

# 1

## Understanding Psychopathology

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### LEARNING OBJECTIVES FOR THIS CHAPTER

- Understand what *Introducing Psychopathology* is about
  - Know the history behind the concept of psychopathology
  - Discuss the philosophical underpinnings of psychopathology
  - Have insight into the classification of mental disorders
  - Realise that cultural and transcultural issues are involved in psychopathology
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At the heart of counselling, psychotherapy and counselling psychology lies an understanding of mental distress. This is why knowledge of psychopathology is crucial for trainees entering these professions. Without it, they can get lost in a maze of psychobabble.

When I was a student, I wished for a book that explained mental disorders in a jargon-free, simple way. During my training, ploughing through the great third edition of the *Diagnostic and Statistical Manual for Mental Disorders* (APA, 1987) was a daunting task. What I needed was a simple introduction to psychopathology. I write the simply presented and jargon-free book I wish I had in the hope that it helps those who use (or will use) talking as a therapeutic ‘tool’ with their clients or patients.

Although having the ability to be a reflective practitioner is key (as I explain later in this chapter), without a breadth and depth of understanding how mental distress manifests in individuals, coupled with a knowledge from theory and research on how to facilitate these people to move in a desired direction, the therapeutic relationship is severely compromised; if indeed, it is present at all. Without such knowledge and understanding, therapists may unwittingly make matters worse. Bearing this in mind, *Introducing Psychopathology* specifically includes points to reflect on. There are teaching and learning features throughout and these are discussed further on.

You do not have to read this book in any particular order. Dip into it at any place. Each chapter can stand in its own right – if you want to find out about being depressed, just go to the chapter that deals with depression. Nevertheless, there is some logic to the order I have written the text. For instance, this chapter is the book’s introduction. The one that follows deals with assessing and referring, because these tasks are normally necessary during a first appointment. Then there is a focus on children before the spotlight shines on adults, and finally I consider possible future avenues. Therefore, you can read *Introducing Psychopathology* from cover to cover for a more comprehensive picture.

### WHAT IS PSYCHOPATHOLOGY?

Psychopathology derives from two Greek words: ‘psyche’ meaning ‘soul’, and ‘pathos’ meaning ‘suffering’. Currently, ‘psychopathology’ is understood to mean the origin of mental disorders, how they develop and their symptoms. Traditionally, those suffering from mental disorders have usually been treated by the psychiatric profession, which adheres to the DSM-IV-TR (APA, 2002) or ICD-10 (WHO, 1992) for classifying mental disorders. It therefore follows that psychiatrists use the term ‘psychopathology’ more than people in other professions. Psychiatrists are medical doctors who then train in mental health and are able to treat with medication or/and in whatever psychotherapy model they have trained in.

Within psychiatry, the term ‘pathology’ refers to disease. However, viewing mental problems as a disease is a contentious point. Psychotherapists, counselling psychologists and counsellors (who specialise in mind matters and are not medics), view apparent mental dysfunction as mental distress, not necessarily related to pathology. So, the term ‘disorder’ is used, rather than ‘disease’. Other words for diagnosing distress within the mind remain: ‘symptoms’ meaning ‘signs’, ‘aetiology’ meaning ‘cause’, and ‘prognosis’ meaning ‘expected outcome’.

### HISTORY AND PHILOSOPHY

Historical and philosophical factors of psychopathology can easily take up a whole volume. This section offers a psychopathology foundation, which can be built on by looking up the related resources and references listed at the end of the chapter.

Historically, the concept of psychopathology is rooted in the medical tradition. This is where the terms ‘diagnosis’, ‘symptoms’, ‘aetiology’ and ‘prognosis’ come from (Murphy, 2010). Psychiatrists categorise severe mental distress into psychopathological disorders whose symptoms they can treat with prescribed drugs, and use the word ‘patients’. Counselling psychologists, counsellors and psychotherapists favour the term ‘clients’ over ‘patients’ (because of the medical connotations of the word ‘patients’) and use talking, more than anything else, as a therapeutic ‘tool’. They also prefer the concept of ‘formulation’ instead of ‘diagnosis, symptoms, aetiology and prognosis’. Throughout this book, instead of repeating ‘counselling psychologists, counsellors and psychotherapists’, I use the word ‘therapists’, or ‘talking-cures’ to mean all three of these professions because although they may require different trainings, their overlap is substantial. But what are the historical roots of these professions?

### Ancient Greece

Medical and talking-cure roots are embedded in the soil of ancient Greek philosophy. Indeed, the philosophy of the western world is rooted in ancient Greece, from which the mould of western-world thinking was wrought, influencing the way in which the west is. Therefore it follows that the source of my views grows from this mould, which shapes my world and consequently this book, because I was born, raised and live in the west. If I visit a non-western country, the cross-cultural differences may be too great for me to comprehend. I might think that I understand someone whose philosophical ‘template’ is embedded within a non-western philosophy, but I may, in my relative ignorance, misunderstand that person. For this reason, the philosophy focused on here relates to the western world. Nevertheless, as therapists in multicultural settings, we need to be aware of a client’s culture and adapt appropriately.

It is possible to trace two fine philosophical threads stemming from the ancient Greek philosophers Plato and Aristotle (Plato's student) to the present day. The threads start together as one, with Plato.

## The Platonic philosophical thread

Plato taught that humans comprise mind, body and spirit, that the latter is eternal and that there are universal truths outside of time and space, such as honesty and respect. Modern Rogerian counselling, with its basic values of honesty (congruence), compassion (empathy) and respect (unconditional positive regard) – neither judging nor psychopathologising – resonate with Plato's philosophy (Rogers, 1961, 1980). According to Plato, if mind, body and spirit are out of balance in individuals, distress or imbalance is created within them (for more on Plato, see Nails, 2006). This philosophical thread weaves its way into the seventeenth century.

### Spinoza

Plato's philosophy influenced Spinoza, who was a seventeenth-century Jewish lens grinder, born in Holland. He stated that the notion of spirit, or God, is central and integral for the body and the mind and, like Plato, believed in an everlasting God. Spinoza philosophised that since our bodies and minds are part of the same divine essence of God, they must not contradict each other. His notion was that distress was not plausible with a harmonious body and mind, and upheld Plato's philosophy of honesty and respect (for more about Spinoza, see LeBuffe, 2010). This fine philosophical thread continued to weave its way, reaching the eighteenth century. At this time, in the UK, conditions for those with mental disorders were inhumane. Inmates in 'madhouses' such as Bedlam (also known as Bethlem and Bethlehem) were referred to as 'mad', 'insane' or 'lunatics'. They were locked up, practically all were naked, force-fed, iron-fettered and lived in disgusting conditions. But there came a change.

### Madness cured

In 1700, a man named David Irish claimed to cure madness by offering mental asylum inmates warmth, nutritious food and drink, positive attention, comfort and care rather than having them manacled and living in filth (for more on Irish, see Hunter and Macalpine 1963). Underlying such humane acts is the assumption that all people deserve a basic amount of nurturing. Tension arose between the two philosophical threads, with purported mind-doctors 'pathologising' madness on the one hand and the move towards a more humane way of treating those in mental asylums on the other (Appignanesi, 2010). Indeed, the modern notion of formulation can be seen as having its genesis in the eighteenth century with the ideas of a great philosopher, Rousseau, who recognised that his formative years related to his 'nerves'.

### Rousseau

During the eighteenth century, the thinking of Rousseau and the Romantic Movement exploded into the western world like a popping champagne cork. This movement aspired to merge reason with emotion and introduced the notion of the relationship between child and parent being important for sanity. It was Rousseau who reflected that adults suffer from mental distress (nerves) due to pain inflicted during their formative years. He claimed that human inequality is behind individual mental distress. His degeneration theory states that the people who have nothing to lose go back to their primitive and low brutish state, whereas those who can fulfil their potential are enabled to move towards gaining the ideal of perfection (for more

## 4 Introducing Psychopathology

on Rousseau see, for example, Farrel, 2006). Contemporary author Gerhardt expresses a similar idea. She illustrates how it is that the countries with the most inequality also have the most mental distress when compared with those with less inequality; she draws on a substantial amount of research findings that back up her theory (2010). This view adds to the tension between an approach to mental health using a medical model (with its focus on pathology) and one advocating talking-cures (which favour formulations).

### Hegel

As history marched from the eighteenth to the nineteenth century, another great philosopher emerged, Hegel, who was immensely influenced by Rousseau's ideas. According to Hegel, philosophy is the best and absolute form of knowledge, derived dialectically, bringing together knowledge and experience (for more on Hegel see, for example, Stern, 2002). Talking therapies blossom from this stem. He was the forerunner of the existential school of psychotherapy, prizing the individual's experience and endeavouring to make sense of life; the very idea of psychopathology is anathema to this school and its philosophy.

### Twentieth and twenty-first centuries

Existentialism eventually developed into Husserl's phenomenology (for more on Husserl see, for example, Smith, 2007), central to which is the describing of phenomena as they are experienced, rather than interpreting or theorising. It does not make a comfortable bedfellow with psychopathology. What is comfortable for phenomenologists is viewing the relationship between one human life and another. This view continues, flourishing into the current interest shown by many therapists that it is the interpersonal relationship which is of paramount importance for good mental health (Gerhardt, 2008; Rudd, 2008; Gilbert, 2010). Plato's philosophical thread, then, leads from ancient Greece through the Romantic Movement to modern times and the perspective that what happens to us as children has an effect on us as adults – and that we can do something about it (Dawson and Allenby, 2010). Growing numbers of twenty-first century authors support this perspective (for example, Read, Bentall and Mosher, 2004; Rudd, 2008; Gerhardt, 2010). Furthermore, if mental functioning becomes profoundly disturbed, some authors entwine the perspective of interacting with an important other in a relationship with that of pathology, thereby easing tension between the two philosophical threads (for example, Baldwin et al., 1982; Gerhardt, 2008).

By continuing to follow Plato's thread, we are led to emerging research showing that troubled minds, on the whole, are not diseased, and that talking with clients can be substantially helpful (Read, Bentall and Mosher, 2004; Lipton, 2008; Dawson and Allenby, 2010; McTaggart, 2011). Robust research such as that conducted by doctors Harriet, Macmillan and their team (2001) reveals that even lifelong suffering from psychopathological disorders or mental problems is not due to biological illness or disease, but to abuse in childhood. There is more information on this in Chapter 12.

So far, we have followed the thread from Plato in ancient Greece (who declared that the soul is in the pumping heart), to the present day; it therefore seems appropriate to now pick up the thread from Aristotle.

## The Aristotelian philosophical thread

Aristotle disagreed with Plato, believing that the soul is in the head and not in the heart, that it dies in the body, and that only reason and rationality are eternal (for more on Aristotle see, for

example, Halper, 2005). Due to this, the initial sturdy thread of ancient Greek philosophy split into two fine ones, which is where the tension between them starts. Following the thread from Aristotle, we again weave our way to the seventeenth century.

### Locke and CBT

Seventeenth-century philosopher Locke said that mental distress results when we link our emotions to ‘wrong’ ideas (for more on Locke, see Grayling, 2005). This way of thinking can be seen in the modern approach of cognitive behaviour therapy (CBT) where certain thoughts of those who seek therapy are viewed as unreasonable and the therapist endeavours to teach the client to change these to reasonable ones, thereby influencing emotions. In other words: to change irrational ideas to rational thoughts and therefore impact on emotion. Within this model, the concept of psychopathology can nestle comfortably. Indeed, there is much literature linking CBT with psychopathological labels (for example, Butler, Melanie and Hackman, 2008; van Niekerk, 2009; Christensen and Griffiths, 2011; Kingdom and Turkington, 2005). What are these labels and how might they be grouped? This is deliberated further on.

### No more demons

To continue following the Aristotelian thread from Locke, we reach the eighteenth century, where the idea of psychopathology took hold due to the notion that madness was a result of illness, rather than being possessed by the devil, and therefore not under the individual’s control. So torturing, which went on previously to remove so-called demons, was stopped and the medical model, with its belief in pharmacology, was adopted, quickly becoming widespread even though much literature supports the perspective that psychological intervention has a powerful effect on individuals (for example, see Rudd, 2003; Gerhardt, 2008; Gilbert, 2010).

### Nineteenth, twentieth and twenty-first centuries

The Aristotelian philosophical thread can be followed from the eighteenth, into the nineteenth century where, due to developments in medicine, theories of mental illness were expanded and bathed in medical descriptive language such as ‘aetiology’ and ‘pathology’.

There was then a sea-change in the twentieth century with the closing down of mental asylums (in the UK) as a result of a move away from the disease model. This created space for an interpersonal approach to share the mental-health arena with the medical model. Consequently, tension between the two philosophical threads eased. Today, the mental-health arena continues to be shared, mainly by those who use formulation to look at psychological issues, with those using psychopathology.

## HOW MENTAL PROBLEMS ARE ORGANISED

In terms of psychopathology, mental problems are labelled according to symptoms (for example, ‘depression’), and theoretically organised by being chunked. Chunking forms categories, for ease of reference, as in the DSM-IV-TR (APA, 2002); an important book which can be, for therapists, what *Gray’s Anatomy* is for medics (Gray, 1974). It is worth noting here that, at the time of writing, the DSM-V is soon due to be published (this is addressed later in the book).

## 6 Introducing Psychopathology

I relate psychopathology to health services such as the NHS in the UK, since a substantial number of therapists work under the umbrella of the NHS and many work as independent practitioners, while others work on a voluntary basis or for corporations. In *Introducing Psychopathology* I discuss cultural and transcultural issues regarding psychopathology and underline medication, since it can have an impact on talking-cures. Prescribed medication can be cross-referenced with Chapters 8 and 9. Clients with diagnosed mental disorders who take prescribed drugs often wish to explore their use of medication with their therapeutic psychological counsellor, which should be achievable within the boundaries of the therapist's knowledge and experience (at the time of writing, therapists are not allowed to prescribe medication). I illustrate my point with a case vignette, further down.

### Mental disorders

Depression, anxiety, bi-polar, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, bulimia nervosa, anorexia nervosa and schizophrenia as well as learning and developmental disorders such as autism, are embraced by the term 'mental disorders'. All of these are clustered under what is known as the Axis I category in DSM-IV-TR (APA, 2002). I define and discuss them in later chapters because they tend to be problems that therapists' clients say they suffer from.

### Personality disorders and intellectual disabilities

There is a category for personality disorders and intellectual disabilities that includes borderline personality disorder (BPD), and mental retardation, for example, Down's Syndrome. This category is classified under Axis II in DSM-IV-TR (APA, 2002). Physical conditions a person is born with are not focussed on in this text because they are not an area that therapists are trained in. However, BPD is defined and discussed as individuals who can identify as suffering from this may be clients of those who use talking as a therapeutic tool.

### Medical conditions and physical disorders

The category for acute medical conditions and physical disorders is classified under Axis III in DSM-IV-TR (APA, 2002). These conditions and disorders incorporate brain injury, medical and physical disorders which aggravate existing diseases or which include symptoms that are similar to other disorders. However, such problems are not fully deliberated on in this book because they are not normally included in the training of therapists.

### Psychosocial and environmental factors contributing to disorders

Psychosocial and environmental factors contributing to disorders of the mind have their own category, classified under Axis IV in DSM-IV-TR (APA, 2002). I deliberate on such factors when discussing disorders. My reasoning is that they have either a positive or negative impact on mental health and therefore it is important to understand these issues.

## Global assessment of functioning or children's global assessment scale

Classified under Axis V in DSM-IV-TR is a category for global assessment of functioning or children's global assessment scale (APA, 2002). Therapists must know about assessment. If, for example, a therapist is referred a client and the referral letter states that the client is suffering from obsessive compulsive disorder (OCD), the therapist should know about this condition and have the ability to assess for themselves, in order to ascertain whether they agree with the referrer or not. Knowing what to do about referrals, whether relating to a child or adult, is part of practising professionally.

## A BIRD'S-EYE-VIEW OF INTRODUCING PSYCHOPATHOLOGY

Our journey through this book takes us via twelve stages. Every stage involves travelling through a different chapter. Thus, each chapter can be focused on either per week or month, depending on the course programme a student is on.

### Chapter 1

The portal into our journey. Here we perceive the essence of the whole book. This stage puts psychopathology into perspective.

### Chapter 2

Our route takes us into assessments and referrals. We see how mental distress is identified. We also perceive the limits of therapists' capabilities.

### Chapter 3

Developmental mental problems is the next stage. Young people are highlighted here. In this way, we see issues that may arise at any time from pre-birth to late teens.

### Chapter 4

We are a third of the way along our journey, travelling through the anxiety disorders. OCD, panic attacks and negative stress are included in this stage.

### Chapter 5

Here, our journey takes us through diagnostic criteria for cognitive disorders. We also voyage through Alzheimer's and vascular disorders. For a more comprehensive view, we take a literary vantage point.

## **Chapter 6**

Here, we travel through mood disorders. Self-harm and suicide are also visited. The difference between just feeling low and depression is spotlighted too.

## **Chapter 7**

Next, our journey takes us to eating and sleeping disorders. For this stage, anorexia and bulimia nervosas are identified. Additionally, problems with over and under-sleeping are floodlit.

## **Chapter 8**

Substance issues are addressed in this section. Substance dependency, commonly called ‘addiction’, is visited. Further, the concepts of compulsively using a substance or using it for social reasons are unpacked.

## **Chapter 9**

We journey through psychotic disorders of schizophrenia, psychosis and psychotic problems. Factors associated with good and bad outcomes are looked at. We also look at signs and causes of such disorders.

## **Chapter 10**

Somatic disorders are deliberated on at the tenth stage of our route. Body dysmorphia and hypochondriasis are covered. We ‘discover’ that a somatic disorder can also include pain.

## **Chapter 11**

We voyage through the personality disorders. Here, we consider borderline, narcissistic, dependent, avoidant, paranoid, schizoid, schizotypal, antisocial, obsessive compulsive and histrionic disorders. Plus, relevant literature is perused.

## **Chapter 12**

An overview of *Introducing Psychopathology* is our final stage, in which holistic approaches to mental health are also viewed. These include emotional literacy and the transpersonal concept. We exit our route via a tantalising glimpse of an amazing yet possible future direction.

## **ASPECTS OF LEARNING**

Students have various ways of learning. For this reason, features I offer include all sorts of ways to learn. These are:

- Reflection points for pondering on, to aid independent thought while processing an understanding of the knowledge learnt.
- Case vignettes, for a fuller perspective of related disorders, helping to provide a deeper insight into the psychopathological areas discussed.
- An appropriate exercise for each chapter which can be used to self-test.
- A succinct summing up of every chapter's contents; this is handy for revision.
- A list of useful resources for the reader who wishes to delve deeper or broader into the issues discussed.

## THE REFLECTIVE PRACTITIONER

Reflecting on what others say, as well as our own personal thoughts, is important for a therapist. For example, if told by your clinical supervisor to do something, reflect on it; you can decide whether you agree or not and then arrive at a (correct) decision. In this way, self-reflection links to self-management. There are many ways to self-reflect and we each have our own pet way. A few examples of self-reflective ways are: sitting still, lying in bed, or keeping a journal/diary. Whichever way we choose, '...we ... need more ... time, more reflection, more immersion ... That doesn't mean we're retreating from the world, so much as we're moving into a deeper experience of it' (Williamson, 2008 p.155, ll.1–5). Being reflective is self-supervision. Therapists are not the only professionals who self-reflect. Priests, for example, have cloisters to walk around for their daily self-reflection.

We need to take daily time out to check in on ourselves compassionately, because we are human and so can be prone to pomposity about ourselves or to developing neuroses or to being overwhelmed. By reflecting, we can get back in touch with our highest values and deepen our own development, which has a ripple effect into our professional development (Bloom, 2011). Indeed, this ripple can influence the therapy model we decide to use with a client.

Although there are government-endorsed guidelines in NICE (2011) stating that specific therapy models are best used for particular disorders, there is mounting evidence that, irrespective of therapeutic approach, it is the relationship between the therapist and client that is of paramount importance (Davis, 2011; Ellis-Christensen, 2011; Krupnick et al., 2011). However, there is pressure and expectation, for instance in the UK within the NHS, to adhere to the NICE guidelines, apparently without question. This seems to be a way of standardising intervention programmes for psychopathological problems.

Psychopathology helps to identify and classify major mental distress. Nevertheless, if a purported disorder results from unbearable stress that has a detrimental effect in the mind of anyone experiencing the distress, is it really a disorder? Or, considering the stress, could it be viewed as a 'normal outcome', rather than a 'mental disorder'? For example, is it normal to dissociate while being tortured, or to stay connected and fully feel the agony? I know what I would rather do. Indeed, soldiers (in the UK) are taught to dissociate from their emotions (Danielson, 2007). Does this mean that all personnel within the British forces suffer from mental disorders? I do not think so!

Important questions arise, because if we are set up (or set ourselves up) to be experts in identifying mental disorders, there is an implication that we know what mental normality is. Yet, there is a paucity of literature defining this term (Seligman, 2011). We live in a poststructuralist or postmodernist society, where there is more than one truth. If we agree on this, then perhaps a patient labelled as psychotic (maybe because of seeing creatures or hearing voices that most others do not see or hear), has a more sensitive or expanded type of perception than

most and is seeing what most are blind or deaf to. In some cultures, for example, Shamanic and Asian cultures (Lukoff, 2007), such a person might be seen as a visionary or spiritual leader. I am being contentious here in the hope of facilitating reflection and debate, as part of the learning experience. Throughout, I do this in various places.

## **CULTURAL AND TRANSCULTURAL ISSUES**

Different disorders, as well as their prevalence in different countries and ethnicities, are involved in cross-cultural issues. It has been vehemently argued that both psychopathology itself and the DSM-IV-TR categories of mental disorders are 90 per cent culture-bound within the USA and the western world (Kleinman, 1997). Intriguingly, a good-enough research project was conducted in Ontario, Canada, where 142 adults aged between 22 and 26 years self-reported being born with very low birth-weight. Findings showed that a statistically significant number suffered as adults either from depression, anxiety or avoidant personality problems (Boyle et al., 2011). It could be useful to have further research conducted internationally to see whether such a correlation exists in other countries between low birth-weight and similar psychological problems in young adults. Societal and cultural factors are very important when it comes to mental health.

There is a gradual move away from disease models relating to mental distress (at least in the UK) and a movement towards explaining meanings, using the concept of formulation rather than diagnosing, while endeavouring to appreciate social and cultural aspects (Bentall, Boyle and Chadwick, 2000). Consequently, there is a re-emerging of the tension between the psychiatric and psychological approaches, coming from the more contemporary comments on the notions of psychopathology from psychologists such as Bentall and his team who bring societal and cultural factors into relief (2000). An awareness of cross-cultural issues and ethnic diversity can help trainees realise that every town and social group has a different culture. For instance, those living in rural areas may cope differently to mental stresses than inner-city people. With this in mind, it is very important that the universality of psychopathology is not assumed, however tempting it might be when perusing findings from research.

## **PSYCHOPATHOLOGY RELATED TO THE HEALTH SERVICE AND INDEPENDENT PRACTICE**

Within the UK, psychopathology is related to health services, either with those who work independently, for a charity, a private organisation or the National Health Service. Not just health service professionals, but anyone can have access to the NICE (2011) guidelines. Although seemingly prescriptive, they can be useful, particularly for trainees in placements when faced with clients, especially for the first time. However, it is important not to forget practice-based evidence.

### **Medication**

Under the health services umbrella, clients seeing a therapist may also be prescribed medicine for a mental health disorder (see Chapters 8 and 9 for more on this). The case vignette below illustrates this point.

## CASE VIGNETTE

Lucy, aged fifty-five, went to see a psychotherapist because she felt anxious. Her doctor had prescribed drugs, which she took diligently. The therapist noticed that Lucy's hands were shaking. During their initial meeting, Lucy said she did not know whether her hands shook because she felt anxious or because of her medication. The therapist looked up the medicine in a reference book and showed Lucy that a side effect is trembling hands. With her permission, he wrote to the doctor stating Lucy's concern about her hands shaking. Lucy's GP responded by changing the medication and gradually reducing it while she was supported by the therapist. Within a month, her hands stopped trembling and she was able to use psychological techniques for managing anxiety. In this case, the client's wish to explore medication was achieved within the boundaries of knowledge and experience of the therapist who liaised appropriately interprofessionally.

## Points to ponder

- If much relevant research shows that the relationship is key in a therapeutic encounter, is it ethical to favour one theoretical model above all others?
- What are the implications of stating that specific symptoms point to a disorder, while we live in a twenty-first century postmodernist or poststructuralist society characterised by the idea that there is more than one truth?
- Is it important or not for therapists to belong to a professional organisation such as the UKCP, BPS, BACP or HCPC?
- If the study of psychopathology identifies mental disorder, how can we identify mental normality?

## Exercise

(Answers are embedded in this chapter.)

- 1 What does 'psychopathology' mean?
- 2 Is body dysmorphia classified as a personality or somatoform disorder?
- 3 Is schizophrenia classified as a substance or psychotic disorder?
- 4 Is bulimia nervosa classified as a sleeping or eating disorder?
- 5 Is depression classified as a mood or cognitive disorder?
- 6 Is social phobia classified as an anxiety or developmental disorder?
- 7 Historically and philosophically, what are the roots of psychopathology embedded in?

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## CHAPTER SUMMARY

Psychopathology is the scientific study of mental disorders.

The history behind psychopathology is rooted in the medical model.

Philosophically, psychopathology stems from ancient Greece.

Within psychopathology, mental disorders are classified into categories of developmental, anxiety, cognitive, mood, eating, sleeping, substance, psychotic, somatoform and personality disorders.

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### LIST OF USEFUL RESOURCES

- Bergman, S.H. (1974) *Dialogical Philosophy from Kierkegaard to Buber* (Jerusalem, The Bialic Institute).
- Capobianco, R. (2010) *Engaging Heidegger* (Toronto, University of Toronto Press).
- Duncan, S.M. (2008) *The Proof of the External World: Cartesian Theism and the Possibility of Knowledge* (Cambridge, James Clarke and Company).
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- Roudinesco, E. (2008) *Philosophy in Turbulent Times* (New York, Columbia University Press).
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### RELEVANT WEBSITES

[www.frontiersin.org/psychopathology](http://www.frontiersin.org/psychopathology)

[http://menshealth.about.com/od/conditions/a/eating\\_disorders.htm](http://menshealth.about.com/od/conditions/a/eating_disorders.htm)

[www.myshrink.com/counseling-theory.php?t\\_id=87](http://www.myshrink.com/counseling-theory.php?t_id=87)

[www.radpsynet.org/journal/vol4-1/moreira.html](http://www.radpsynet.org/journal/vol4-1/moreira.html)

[www.thesudentroom.co.uk/wiki/Revision:Psychopathology](http://www.thesudentroom.co.uk/wiki/Revision:Psychopathology)

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