

Section

Rationale, structure, and overview

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Introduction

Nadine Pelling

Abnormal psychology is often a core course in both undergraduate and postgraduate psychology programs across North America, Europe, and Australasia. The vast majority of abnormal psychology textbooks come from the United States of America (US). This academic focus on US abnormal psychology is not surprising given the relatively large number of people living in the US, that it is ranked third in terms of country population in the world, and is the most populous country in which English is the primary language spoken (Statistics Times, 2016; United Nations Department of Economic and Social Affairs/Population Division, 2015). Additionally, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) originates from the US. The available US resources are, understandably, US-centric and contain mostly US statistics and applied examples. Furthermore, if reference to community resources is made these are likely to be US-based and not accessible, or of low relevance, to Australasian populations.

There are few abnormal psychology resources that present Australian and New Zealand (NZ) materials including statistics, case studies, and community resources. Recent Australian-focused resources include a special issue published by Pelling (2015) in the *International Journal of Mental Health*. Further, there are both Australian- and NZ-based authors publishing practice- and education-relevant abnormal psychology resources. However, up until now no resource has existed detailing the Australian and NZ experience and response to abnormal psychology matters in a succinct and applied manner. This handbook on abnormal psychology in the Australian and NZ context is designed specifically to make such academic and applied abnormal psychology resources available.

This handbook has been compiled to include material by lead researchers and applied practitioners from Australia and NZ. Consequently, the resulting resource is valuable to both students of abnormal psychology and also applied mental health practitioners across Australia and NZ. We hope you enjoy reading and making use of this handbook which purposefully highlights and showcases our Australasian research and practice relating to abnormal psychology.

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References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

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Statistics Times. (2016). *List of North American countries by population 2015*. Available: <http://statisticstimes.com/population/north-american-countries-by-population.php>

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Handbook structure

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This handbook has been purposefully created to focus on Australian and New Zealand (NZ) abnormal psychology research, statistics, and applied practice. This handbook has thus been designed with a specific structure for ease of use. Specifically, after general handbook rationale and structure information is offered, some basic information regarding abnormal psychology and applied practice is provided. This presentation is followed by a brief examination of the cultural and demographic compositions of Australia and NZ and related resources. The bulk of this handbook then examines various psychological disorders. Finally, the handbook concludes with an examination of two psychological practice-related items relevant to abnormal psychology: suicide and non-suicidal self-harm and then mandated or involuntary treatment.

As noted previously, the bulk of this handbook focuses on various psychological disorders. The disorders examined are those presented in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), and are in the same order as in the *DSM-5*. The exceptions to this presentation are those disorders for which there was limited Australian- and NZ-based information to justify inclusion in this handbook. Therefore, this handbook examines 17 specific disorders (or areas of treatment foci) whereas the *DSM-5* presents a greater number of diagnostic categories.

For each disorder (or area of treatment focus) examined, a standard organisation has been maintained for presentation. Explicitly, contributing authors have been asked to begin with an introduction to each disorder (or area of treatment focus) including an examination of **signs** and **symptoms**, followed by an examination of the presentation of same in Australia and then NZ including **incidence** and **prevalence**, and then to present a case example. Cases have been chosen to focus on either an Australian or NZ example, and to comply with ethical standards relating to the presentation of client information for educational purposes (specifically, either a created or composite example is presented). Specific de-identified client material has only been used with the written permission of said client (Australian Psychological Society, 2007). Authors have

identified research and practice support information specific to both Australia and NZ. References are provided for readers who wish to explore the topics examined in context in greater detail.

Key terms

- **Sign.** Objective evidence of a disorder. A sign can be recognised by others.
- **Symptom.** Subjective evidence of a disorder. Others know about a symptom if they are told about it.
- **Incidence.** The rate of newly diagnosed disorders. An incidence rate can be relatively high but a prevalence rate relatively low if the disorder in question resolves quickly.
- **Prevalence.** The actual number of diagnosed disorders. A prevalence rate can be relatively high but an incidence rate can be relatively low if the disorder in question does not resolve quickly.

To purposefully limit the size of this handbook authors have provided additional case examples and short-answer questions with answers relating to their specific focus area separately for inclusion on this handbook’s companion website instead of in the main handbook. These supplementary materials will be made available exclusively to instructors using this handbook to facilitate the use of the book in an educational setting.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Australian Psychological Society. (2007). *Code of ethics*. Melbourne, Vic: Author.

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Abnormal psychology overview

Nadine Pelling

Defining abnormality

Abnormality can be defined in a number of ways. However, in terms of psychological difficulties the term “abnormality,” or “psychopathology,” generally refers to a problematic pattern of thought, feeling, and/or behaviour that disrupts one’s sense of wellness or functioning either socially or occupationally. A mental or psychological disorder involves a recognisable set of symptoms and signs that cause distress to the individual involved and impair their functioning (Burton, Westen, & Kowalski, 2015). The psychopathological signs and symptoms presented by an individual are “recognisable” when compared with various classification systems and thus are used to make a diagnosis.

There are two main classifications systems used to make mental health related diagnoses: the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association (5th ed.; *DSM-5*; 2013) and the *International Statistical Classification of Diseases and Related Health Problems 2010 Edition* (*ICD-10*) (World Health Organisation, 2011). An examination of the pros and cons of both classifications is beyond the scope of this handbook. Therefore, the *DSM-5* will simply be described in terms of structure and use as this is the classification system that was focused on when structuring this handbook.

DSM-5 overview

The *DSM-5* is the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* in use and outlines recognisable sets of symptoms and signs that distress individuals and impair their functioning, most often focused on for treatment and support. The *DSM-5* itself presents material in sections, including background regarding the development of the *DSM-5*, with the bulk of material being related to the diagnostic criteria for the various disorders.

The *DSM-5* provides applied clinicians with an organising framework as well as a common language regarding signs and symptoms and thus diagnoses that can assist communication and assist and guide research and treatment. The information presented in the *DSM-5* includes how various cognitive, emotional, and/or behavioural signs and symptoms cluster together in the diagnoses described. The use of a diagnosis thus creates a shared understanding with other practitioners familiar with the diagnostic classification system used. Therefore, communication between practitioners is made more efficient. There are, of course, drawbacks as well as benefits to the use of diagnostic labels and interested readers are referred to Beccaria (2013) for a detailed yet concise review of the *DSM-5* and discussion of such topics.

The *DSM-5* groups clinical disorders into 22 main areas from neurodevelopmental disorders to substance-related and addictive disorders through to other conditions that may be the focus of clinical attention. This handbook explores most of these within the Australian and New Zealand (NZ) context.

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Applied professions

A number of professions work with those impacted by mental illness. The main professional areas in Australia and NZ to work with mental illness include psychology, counselling, social work, and psychiatry.

In Australia applied psychological practice is legally regulated by the Psychology Board of Australia with support from the Australian Health Practitioner Regulation Agency. Similarly, in NZ psychology is regulated by the New Zealand Psychologists Board. The main association that provides support to psychological practitioners in Australia, and the one that provides the ethical code that must be used by psychologists, is the Australian Psychological Society. The New Zealand Psychological Society supports psychologists in NZ.

Counselling is voluntarily regulated in Australia with two main associations mainly involved in the promotion of counselling services and support of counselling practitioners: the Australian Counselling Association and the Psychotherapy and Counselling Federation of Australia. These two associations have a joint register called the Australian Register of Counsellors and Psychotherapists. In NZ the New Zealand Association of Counsellors voluntarily regulates and supports counselling and counselling practitioners.

Social work is voluntarily regulated in Australia by the Australian Association of Social Workers. In NZ, the New Zealand Association of Social Workers operates in a similar capacity.

Psychiatry is a branch of medicine. Psychiatrists, unlike psychologists, are thus medical practitioners. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating, and representing psychiatrists in both Australia and NZ (www.ranzcp.org).

New Zealand – psychology, counselling, and social work regulation and associations

- Psychology:
 - New Zealand Psychologists Board (psychologistsboard.org.nz)
 - The New Zealand Psychological Society (<http://psychology.org.nz>)
- Counselling:
 - New Zealand Association of Counsellors (<http://nzac.org.nz>)
- Social work:
 - Aotearoa New Zealand Association of Social Workers (<http://anzasw.nz>)

Australia – psychology, counselling, and social work regulation and associations

- Psychology:
 - Psychology Board of Australia (www.psychologyboard.gov.au)
 - Australian Psychological Society (<http://psychology.org.au>)
- Counselling:
 - Australian Counselling Association (<http://theaca.net.au>)
 - Psychotherapy and Counselling Federation of Australian (www.pacfa.org.au)
 - Australian Register of Counsellors and Psychotherapists (www.arcapregister.com.au)
- Social work:
 - Australian Association of Social Workers (www.aasw.asn.au)

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References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Beccaria, G. (2013). *A student's guide to the DSM-5*. Milton, Australia: John Wiley & Sons.

Burton, L., Westen, D., & Kowalski, R. (2015). *Psychology: An Australian and New Zealand edition* (4th ed.). Milton, Australia: John Wiley & Sons.

World Health Organisation. (2011). *International statistical classification of diseases and related health problems 2010 edition (ICD-10)*. Geneva: Author. Available: www.who.int/classifications/icd/en/

Section 

Cultural diversity and resources

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Diversity in Australia

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Introduction

Notwithstanding the overarching distinction between Indigenous and non-Indigenous Australians, diversity in Australia is for the most part synonymous with country of birth, migrant generation, and the more esoteric expression of these data in what we term “culture”. And with almost half of the population either first or second generation immigrant, Australia is home to one of the world’s most ethnically diverse populations. Socio-economic diversity is of course intimately connected to these demographic characteristics, but for the most part appears in Australian data collections disaggregated either by geographic area or overseas born/Australian born rather than broad ethnic group because of the way in which Australian statistics are presented. This is in contrast with the approach in New Zealand (NZ) which disaggregates most publicly available data by ethnicity (see Chapter 5 describing NZ’s population). In other words, there are many ways of measuring, interpreting, collecting, and presenting *diversity* data. Australia tends to present diversity data in groups related to geographic area and nation of origin whereas NZ presents diversity in collections relating to ethnicity first and foremost.

Australia – what is diversity?

There are many aspects of diversity. These include items often focused upon in therapeutic contexts and psychological studies: age, family background, gender, race, religion, sexual orientation, socio-economic status, ability/disability, and nation of origin.

An examination or analysis of diversity (diversity analysis) in populations can focus on two broad types of diversity: inherent diversity (traits people are born with) and acquired diversity (aspects gained from experience).

Examples of inherent diversity would be one’s country of birth and sex. Acquired diversity characteristics are increasingly attributed to personal, social, and economic success.