PSYCHOPATHOLOGY

From Science to Clinical Practice

SECOND EDITION

edited by
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About the Editors

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Preface

Chris Muran, a prominent and prolific clinical psychologist, once said that publishing a book is like getting a medal or a trophy in sport. You work very hard for a long time, you get a sign of recognition for your accomplishments, you put that sign on a wall or a bookshelf, you look at it a few times, and then you move on to another challenge.

We, the first two editors, worked intensively and extensively on the first edition of *Psychopathology: From Science to Clinical Practice.* The collaboration that took place between us and the influential authors we had recruited also felt like playing an exciting sport—and playing on a successful team! We were obviously proud to get the book in our hands and happy to look at it (more than a few times, truth to be told), but it did not stay on a bookshelf for very long. This is because we have been using it to guide our writing and research (let alone clinical practice) and, most frequently and consistently, we have used it to enhance our graduate teaching.

Our own use of this first edition fit with the purposes we had in mind when designing it. As conveyed by its title, this book was aimed at weaving together information about basic research on psychopathology and the treatment of clinical problems. As psychotherapy (L. G. C.) and psychopathology (T. F. O.) researchers, we wanted the book to expand the boundaries of our respective knowledge. We also intended for the book to serve as a practical reference for clinicians. It was, however, designed primarily as a textbook for graduate students in the field of mental health. More specifically, it was created to address a major source of disconnection in the training of these professional disiplines.

A note about language: In this book, we use *they/them/their* when referring to a single individual. We have made this choice to be inclusive of readers who do not identify with masculine or feminine pronouns.

A course on psychopathology is one of the few course requirements in all accredited programs related to mental health care. Typically, this course has two foci: description of each disorder (DSM criteria, clinical features, comorbidity, onset, etc.) and etiology (variables that are involved in the cause and/or the maintenance of the disorder). This information is relatively standard, and it is covered clearly in existing textbooks. Unfortunately, very few sources (either textbooks or primary journal articles) address the need to establish connections between basic psychopathology research and treatment, and few provide anything more than superficial coverage of treatment issues. Coverage of basic psychopathology research far outweighs the space devoted to treatment procedures aimed at the various kinds of mental disorders with which practicing clinicians work on a regular basis. As such, most textbooks miss a tremendous opportunity to solidify the bridge between science and clinical practice.

Our textbook was designed to correct this failed opportunity. Specifically, it covers the basic, conventional topics of psychopathology, while also providing a more extensive and thoughtful discussion of the connections between basic research and clinical practice. We believe this is a two-way street. Many hypotheses that have guided scientific studies of psychopathology have been derived from clinical experience. Conversely, many findings from basic research have been extended to the realm of clinical practice. The chapters of our book focus on these connections. Each chapter provides students with relevant clinical guidelines derived from basic research in psychopathology, as they relate to assessment and case formulation, as well as treatment plan and interventions.

We, again the first two editors, were delighted when The Guilford Press invited us to begin working on a second edition of this book. To be completely honest, while we were happy with the feedback we had received from students and practitioners, we were surprised and rather humbled that it did well enough to provide us with an opportunity to play together again—it is one thing to get a medal or a trophy, but quite another one to go for a repeat experience.

Working with Guilford's staff on how to make this new challenge as enjoyable and successful as the first one, we agreed that we needed to broaden our editorial perspectives. We also agreed that the best strategy would be to invite Abigail Powers Lott to join us as a third member of the editorial team. Representing a "new generation" of clinical researchers, Abby's paths of scholarship have been perfectly in sync, in terms of both content and process, with the major aim of the book. For example, following over a decade of research into the transdiagnostic impact of trauma exposure across the lifespan, she has translated that research into disseminating culturally responsive treatments for traumatized individuals in underserved communities. Abby's experience as an author on one of the chapters in the first edition, coupled with her broad background in both research and practice, made her a perfect colleague (or teammate) to expand our respective knowledge and improve our editorial (one might say, coaching) partnership.

We further agreed, this time with Abby, to maintain some key elements of the first edition—the most crucial being that each chapter be coauthored by a pair or a small team of authors. For most of the chapters, at least one author was an expert in psychopathology research and at least one other author was an expert in treatment research (for some of our chapters, the authors were experts in both fields). Our

experience with the first edition confirmed that such teamwork can lead to new ways of thinking about psychopathology and clinical practice. It also fostered new and exciting experience in writing these book chapters (a process that, too frequently, tends to involve mainly cutting and pasting old materials!).

For the second edition, we also decided that we would continue to focus on presenting problems that, for the sake of clinical relevance, meet three criteria. They have to show a moderate to high level of prevalence in the general population, as well as a moderate to high prevalence in treatment settings; and they need to be the focus of a substantial research literature. Several disorders (e.g., dissociative identity disorder, somatic symptom disorder, and gender dysphoria) are not covered because they are not encountered frequently in clinical practice and/or there is not enough basic research on which to build an effective case formulation and treatment plan. The clinical problems covered in the first edition of this book were depression, generalized anxiety disorder, panic disorder and phobias, obsessive–compulsive disorder, posttraumatic stress disorder, eating disorders, substance abuse disorders, personality disorders, bipolar disorders, positive and negative symptoms of schizophrenia, as well as marital and relationship discord. We agreed to keep all of the chapters that were included in the first edition, with the exception of the chapters on positive and negative symptoms. In the current edition, these symptoms are addressed in a single, integrated chapter on schizophrenia.

We also wanted to preserve the structure of these chapters across the two editions of the book. As such, each chapter provides a solid descriptive and etiological grounding to understand psychopathology within the perspective of our current knowledge. Each presents an up-to-date survey of typical symptoms, clinical features (e.g., interpersonal, social, occupational, health, sleep, and sexual problems), course (e.g., onset, duration, outcome, relapse), epidemiology (e.g., prevalence, gender and cross-cultural differences), comorbidity, and etiology (i.e., vulnerability factors involved in cause, maintenance, recurrence, and/or relapse). The authors have also derived clinical implications from the research findings they reviewed, anticipating readers' question: How is this relevant for understanding and treating my clients? Interestingly, because these clinical implications are drawn from basic research in psychopathology, they are not restricted to any one theoretical model underlying current forms of psychotherapy.

All of the chapters on specific clinical problems identify psychosocial (and medical) treatments that have been empirically validated. While these psychosocial interventions have been linked to particular models of therapy, the authors have also derived targets, general strategies, or principles of intervention from these treatments—formulating them in a way that is not necessarily tied to the specific techniques or terminology associated with a particular approach to therapy. As such, these chapters provide guidelines that could be assimilated (sometimes after specialized training) in the practice of clinicians, irrespective of their preferred theoretical orientation.

As in the first edition, we also wanted to open the book with an introductory chapter that discusses general issues in psychopathology, as well as their relevance for the conceptualization, assessment, and treatment of patients. The book closes with a final chapter that attempts to identify similarities among different clinical problems by examining clinical and etiological issues that cut across them, and by

providing general recommendations that may improve their assessment and treatment.

To improve on the first edition, we decided to pursue a number of expansions. First and foremost, we added three chapters adressing the following clinical problems: suicide, sleep difficulties, and sexual dysfunction. We chose these transdiagnostic issues because they are frequent targets of interventions in clinical practice, and because they have been the focus of substantial basic and/or applied research. To address these new territories of knowledge and action, we recruited three pairs of visible researchers who were ready to engage in a new, fresh, and collaborative writing project with someone at the same career level as their own, but with a different expertise in the field.

We also wanted the revision of the chapters included from the first edition to expand on what we know empirically and how we work clinically. We shaped these expansions by asking authors to update the chapters with regard to psychopathology research and to modify, if and when needed, the scope of therapeutic guidelines that might be derived from such research—in terms of case formulation, treatment plan, or principles of interventions. For the revision of these chapters, we were fortunate to "re-sign" most of our highly recognized scholars, as well as to "sign up" a number of outstanding early career contributors to the fields of psychopathology and psychotherapy. We dare to say that in our pursuit of a new medal or trophy, we have again been able to gather an all-star team of accomplished "veterans" and promising "rookies."

We believe the first edition of this book has been successful because it has allowed students to more fully integrate empirical and clinical knowledge within their training. In line with the current emphasis on evidence-based practice, we have also been pleased to hear that it has served as a relevant resource for experienced practitioners, allowing them to conduct therapy while being informed by research on psychopathology. We hope the second edition will also be successful in these aims. We also hope it will offer valuable guidance to psychotherapy researchers by identifying predictor, moderator, and mediator variables that could be the focus of treatment interventions. Furthermore, we hope it will be helpful to psychopathology researchers by highlighting phenomena from clinical practice that have an important bearing on issues and problems that they ought to address.

Pursuing these ambious goals has required the help and support of many individuals. First, we want to thank our authors for contributing chapters that are, in our opinion, highly informative, insightful, and innovative—let alone elegantly written. We are also grateful for the vote of confidence and collaborative spirit of The Guilford Press, and in particular for the assistance provided by Jane Keislar. Most importantly, we want to express our gratitude to the members of our respective families, who all deserve much more than medals and trophies!

Louis G. Castonguay
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CHAPTER 1

General Issues in Understanding and Treating Psychopathology

Thomas F. Oltmanns
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The practice of any mental health profession (clinical and counseling psychology, psychiatry, social work) depends heavily on the ability to recognize and conceptualize various forms of mental disorder. Therapists, irrespective of their professional background and theoretical orientation, must be aware of the varied manifestations of psychopathology. They also have to understand many forms of vulnerability that set the stage for the development and maintenance of commonly occurring mental disorders that eventually touch all of our lives, either directly or indirectly. Mental disorders are a leading cause of disability around the world, and within the United States, neuropsychiatric disorders are the leading cause of disease-related disability and risk for early mortality (Murray et al., 2013; Whiteford, Ferrari, Degenhardt, Feigin, & Vos, 2015).

The individual chapters in this book provide truly unique reviews of the professional literature concerned with specific forms of psychopathology. Each is written by a team of scholars that includes recognized experts in the treatment of the condition, as well as leaders in the scientific study of the causes of the disorder. They have worked together to produce a creative synthesis describing the nature of the disorder (e.g., symptoms, course, epidemiology, and etiology) and the treatment implications that follow from this knowledge (assessment, case formulation, and/or principles of change). These chapters represent classic examples of the thoughtful integration of science and practice: Clinical experience raises important research questions, and evidence from scientific studies leads to the development and evaluation of improved treatment procedures. In this opening chapter, we discuss several basic issues that lay the foundation for subsequent chapters discussing specific types of psychopathology.

DEFINING MENTAL DISORDERS

Any systematic review of what is known about psychopathology first requires attention to how the construct of "mental disorder" is defined. Should some (if not all) mental disorders be conceptualized (completely or in part) as diseases, character flaws, deficits, or problems of living? How are mental disorders distinguished from behaviors that are simply idiosyncratic, eccentric, or out of favor within a particular culture? These questions determine, sometimes explicitly but most often implicitly, how a mental health professional responds to a particular client or patient, including issues such as whether the person should receive treatment, and what kind of treatment should be provided. Many attempts have been made to define abnormal behavior, but none is entirely satisfactory. No one has provided a universal definition that can account for all situations in which the concept of mental disorder is invoked (Pilgrim, 2005; Zachar & Kendler, 2007).

Arguably, one of the most influential and widely invoked definitions of "mental disorder" was proposed by Wakefield (1992, 2010). According to his argument, a behavioral condition should be considered a mental disorder if, and only if, it meets two criteria:

1. The condition results from the inability of some internal mechanism (mental or physical) to perform its natural function. In other words, something inside the person is not working properly. Examples of such mechanisms include those that regulate levels of emotion, and those that distinguish between real auditory sensations and imagined ones.
2. The condition causes some harm to the person as judged by the standards of the person's culture. These negative consequences are measured in terms of the person's own subjective distress or difficulty performing expected social or occupational roles.

Using Wakefield's terms, mental disorders are defined as "harmful dysfunctions." One element ("dysfunction") of this definition is an attempt to incorporate (as much as it is possible) an objective evaluation of behavior. Wakefield argues that internal processes (e.g., cognition and perception) have a natural function, and that this function is to allow an individual to perceive the world in ways that are shared with other people and to engage in rational thought, problem solving, and adaptive behavior. The dysfunctions in mental disorders are assumed to be the product of disruptions of thought, feeling, communication, perception, and motivation.

This view of mental disorder also recognizes that all types of dysfunction do not lead to a disorder. Only dysfunctions that result in significant harm to the person are considered to be disorders. There are, for example, many types of physical dysfunction, such as albinism, reversal of heart position, and fused toes, that clearly represent a significant departure from the way that some biological process ordinarily functions. These conditions are not considered to be disorders, however, because they are not necessarily harmful to the person.

By definition, mental disorders are harmful to the person's adjustment. They typically affect family relationships, as well as success in educational and occupational activities. There are, of course, other types of harm associated with mental

disorders. These include subjective distress, such as high levels of anxiety or depression, as well as more tangible outcomes, such as suicide.

The definition of abnormal behavior presented in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013), which in the United States is considered a standard diagnostic system, incorporates many of the factors we have already discussed. According to this definition, a "mental disorder" is "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (p. 20). The manual also notes that mental disorders are associated with subjective distress or impairment in social functioning. DSM-5 also excludes several conditions from consideration as mental disorders. These include (1) an expectable or culturally sanctioned response to a particular event (e.g., death of a loved one); (2) socially deviant behavior (e.g., the actions of political, religious, or sexual minorities); and (3) conflicts that are between the individual and society (e.g., voluntary efforts to express individuality).

The DSM definition places primary emphasis on the consequences of certain behavioral syndromes. Accordingly, mental disorders are defined by clusters of persistent, maladaptive behaviors that are associated with personal distress, such as anxiety or depression, or with impairment in social functioning, such as job performance or personal relationships. This definition, therefore, recognizes the concept of dysfunction, and it spells out ways in which the harmful consequences of a disorder might be identified.

The practical boundaries of abnormal behavior are defined by the list of disorders included in the DSM. Therefore, the manual provides a simplistic, though practical, explanation of how someone's behavior might be considered pathological: It would be considered abnormal if the person's experiences fit the description of one of the forms of mental disorder listed in the diagnostic manual. Conceptually, however, it could be argued that a valid and adequate description of a mental disorder, such as major depression, cannot be restricted to its symptomatic picture. In order to define and understand major depression, it is necessary to consider a description of other clinical features (e.g., marital and health problems with which it is frequently associated), as well as a number of additional issues, such as its typical course (onset, duration, recurrence, relapse), prevalence (across gender and culture), patterns of comorbidity, and vulnerability factors.

In an effort to move beyond the DSM-5 definition of mental disorder, many researchers have moved toward empirical approaches of mapping dimensions of dysfunction and their interrelatedness as opposed to relying on categorical diagnoses. The hierarchical taxonomy of psychopathology (HiTOP) is a dimensional model of psychopathology that includes most mental disorders (e.g., mood, anxiety, substance use, psychotic, and personality disorders) (Kotov et al., 2017). At the highest level is a general factor of psychopathology (*p* factor), which has been replicated across several samples in many contexts (Caspi et al., 2014; Smith, Atkinson, Davis, Riley, & Oltmanns, 2020). The *p* factor is shared across all dimensions of psychopathology and represents an index of nonspecific impairment. Beneath the *p* factor are three broad domains of internalizing disorders, externalizing disorders, and thought disorder. Many argue that the structure of general personality is fundamental to

understanding the HiTOP dimensional model of psychopathology, and that in order to understand and define mental disorders, one must consider personality as a core component to the manifestation of psychopathology (Widiger et al., 2019). Another definition of psychopathology that has recently received attention is "network theory," an approach suggesting that mental disorders arise from the causal interaction between symptoms within a given network (Borsboom, 2017).

Mental disorders are actually best conceived as "hypothetical constructs" (Morey, 1991; Neale & Oltmanns, 1980), which simply are abstract, explanatory devices. In the case of behavioral disorders, a hypothetical construct (i.e., a particular mental disorder) is an internal event whose existence is inferred on the basis of observable behaviors and the context in which they occur. The construct itself cannot be directly observed, but it is tied to overt referents that can be observed. For example, we cannot measure major depression directly, but we can see that the person no longer enjoys formerly pleasurable activities, has withdrawn from social contacts, is sleeping more than usual, has lost their appetite, and frequently talks about feeling worthless. Beyond these specific symptoms, the utility of a hypothetical construct ultimately depends on the extent to which it enters into relationships with other constructs and observable events (interrelated dimensions of human functioning). With this approach, a mental disorder is therefore defined by more than simply the diagnostic criteria identified in a manual such as DSM-5.

Clinically, this approach to defining a disorder (e.g., major depression) does not imply that clinicians should disregard "official" diagnostic criteria. Rather, it suggests that in order to conduct more comprehensive assessments and case formulations of their clients, as well as to identify a more complete list of potential targets for intervention, therapists should complement their diagnostic (DSM-based) evaluation with a careful consideration of nonsymptomatic factors that have been empirically associated with this disorder. One of our goals in this book is to provide a review of research on the factors that appear to contribute to the nature of each of the several specific forms of psychopathology.

In the chapters to come, authors focus on describing mental disorders, the impact of those disorders on people who suffer from them, the factors that provoke and maintain these disorders, and relevant evidence-based strategies for clinical interventions to alleviate them and/or help patients manage them. These chapters do not delineate specific criteria from the official diagnostic manuals that are widely in use (the DSM and the *International Classification of Diseases* [ICD]). If you are interested in those criteria, we encourage you to review them in the manuals themselves: DSM-5 (American Psychiatric Association, 2013) and ICD-11 (World Health Organization, 2019).

EPIDEMIOLOGY

Basic understanding of mental disorders requires data about the frequency with which these disorders occur. Moreover, important clinical, organizational, and social decisions can be based on epidemiological information, such as whether the frequency of a disorder has increased or decreased during a particular period, whether it is more common in one geographic area than in another, and whether

certain types of people—based on factors such as gender, ethnicity, and socioeconomic status—are at greater risk than other types for the development of the disorder. Health administrators often use such information to make decisions about the allocation of resources for professional training programs, treatment facilities, and research projects. As described in this book, answers to such questions have also provided insights and generated further research on possible risk factors for specific disorders.

How prevalent are the various forms of abnormal behavior? One important dataset regarding this question comes from a large-scale study known as the National Comorbidity Survey Replication (NCS-R) conducted between 2001 and 2003 (Kessler et al., 2005; Kessler, Merikangas, & Wang, 2007). We use this study to illustrate an overall impression regarding the prevalence of mental disorders because it collected evidence of many major forms of mental disorders simultaneously in one large group of individuals. Specifically, members of the NCS-R research team interviewed a nationally representative sample of approximately 9,000 people living in the continental United States. Questions were asked pertaining to several (but not all) of the major disorders listed in DSM-IV (American Psychiatric Association, 1994). The NCS-R found that 46% of the people they interviewed received at least one *lifetime* diagnosis (meaning that they met the criteria for one of the disorders assessed at some point during their lives), with first onset of symptoms usually occurring during childhood or adolescence. This proportion of the population is much higher than many people expect, and it underscores the point we made at the beginning of this chapter: All of us can expect to encounter the challenges of a mental disorder—either for ourselves or for someone we love—at some point during our lives.

Figure 1.1 illustrates some results from this study using 12-month prevalence rates—the percentage of people who had experienced each disorder during the most recent year. The most prevalent specific types of disorder were major depression (17%) and alcohol abuse (13%). Various kinds of anxiety disorders were also relatively common. Substantially lower prevalence rates were found for obsessive–compulsive disorder and bipolar disorder, which each affect approximately 2% of the population. These lifetime prevalence rates are consistent with data reported by other, subsequent studies regarding the prevalence of mental disorders. More specific and recent evidence regarding specific forms of mental disorder are presented in each of the later chapters in this book.

Although many mental disorders are quite common, they are not always seriously debilitating. The NCS-R investigators assigned each case a score with regard to severity, based on the magnitude and number of symptoms, as well as the level of occupational and social impairment that the person experienced. Averaged across all of the disorders diagnosed in the past 12 months, 40% of cases were rated as *mild*, 37% as *moderate*, and only 22% as *severe*. Mood disorders were most likely to be rated as severe (45%), while anxiety disorders were less likely to be rated as severe (23%). These findings have important clinical (and social) implications, as they suggest that not all individuals meeting criteria of a diagnosis necessarily need immediate treatment. At the same time, it is worth noting that interventions (of varied length and intensity) might be beneficial for some individuals suffering from low-level distress and impairment, as subclinical levels of symptoms can, for some disorders, signal the eventual emergence of acute and severe symptoms.

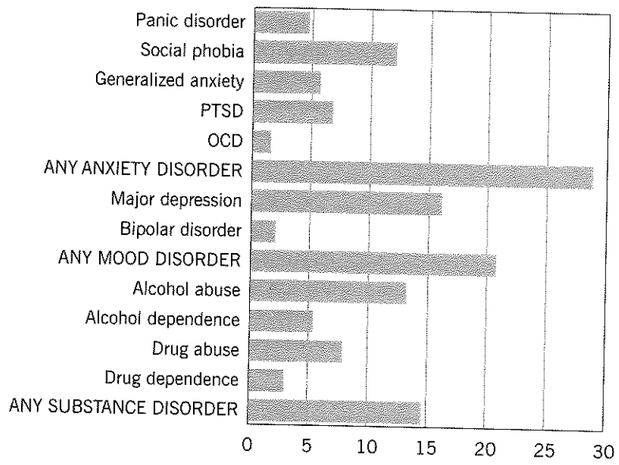

FIGURE 1.1. Twelve-month prevalence rates for various mental disorders (NCS-R data). Data from Kessler, Merikangas, and Wang (2007). PTSD, posttraumatic stress disorder; OCD, obsessive–compulsive disorder. The NCS-R used DSM-IV definitions of mental disorders. Thus, PTSD and OCD were still considered forms of anxiety disorder, and the distinction between substance dependence and substance abuse was still recognized.

Epidemiological studies such as the NCS-R have consistently found gender differences for many types of mental disorder: Major depression, anxiety disorders, trauma and stress-related disorders, and eating disorders are more common among women; alcoholism and antisocial personality disorders are more common among men. Patterns of this sort are highlighted throughout the chapters in this book as clues for possible causal mechanisms in some of these disorders.

Epidemiologists also measure the extent of mental disorders' impact on people's lives. The Global Burden of Disease Study 2010 included a systematic review of all epidemiological data on diseases, injuries, and related risk factors across 187 countries from 1990 to 2010. Whiteford and colleagues (2015) examined the specific global burden of mental, neurological, and substance use disorders from that sample in 2010 and found that these disorders accounted for 10.4% of global disability-adjusted life years and 28.5% of global years lived with disability; mental disorders represented the largest proportion of disability-adjusted life years (56.7%) among these types of disorders. Within the United States, mental and behavioral disorders are the largest contributor to years lived with disability, and in particular, major depression, anxiety disorders, and substance use disorders are among the top 15 contributors to chronic disability and early mortality (Murray et al., 2013). The burden of mental disorders has greatly increased in the past 10 years and will likely continue to increase by the year 2030. These surprising results indicate strongly that mental disorders are one of the world's greatest health challenges.

CULTURE AND PSYCHOPATHOLOGY

As evidence regarding the global burden of disease clearly documents, mental disorders affect people all over the world. That does not mean, however, that the symptoms of psychopathology and the expression of emotional distress take the same form in all cultures. Epidemiological studies comparing the frequency of mental disorders in different cultures suggest that some disorders, such as schizophrenia, show important consistencies in cross-cultural comparisons. They are found in virtually every culture that social scientists have studied. Other disorders, such as bulimia nervosa, are more specifically associated with cultural factors, as revealed by comparisons of prevalence in different parts of the world and changes in prevalence over several generations. Almost 90% of patients with bulimia are women. Within the United States, the incidence of bulimia is much higher among university women than among working women, and it is more common among younger women than among older women (Udo & Grilo, 2018). The prevalence of bulimia is much higher in Western nations than in other parts of the world. Furthermore, the number of cases increased dramatically during the latter part of the 20th century (Keel & Klump, 2003). As discussed later in this book, these patterns suggest that holding particular sets of values related to eating and to women's appearance is an important ingredient in establishing risk for development of an eating disorder.

The strength and nature of the relationship between culture and psychopathology varies from one disorder to the next. Several general conclusions can be drawn from cross-cultural studies of psychopathology (Draguns & Tanaka-Matsumi, 2003), including the following points:

- All mental disorders are shaped, to some extent, by cultural factors.
- No mental disorders are entirely due to cultural or social factors.
- Psychotic disorders are less influenced by culture than are nonpsychotic disorders.
- The symptoms of certain disorders are more likely to vary across cultures than are the disorders themselves.

Clinicians must consider the influence of cultural factors in both the expression and recognition of symptoms of mental disorders. People express extreme emotions in ways that are shaped by the traditions of their families and other social groups to which they belong. Intense, public displays of anger or grief might be expected in one culture but be considered signs of disturbance in another. Interpretations of emotional distress and other symptoms of disorder are influenced by the explanations that a person's culture assigns to such experiences. Religious beliefs, social roles, and sexual identities all play an important part in constructing meanings that are assigned to these phenomena (Hwang, Myers, Abe-Kim, & Ting, 2008). The most obvious clinical implication one can derive from these important issues is that the accuracy and utility of a clinical diagnosis depend on more than a simple count of the symptoms that appear to be present. They also hinge on the clinician's ability to consider the cultural context in which the problem appeared. This is a particularly challenging task when the clinician and the person with the problem do not share the same cultural background.

Clinicians can also become sensitized to the importance of cultural issues by considering cultural concepts of distress, patterns of erratic or unusual thinking and behavior that have been identified in diverse societies around the world and do not fit easily into the other diagnostic categories. A list of these syndromes is included in the appendix of DSM-5. They have also been called "culture-bound syndromes," because they are considered to be unique to particular societies, particularly in non-Western or developing countries. Their appearance is easily recognized and understood to be a form of abnormal behavior by members of certain cultures, but they do not conform to typical patterns of mental disorder seen widely across areas in the United States or Europe. Cultural concepts of distress have also been called "idioms of distress." In other words, they represent a manner of expressing negative emotion that is unique to a particular culture and cannot be easily translated or understood in terms of its individual parts.

One syndrome of this type is a phenomenon known as *ataques de nervios,* which has been observed most extensively among people from Puerto Rico and other Caribbean countries (Lewis-Fernández et al., 2002; San Miguel et al., 2006). Descriptions of this experience include four dimensions, in which the essential theme is loss of control—an inability to interrupt the dramatic sequence of emotion and behavior. These dimensions include emotional expressions (an explosion of screaming and crying, coupled with overwhelming feelings of anxiety, depression, and anger), bodily sensations (including trembling, heart palpitations, weakness, fatigue, headache, and convulsions), actions and behaviors (dramatic, forceful gestures that include aggression toward others, suicidal thoughts or gestures, and trouble eating or sleeping), and alterations in consciousness (marked feelings of "not being one's usual self," accompanied by fainting, loss of consciousness, dizziness, and feelings of being outside of one's body).

Ataques are typically provoked by situations that disrupt or threaten the person's social world, especially the family. Many *ataques* occur shortly after the person learns unexpectedly that a close family member has died. Others result from an imminent divorce or occur after a serious conflict with a child. Women are primarily responsible for maintaining the integrity of the family in this culture, and they are also more likely than men to experience *ataques de nervios.* Puerto Rican women from poor and working-class families define themselves largely in terms of their success in building and maintaining a cohesive family life. When this social role is threatened, an *ataque* may result. This response to threat or conflict—an outburst of powerful, uncontrolled negative emotion—expresses suffering, while simultaneously providing a means for coping with the threat. It serves to signal the woman's distress to important other people and to rally needed sources of social support.

What is the relation between cultural concepts of distress and the formal categories listed in the DSM or the ICD? The answer is unclear and also varies from one syndrome to the next. Are they similar problems that are simply given different names in other cultures? Probably not, at least not in most instances (Guarnaccia & Pincay, 2008). In some cases, people who exhibit behavior that would fit the definition of a culture-bound syndrome would also qualify for another diagnosis, if diagnosed by a clinician trained in the use of the diagnostic manual (Tolin, Robison, Gaztambide, Horowitz, & Blank, 2007). But not everyone who displays the culture-bound

syndrome meets criteria for another mental disorder, and of those who do, not all would receive the same diagnosis.

The DSM's glossary on cultural concepts of distress has been praised as a significant advance toward integrating cultural considerations into the classification system (Trinh, Son, & Chen, 2019). It has also been criticized for its ambiguity. The most difficult conceptual issue involves the boundary between culture-bound syndromes and categories found elsewhere in the diagnostic manual. Some critics have noted that if culturally unique disorders must be listed separately from other, "mainstream" conditions, then certain disorders now listed in the main body of the manual—especially eating disorders, such as bulimia—should actually be listed as culture-bound syndromes. Like *ataques de nervios,* bulimia nervosa is a condition that is found primarily among a limited number of cultures (Keel & Klump, 2003). "Dissociative amnesia"—the inability to recall important personal information regarding a traumatic event—also resembles culture-bound syndromes because it appears to be experienced only by people living in modern, developed cultures (Pope, Poliakoff, Parker, Boynes, & Hudson, 2007).

Though it is imperfect, DSM-5's list of cultural concepts of distress raises important conceptual and clinical implications. The fact that some diagnostic categories that are familiar to most mental health professionals working in Western or developed countries are unique to their cultural environment helps to challenge the frequently held assumption that culture shapes only conditions that appear to be exotic in faraway lands. At a more direct, clinical level, the glossary serves to make clinicians more aware of the extent to which their own views of what is normal and abnormal have been shaped by the values and experiences of their own culture (Mezzich, Berganza, & Ruiperez, 2001).

DSM-5 also now includes the Cultural Formulation Interview (CFI), a supplemental module that serves as a semistructured assessment tool to assist providers in clarifying the contribution of culture to clinical symptoms at any point during clinical care (Lewis-Fernández et al., 2014). The core interview, the first and main component of the CFI, includes 16 open-ended questions related to a cultural definition of the psychological problem, cultural perceptions related to the problem (e.g., with regard to cause, context, and support), and cultural factors affecting coping or help-seeking behaviors. Other components of the CFI include an informant report and other supplemental modules that can be used as needed. The CFI can be used with any client, regardless of whether a clinician has questions about how their culture may impact the presentation of clinical symptoms, and the CFI serves as a valuable tool to ensure that relevant and important cultural factors are not missed during case conceptualization and throughout treatment.

CLASSIFICATION OF PSYCHOPATHOLOGY

One might argue that efforts to classify mental disorders are as important and have raised as much controversy as efforts to define them. Despite many tribulations and debates associated with the classification of psychopathology, this process has served several purposes. A classification system helps clinicians to (1) identify (as accurately

and comprehensively as possible) their clients' problems and (2) formulate a plan of intervention that is most likely to be effective for these difficulties. A classification system also serves an important role in the search for new knowledge. The history of medicine is filled with examples of problems that were recognized long before they could be treated successfully. The classification of a specific set of symptoms has often laid the foundation for research that eventually identified a cure or a way of preventing the disorder.

Modern classification systems in psychiatry were introduced shortly after World War II. During the 1950s and 1960s, psychiatric classification was widely criticized. One major criticism focused on the lack of consistency in diagnostic decisions (Nathan & Langenbucher, 2003). Independent clinicians frequently disagreed with one another about the use of diagnostic categories. Objections were also raised from philosophical, sociological, and political points of view. For example, some critics charged that diagnostic categories in psychiatry would be more appropriately viewed as "problems in living" than as medical disorders (Szasz, 1963). Others were concerned about the negative impact of using diagnostic labels. In other words, once a psychiatric diagnosis is assigned, the person so labeled might experience discrimination of various kinds, and also find it more difficult to establish and maintain relationships with other people. These are all serious problems that continue to be the topic of important, ongoing discussions involving mental health professionals, as well as patients and their families. Debates regarding these issues did fuel important improvements in the diagnosis of mental disorders, including emphasis on the use of detailed criterion sets for each disorder.

Currently, two diagnostic systems for mental disorders are widely recognized. We have already mentioned DSM-5, which is published by the American Psychiatric Association. The other—the ICD—is published by the World Health Organization. Both systems were first developed shortly after World War II and have been revised several times. The World Health Organization's manual is in its 11th edition and is therefore known as ICD-11. Deliberate attempts are made to coordinate the production of DSM and ICD manuals. Most of the categories listed in the manuals are identical, and the criteria for specific disorders are usually similar. More than 200 specific diagnostic categories are described in the current edition of DSM. Importantly, under both systems (DSM and ICD), a person can be assigned more than one diagnosis if they meet criteria for more than one disorder.

EVALUATION OF PSYCHIATRIC CLASSIFICATION

The most important issue in the evaluation of a diagnostic category is whether it is *useful* (Kendell & Jablensky, 2003). By knowing that a person fits into a particular group or class, do we learn anything meaningful about that person? For example, is the person who fits the diagnostic criteria for schizophrenia likely to improve when they are given antipsychotic medication? Or is that person likely to have a less satisfactory level of social adjustment in five years than a person who meets diagnostic criteria for bipolar mood disorder? Does the diagnosis tell us anything about the factors or circumstances that might have contributed to the onset of this problem? These questions are concerned with the validity of the diagnostic category.

Validity is, in a sense, a reflection of the success that has been achieved in understanding the nature of a disorder. Have important facts been discovered? Systematic studies aimed at establishing the validity of a disorder may proceed in a sequence of phases (Robins & Guze, 1989). After a clinical description has been established, diagnostic categories are refined and validated through a process of scientific exploration. Unfortunately, relatively few of the disorders listed in the official diagnostic manual are supported by an extensive set of research evidence supporting all possible aspects of validity.

It may be helpful to think of different forms of validity in terms of their relationship in time with the appearance of symptoms of the disorder. *Etiological validity* is concerned with factors that contribute to the onset of the disorder. These are things that have happened in the past. Was the disorder regularly triggered by a specific set of events or circumstances? Did it run in families? The ultimate question with regard to etiological validity is whether there are any specific causal factors that are regularly, and perhaps uniquely, associated with this disorder. If we know that a person exhibits the symptoms of the disorder, do we in turn learn anything about the circumstances that originally led to the onset of the problem?

Concurrent validity is concerned with the present time and with correlations between the disorder and other symptoms, circumstances, and test procedures. Is the disorder currently associated with any other types of behavior, such as performance on psychological tests? Do precise measures of biological variables, such as brain structure and function, distinguish reliably between people who have the disorder and those who do not? Clinical studies aimed at developing a more precise description of a disorder also fall into this type of validity.

Predictive validity is concerned with the future and with the stability of the problem over time. Will it be persistent? If it is short-lived, how long will an episode last? Will the disorder have a predictable outcome? Do people with this problem typically improve if they are given a specific type of medication or a particular form of psychotherapy?

The overall utility of a diagnostic category depends on the body of evidence that accumulates as scientists seek answers to questions raised by these multiple forms of validity (*reliability*, or consistency of the diagnostic decisions, is also crucial, as it precedes validity). At this point in time, some disorders included in the diagnostic manual are based on a much more extensive foundation of evidence than others. Thus, more research needs to confirm and enhance the validity (thus, the utility) of our current diagnostic categories. Such research should be conducted in parallel with other efforts (conceptual and empirical) to address serious criticism directed toward the diagnostic manual.

LIMITATIONS OF AND POSSIBLE IMPROVEMENTS TO THE DSM

Developing each edition of the DSM involves a tremendous amount of work (with regard to both theory and research), and each new edition represents an improvement over previous ones (see Frances & Widiger, 2012). Nevertheless, several enduring issues remain to be resolved. One fundamental question that applies to every disorder involves the boundary between normal and abnormal behavior. DSM-5

is based on a categorical approach to classification, but most of the symptoms that define the disorders are actually dimensional in nature. Depressed mood, for example, can vary continuously, from the complete absence of depression to moderate levels of depression, on up to severe levels of depression. The same issue applies to symptoms of anxiety disorders, eating disorders, and substance use disorders. These are all continuously distributed phenomena, and there is not a bright line that divides people with problems from those who do not have problems. DSM-5 does include a greater focus on dimensional conceptualizations of certain disorders (e.g., including a spectrum for schizophrenia and for substance use disorders, the alternative model of personality disorder in Section III) in comparison to DSM-IV. Nevertheless, the DSM remains a categorical classification of separate disorders.

The absence of a specific definition of social impairment is another conceptual and clinical issue that has plagued the current diagnostic manual. Most disorders in the DSM include the requirement that a particular set of symptoms causes "clinically significant distress or impairment in social or occupational functioning." However, no specific measurement procedures are provided to make this determination. Mental health professionals must rely on their own subjective judgment of a person's symptoms to decide how distressed or how impaired a person must be in order to qualify for a diagnosis. There is an important need for more specific definitions of these concepts, and better measurement tools are needed for their assessment.

In addition, criticisms of the current classification system have emphasized broad conceptual issues. Some clinicians and investigators have argued that the syndromes defined in the DSM do not represent the most useful ways to think about psychological problems, in terms of either planning current treatments or designing programs of research. For example, it might be better to focus on more homogeneous dimensions of dysfunction, such as anxiety or angry hostility, rather than on syndromes (groups of symptoms) (Smith & Combs, 2010). Clinically and empirically, this raises questions such as the following: Should we design treatments for people who exhibit distorted, negative ways of thinking about themselves, regardless of whether their symptoms happen to involve a mixture of depression, anxiety, or some other pattern of negative emotion or interpersonal conflict? Indeed, in recent years there has been a greater move toward the development and implementation of transdiagnostic treatments for mental disorders (e.g., the unified protocol for transdiagnostic treatment of emotional disorders; Barlow et al., 2017).

No definite answer is available at this point in time. It would certainly be premature to cut off consideration of these alternatives just because they address problems in a way that deviates from the official diagnostic manual. In our current state of uncertainty, diversity of opinion should be encouraged, particularly if it is grounded in cautious skepticism and supported by rigorous scientific inquiry.

From an empirical and clinical point of view, the DSM is hampered by a number of problems that suggest it does not classify clinical problems into syndromes in the simplest and most beneficial way (Helzer, Kraemer, & Krueger, 2006). One of the thorniest issues involves "comorbidity," which is defined as the simultaneous appearance of two or more disorders in the same person. Comorbidity rates are very high for mental disorders as defined in the DSM system (Eaton, South, & Krueger, 2010). For example, in the NCS, among those people who qualified for at least one diagnosis at some point during their lifetime, 56% met the criteria for two or more

disorders. A small subgroup, 14% of the sample, actually met the diagnostic criteria for three or more lifetime disorders. That group of people accounted for almost 90% of the *severe* disorders in the study.

There are several ways to interpret comorbidity (Krueger, 2002). Some people may independently develop two separate conditions. In other cases, the presence of one disorder may lead to the onset of another. Unsuccessful attempts to struggle with prolonged alcohol dependence, for example, might lead a person to become depressed. Neither of these alternatives creates conceptual problems for the DSM; it makes sense that some people have more than one disorder and that one disorder can lead to another. Unfortunately, the high rates of comorbidity that have been observed empirically suggest that these explanations account for a small proportion of overlap between categories. In a large proportion of cases, the overlapping manifestations of more than one disorder do not seem to reflect clearly distinct diagnostic constructs.

Major clinical problems associated with comorbidity can arise when a person with a mixed pattern of symptoms, usually of a severe nature, simultaneously meets the criteria for more than one disorder. Consider, for example, a client who was treated by one of us (T. F. O.). This man experienced a large number of diffuse problems associated with anxiety, depression, and interpersonal difficulties. According to the DSM system, he would have met the criteria for major depressive disorder, generalized anxiety disorder, and obsessive–compulsive disorder, as well as three types of personality disorder. It might be said, therefore, that he suffered from at least six types of mental disorder. But is that really helpful? Is it the best way to think about his problems? Would it be more accurate to say that he had a complicated set of interrelated problems that were associated with worrying, rumination, and the regulation of high levels of negative emotion, and that these problems constituted one complex and severe type of disorder?

The comorbidity issue is related to another limitation of the DSM: the failure to make better use of information regarding the course of mental disorders over time. More than 100 years ago, when schizophrenia and bipolar mood disorder were originally described, the distinction between them was based heavily on observations regarding their long-term course. Unfortunately, most disorders listed in the DSM are defined largely in terms of snapshots of symptoms at particular points in time. Diagnostic decisions are seldom based on a comprehensive analysis of the way that a person's problems evolve over time. If someone meets the criteria for more than one disorder, does it matter which one came first? Is there a predictable pattern in which certain disorders follow the onset of others? What is the nature of the connection between childhood disorders and adult problems? Our knowledge of mental disorders would be greatly enriched if greater emphasis were placed on questions regarding lifespan development (Buka & Gilman, 2002; Oltmanns & Balsis, 2011).

Progress on understanding some of the traditional diagnostic categories in the DSM has been quite slow over the past 50 years, and it has led many to wonder whether there are better ways to approach classification and thus treatment. A number of alternative models of psychopathology have been developed as a counter to the "top-down," categorically based DSM classification system. HiTOP, as described earlier, was developed to understand the natural organization of psychopathology (Kotov et al., 2017) and emerged with a hierarchical dimensional structure of psychopathology, including a single general *p* factor and three broad domains under the

p factor (internalizing, externalizing, and thought disorder) (Smith et al., 2020). The Research Domain Criteria (RDoC; Insel et al., 2010) framework was created by the National Institute of Mental Health to encourage the development of a dimensional classification system of psychological processes that link with specific neural bases and are related to various aspects of psychopathology. A main goal of RDoC is to understand biological processes relevant to psychopathology, and many researchers are now taking this approach to studying psychopathology. Whether a "bottom-up" approach will yield better results in understanding clinical problems is a question that is likely to remain at the forefront of the mental health field in the decade ahead.

The classification issues identified earlier are being considered by the experts who develop each new edition of the DSM and the ICD. Of course, all of them will not be solved immediately. Attempts to provide solutions to these problems and limitations ensure that the classification system will continue to be revised. As before, these changes will be driven by the interaction of clinical experience and empirical evidence. Students, clinicians, and research investigators should all remain skeptical when using this classification system and its successors. At the same time, the complexity of psychopathology and its treatment should encourage all scholars and providers in the field of mental health to pay close attention to our current knowledge, and to derive from it new and creative ways to think about and intervene with mental disorders. The following chapters in this book have been written with this goal in mind.

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CHAPTER 2

Depression

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It is estimated that 16% of the general population experiences clinically significant depression in a given 12-month period (Kessler, Tat Chiu, Demler, & Walters, 2005). In addition to the impact on affected individuals and their families, depressive disorders place a burden of almost $50 billion per year on the American economy, accounting for over 20% of costs for all mental illness (Stewart, Ricci, Chee, Hahn, & Morganstein, 2003). Compared to other physical and mental disorders, depression is the leading cause of disability worldwide according to the World Health Organization (James et al., 2018). Given the substantial personal and societal costs of this disorder, efforts to identify vulnerability factors and effective interventions for depression are particularly important.

Our goal in this chapter is to present basic psychopathology research in depression and to discuss the treatment implications of these findings. Though all depressive disorders share similar features (Gotlib & LeMoult, 2014), there are some important differences between diagnostic categories that are not covered in this chapter. Instead, we focus here on depressive symptoms in general and major depressive disorder (MDD) in particular. We first describe the phenomenology of depression, including its associated clinical features and course. We then discuss the etiology of depression and focus in particular on novel empirical findings. After each section, we address the clinical implications of the findings. This is a timely and important task because, even though effective depression treatments exist, these interventions have undergone few changes in the past decades, and rates of recurrence of depression are still high even after successful treatment.