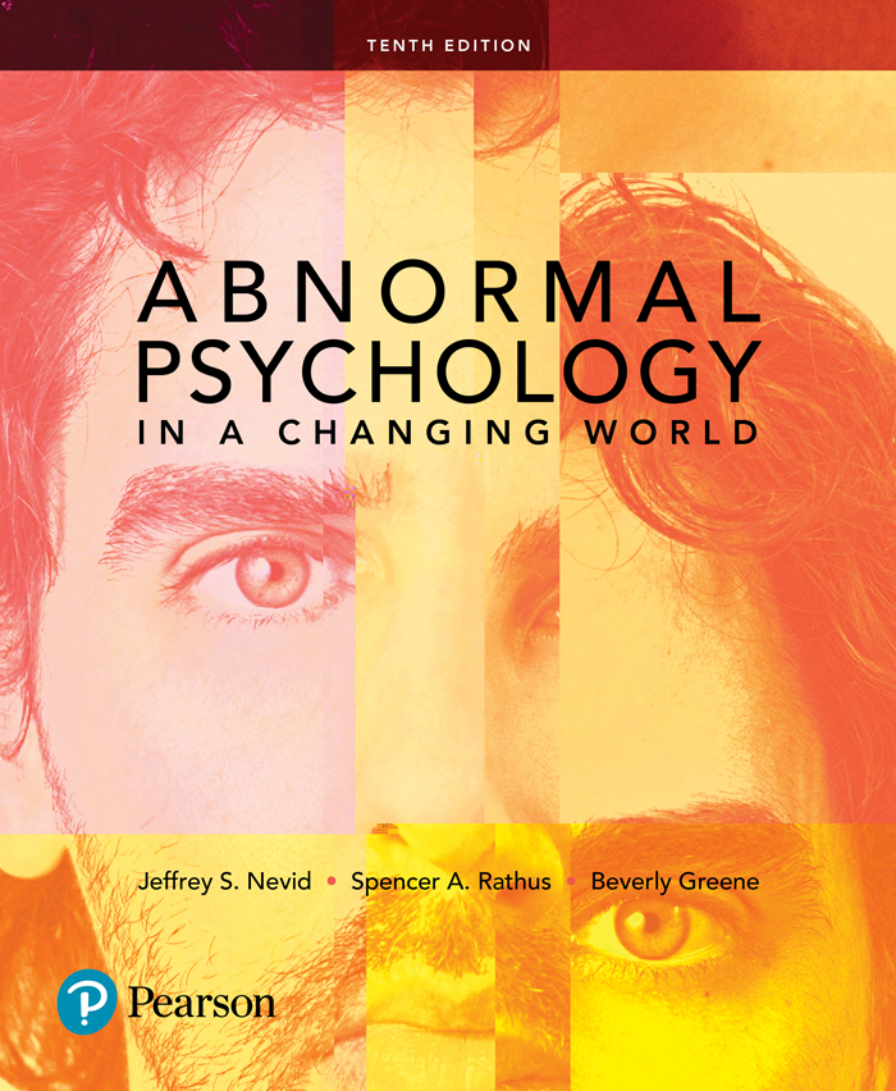
TENTH EDITION
ABNORMAL PSYCHOLOGY
IN A CHANGING WORLD
Jeffrey S. Nevid • Spencer A. Rathus • Beverly Greene
Pearson

Abnormal Psychology

In a Changing World

TENTH EDITION

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Brief Contents

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Contents

Preface

Welcome to the tenth edition of *Abnormal Psychology in a Changing World*. In preparing this new edition, we have endeavored to cull the most recent scientific developments that inform and broaden our understanding of abnormal behavior. Our aim in writing this text is to present scientific advances in ways that both stimulate student interest and make complex material accessible and understandable.

We approach the teaching of abnormal psychology with five fundamental goals in mind:

1. To help students distinguish abnormal from normal behavior and acquire a better understanding of abnormal behavior
2. To increase student awareness of and sensitivity to the struggles of people suffering from the challenges we discuss
3. To help students understand the conceptual bases of abnormal behavior patterns
4. To help students understand how our knowledge of abnormal behavior is informed by research developments in the field
5. To help students understand how psychological disorders are classified and treated

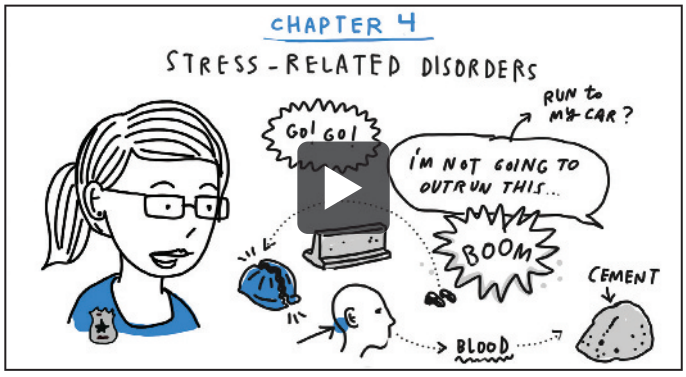
What's New in the Tenth Edition

REVEL™ DESIGNED FOR THE WAY TODAY'S STUDENTS READ, THINK, AND LEARN When students are engaged deeply, they learn more effectively and perform better in their courses. This simple fact inspired the creation of REVEL: an immersive learning experience designed for the way today's students read, think, and learn. Built in collaboration with educators and students nationwide, REVEL is the newest, fully digital way to deliver respected Pearson content.

REVEL enlivens course content with media interactives and assessments—integrated directly within the authors' narrative—that provide opportunities for students to read about and practice course material in tandem. This immersive experience boosts student engagement, which leads to better understanding of concepts and improved performance throughout the course.

The Tenth Edition includes integrated videos, animations, and media content throughout, allowing students to explore topics more deeply at the point of relevancy

Watch



REVEL also offers the ability for students to assess their content mastery by taking multiple-choice quizzes that offer instant feedback and by participating in a variety of writing assignments such as peer-reviewed questions and auto-graded assignments.

Learn more about REVEL at

www.pearsonhighered.com/revel.

NEW FEATURE: *ABNORMAL PSYCHOLOGY IN THE DIGITAL AGE* When we began teaching, a *tablet* was something you took if you had a headache, a *text* was a book a professor assigned for class, and a *web* was something that a spider spun. Today, these words have taken on additional meanings, reflecting the many ways in which contemporary life has changed as the result of modern technology. Students today are digital natives who have never known a time without cell phones, laptops, and the Internet. Texting has become the preferred method of communication for many people today, especially college-age students.

Changes in personal technology are among the most important challenges of adjusting to a changing world. In this text, we consider the impact of changing technology on the study of abnormal psychology by examining how advances in electronic communication are applied in assessment and treatment of psychological disorders. We also examine the psychological effects of Internet use and social media on behavior, including concerns about the problem of Internet addiction.

Here are few examples of topics from a new feature called ***Abnormal Psychology in the Digital Age*** that is

intended to highlight ways in which personal technology is changing our study of abnormal psychology:

- Smartphones and Social Media as Research Tools
- Tracking Symptoms by Smartphone
- Virtual Therapy: The Next Best Thing to Being There
- Does Facebook Make You Sadder? The Unintended Consequences of Social Comparison
- Internet Addiction
- How Do I Shape Up? Risks of Social Media Comparisons on Body Image
- "Cybersex Addiction"—A New Psychological Disorder?
- Are You a Facebook Extravert? Or a Twitter Narcissist?
- Helping Autistic Children Communicate: We've Got an App for That

Maintaining Our Focus

Abnormal Psychology in a Changing World is a complete learning and teaching package that brings into focus the following major objectives: (1) putting a human face on the study of abnormal psychology; (2) adopting an interactionist or biopsychosocial model of abnormal behavior; (3) exploring the many contributions from neuroscience research to the study of abnormal psychology; (4) maintaining currency with a changing field; (5) examining key issues in a changing world that inform our understanding of abnormal psychology; and (6) adopting a student-centric approach to pedagogy that focuses on helping students succeed in the course.

FOCUS ON THE HUMAN SIDE OF ABNORMAL PSYCHOLOGY: THE "I" FEATURE A hallmark of our approach is helping students understand the basic human dimension that underlies the study of abnormal psychology. We study psychological disorders, but we never lose sight of the fact that we're talking about the lives of people affected by these types of problems. We also understand that an undergraduate textbook in abnormal psychology is not a training manual or compendium of psychological disorders, symptoms, and treatments. It is a teaching device to introduce students to the study of abnormal behavior and help them understand the challenges and struggles faced by people with psychological disorders.

We invite students to enter the world of people suffering from many different types of disorders by including many illustrative case examples and video case interviews of real people and by adopting a distinctive pedagogical feature that takes this approach an important step further—the **"I"** feature.

The **"I"** feature brings students directly into the world of people affected by psychological disorders. Here, students will read brief, first-person narratives from people with psychological disorders as they tell their own stories in their own words. Incorporating first-person narratives helps break down barriers between "us" and "them" and encourages students to recognize that mental health problems are a concern to us all. Students will encounter these poignant personal stories at the beginning of every chapter and throughout the text. A sampling of **"I"** features includes the following:

- "Jerry Has a Panic Attack on the Interstate" (Panic Disorder)
- "Jessica's Little Secret" (Bulimia Nervosa)
- "Walking on Eggshells" (Borderline Personality Disorder)
- "I Hear Something You Can't Hear" (Schizophrenia)

FOCUS ON AN INTERACTIONIST APPROACH We approach our writing with the belief that a better understanding of abnormal psychology is gained by adopting a biopsychosocial orientation that takes into account the roles of psychological, biological, and sociocultural factors and their interactions in the development of abnormal behavior patterns. We emphasize the value of taking an interactionist approach as a running theme throughout the text. We feature a prominent interactionist model, the diathesis–stress model, to help students better understand the factors contributing to different forms of abnormal behavior.

FOCUS ON NEUROSCIENCE We incorporate important advances in neuroscience that inform our understanding of abnormal behavior patterns, building upon the solid foundations of previous editions. Students will read about the search for endophenotypes in schizophrenia, the latest developments in the important emerging field of epigenetics, how brain scans may be used to diagnose psychological disorders and to probe the workings of the meditative brain, the potential use of drugs to enhance the effectiveness of exposure therapy for PTSD, and emerging brain research that focuses on whether disturbing memories linked to PTSD might be erased.

FOCUS ON KEEPING PACE WITH AN EVER-CHANGING FIELD The text integrates the latest research findings and scientific developments in the field. In all, we include more than 1,000 references to research developments in the field in just the past few years. We also present these research findings in a way that makes complex material engaging and accessible for students.

FOCUS ON KEY ISSUES IN OUR CHANGING WORLD The ***A CLOSER Look*** boxed features provide opportunities for further exploration of selected topics that reflect cutting-edge issues in the field and challenges we face in contemporary society. A number of the ***A CLOSER Look*** features also focus on advances in neuroscience research.

FOCUS ON STUDENT-CENTRIC PEDAGOGY We continually examine our pedagogical approach to find even better ways of helping students succeed in this course. To foster deeper understanding, we include many pedagogical aids, including ***TRUTH or FICTION*** chapter openers to capture

student attention and interest, ***self-scoring questionnaires*** to encourage active learning through self-examination, ***capsulized summaries*** of disorders that students can use as study charts, and ***chapter summaries*** organized around key learning objectives.

"TRUTH or FICTION" Chapter Openers Each chapter begins with a set of ***TRUTH or FICTION*** questions to whet the student's appetite for the subject matter within the chapter. Some items challenge preconceived ideas and common folklore and debunk myths and misconceptions, whereas others highlight new research developments in the field. Instructors and students have repeatedly reported to us that they find this feature stimulating and challenging.

The ***TRUTH or FICTION*** questions are revisited and answered in the sections of the chapter in which the topics are discussed. Students are thus given feedback concerning the accuracy of their preconceptions in light of the material being addressed.

Self-Scoring Questionnaires These questionnaires on various topics involve students in the discussion at hand and encourage them to evaluate their own attitudes and behavior patterns. In some cases, students may become more aware of troubling concerns, such as states of depression or problems with drug or alcohol use, which they may want to bring to the attention of a helping professional. We have carefully developed and screened the questionnaires to ensure that they provide students with useful information to reflect upon as well as serving as a springboard for class discussion.

Overview Charts These "see-at-a-glance" overview charts provide capsulized summaries of various disorders. We are gratified by the many comments from students and professors regarding the value of these study charts.

"Summing Up" Chapter Summaries Our ***Summing Up*** chapter summaries provide brief answers to the learning objectives posed at the beginning of the chapter. The ***Summing Up*** sections provide students with feedback they can use to compare their answers with those provided in the text.

The Fully Integrated Textbook

We seek to provide students with a cohesive understanding of abnormal psychology by integrating a number of key features throughout the text.

INTEGRATING THE *DSM-5* We integrate the *DSM-5* throughout the text by applying *DSM-5* criteria in both the body of the text and the many accompanying overview charts. We also cover a wide range of newly diagnosed disorders in the *DSM-5*, including hoarding disorder, premenstrual dysphoric disorder, disruptive mood dysregulation disorder, major and mild neurocognitive disorders, somatic symptom disorder, illness anxiety disorder, pyromania, REM sleep behavior disorder, and social (pragmatic) communication disorder.

Although we recognize the importance of the *DSM* system in the classification of psychological or mental disorders, we believe a course in abnormal psychology should not taught as a training course in the *DSM* or as a psychodiagnostic seminar. We also bring to the student's attention the many limitations of the *DSM* system.

INTEGRATING DIVERSITY We examine abnormal behavior patterns in relation to factors of diversity such as ethnicity, culture, gender, sexual orientation, and socioeconomic status. We believe students need to understand how issues of diversity affect the conceptualization of abnormal behavior as well as the diagnosis and treatment of psychological disorders. We also believe that coverage of diversity should be fully integrated directly in the text, not separated off in boxed features.

INTEGRATING THEORETICAL PERSPECTIVES Students often think that one theoretical perspective must ultimately be right and all the others wrong. Our approach is to dispel this notion by taking into account the different theoretical viewpoints that inform contemporary understandings of abnormal psychology. We also help students integrate these diverse viewpoints in our ***TYING it together*** features. Importantly, we explore potential causal pathways involving interactions of psychological, sociocultural, and biological factors. We hope to impress upon students the importance of taking a broader view of the complex problems we address by considering the influences of multiple factors and their interactions.

INTEGRATING VIDEO CASE EXAMPLES WITHIN THE REVEL LEARNING PLATFORM Students can learn about the clinical features of specific disorders by reading the many case examples interspersed throughout the text. Many of these illustrative case examples are drawn from our own clinical files and those of leading mental health professionals. This edition is now integrated with the REVEL electronic learning platform, so students can also watch video case examples illustrating many of the disorders discussed in the text. Video case examples provide students with opportunities to see and hear individuals with different types of psychological disorders. Video case examples also put a human face on the subject matter, making complex material more directly accessible.

INTEGRATING CRITICAL THINKING We encourage students to think more deeply about key concepts in abnormal psychology by including two sets of critical thinking items in each chapter. First, the ***@Issue*** feature highlights current controversies in the field and includes several critical thinking questions that challenge students to think further about the issues discussed in the text. Second, the critical thinking activity at the end of each chapter challenges students to think carefully and critically about concepts discussed in the chapter and to reflect on how these concepts relate to their own experiences or experiences of people they know.

The ***@Issue*** critical thinking boxed feature highlights current controversies in the field and poses critical

thinking questions students can answer. Students may begin the course with an expectation that our knowledge of abnormal psychology is complete and incontrovertible. They soon learn that while we have learned much about the underpinnings of psychological disorders, much more remains to be learned. They will also learn that there are many current controversies in the field. By spotlighting these controversies, we encourage students to think critically about these important issues and examine different points of view. Examples of ***@Issue*** boxed feature topics include the following:

- Should Therapists Treat Clients Online?
- What Accounts for the Gender Gap in Depression?
- Should We Use Drugs to Treat Drug Abuse?
- Is Mental Illness a Myth?

To integrate writing across the curriculum (WAC) objectives, instructors may wish to assign critical thinking questions in the ***@Issue*** features as well as additional critical thinking questions at the end of each chapter as required or for extra-credit writing assignments.

INTEGRATING LEARNING OBJECTIVES WITH BLOOM'S TAXONOMY We introduce learning objectives at the start of each chapter, organized in terms of the IDEA model of course assessment, which comprises four key learning goals in the study of abnormal psychology that spell out the convenient acronym *IDEA*:

- **Identify** parts of the nervous system, major contributors to the study of abnormal psychology, specific disorders within general diagnostic categories, etc.
- **Define** or **Describe** key terms and concepts
- **Evaluate** or **Explain** underlying mechanisms and processes in abnormal behavior
- **Apply** concepts of abnormal behavior to examples in real life

The IDEA model is integrated with the widely used taxonomy of educational objectives developed by renowned educational researcher Benjamin Bloom. Bloom's taxonomy is arranged in increasing levels of cognitive complexity. The lowest levels comprise basic knowledge and understanding, the middle level involves application of knowledge, and the upper levels involve higher-level skills of analysis, synthesis, and evaluation.

The learning objectives identified in IDEA represent three basic levels in Bloom's taxonomy. The **Identify, Describe**, and **Define** learning objectives represent basic levels of cognitive skills in Bloom's taxonomy (i.e., *knowledge* and *comprehension* in the original taxonomy, or *remembering* and *understanding* in the revised taxonomy). The **Apply** learning objective reflects intermediate level skills involved in application of psychological concepts to life examples. The **Evaluate** and **Explain** learning objectives assess more complex, higher-order skills in the hierarchy involving skills relating to analysis, synthesis, and evaluation of psychological knowledge (or *analyzing* and *evaluating* domains as represented in the revised Bloom taxonomy). By building exams around these learning objectives, instructors can assess not just overall student knowledge, but also student acquisition of higher-level skills in Bloom's taxonomy.

Ancillaries

No matter how comprehensive a textbook is, today's instructors and students require a complete teaching package to advance teaching and comprehension. *Abnormal Psychology in a Changing World* is accompanied by the following ancillaries:

MYPSYCHLAB FOR ABNORMAL PSYCHOLOGY (ISBN: 0134447476) MyPsychLab is an online homework, tutorial, and assessment program that truly engages students in learning. It helps students better prepare for class, quizzes, and exams—resulting in better performance in the course. It provides educators with a dynamic set of tools for gauging individual and class performance.

SPEAKING OUT: INTERVIEWS WITH PEOPLE WHO STRUGGLE WITH PSYCHOLOGICAL DISORDERS This set of video segments allows students to see firsthand accounts of patients with various disorders. The interviews were conducted by licensed clinicians and range in length from 8 to 25 minutes. Disorders include major depressive disorder, obsessive–compulsive disorder, anorexia nervosa, PTSD, alcoholism, schizophrenia, autism, ADHD, bipolar disorder, social phobia, hypochondriasis, borderline personality disorder, and adjustment to physical illness. These video segments are available through REVEL as well as MyPsychLab.

- Volume 1: ISBN 0131933329
- Volume 2: ISBN 0136003036
- Volume 3: ISBN 0132308916

INSTRUCTOR'S MANUAL (ISBN: 0134516958) A comprehensive tool for class preparation and management, each chapter includes learning objectives, a chapter outline, lecture and discussion suggestions, "think about it" discussion questions, activities and demonstrations, suggested video resources, and a sample syllabus. Available for download from the Instructor's Resource Center at www.pearsonhighered.com.

TEST BANK (ISBN: 0134517989) The Test Bank has been rigorously developed, reviewed, and checked for accuracy to ensure the quality of both the questions and the answers. It includes fully referenced multiple-choice, true/false, and concise essay questions. Each question is accompanied by a page reference, difficulty level, skill type (factual, conceptual or applied), topic, and correct answer. Available for download from the Instructor's Resource Center at www.pearsonhighered.com.

MYTEST (ISBN: 0134447549) A powerful assessment-generation program that helps instructors easily create and print quizzes and exams. Questions and tests can be authored

online, allowing instructors ultimate flexibility and the ability to efficiently manage assessments anytime and anywhere. Instructors can easily access existing questions and edit, create, and store questions using a simple drag-and-drop technique and Word-like controls. Data about each question provides the difficulty level and the page number of the corresponding text discussion. For more information, go to www.PearsonMyTest.com.

LECTURE POWERPOINT SLIDES (ISBN: 0134516974) PowerPoint slides provide an active format for presenting concepts from each chapter and feature relevant figures and tables from the text. Available for download from the Instructor's Resource Center at www.pearsonhighered.com.

ENHANCED LECTURE POWERPOINT SLIDES WITH EMBEDDED VIDEOS (ISBN: 0134516931) The lecture PowerPoint slides have been embedded with select videos pertaining to each disorder chapter, enabling instructors to show videos within the context of their lectures. Available for download from the Instructor's Resource Center at www.pearsonhighered.com.

POWERPOINT SLIDES FOR PHOTOS, FIGURES, AND TABLES (ISBN: 0134516966) These slides contain only the photos, figures, and line art from the textbook. Available for download from the Instructor's Resource Center at www.pearsonhighered.com.

Acknowledgments

With each new edition, we try to capture a moving target, as the literature base that informs our understanding continues to expand. We are deeply indebted to the thousands of talented scholars and investigators whose work has enriched our understanding of abnormal psychology. Thanks to our colleagues who reviewed our manuscript through earlier editions and continue to help us refine and strengthen our presentation of this material:

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We especially wish to thank the two people without whose inspiration and support this effort never would have materialized or been completed, Judith Wolf-Nevid and Lois Fichner-Rathus. We invite students and instructors to contact us at the email addresses below with any comments, suggestions, and feedback. We'd love to hear from you.

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JEFFREY S. NEVID is Professor of Psychology at St. John's University in New York, where he directs the Doctoral Program in Clinical Psychology, teaches at the undergraduate and graduate levels, and supervises doctoral students in clinical practicum work. He received his Ph.D. in Clinical Psychology from SUNY Albany and was a staff psychologist at Samaritan Hospital in Troy, New York. He was also a National Institute of Mental Health Post-Doctoral Fellow in Mental Health Evaluation Research at Northwestern University. He holds a Diplomate in Clinical Psychology from the American Board of Professional Psychology, is a Fellow of the American Psychological Association and the Academy of Clinical Psychology, and has served on the editorial boards of several journals and as Associate Editor of the *Journal of Consulting and Clinical Psychology*.

Dr. Nevid has amassed more than 200 research publications and professional presentations. His research publications have appeared in such journals as *Journal of Consulting and Clinical Psychology, Health Psychology, Journal of Occupational Medicine, Behavior Therapy, American Journal of Community Psychology, Professional Psychology: Research and Practice, Journal of Clinical Psychology, Journal of Nervous and Mental Disease, Teaching of Psychology, American Journal of Health Promotion, Clinical Psychology and Psychotherapy*, and *Psychology and Psychotherapy: Theory, Research, and Practice*. Dr. Nevid is also author of the book *Choices: Sex in the Age of STDs* and the introductory psychology text, *Psychology: Concepts and Applications*, as well as several other college texts in the fields of psychology and health that he coauthored with Dr. Spencer Rathus. The 9th edition of *Abnormal Psychology in a Changing World* was honored in 2015 by receiving the Best Coverage of Child Maltreatment in Undergraduate Psychology Textbooks award. The award was bestowed by Division 56 (Trauma) of the American Psychological Association in recognition of the textbook's outstanding coverage of traumatic disorders linked to childhood maltreatment. Dr. Nevid is also actively involved in a program of pedagogical research that focuses on helping students become more effective learners.

SPENCER A. RATHUS received his Ph.D. from the University at Albany. He is on the faculty of the College of New Jersey. His areas of interest include psychological assessment, cognitive behavior therapy, and deviant behavior. He is the originator of the Rathus Assertiveness Schedule, which has become a Citation Classic. He has authored several college texts, including *PSYCH, HDEV*, and *Childhood and Adolescence: Voyages in Development*. He also coauthored *Making the Most of College* with Lois Fichner-Rathus; *AIDS: What Every Student Needs to Know* with Susan Boughn; *Behavior Therapy, Psychology and the Challenges of Life, Your Health*, and *HLTH* with Jeffrey S. Nevid; and *Human Sexuality in a Changing World* with Jeffrey S. Nevid and Lois Fichner-Rathus. His professional activities include service on the American Psychological Association Task Force on Diversity Issues at the Precollege and Undergraduate Levels of Education in Psychology, and on the Advisory Panel, American Psychological Association, Board of Educational Affairs (BEA) Task Force on Undergraduate Psychology Major Competencies.

BEVERLY A. GREENE is Professor of Psychology at St. John's University and a Fellow of seven divisions of the American Psychological Association and the Academy of Clinical Psychology. She holds a Diploma in Clinical Psychology and serves on the editorial boards of numerous scholarly journals. She received her Ph.D. in Clinical Psychology from Adelphi University and was founding coeditor of the *APA Society for the Study of Lesbian, Gay, and Bisexual Issues* series, *Psychological Perspectives on Lesbian, Gay and Bisexual Issues*. Dr. Greene is also coeditor of *The Psychologists Desk Reference; A Minyan of Women: Family Dynamics, Jewish Identity and Psychotherapy Practice*; and *Psychological Health of Women of Color: Intersections, Challenges and Opportunities*. She has more than 100 professional publications, of which 10 have received national awards for distinguished contributions to the psychological literature.

Dr. Greene was the recipient of the APA 2003 Committee on Women in Psychology Distinguished Leadership Award; the 1996 Outstanding Achievement Award from the APA Committee on Lesbian, Gay, and Bisexual Concerns; the 2004 Distinguished Career Contributions to Ethnic Minority Research Award from the APA Society for the Study of Ethnic Minority Issues; the 2000 Heritage Award from the APA Society for the Psychology of Women; the 2004 Award for Distinguished Senior Career Contributions to Ethnic Minority Research (APA Division 45); and the 2005 Stanley Sue Award for Distinguished Professional Contributions to Diversity in Clinical Psychology (APA Division 12). Her coedited book, *Psychotherapy with African American Women: Innovations in Psychodynamic Perspectives and Practice*, was also honored with the Association for Women in Psychology's 2001 Distinguished Publication Award. In 2006, she was the recipient of the Janet Helms Award for Scholarship and Mentoring from the Teacher's College, Columbia University Cross Cultural Roundtable, and the 2006 Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology (APA Division 12). In 2009, Dr. Greene was honored as the

recipient of the APA Award for Distinguished Senior Career Contribution to Psychology in the Public Interest. She has served as an elected representative to the APA Council and member at large of the Women's and Public Interest Caucuses of the Council. Dr. Greene is also the 2012 recipient of the Association for Women in Psychology's Jewish Women's Caucus award for scholarship and the association's 2012 Espin award for scholarship that makes a significant contribution toward the study of the convergence of ethnicity, religion, and sexual orientation. In 2013, she was honored as a Distinguished Elder at the National Multicultural Conference and Summit, and in 2015 she was the recipient of the Henry Tomes Award for Distinguished Senior Career Contributions to the Advancement of Ethnic Minority Psychology.

Chapter 1

Introduction and Methods of Research

Learning Objectives

1.1 **Identify** criteria professionals use to determine whether behavior is abnormal and **apply** these criteria to case examples discussed in the text.

1.2 **Describe** the current and lifetime prevalence of psychological disorders in the United States and **describe** differences in prevalence as a function of gender and age.

1.3 **Describe** the cultural bases of abnormal behavior.

1.4 **Describe** the demonological model of abnormal behavior.

1.5 **Describe** the origins of the medical model of abnormal behavior.

1.6 **Describe** the treatment of mental patients during medieval times.

1.7 **Identify** the leading reformers of the treatment of the mentally ill and **describe** the principle underlying moral therapy and the changes that occurred in the treatment of mental patients during the 19th and early 20th centuries.

1.8 **Describe** the role of mental hospitals in the mental health system.

1.9 **Describe** the goals and outcomes of the community mental health movement.

1.10 **Describe** the medical model of abnormal behavior.

1.11 **Identify** the major psychological models of abnormal behavior.

1.12 **Describe** the sociocultural perspective on abnormal behavior.

1.13 **Describe** the biopsychosocial perspective on abnormal behavior.

1.14 **Identify** four major objectives of science.

1.15 **Identify** the four major steps in the scientific method.

1.16 **Identify** the ethical principles that guide research in psychology.

1.17 **Explain** the role of the naturalistic method of research and **describe** its key features.

1.18 **Explain** the role of the correlational method of research and **describe** its key features.

1.19 **Explain** the role of the experimental method of research and **describe** its key features.

1.20 **Explain** the role of the epidemiological method of research and **describe** its key features.

1.21 **Explain** the role of the kinship studies and **describe** their key features.

1.22 **Explain** the role of the case study and **describe** its limitations.

TRUTH *or* FICTION

T☐ F☐ Unusual behavior is abnormal. (p. 5)

T☐ F☐ About one in 10 American adults suffers from a diagnosable mental or psychological disorder in any given year. (p. 8)

T☐ F☐ Although effective treatments exist for some psychological disorders, we still lack a means of effectively treating most types of psychological disorders. (p. 9)

T☐ F☐ Psychological problems like depression may be experienced differently by people in different cultures. (p. 10)

T☐ F☐ A night's entertainment in London a few hundred years ago might have included gaping at the inmates at the local asylum. (p. 13)

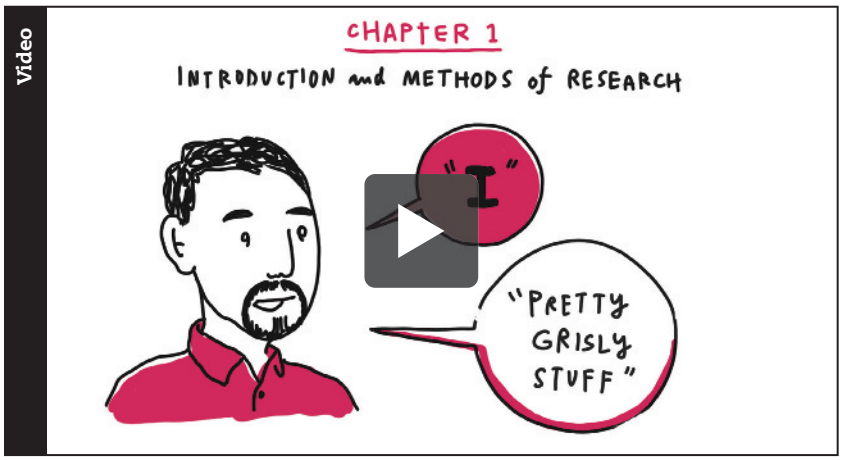
T☐ F☐ Despite changing attitudes in society toward homosexuality, the psychiatric profession continues to classify homosexuality as a mental disorder. (p. 20)

T☐ F☐ In a recent experiment, pain patients reported some relief from pain after taking a placebo pill, even though they were told the pill was merely a placebo. (p. 27)

T☐ F☐ Recent evidence shows there are literally millions of genes in the nucleus of every cell in the body. (p. 30)

T☐ F☐ Case studies have been conducted on dead people. (p. 31)

Watch CHAPTER INTRODUCTION: INTRODUCTION AND METHODS OF RESEARCH



"Pretty Grisly Stuff"

I never thought I'd ever see a psychologist or someone like that, you know. I'm a police photographer and I've shot some pretty grisly stuff, corpses and all. Crime scenes are not like what you see on TV. They're more grisly. I guess you kind of get used to it. It never bothered me, just maybe at first. Before I did this job, I worked on a TV news chopper. We would take shots of fires and rescues, you know. Now I get uptight sitting in the back seat of a car or riding an elevator. I'll avoid taking an elevator unless I really have no other choice. Forget flying anymore. It's not just helicopters. I just won't go in a plane, any kind of plane.

I guess I was younger then and more daring when I was younger. Sometimes, I would hang out of the helicopter to shoot pictures with no fear at all. Now, just thinking about flying makes my heart race. It's not that I'm afraid the plane will crash. That's the funny thing. Not ha-ha funny, but peculiar, you know. I just start trembling when I think of them closing that door, trapping us inside. I can't tell you why.

From the Author's Files

Phil, 42, a police photographer

"Cowering Under the Covers"

A 45-year-old woman with bipolar disorder describes what it feels like when she goes into a high: "I no longer feel like an ordinary housewife. Instead I feel organized and accomplished and I begin to feel I am my most creative self. I can write poetry easily. I can compose melodies without effort. I can paint. My mind feels facile and absorbs everything . . . I see myself as being able to accomplish a great deal for the good of people. I have countless ideas about how the environment problem could inspire a crusade for the health and betterment of everyone . . . I feel pleasure, a sense of euphoria or elation. I want it to last forever. I don't seem to need much sleep. I've lost weight and feel healthy and I like myself. I've just bought six new dresses, in fact, and they look quite good on me. I feel sexy and men stare at me. Maybe I'll have an affair, or perhaps several."

Feeling exhilarated and in high spirits, she experiences what she describes as *the full joy of living*. But then: "When I go beyond this stage, I become manic [and] . . . begin to see things in my mind that aren't real." She describes how one night she created an entire movie in her mind that seemed so real it was as though she was watching the movie unfold before her eyes. She was filled with a sense of sheer terror, "as if it were actually happening, when I knew that an assassination scene was about to take place. I cowered under the covers and became a complete shaking wreck . . . My screams awakened my husband, who tried to reassure me that we were in our bedroom and everything was the same. There was nothing to be afraid of. Nevertheless, I was admitted to the hospital the next day."

SOURCE: *Fieve, 1975, pp. 27–28*

"I" Thomas Hears Voices

I've been diagnosed as having paranoid schizophrenia. I also suffer from clinical depression. Before I found the correct medications, I was sleeping on the floor, afraid to sleep in my own bed. I was hearing voices that, lately, had turned from being sometimes helpful to being terrorizing. The depression had been responsible for my being irritable and full of dread, especially in the mornings, becoming angry over frustrations at work, and seemingly internalizing other people's problems.

The voices, human sounding, and sounding from a short distance outside my apartment, were slowly turning nearly all bad. I could hear them jeering me, plotting against me, singing songs sometimes that would only make sense later in the day when I would do something wrong at work or at home. I began sleeping on the floor of my living room because I was afraid a presence in the bedroom was torturing good forces around me. If I slept in the bedroom, the nightly torture would cause me to make mistakes during the day. A voice, calling himself Fatty Acid, stopped me from drinking soda. Another voice allowed me only one piece of bread with my meals.

SOURCE: *Campbell, 2000, reprinted with permission of the National Institute of Mental Health*

Thomas, a young man diagnosed with schizophrenia and major depression

These three people—like many you will meet in this text—struggle with problems that mental health professionals classify as psychological or mental disorders. A **psychological disorder** is a pattern of abnormal behavior associated with states of significant emotional distress, such as anxiety or depression, or with impaired behavior or ability to function, such as difficulty holding a job or distinguishing reality from fantasy. **Abnormal psychology** is the branch of psychology that studies abnormal behavior and ways of helping people who are affected by psychological disorders.

The study of abnormal psychology is illuminated not only by extensive research on the causes and treatments of psychological disorders reported in scientific journals but also by the personal stories of people affected by these problems. In this text, we will learn from these people as they tell their stories in their own words. Through first-person narratives, case examples, and video interviews, researchers enter the world of people struggling with various types of psychological disorders that affect their moods, thinking, and behavior. Some of these stories may remind you of the experiences of people close to you, or perhaps even yourself. We invite you to explore with us the nature and origins of these disorders and ways of helping people who face the many challenges they pose.

Let's pause for a moment to raise an important distinction. Although the terms *psychological disorder* and *mental disorder* are often used interchangeably, we prefer using the term *psychological disorder*, primarily because it puts the study of abnormal behavior squarely within the purview of the field of psychology. Moreover, the term *mental disorder* (also called *mental illness*) is derived from the **medical model** perspective, which views abnormal behaviors as symptoms of an underlying illness or brain disorder (Insel & Cuthbert, 2015). Although the medical model is a major contemporary model for understanding abnormal behavior, we believe we need to take a broader view of abnormal behavior by incorporating psychological and sociocultural perspectives as well.

In this chapter, we first address the difficulties of defining *abnormal behavior*. We see that throughout history, abnormal behavior has been viewed from different perspectives. We chronicle the development of concepts of abnormal behavior and its treatment. We see that in the past, treatment usually referred to what was done *to* rather than *for* people with abnormal behavior. We then describe the ways in which psychologists and other scholars study abnormal behavior today.

How Do We Define Abnormal Behavior?

We all become anxious or depressed from time to time, but is this abnormal? Anxiety in anticipation of an important job interview or a final examination is perfectly normal. It is appropriate to feel depressed when you have lost someone close to you or when you have failed at a test or on the job. Where is the line between normal and abnormal behavior?

One answer is that emotional states such as anxiety and depression may be considered abnormal when they are not appropriate to the situation. It is normal to feel down when you fail a test, but not when your grades are good or excellent. It is normal to feel anxious before a college admissions interview, but not normal to panic before entering a department store or boarding a crowded elevator.

Abnormality may also be suggested by the magnitude of the problem. Although some anxiety is normal enough before a job interview, feeling that your heart might leap from your chest—and consequently canceling your interview—is not, nor is it normal to feel so anxious in this situation that your clothing becomes soaked with perspiration. **T / F**

TRUTH *or* FICTION

Unusual behavior is abnormal.

☑ **FALSE** Unusual or statistically deviant behavior is not necessarily abnormal. Exceptional behavior also deviates from the norm.

Criteria for Determining Abnormality

1.1 Identify criteria professionals use to determine whether behavior is abnormal and apply these criteria to case examples discussed in the text.

Mental health professionals apply various criteria when making judgments about whether behavior is abnormal. The most commonly used criteria include the following:

1. *Unusualness.* Behavior that is unusual is often considered abnormal. Only a few of us report seeing or hearing things that are not really there; "seeing things" and "hearing things" are almost always considered abnormal in our culture, but such experiences are sometimes considered normal in certain types of spiritual experiences. Moreover, hearing voices and other forms of hallucinations under some circumstances are not considered unusual in some preliterate societies.

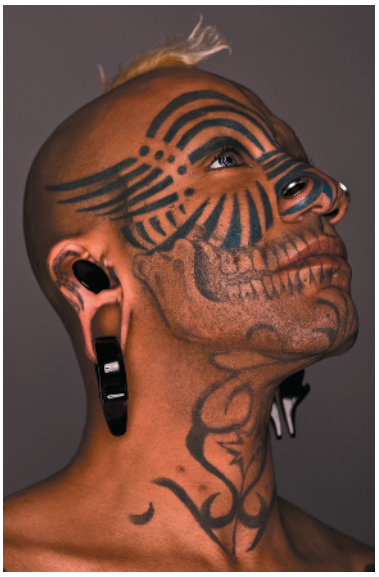
   However, becoming overcome with feelings of panic when entering a department store or when standing in a crowded elevator is uncommon and considered abnormal. Uncommon behavior is not in itself abnormal. Only one person can hold the record for swimming the fastest 100 meters. The record-holding athlete differs from the rest of us but, again, is not considered abnormal. Thus, rarity or statistical deviance is not a sufficient basis for labeling behavior abnormal; nevertheless, it is often one of the yardsticks used to judge abnormality.

2. *Social deviance.* All societies have norms (standards) that define the kinds of behavior that are acceptable in given contexts. Behavior deemed normal in one culture may be viewed as abnormal in another. For example, people in our culture who assume that all male strangers are devious are usually regarded as unduly suspicious or distrustful—but such suspicions were justified among the Mundugumor, a tribe of cannibals studied by anthropologist Margaret Mead (1935). Within that culture, male strangers *were* typically malevolent toward others, and it was normal to feel distrustful of them. Norms, which arise from the practices and beliefs of specific cultures, are relative standards, not universal truths.

   Thus, clinicians need to weigh cultural differences when determining what is normal and abnormal. Moreover, what strikes one generation as abnormal may be considered normal by the next. For example, until the mid-1970s, homosexuality was classified as a mental disorder by the psychiatric profession (see *Thinking Critically: What Is Abnormal Behavior?* on page 20). Today, however, the psychiatric profession no longer considers homosexuality a mental disorder, and many people argue that contemporary societal norms should include homosexuality as a normal variation in behavior.

   When normality is judged on the basis of compliance with social norms, nonconformists may incorrectly be labeled as mentally disturbed. We may come to brand

WHEN IS ANXIETY ABNORMAL? Negative emotions such as anxiety are considered abnormal when they are judged to be excessive or inappropriate to the situation. Anxiety is generally regarded as normal when it is experienced during a job interview, so long as it is not so severe that it prevents the interviewee from performing adequately. Anxiety is deemed to be abnormal if it is experienced whenever one boards an elevator.



IS THIS MAN ABNORMAL?
Judgments of abnormality take into account the social and cultural standards of society. Do you believe this man's body adornment is a sign of abnormality or merely a fashion statement?

behavior that we do not approve of as "sick" rather than accept that the behavior may be normal, even though it offends or puzzles us.

3. *Faulty perceptions or interpretations of reality.* Normally, our sensory systems and cognitive processes permit us to form accurate mental representations of the environment. Seeing things and hearing voices that are not present are considered hallucinations, which in our culture are generally taken as signs of an underlying mental disorder. Similarly, holding unfounded ideas or *delusions*—such as believing that the CIA or the Mafia is out to get you—may be regarded as a sign of mental disturbance—unless, of course, they *are real*. (As former U.S. Secretary of State Henry Kissinger is said to have remarked, "Even paranoid people have enemies.")

   It is normal in the United States to say that one talks to God through prayer. If, however, a person insists on having literally seen God or heard the voice of God—as opposed to, say, being divinely inspired—we may come to regard her or him as mentally disturbed.

4. *Significant personal distress.* States of personal distress caused by troublesome emotions, such as anxiety, fear, or depression, may be abnormal. As we noted earlier, however, anxiety and depression are sometimes appropriate responses to a situation. Real threats and losses do occur in life, and *lack* of an emotional response to them would be regarded as abnormal. Appropriate feelings of distress are not considered abnormal unless the feelings persist long after the source of anguish has been removed (after most people would have adjusted) or if they are so intense that they impair an individual's ability to function.

5. *Maladaptive or self-defeating behavior.* Behavior that leads to unhappiness rather than self-fulfillment can be regarded as abnormal. Behavior that limits one's ability to function in expected roles or to adapt to one's environments may also be considered abnormal. According to these criteria, heavy alcohol consumption that impairs health or social and occupational functioning may be viewed as abnormal. Agoraphobic behavior, characterized by intense fear of venturing into public places, may be considered abnormal; it is both uncommon and maladaptive because it impairs an individual's ability to fulfill work and family responsibilities.

6. *Dangerousness.* Behavior that is dangerous to oneself or other people may be considered abnormal. Here, too, the social context is crucial. In wartime, people who sacrifice their lives or charge the enemy with little apparent concern for their own safety may be characterized as courageous, heroic, and patriotic, but people who threaten or attempt suicide because of the pressures of civilian life are usually considered abnormal.

   Football and hockey players who occasionally get into fistfights or altercations with opposing players may be normal enough. Given the nature of these sports, unaggressive football and hockey players would not last long in college or professional ranks. However, players involved in frequent altercations may be regarded as abnormal. Physically aggressive behavior is most often maladaptive in modern life. Moreover, physical aggression is ineffective as a way of resolving conflicts—although it is by no means uncommon.

Abnormal behavior thus has multiple definitions. Depending on the case, some criteria may be weighted more heavily than others, but in most cases, a combination of these criteria is used to define abnormality. Watch the video *The Big Picture: What Does It Mean to Have a Mental Disorder?* to learn more about the line between normal and abnormal behavior.

Watch THE BIG PICTURE: WHAT DOES IT MEAN TO HAVE A MENTAL DISORDER?

APPLYING THE CRITERIA Let's return to the three cases we introduced at the beginning of the chapter. Consider the criteria we can apply to determine whether the behaviors reported in these vignettes are abnormal. Note that the abnormal behavior patterns in these three cases are unusual in the statistical sense. Most people do not encounter these kinds of problems, although we should add that these problems are far from rare. The problem behaviors also meet other criteria of abnormality, as we shall discuss.

Phil suffered from *claustrophobia*, an excessive fear of enclosed spaces. (This is an example of an anxiety disorder and is discussed more fully in Chapter 5.) His behavior was unusual (relatively few people are so fearful of confinement that they avoid flying in airplanes or riding on elevators) and was associated with significant personal distress. His fear also impaired his ability to carry out his occupational and family responsibilities. However, he was not hampered by faulty perceptions of reality. He recognized that his fears exceeded a realistic appraisal of danger in these situations.

What criterion of abnormality applies in the case of the woman who cowered under the blankets? She was diagnosed with *bipolar disorder* (formerly called manic-depression), a type of mood disorder in which a person experiences extreme mood swings, from the heights of elation and seemingly boundless energy to the depths of depression and despair. (The vignette described the manic phase of the disorder.) Bipolar disorder, which is discussed in Chapter 7, is associated with extreme personal distress and difficulty functioning effectively in normal life. It is also linked to self-defeating and dangerous behavior, such as reckless driving or exorbitant spending during manic phases and attempted suicide during depressive phases. In some cases, like the one presented here, people in manic phases sometimes have faulty perceptions or interpretations of reality, such as hallucinations and delusions.

Thomas suffered from both schizophrenia and depression. It is not unusual for people to have more than one disorder at a time. In the parlance of the psychiatric profession, these clients present with *comorbid* (co-occurring) diagnoses. Comorbidity complicates treatment because clinicians need to design a treatment approach that focuses on treating two or more disorders. Schizophrenia meets a number of criteria of abnormality, including statistical infrequency (it affects about 1% of the general population). The clinical features of schizophrenia include socially deviant or bizarre behavior, disturbed perceptions or interpretations of reality (delusions and hallucinations), maladaptive behavior (difficulty meeting responsibilities of daily life), and personal distress. (See Chapter 11 for more detail on schizophrenia.) Thomas, for example, was plagued by auditory hallucinations (terrorizing voices), which were certainly a source of significant distress. His thinking was also delusional, because he believed that "a presence" in his bedroom was "torturing good forces," surrounding him and causing him to make mistakes during the day. In Thomas's case, schizophrenia was complicated by depression that involved feelings of personal distress (irritability and feelings of dread). Depression is also associated with dampened or downcast mood, maladaptive behavior (difficulty getting to work or school or even getting out of bed in the morning), and potential dangerousness (possible suicidal behavior).

It is one thing to recognize and label behavior as abnormal; it is another to understand and explain it. Philosophers, physicians, natural scientists, and psychologists have used various approaches, or *models*, in the effort to explain abnormal behavior. Some approaches have been based on superstition; others have invoked religious explanations. Some current views are predominantly biological; others are psychological. In considering various historical and contemporary approaches to understanding abnormal behavior, let's first look further at the importance of cultural beliefs in determining which behavior patterns are deemed abnormal.

Abnormal Psychology—By the Numbers

1.2 Describe the current and lifetime prevalence of psychological disorders in the United States and describe differences in prevalence as a function of gender and age.

The problem of abnormal behavior might seem the concern of only a few. After all, relatively few people are ever admitted to a psychiatric hospital. Most people never seek the help of a mental health professional such as a psychologist or psychiatrist. Fewer still ever plead *not*

TRUTH *or* FICTION

About one in 10 American adults suffers from a diagnosable mental or psychological disorder in any given year.

☑ **FALSE** It's actually about one in four American adults.

guilty to crimes on grounds of insanity. Most of us probably have at least one relative we consider *eccentric*, but how many of us have relatives we consider *crazy*? And yet, the truth is that abnormal behavior affects all of us in one way or another. Let's break down the numbers.

If we limit our discussion to diagnosable mental disorders, nearly one in two of all Americans (46%) are directly affected at some point in their lives (Kessler, Berglund, et al., 2005; see Figure 1.1). About one in four adult Americans (26%) experience a diagnosable psychological disorder in any given year (Kessler, Chiu, et al., 2005). **T / F**

According to the World Health Organization, the United States has the highest rates of diagnosable psychological disorders among 17 countries they surveyed (Kessler et al., 2009). American women are more likely than men to suffer from psychological disorders, especially mood disorders (discussed in Chapter 7; "Women More at Risk," 2012). In addition, twice as many young adults (ages 18–25) are affected by psychological disorders than are people over 50.

If we also include the mental health problems of our family members, friends, and coworkers and take into account those who foot the bill for treatment in the form of taxes and health insurance premiums, as well as lost productivity due to sick days, disability leaves, and impaired job performance inflating product costs, then clearly all of us are affected to one degree or another.

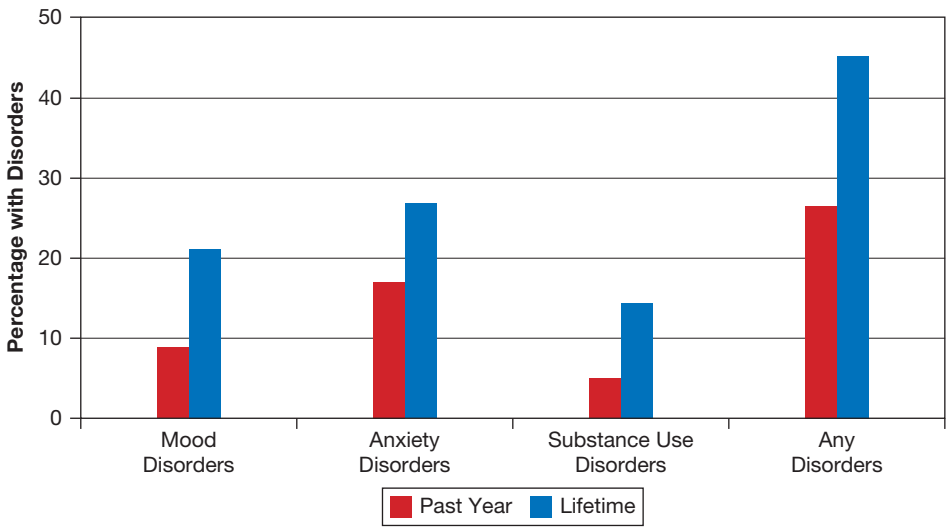
SURGEON GENERAL'S REPORT ON MENTAL HEALTH The U.S. Surgeon General issued an important report to the nation at the turn of the new millennium that is still pertinent today. The report focused attention on mental health problems. Here are some of the key conclusions from the report (Satcher, 2000; U.S. Department of Health and Human Services, 1999):

- Mental health reflects the complex interaction of brain functioning and environmental influences.
- Effective treatments exist for most mental disorders, including psychological interventions, such as psychotherapy and counseling and psychopharmacological or

Figure 1.1 Lifetime and past year prevalences of psychological disorders.

This graph is based on a nationally representative sample of 9,282 English-speaking U.S. residents aged 18 and older. We see percentages of individuals with diagnosable psychological disorders either during the past year or at some point in their lives for several major diagnostic categories. The *mood disorders* category includes major depressive episode and bipolar disorder (discussed in Chapter 7). *Anxiety disorders* include panic disorder, agoraphobia without panic disorder, social phobia, specific phobia, and generalized anxiety disorder (discussed in Chapter 5). *Substance use disorders* involve alcohol or other drugs and are discussed in Chapter 8.

SOURCE: Kessler, Chiu, et al., 2005; Kessler, Berglund, et al., 2005.



drug therapies. Treatment is often more effective when psychological and psychopharmacological treatments are combined. T / F

- Progress in developing effective prevention programs in the mental health field has been slow because we do not know the causes of mental disorders or ways of altering known influences, such as genetic predispositions. Nonetheless, some effective prevention programs have been developed.
- Although 15% of American adults receive some form of help for mental health problems each year, many who need help do not receive it.
- Mental health problems are best understood when we take a broader view and consider the social and cultural contexts in which they occur.
- Mental health services need to be designed and delivered in a manner that takes into account the viewpoints and needs of racial and ethnic minorities.

The Surgeon General's report provides a backdrop for our study of abnormal psychology. As we shall see throughout the text, we believe that understandings of abnormal behavior are best revealed through a lens that takes into account interactions of biological and environmental factors. We also believe that social and cultural (or *sociocultural*) factors need to be considered in attempts to both understand abnormal behavior and develop effective treatment services.

TRUTH *or* FICTION

Although effective treatments exist for some psychological disorders, we still lack the means of effectively treating most types of psychological disorders.

☑ **FALSE** The good news is that effective treatments exist for most psychological disorders.

Cultural Bases of Abnormal Behavior

1.3 Describe the cultural bases of abnormal behavior.

As noted, behavior that is normal in one culture may be deemed abnormal in another. Australian Aborigines believe they can communicate with the spirits of their ancestors and that other people, especially close relatives, share their dreams. These beliefs are considered normal within Aboriginal culture. Were such beliefs to be expressed in our culture, they would likely be deemed delusions, which professionals regard as a common feature of schizophrenia. Thus, the standards we use in making judgments of abnormal behavior must take into account cultural norms.

Kleinman (1987, p. 453) offers an example of "hearing voices" among Native Americans to underscore the ways in which judgments about abnormality are embedded within a cultural context:

> Ten psychiatrists trained in the same assessment technique and diagnostic criteria who are asked to examine 100 American Indians shortly after the latter have experienced the death of a spouse, a parent or a child may determine with close to 100% consistency that those individuals report hearing, in the first month of grieving, the voice of the dead person calling to them as the spirit ascends to the afterworld. [Although such judgments may be consistent across observers,] the determination of whether such reports are a sign of an abnormal mental state is an interpretation based on knowledge of this group's behavioral norms and range of normal experiences of bereavement.

To these Native Americans, bereaved people who report hearing the spirits of the deceased calling to them as they ascend to the afterlife are normal. Behavior that is normative within the cultural setting in which it occurs should not be considered abnormal.

Concepts of health and illness vary across cultures. Traditional Native American cultures distinguish between illnesses that are believed to arise from influences outside the culture, called "White man's sicknesses," such as alcoholism and drug addiction, and those that emanate from a lack of harmony with traditional tribal life and thought, which are called "Indian sicknesses" (Trimble, 1991). Traditional healers, shamans, and medicine men and women are called on to treat Indian sicknesses. When a problem is thought to have its cause outside the community, help is sought from "White man's medicine."

A TRADITIONAL NATIVE AMERICAN HEALER. Many traditional Native Americans distinguish between illnesses believed to arise from influences external to their own culture ("White man's sicknesses") and those that emanate from a lack of harmony with traditional tribal life and thought ("Indian sicknesses"). Traditional healers such as the one shown here may be called on to treat Indian sicknesses, whereas "White man's medicine" may be sought to help people deal with problems whose causes are seen as lying outside the community, such as alcoholism and drug addiction.