explanation of mental health phenomena. According to Descartes, because minds could not be diseased, mental health problems must be located in the body, and more specifically in the brain. It's at this point that psychopathology moved from being a concern of theology or demonology to being in the realm of medicine (Davey, 2018b).

The medical model of psychopathology was a significant 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**, and 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 attempt to explain symptoms in terms of such factors as brain abnormalities (e.g., in dementia, autism) biochemical imbalances (especially imbalances of brain neurotransmitters) (e.g., major depression, bipolar disorder, schizophrenia), genetic factors (e.g., learning disabilities, autism, schizophrenia), chromosome disorders (e.g., intellectual disabilities), congenital risk factors (such as maternal infections during pregnancy) (e.g., intellectual disorders, attention-deficit-hyperactivity disorder [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, nor is biological dysfunction necessarily a factor underlying all psychopathology. As we shall see later—it is often a person's experiences that are problematic, not their biological substrates.

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

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.

First, an obvious implication is that it implies that medical or biological causes underlie psychopathology. This is by no means always the case, and bizarre behaviour can be developed by perfectly normal learning processes. For example, 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 they acquire 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 has led to them thinking and acting in the way they do.

Second, 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 (Lund et al., 2018), 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 Chapter 5, Section 5.3.3). All of these factors arguably contribute to a full understanding and explanation of psychopathology.

recovery model Broad-ranging treatment approach which acknowledges the influence and importance of socio-economic status, employment and education and social inclusion in helping to achieve recovery from mental health problems.

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 number of reasons:

1. Rather than reflecting a dysfunction, psychopathology might just represent a more extreme form of normal behaviour. We all get anxious, we all worry, and we all get depressed. Yet anxiety, worry, and depression in their extreme form provide the basis of many of the common 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 generalised anxiety disorder (GAD, see Chapter 6). Nevertheless, there is no reason to suppose that the cognitive mechanisms that generate the occasional worry bout in all of us are not the same ones that generate chronic worry in others (Davey & Meeten, 2016). In this sense, psychopathology can be viewed as being on a dimension rather than being a discrete phenomenon that is separate from normal experience, and there is accumulating evidence that common psychopathology symptoms such as anxiety and depression are on a dimension from normal to distressing, rather than being qualitatively distinct (e.g., Haslam, Holland, & Kuppens, 2011; Lupien et al., 2017).
2. By implying that psychopathology is caused by a normal process that is broken, imperfect or dysfunctional, the medical model may have an important influence on how we view people suffering from mental health problems, and indeed, how they might view themselves. At the very least it can be stigmatising to be labelled as someone who is biological 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 (see Section 1.4).

1.1.3 From Asylums to Community Care

Prior to the eighteenth 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 hospices for these diseases were converted into **asylums** for the confinement of individuals with mental health problems.

Because in many countries there was no coordinated government response to mental health issues until the nineteenth century, individual privately funded hospitals or 'madhouses' began to appear prior to this time, and in the UK the most famous of these was the **Bethlem Hospital** in Moorfields, London that 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

Bethlem Hospital One of the first psychiatric hospitals originally established in Moorfields, London

backgrounds—especially young pregnant women, who were considered to be 'wayward' or 'morally degenerate'. This growing hotchpotch of inmates in eighteenth and nineteenth 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 nineteenth 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 US 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).

moral treatment Approach to the treatment of asylum inmates, developed by the Quaker movement in the UK, which abandoned contemporary medical approaches in favour of understanding, hope, moral responsibility, and occupational therapy.

Even into the twentieth century and up until the 1970s in both the UK and the US, hospitalisation was usually the norm for individuals with severe mental health problems, and lifelong hospitalisation 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 (Photo 1.1). Because of the growing numbers of inpatients 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 hospitalisation were being recognised 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 that 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 (Cumming & Cumming, 1962; Paul & Lentz, 1977). A further therapeutic refinement of the hospital environment came in the 1970s with the development of **token economy** programmes (Ayllon & Azrin, 1968; see Hackenberg, 2018, for a review of research and application). These were programmes based on operant reinforcement, where patients would receive tokens (rewards) for emitting 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 and Magaro (1971) showed that patients in a token economy ward improved significantly more than patients in a traditional ward, and Gershone, Errickson, Mitchell, and Paulson (1977) found that

PHOTO 1.1 *This photograph shows a ward in Cardiff City Mental Hospital, Whitchurch, UK, in the early twentieth century. Beds are crowded close together allowing little personal space for patients, who were often hospitalised for much of their life. https://www.bbc.co.uk/news/uk-wales-south-east-wales-35766956.*

milieu therapies The first attempts to structure the hospital environment for patients, which attempted to create a therapeutic community on the ward in order to develop productivity, independence, responsibility and feelings of self-respect.

token economy A reward system which involves participants receiving tokens for engaging in certain behaviours, which at a later time can be exchanged for a variety of reinforcing or desired items.

patients in a token economy scheme 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, Tenhula, & Green-Paden, 2005). There were a number of reasons for this decline, and these include the legal and ethical difficulties of withholding desired materials and events so they can be used as reinforcers, and a lack of consensus on whether behaviours nurtured in token economy schemes were maintained after the scheme ended and whether they generalised to other environments and settings (Davey, 1998; Glynn, 1990).

In 1963, the US Congress passed a Community Mental Health Act that specified that, rather than be detained and treated in hospitals, people with mental health problems had the right to receive a broad range of services in their communities. These services included outpatient therapy, emergency care, preventative care, and aftercare. Growing concerns about the rights of mental health patients and a change in social attitudes away from the stigma associated with mental health problems meant that other countries around the world swiftly followed suit in making mental health treatment and aftercare available in the community (Hafner & van der Heiden, 1988). These events led to the development of a combination of services usually termed assertive community treatment or assertive outreach, and, in the US alone, by the 1990s this had led to around a 10-fold decrease in the number of people being treated in hospital for mental health problems (Torrey, 2001).

Given these developments, treatment and care of individuals diagnosed with severe mental health problems has moved away from long-term hospitalisation 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 result of the development of more effective early intervention treatments and supportive community care and outreach programmes, and even for individuals diagnosed with a serious mental health problem, length of stay typically ranges from a few days to just a few weeks depending on the nature of the diagnosis (Jacobs et al., 2015). Nevertheless, even when living back in their communities, it was clear that many individuals diagnosed with mental health problems would often need support and supervision. They would need help maintaining their necessary medication regime, finding and keeping a job or applying for and securing welfare benefits. They may also need help with many aspects of normal daily living that others would take for granted, such as personal hygiene, shopping, feeding themselves, managing their money, and coping with social interactions and life stressors. Today in the UK, these outreach services are delivered by a **Community Mental Health Team** (CMHT) that can include psychiatrists, clinical psychologists, social workers, and nurses, and in more complex cases a Care Programme Approach (CPA) might be applied where an individual care plan is developed to provide ongoing support (NHS England, 2019). Many mental health services also have **Assertive Outreach Teams** whose function is to help individuals with mental health problems who find it difficult to work with mental health services or have related problems such as violence, self-harm, homelessness, or substance abuse. Assertive outreach staff would expect to meet their clients in their own

PHOTO 1.2 *Assertive Outreach staff try to meet their clients in their own environments, and for many homeless individuals suffering psychotic symptoms this may mean parks, streets, and cafes. The aim of such programmes is to help individuals with their medication regimes, provide assistance in dealing with everyday life and its stressors and securing welfare benefits. These programmes also aim to help build a long-term relationship between the individual and local mental health services. https://www.julianhouse.org.uk/life-as-an-outreach-worker.*

environments, whether that is a home, café, park, or street, with the aim of building up a long-term relationship between the client and mental health services (Photo 1.2). (Video https://www.youtube.com/watch?v=zBcmTUMJZfI shows how crisis mental health services are delivered in parts of London using dedicated teams of mental health professionals). (Treatment in Practice 1.1).

CLINICAL PERSPECTIVE: TREATMENT IN PRACTICE 1.1
THE PROS AND CONS OF HOSPITALISATION

Why might I need to go to hospital?

If you're experiencing a mental health crisis, staying in hospital might be the best way to keep you safe and provide you with the level of treatment you need. This might be because:

- you need to be admitted for a short period for further assessment
- there's a risk to your safety if you don't stay in hospital, for example, if you are severely self-harming or at risk of acting on suicidal thoughts
- there is a risk you could harm someone else
- there isn't a safe way to treat you at home
- you need more intensive support than can be given to you elsewhere.

Is hospital treatment right for me?

Your experience of being treated in hospital can depend on:

- the hospital you go to
- what kind of treatment you receive
- your personal feelings about being in hospital.

Some people prefer being in hospital while others find it very difficult. This table lists some aspects of hospital stays you might want to consider:

Potential advantages	Potential disadvantages
• You're likely to have access to a range of talking therapies and medication. • Trained staff are around to support you, for example, if you feel like self-harming. • You might feel you're getting a welcome break from stressful experiences or problems. • It can provide structure in your day and there are people around you.	• You can't always decide what you do, so there might be times when you feel bored or have to do activities you don't enjoy. • You don't have all your own things around you. • You won't be able to have family or friends near you whenever you like. • Nearly all hospitals have single-sex sleeping accommodation, but some may have mixed facilities during the day which some people find difficult. • You can't always leave when you want to. • You may be assessed under the Mental Health Act if you try to leave permanently (see our page on leaving hospital as a voluntary patient for more information).

How can I access it?

If you think staying in hospital could help you, then you can ask your GP, psychiatrist or another health care professional to refer you.

If you choose to go into hospital, you are considered a **voluntary patient** (also known as an **informal patient**). This means that:

- you should have the right to come and go from the hospital (within reason)
- you may discharge yourself if you decide to go home.

Unfortunately many areas have a shortage of available beds, so it might not always be possible for you to be treated in hospital - even if that's what you'd prefer. (Our page on voluntary patients has more information, including on the advantages and disadvantages of being a voluntary patient.)

About locked wards

Locked wards are a kind of hospital ward where you can't come and go freely.

- The doors may be physically locked, or you might need to get permission to leave the ward.
- Some wards might only be locked at certain times, but others may be locked all the time.
- Some locked wards have access to a secure outdoor space, like a garden or courtyard.

On most psychiatric wards there will be a mixture of voluntary patients and patients who are sectioned under the Mental Health Act. Health services have an equal duty to keep all these patients safe. For these reasons many psychiatric wards are locked, so if you are in hospital by choice you might feel like your freedom is more restricted than you would like.

Could I be forced to go to hospital?

If a group of mental health professionals agree that hospital treatment would be in your best interests to keep you or others safe, then they could detain you in hospital under the Mental Health Act (sometimes called being sectioned) – even if you don't want to be there.

See our pages on sectioning for information about the circumstances in which you can be sectioned, and about your legal rights.

What happens when I leave hospital?

There are some differences in what happens when you leave hospital depending on whether you are a voluntary patient or have been sectioned under the Mental Health Act.

- If you are a **voluntary patient**, see our pages on voluntary patients.
- If you have been **sectioned under the Mental Health Act**, see our pages on sectioning, discharge from hospital, and aftercare under section 117 of the Mental Health Act.

From https://www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/treatment-in-hospital/#.XS70Yi2ZPxo

Read Claire's Blog about her experiences of going into hospital during a crisis: https://www.mind.org.uk/information-support/your-stories/in-crisis-my-experience/#.XS73pS2ZPxr

1.1.4 Summary

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 lifelong 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).

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

- 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*, *Peter, Jo,* and *Erica* are ones for which they would be happy to receive some structured help and support. 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 second, knowledge of the aetiology of many psychopathologies is still very much in its infancy, so we are not yet in a position to provide a classification of psychopathologies that is based on causal factors. This leads us to try to define psychopathology in ways that are independent of the possible causes of such problems—and, as we shall see, many attempts to do this have important ethical and practical implications.

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 textbooks 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

abnormal psychology An alternative definition of psychopathology, albeit with stigmatizing connotations relating to not being 'normal'.

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) (see Rose et al., 2016, for a discussion of how mental health service-user led organisations interact with mental health decision makers to bring about change), charitable organisations such as *Mind* and *Rethink*, that champion the rights of mental health service users (https://www.mind.org.uk and https://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 (http://www.time-to-change.org.uk).

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.

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 minimise 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 approximately two standard deviations or more below the population mean, this is taken as an indicator of intellectual disability (see Chapter 17, Table 17.6). 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 2.5%–3% of the population) (Figure 1.1). However, there are at least two important problems with using deviations from statistical norms as indications of psychopathology. First, in the intellectual disability case, an IQ of less than 70 may be statistically rare, but rather than simply forcing the individual into a diagnostic category, a better approach would be to evaluate the specific needs of individuals with intellectual disabilities in a way that allows us to suggests strategies, services, and supports that will optimise individual functioning. Second, 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 lends some objectivity and measurability to our definition. However, where we draw our cut-off points between 'normality' and 'abnormality' will still be a subjective judgement.

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

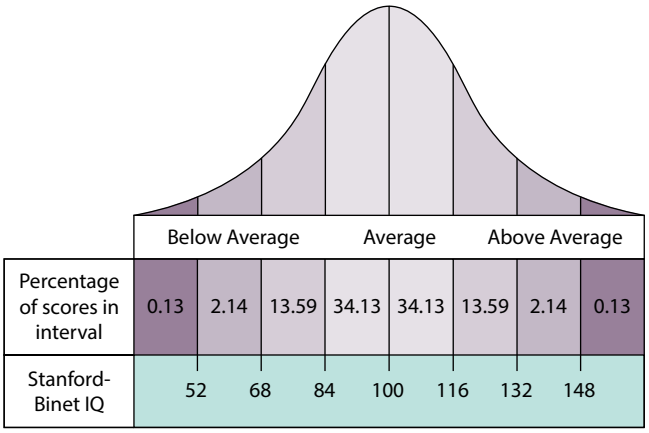


FIGURE 1.1 *This figure represents a normal distribution curve for IQ scores. From this distribution it can be seen that 68% of people score between 84 and 116 points, while only 2.27% of people have an IQ score below 68 points. This graph suggests that around 2–3% of the population will have IQs lower 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% of the population have an IQ score greater than 132 points.*

Finally, emotions such as anxiety and depression that underlie the most common mental health problems are not statistically rare emotions. They are experienced almost daily by most people, and this represents another reason why deviation from the statistical norm does not make a good basis on which to define psychopathology.

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 we consider to be the social norms for that

culture. We assume (perhaps quite wrongly) that socially normal and acceptable behaviours have evolved to represent adaptive ways of behaving and that anyone who deviates from these norms is exhibiting psychopathology. However, it is very difficult to use deviation from social norms, 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 (i.e., '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 disorders that appear to consist of 'revisionist' views and beliefs. For example, '*reformist delusions*' was a label for beliefs 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* was 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, (a) 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) (Bryant, 2019), and (b) 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 mainly in Latinos from the Caribbean (Moitra, Duarte-Velez, Lewis-Fernàndez, Weisberg, & Keller, 2018; Salman et al., 1998), and **Seizisman**, a state of psychological paralysis found in the Haitian community (Nicolas, DeSilva, Grey, & Gonzalez-Eastep, 2006) (Focus Point 1.3).

ataque de nervios A form of panic disorder found in Latinos from the Caribbean.

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

FOCUS POINT 1.3

PSYCHOPATHOLOGY AND CULTURE

Psychopathology can manifest itself in different forms in different cultures, and this can lead to some disorders that are culture-specific (i.e., have a set of symptoms which are found only in that particular culture). Two such examples are *Ataque de Nervos*, 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 et al., 2006).

Ataque de Nervos

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 Nervos* has begun to show that it is found predominantly in women, those over 45 years of age, and from low socio-economic backgrounds and disrupted marriages (Guarniccia, De La Cancela, & Carrillo, 1989), The symptoms appear to resemble many of those found in panic disorder, but with a coexisting affective disorder characterised by emotional lability and anger (Salman et al., 1998).

From this research, it appears that *Ataque de Nervos* 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 externalised 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, disorganised, 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' (From Nicolas et al., 2006, p. 705).

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 down a job, can cope with the demands of being a parent, develop loving relationships, or function socially. In its extreme form, maladaptive behaviour might involve behaving in a way that is a threat to the health and well-being of the individual and to others. It is certainly the case that current diagnostic criteria, such as those in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5), do use deficits in social, occupational, and educational functioning as one criterion for defining many mental health problems, but it is by no means the only criterion by which those conditions 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 could 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 the extreme behaviours which are consequences of severe paranoia (see Chapter 8, Section 8.5.2). The problem with this type of definition is that we still know very little about the brain mechanisms that generate psychopathology symptoms (both biological and psychological mechanisms), 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 et al., 2011; 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 qualitatively different from normal behaviour as the harmful dysfunction model would imply.

harmful dysfunction Assumption that psychopathology is defined by the 'dysfunction' of a normal process that has the consequence of being in some way harmful.

1.2.4 Distress and Disability

In Chapter 2 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 mental health problem one of the most common requirements is that the symptoms must cause 'clinically significant distress or impairment in social, academic, or occupational functioning'. It is clearly the case that many individuals with severe symptoms of psychopathology do suffer considerable personal distress—often to the point of wanting to take their own lives. Defining psychopathology in terms of the degree of distress and impairment expressed by the sufferer is useful in a number of ways. First, it allows people to judge their own 'normality' rather than subjecting them to judgements about their 'normality' made by others in society such as psychologists or psychiatrists. Many people who are diagnosed with mental health problems 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. Second, 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 the life they are living. In addition to this, there is plenty of evidence that psychological distress is closely associated with poor quality of life and a lowered ability to cope with stress and life problems (Arvidsdotter, Marklund, Kylén, Taft, & Ekman, 2016; Atkins, Naismith, Luscombe, & Hickie, 2013)—factors that would offer additional good reason for providing support and help for individuals experiencing distress.

However, as attractive as this definition for defining psychopathology seems, it does have a number of difficulties. First, this approach does not provide any standards by which we should judge behaviour itself. For example, in *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? In addition, psychopathology classification schemes do include diagnostic categories 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 antisocial personality disorder frequently exhibit behaviour that is impulsive, emotional, threatening, and harmful to themselves and others. Yet they are rarely willing to admit that their behaviour is unusual or problematic.

1.2.5 Summary

None of these individual ways of defining psychopathology is ideal. They may fail to include examples of behaviour that we intuitively believe are representative of mental health problems (the distress and impairment approach), they may include examples we intuitively feel are *not* examples of psychopathology (e.g., the statistical approach, the deviation from social norms approach), or they may represent forms of 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.

SELF-TEST QUESTIONS

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

SECTION SUMMARY

1.2 DEFINING PSYCHOPATHOLOGY

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

1.3 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 has 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 scientific knowledge, to current models of care. This section introduces 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. First, 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, etc. 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**. Second, 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 unusual or biased 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

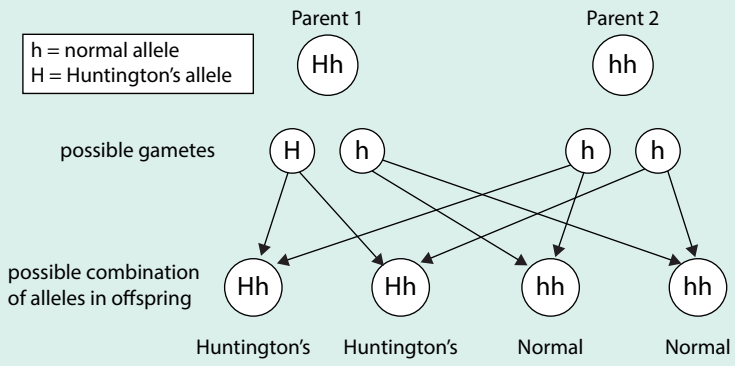
Genetics The study of heredity and the variation of inherited characteristics.

Genetics is a fast growing and important branch of science, and collaborations such as the Human Genome Project are attempting to identify those genes that may be responsible for human characteristics, disorders, and diseases (Collins & McKusick, 2001; Lander, 2011). 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 Point 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.

FOCUS POINT 1.4

THE GENETICS OF INHERITING MENTAL HEALTH PROBLEMS

Huntington's disease is a degenerative neurological conditioning 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 needs only 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% chance of inheriting the mutant version of the gene from their parent. A grandchild of a person with Huntington's disease has a 25% 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 only if 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.

The way in which genetics might influence psychopathology can be studied in a variety of ways: (a) 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; (b) **twin studies** compare the probability with which monozygotic (MZ) and dizygotic (DZ) twins both develop psychopathology symptoms. MZ twins (identical twins) share 100% of their genetic material, whereas DZ twins (nonidentical twins) share only 50% of their genes, so a genetic explanation of psychopathology would predict that there would be greater concordance in the diagnosis of a mental health problem in MZ than in DZ twins (see Chapter 8 for some examples of this approach); and (c) 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; see McAdams et al., 2018, for methods of exploring intergenerational genetic associations). 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.

concordance studies Studies designed to investigate the probability with which family members or relatives will develop a psychological disorder depending on how closely they are related – or, more specifically, how much genetic material they have in common.

twin studies Studies in which researchers have compared the probability with which monozygotic (MZ) and dizygotic (DZ) twins both develop symptoms indicative of a psychopathology inorder to assess genetic contributions to that psychopathology.

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 understanding of psychosis, see Chapter 8). (see https://www.youtube.com/watch?v=yuMi50PrwIM). This interaction between genes and experiences gives rise to the notion of heritability. **Heritability** is a measure of the degree to which symptoms can be accounted for by genetic factors; this ranges from 0 to 1, and the nearer this figure is to 1, the more important are genetic factors in explaining the symptoms. 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.

diathesis-stress model Model that suggests a mental health problem develops because of an interaction between a genetic predisposition and our interactions with the environment.

Heritability A measure of the degree to which symptoms can be accounted for by genetic factors. It ranges from 0 to 1, and the nearer this figure is to 1, the more important are genetic factors in explaining the symptoms.

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 (see Uher & Zwicker, 2017, for a review of genetic approaches to understanding psychopathologies). 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

molecular genetics Genetic approach that seeks to identify individual genes that may be involved in transmitting psychopathology symptoms.

genetic linkage analysis A method of identifying individual genes by comparing the inheritance of characteristics for which gene location is known (e.g. eye colour) with the inheritance of psychopathology symptoms.

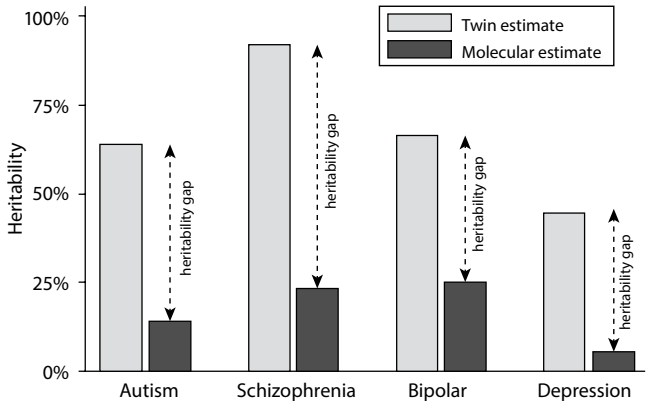


FIGURE 1.2 *The heritability gap.*
Source: From Uher & Zwicker (2017).

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 heterogenous nature of mental health problems (e.g., Badner & Gershon, 2002; Faraone et al., 2007; Levinson, Lewis, & Wise, 2002). Finally, an alternative means of identifying psychopathology-relevant genes is to use nonhuman 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 et al., 2002).

However, we must be cautious about how heritability estimates are calculated. Different methods can often provide very different heritability estimates, and this phenomenon is known as the '**heritability gap**'. Figure 1.2 shows dramatic differences in the heritability estimates for some common psychopathologies when we compare heritability estimates based on concordance measures with estimates based on molecular genetic analyses. The most likely explanation for this 'heritability gap' is that twin studies may often erroneously attribute genetic effects to individuals growing up in the same family or environment (i.e., MZ twins) whereas this factor is not a confound when molecular studies are carried out on unrelated individuals (Uher & Zwicker, 2017).

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 PTSD, which then puts such individuals at higher risk of developing PTSD after highly traumatic life experiences (Yehuda et al., 2010). This has important implications for our understanding of how mental health problems develop and the aetiology of those disorders (Guintivano & Kaminsky, 2016; Kofink, Boks, Timmers, & Kas, 2013).

Neuroscience

neuroscience The scientific study of the nervous system.

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 organises 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 1.3). 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

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

cerebral cortex The outer, convoluted area 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.

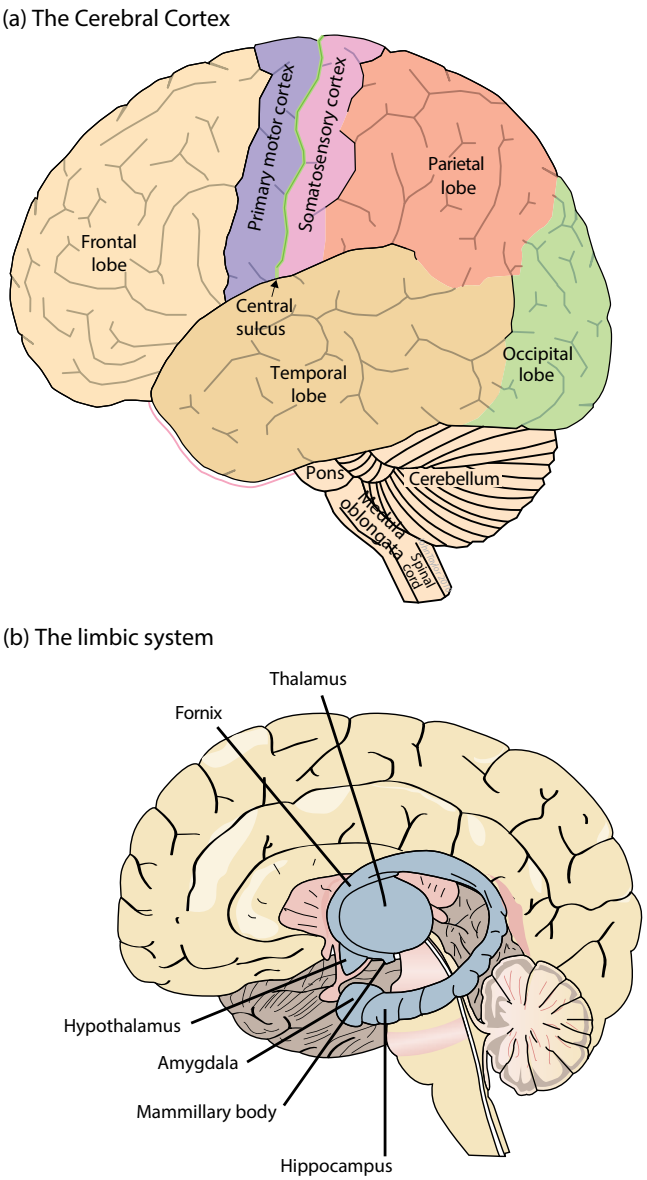


FIGURE 1.3 *The neuroanatomy of the brain.*
(a) The cerebral cortex.
(b) The limbic system.

parietal lobe Brain region associated with visuomotor coordination.

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

be a focus for memory processes, and the **parietal lobe** is associated with visuo-motor 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 (Miller & Cummings, 2017). 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 personality disorders, impulsivity, euphoria, aggressive behaviour, and deficits in emotional regulation (Falquez et al., 2015; Sebastian et al., 2014).

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 1.3) 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 et al., 2012). Because of this role, the amygdala is important in activating phobic fear (Ahs et al., 2009), and depressed individuals show more activity in the amygdala when viewing emotional stimuli than nondepressed individuals (Sheline et al., 2001).

limbic system A brain system comprising the hippocampus, mamillary 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 important in adrenocorticotropic hormone secretion and is also critical in learning about the context of affective reactions.

amygdala The region of the brain responsible for coordinating and initiating responses to fear.

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 signals between neurones (see Figure 1.4). There are many different types of 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, including **dopamine**,

dopamine A compound that exists in the body as a neurotransmitter and as a precursor of other substances including adrenalin.

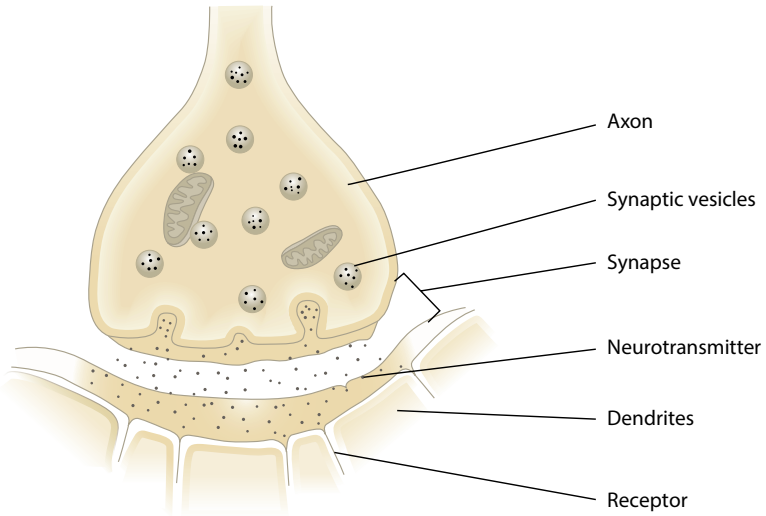


FIGURE 1.4 *Neurons, neurotransmitters, and nerve impulses.*
The cells in the brain are called neurons and consist of (a) the cell body, (b) dendrites, and (c) one or more axons of varying length. When a neuron sends a signal to another neuron, a nerve impulse travels down the axon to the synapse between the two neurons. The end of the axon contains synaptic vesicles which are small structures filled with neurotransmitters. When the neurotransmitter is released into the synapse, some of the molecules reach the receptor and a message is sent to the postsynaptic cell. Once a presynaptic neuron has sent its signal, the synapse then has to return to its normal state by either breaking down any remaining neurotransmitter in the synapse or taking it back into the axon through a process called reuptake.

serotonin An important brain neurotransmitter where low levels are associated with depression.

norepinephrine A neurotransmitter thought to play a role in anxiety symptoms.

gamma-aminobutyric acid (GABA) A neurotransmitter thought to play a role in anxiety symptoms.

serotonin, **norepinephrine**, and **gamma-aminobutyric acid** (**GABA**). Abnormalities in levels of serotonin and norepinephrine have been implicated in the symptoms of mood disorders (see Chapter 7), dopamine is central to important theories of schizophrenia and psychotic symptoms (see Chapter 8, Section 8.5), and norepinephrine and GABA may play a role in anxiety symptoms (Kaur & Singh, 2017; Liu, Zhao, & Guo, 2018; Monaco, Coley, & Gao, 2016). Even so, the functions of neurotransmitters are often not simple or easy to define. For example, dopamine has many functions in the brain, including important roles in regulating voluntary movement, motivation, and reward and is critically involved in mood, attention, and learning. Similarly, early theories of the role of neurotransmitters in psychopathology symptoms tended to assume that symptoms were caused by either too little or too much of a particular neurotransmitter. This picture, however, is much too simple, and more recent theories suggest that symptoms may be associated with much more complex interactions between different neurotransmitters (e.g., Carlsson et al., 2001; Devor et al., 2017).

Summary

Most chapters of this book have a section on biological explanations of psychopathology where explanations of the causes of symptoms are discussed in terms of genetics, brain structure and function, and brain neurotransmitters. Because behaviour and thought cannot occur in the absence of a biological substrate, 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, and they will also provide us with information about whether abnormalities in brain function or neurotransmitter activity is 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 affect their emotions, and how distress is experienced and manifested). We discuss some of these alternative—but complimentary—paradigms later in the chapter. But for a fuller introductory coverage of neuroscience, the brain and behaviour, see Ward and King (2018).

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 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).

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

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

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

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

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

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

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

The **superego** develops out of both the id and ego, and represents our attempts to integrate 'values' that we learn from our parents or society. Freud argued that we will often judge ourselves by 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.

superego Key concept in Sigmund Freud's psychoanalytic theory. The superego develops out of both the id (innate instinctual needs) and ego (a rational part of the psyche that attempts to control the impulses of the id), and represents our attempts to integrate 'values' that we learn from our parents or society.

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

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

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

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

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

TABLE 1.1 *Defence mechanisms in psychoanalytic theory*

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

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

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

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

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

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

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

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

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

life display 'oral stage characteristics' such as extreme dependence on others. Other stages of development include the anal stage (18 months to 3 years), the phallic stage (3–5 years), the latency stage (5–12 years), and the genital stage (12 years to adulthood).

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 in 2010 as many as 18% of modern practicing clinical psychologists identified themselves at least in part with a psychoanalytical or psychodynamic approach to psychopathology (Norcross & Karpiak, 2012). Psychoanalysis was also the first approach to introduce a number of perspectives on psychopathology that are still important today, including (a) the view that psychopathology can have its origins in early experiences rather than being a manifestation of biological dysfunction, and (b) 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 evidence-based researchers attempt to understand psychopathology. This is largely because the central concepts in psychoanalytic theory are hard to objectively define and measure. Because concepts such as the id, ego, and superego are difficult to observe and measure, it is therefore difficult to conduct objective research on them to see if they are actually related to symptoms of psychopathology in the way that Freud and his associates describe (Fonagy, 2003).

The behavioural model

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

During the 1950s and 1960s, many clinical psychologists became disillusioned by psychoanalytic approaches to psychopathology and sought an approach that was more scientific and objective. They turned to that area of psychology known as **learning theory**, and argued that just as adaptive behaviour can be acquired through learning, then so can many forms of dysfunctional behaviour (Davey, 1998). 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).

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

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

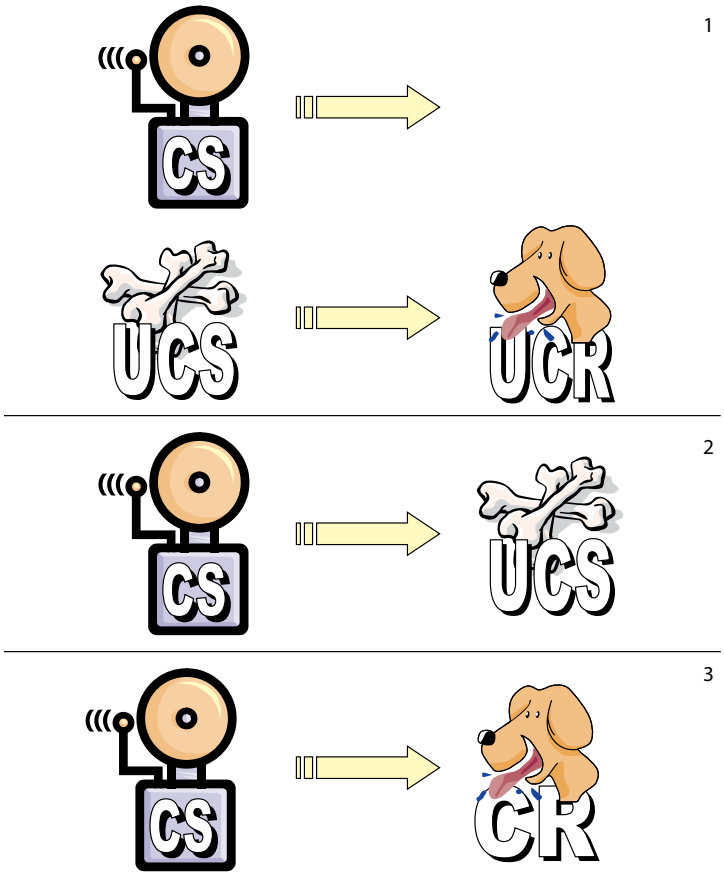


FIGURE 1.5 *Classical conditioning.*
(a) Before conditioning takes place, Pavlov's dog salivates only to the presentation of food and not to the presentation of the bell; (b) pairing the bell with food then enables the dog to learn to predict food whenever it hears the bell, and (c) this results in the 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 6.1).

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 1.5. In contrast, **operant conditioning** represents the learning of a specific behaviour or response because that behaviour has certain rewarding or reinforcing consequences. A prototypical example of operant conditioning is a hungry rat learning to press a lever to obtain food in an experimental chamber called a Skinner Box (see Photo 1.3).

operant conditioning The modification of behaviour as a result of its consequences. Rewarding consequences increase the frequency of the behaviour, punishing consequences reduce its frequency.

These two forms of learning have been used to explain a number of examples of psychopathology. First, 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; Doogan & Thomas, 1992; Kuch, 1997). Classical conditioning processes have also been implicated in a number of other forms of psychopathology, including the acquisition of 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

PHOTO 1.3 *Operant Conditioning. In operant conditioning, the rat learns to press the lever in this Skinner Box because it delivers food, and food acts to reinforce that behaviour so that it occurs more frequently in the future (known as operant reinforcement). Operant reinforcement has been used to explain how many behaviours that are typical of psychopathology are acquired and maintained. That is, many bizarre and disruptive behaviours may be acquired because they actually have positive or rewarding outcomes.*

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., Runegaard, Jensen, Wörtwein, & Gether, 2018; Schacter, 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 (Machalicek et al., 2014).

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 Chapter 4). 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.

behaviour therapy A term currently used for all interventions that attempt to change the client's behaviour (and have largely been based on principles from learning theory).

behaviour modification Behavioural treatment methods based on operant conditioning principles, which assume that learnt psychopathology could be 'unlearnt' using normal learning processes.

As influential as the behavioural approach has been over the years, it too has limitations. For example, many psychopathologies are complex and symptoms are acquired gradually over many years (e.g., obsessive-compulsive disorder, substance dependence, somatoform disorders, etc.). It would be almost impossible to trace the reinforcement history of such symptoms across time in an attempt to verify that reinforcement processes had shaped these psychopathologies. Second, 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 characterised 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 describe these phenomena accurately and inclusively. The cognitive approaches we 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 roughly one in three modern clinical psychologists would describe their approach as cognitive (Norcross & Karpiak, 2012). Primarily, this approach considers psychopathology to be the result of individuals acquiring irrational beliefs, developing dysfunctional or unusual ways of thinking, and processing information in biased ways. It was an approach first pioneered by Albert Ellis (1962) and Aaron Beck (1967). Albert Ellis argued that emotional distress (such as anxiety or depression) is caused primarily because people develop a set of irrational beliefs by which they need to judge their behaviour. Some people become anxious, for example, because they make unrealistic demands on themselves. The anxious individual may have developed unrealistic beliefs such as 'I must be loved by everyone', and the depressed individual may believe "I am incapable of doing anything worthwhile." Judging their behaviour against such 'dysfunctional' beliefs causes distress. Aaron Beck developed a highly successful cognitive therapy for depression based on the view that depressed individuals have developed unrealistic distortions in the way they perceive themselves, the world, and their future (see Chapter 7). For example, Beck's 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 (Strauss, 2019).

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 (see also https://www.babcp.com/public/What-is-CBT.aspx; Rakovshik, 2019)

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

As successful as the cognitive approach seems to have been in recent years, it too 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 rationalise 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 humanistic-existential approach is **client-centred therapy** developed by Carl Rogers (1951, 1987; Joseph, 2017). 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.

client-centred therapy An approach to psychopathology stressingthe goodness of human nature, assuming that if individuals areunrestricted by fears and conflicts, they will develop into well-adjusted, happy individuals.

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

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

As we said earlier, this type of approach to psychopathology does not put 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 themselves as worthy, respected and achieving individuals). Approaches such as humanistic and existentialist ones are difficult to evaluate. For example, some controlled studies have indicated that clients undergoing client-centred therapy tend to fair no better than those undergoing nontherapeutic control treatments (Greenberg, Watson, & Lietaer, 1998; Patterson, 2000), whereas some other studies suggest a significant effectiveness of person-centred counselling

over a 5-year period when compared with a waiting list control group (Gibbard & Hanley, 2008). Even so, exponents of existential therapies believe that experimental methodologies are inappropriate for estimating the effectiveness of such therapies, because such methods either dehumanise the individuals involved or are incapable of measuring the kinds of existential benefits that such approaches claim to bestow (May & Yalom, 1995; Walsh & McElwain, 2002). 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.

Summary

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.

FOCUS POINT 1.5

SOCIOCULTURAL FACTORS AND PSYCHOPATHOLOGY

There is a growing realisation 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 discuss some examples of these here.

Gender

Your gender is likely to be a significant factor in whether you are likely to be diagnosed with a particular mental health problem. For example, the prevalence of major depression is twice as high in women as it is in men (Kuehner, 2016); women are significantly more likely to develop anxiety-based problems such as social anxiety disorder, panic disorder, or GAD, and to suffer trauma- and stress-related mental health problems (see Chapter 6). Women are also significantly more likely to be diagnosed with eating disorders such as anorexia nervosa or bulimia nervosa (Zayas et al., 2018; see Chapter 10), but males are more likely to be diagnosed with conduct disorders, 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, for example, sex hormone differences (Li & Graham, 2017), 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) (Mayor, 2015), or differences in gender-based coping practices (e.g., women ruminate more than men, whereas men frequently react to stress by distracting themselves, Just & Alloy, 1997). A comprehensive discussion of the many possible explanations for gender differences in diagnosis and prevalence rates is provided by Hartung and Lefler (2019).

Culture

The culture in which you live can also be a factor that will determine whether you will be diagnosed with 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% and 19% (Weissman et al., 1996), with some of the highest prevalence estimates for depression being found in some of the wealthiest countries in the world (Kessler & Bromet, 2013). These cultural-demographic differences may be caused by the stigma associated with reporting symptoms in some societies, cultural differences in diagnosing symptoms, and depression being expressed in more physical terms in some societies (called somatisation), or simply by cultural difference in the way people report their depression or the methodologies used to collect data about depression (Compton et al., 1991; Huang, Beshai, & Mabel, 2016; Patten, 2003). Eating disorders are another example where prevalence rates are higher in most Western cultures but in the past have only rarely been reported in less socio-economically developed societies (Keel & Klump, 2003). However, in recent times, 'Westernisation', industrialisation, and urbanisation of underdeveloped countries do seem to be associated with rises in the levels of eating disorders reported in those countries (Pike & Dunne, 2015). Finally, some combinations of mental health problems may be found only in certain specific cultures and may 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 of White European origin. Conversely, specific types of eating disorders—such as anorexia nervosa—have been diagnosed more commonly in White women than Black women (Walcott, Pratt, & Patel, 2003). In some of these cases, there may be a genetic component, for example, 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 (Li, Zhao, & Gelernter, 2012), but equally it may be the case that diagnostic criteria are either wittingly 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, Chapter 2). For example, Black Americans with severe depression are significantly more likely than other racial or ethnic groups to be misdiagnosed with schizophrenia (Gara, Minsky, Silverstein, Miskimen, & Strakowski, 2019), and such differential effects may reflect differential diagnoses driven by implicit racial and ethnic stereotyping.

Socio-economic Conditions

Finally, the socio-economic conditions in which an individual is either raised or lives in are an important contributor to the development of psychopathology (Lund et al., 2018). Obvious examples include the development of conduct disorders, some personality disorders such as antisocial personality disorder, and substance abuse and dependency problems, many of which are associated with poverty and low socio-economic conditions (Karriker-Jaffe, 2013; Walsh et al., 2013). However, poverty is also a risk factor for the development of many common mental health problems such as depression (Freeman et al., 2016), and the development of anxiety disorders in women—but not necessarily men (Mwinyi et al., 2017). Reasons for the association between poor socio-economic conditions and psychopathology may include the additional stressors and traumas that accompany poverty, such as unemployment, substandard accommodation, and neglect, and poverty also brings with it feelings of a lack of control over one's own life and an inability to access the resources that could actively change poor living conditions (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, Pugach, Skolnik, & Smith, 2013).

SELF-TEST QUESTIONS

- What are the main approaches to understanding psychopathology that are advocated by the biological approach?
- What are the pros and cons of attempting to explain mental health problems in terms of genetics?
- 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

- *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, the cognitive 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 perspective and develop a sense of meaning in life.

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 can lead to a 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 (Client's Perspective 1.1) (Video—five young people share their experiences of mental health problems and stigma: https://www.youtube.com/watch?v=vzmfdECUvxM). In the following sections we look at (a) what mental health stigma is, (b) Who holds stigmatising beliefs and attitudes?, (c) What causes stigma? (d) Why does stigma matter? and (e) How can we eliminate stigma?

CLIENT'S PERSPECTIVE 1.1

Lewis is a university lecturer who has suffered from depression for much of his life. Here is his view of the mental health stigma he encountered:

'There can be no doubt that there is considerable stigma associated with depression. I am repeatedly congratulated for being so brave, even courageous, in talking so openly about my depression. I, in fact, am a "performer" and there is no bravery, but these comments show how others view depression and that it is highly stigmatised. An example of how stigma can present a particularly difficult problem for sportsmen is provided by the case of a professional footballer, Stan Collymore who played for England. He had a severe depression and his career went into a rapid decline. He says that he can never forgive the Aston Villa manager for the way he reacted to his depression. He told him to pull his socks up and that his idea of depression was that of a woman living on a 20th floor flat with kids. The *Sun* newspaper said that he should be kicked out of football as how could anyone be depressed when he is earning so much money. He bitterly remarks that if you suffer from an illness that millions of others suffer from, but it is a mental illness which leads many to take their own lives, then you are called spineless and weak.'(From Wolpert, 2001, Stigma of depression—a personal view. *British Medical Bulletin,* 57, 221–224.

1.4.1 What Is Mental Health Stigma?

Mental health stigma Mental health stigma can be divided into two distinct types: social stigma is characterised by prejudicial attitudes and discriminating behaviour directed towards individuals with mental health problems. Perceived stigma or self-stigma is 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.

social stigma Stigma characterised 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 can be divided into a number of distinct types: **social stigma** is characterised 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, **internalised stigma**, **perceived stigma,** or **self-stigma** is the internalising by the mental health sufferer of their perceptions of discrimination where perceived stigma can significantly affect feelings of shame and lead to poorer treatment outcomes (Link, Cullen, Struening, & Shrout, 1989; Perlick et al., 2001). A third type of mental health stigma is **associative stigma** which is the prejudice and discrimination experienced by families because of their relationship with the person with mental health problems (Corrigan & Nieweglowski, 2019).

In relation to social stigma, studies have suggested that stigmatising attitudes towards people with mental health problems are widespread and commonly held (Byrne, 1997; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Heginbotham, 1998). In a survey of over 1,700 adults in the UK, Crisp et al. (2000) found that (a) the most commonly held belief was that people with mental health problems were dangerous—especially those with schizophrenia, alcoholism, and drug dependence; (b) people believed that some mental health problems such as eating disorders and substance abuse were self-inflicted; and (c) respondents believed that people with mental health problems were generally hard to talk to. People tended to hold these negative beliefs regardless of their age, regardless of what knowledge they had of mental health problems, and regardless of whether they knew someone who had a mental health problem. More recent studies of attitudes to individuals with a diagnosis of schizophrenia or major depression convey similar findings. In both forms of psychopathology, a significant proportion of members of the public considered that people with mental health problems such as depression or schizophrenia were likely to lose control, be unpredictable, and be dangerous, and they would be less likely to employ someone with a mental health problem (Mannarini & Rossi, 2019; Reavley & Jorm, 2011; Wang & Lai, 2008). Importantly, mental health stigma is an almost universal phenomenon that can be found in most cultures, and similar forms of mental health prejudice and discrimination can be found regardless of significant differences in cultural backgrounds (Abdullah & Brown, 2011; Grover et al., 2017; Mannarini, Boffo, Rossi, & Balottin, 2018)

Finally, while many forms of mental health stigma are overt and represent discriminatory beliefs and opinions openly held by many members of society, unconscious negative beliefs about mental health problems can often be found using implicit bias tasks with participants who claim *not* to hold stigmatising beliefs about mental health problems (Mannarini & Buffo, 2014; Schlier & Lincoln, 2019) (similar findings are often found with racist beliefs which may exist as unconscious implicit biases). Such implicit biases operating outside of an individual's conscious control appear to reflect stigmatisation based on 'in-group' versus 'out-group' distinctions, where those with mental health problems are implicitly categorised as members of an 'out-group' (Schlier & Lincoln, 2019). The fact that such stigmatising beliefs can operate outside of conscious awareness poses some significant challenges for interventions designed to alleviate mental health stigma.

1.4.2 Who Holds Stigmatising 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. 46% 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% experienced stigma from peers which often led to friendship losses and social rejection (Connolly, Geller, Marton, & Kutcher (1992), and 35% 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 including amongst nursing students (Chang et al., 2017), medical students and qualified medical doctors (Wallace, 2012). These discriminatory beliefs may exist because 'the stigma of mental illness thrives in the medical profession as a result of the culture of medicine and medical training, perceptions of physicians and their colleagues, and expectations and responses

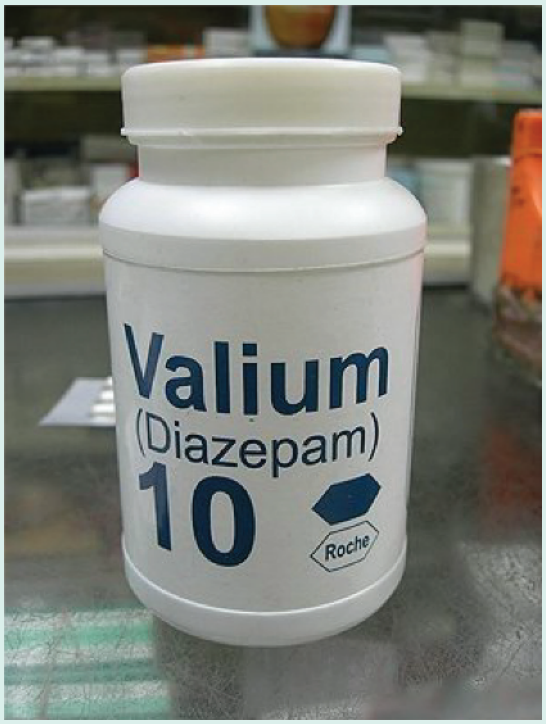
of health care systems and organizations' (Wallace, 2010, p. 3)—quite a list of potential culprits!

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 brutalised. 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' (i.e., for some people individuals with mental health problems belong to a social 'out-group'), but none of these beliefs has any basis in fact (e.g., Swanson, Holzer III, Ganju, & Jono, 1990; Varshney, Mahapatra, Krishnan, Gupta, & Deb, 2016). 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. First, 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 (e.g., Read & Harré, 2001) (Focus Point 1.6). Second, the medical model implies diagnosis, and diagnosis implies a label that is applied to

FOCUS POINT 1.6

CREATING MENTAL HEALTH PROBLEMS THROUGH THE 'MEDICALISATION OF NORMALITY'



It is worth considering when an everyday 'problem in living' becomes something that should be categorised 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'.

A 2018 survey of over 1,000 GPs by the Mental Health Charity *Mind* found that over 40% of consultations with patients seen by GPs involved mental health issues (Mind, 2018), and experiencing **depression** is one of the most common reasons for consulting a doctor or GP in the UK (Singleton et al., 2001). In order for GPs to be able to provide treatment for such individuals, there is often a tendency for patients to present distress as depression in order to secure support or medication (Middleton, Shaw, Hull, & Feder, 2005), and doctors and GPs may even misdiagnose symptoms as depression when validated assessments would not indicate a diagnosis (Carey et al., 2014). For example, while epidemiological studies in the early 2000s suggested that the prevalence rates for depression in the general population were fairly constant, there was at the same time a significant increase in depression

being diagnosed by GPs and physicians, and a significant increase in the prescription of antidepressant medications (Dowrick & Frances, 2013).

Effects such as this may have contributed to the common view expressed by lay people that depression is a 'disease' rather than a normal consequence of everyday life stress (Lauber, Falcato, Nordt, & Rossler, 2003). If lay people already view depression as a 'disease' or biological illness, and GPs are more than willing to diagnose it, then we run the risk of the 'medicalisation' of normal everyday negative emotions such as mild distress or even unhappiness (Shaw & Woodward, 2004).

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) or with influencing the view that this person is a member of an 'out-group' of some kind, and this again will perpetuate the view that people with mental health problems are different and should be treated with caution.

We discuss ways in which stigma can be addressed later, but it must also be acknowledged here that the media regularly play a role in perpetuating stigmatising stereotypes of people with mental health problems. Media portrayals of mental health problems have long been recognised as being misleading and stigmatising, and the popular press is a branch of the media that is frequently criticised for perpetuating these stereotypes. A study of mental health-related stories in nine UK newspapers published in 2017 found that over half of the articles were negative in tone, and 18.5% indicated an association with violence (Chen & Lawrie, 2017). But maybe there is some positive movement on this. Bowen and Lovell (2019) explored how UK newspapers had represented mental health issues on their Twitter feeds between 2014 and 2017. They did identify a significant decrease in the proportion of mental health tweets that were characterised as 'bad news' over that period. But even in 2017, 24% of these tweets were still considered as 'bad news'.

Blame can also be levelled at the entertainment media. For example, cinematic depictions of schizophrenia are often stereotypic and characterised 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 only a minimal decrease in the news media's publication of stigmatising articles, suggesting that the media is still a significant source of stigma-relevant misinformation (Thornicroft et al., 2013).

1.4.4 Why Does Stigma Matter?

Stigma is a form of social discrimination and prejudice, the social effects of which 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 et al., 2001). In particular, self-stigma is correlated with a number of negative outcomes including poorer employment success, increased social isolation (Yanos, Roe, & Lysaker, 2010), negative attitudes towards treatment seeking (Sickel, Seacat, & Nabors, 2019), poorer adherence to medication regimes (Farabee, Hall, Zaheer, & Joshi, 2019), and poorer ability to regulate emotions (Burton, Wang, & Pachankis, 2018). 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 social 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 and often represent implicit biases in attitudes toward those with mental health problems 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 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 by both charities and mental health service providers (http://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 always be effective alone—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! (Caldwell & Jorm, 2001; Wallace, 2010). As a consequence, attention has turned towards some methods identified in the social psychology literature for improving inter-group relations and reducing prejudice (Brown, 2010). These methods aim to promote events encouraging 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' Roadshows*, which set up events in prominent town centre locations with high footfall). Analysis of these kinds of intergroup events suggests that they (a) improve attitudes towards people with mental health problems, (b) increase future willingness to disclose mental health problems, and (c) promote behaviours associated with anti-stigma engagement (Evans-Lacko et al., 2012; Thornicroft, Brohan, Kassam, & Lewis-Holmes, 2008).

Time to Change A national UK programme aiming to promote awareness of mental health problems and to combat stigma and discrimination.

As well as the need to inform and educate members of the public about mental health stigma, there is also a need to create interventions that will reduce internalised stigma in those suffering from mental health problems. A variety of methodologies have been successfully employed to reduce internalised stigma, and these include (a) psychoeducational interventions, (b) CBT interventions aimed at modifying self-stigmatising beliefs, (c) interventions based on understanding the causes of mental health problems, and (d) multifaceted interventions that combine several of the above (Alonso, Guillen, & Munoz, 2019). Such interventions have been shown to reduce measures of internalised stigma, facilitate subjective measures of recovery or coping, and improve self-efficacy and insight (e.g., Wood, Byrne, Varese, & Morrison, 2016).

SELF-TEST QUESTIONS

- What are the different types of mental health stigma?
- What kinds of factors may be responsible for causing and maintaining mental health stigma?
- What kinds of interventions have been developed to try and reduce mental health stigma?

SECTION SUMMARY

1.4 MENTAL HEALTH AND STIGMA

- *Social stigma* is characterised by prejudicial attitudes and discriminating behaviour directed towards individuals with mental health problems
- *Internalised stigma, perceived stigma,* or *self-stigma* is the internalising by the mental health sufferer of their perceptions of discrimination
- 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, as well as on employment prospects, and increased social isolation.
- Campaigns to challenge mental health stigma will usually be multifaceted and will need to challenge existing stereotypes of people with mental health problems.

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 type 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 both social stigma and internalised stigma are a valuable component of most mental health services.