

abnormal
FOURTH
EDITION

PSYCHOLOGY

A SCIENTIST-PRACTITIONER APPROACH

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Pearson

Abnormal Psychology:

A Scientist-Practitioner Approach

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To our parents

Anthony and Jean Casamassa

Frank and Marie Bulik

Pat and Bob Stanley

Thank you for teaching us the value of education and for providing the love and encouragement that allow us to achieve our dreams.

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Preface

As we prepare the fourth edition of this textbook, we reflect on the positive response to the previous editions, and we are pleased to find that our scientist-practitioner approach still resonates with both students and professors. Abnormal psychology remains one of the most popular courses among undergraduate students as national and world events impel us to advance our understanding of human behavior and the forces that influence it. What drives someone to take a gun and shoot a member of the U.S. Congress? How could a celebrity, who seemingly has everything—wealth, family, fame—shoplift a \$50 jewelry item? There are no easy answers to these questions, and in fact, simplistic answers based on fraudulent science, such as “the measles vaccine causes autism,” are harmful both to the public who believes in and acts on the false information and the scientists who spend their time carefully seeking empirically based answers.

The fourth edition of this textbook is another opportunity for students to see science in action. Based on the diagnostic schemas of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, students are exposed to the evolving nature of our catalog of psychological disorders, as research sheds new light on syndromes and forces scientists and clinicians to grapple with disparate data sets and to work together to produce a scientifically accurate and clinically meaningful system for understanding and communicating about abnormal behavior. Because the DSM-5 is still relatively new, there are some areas of abnormal behavior where the research has not yet caught up to the new diagnostic criteria. This is particularly relevant in chapters where revisions to the diagnoses were extensive. The new criteria have been adopted; however, the epidemiological data for the new disorders are not available—researchers simply have not had time to conduct studies using the new criteria. In those instances, we rely on the published data based on the DSM-IV categories, while giving appropriate caveats to help bridge the transition to the DSM-5 criteria.

Although our diagnostic criteria evolve, understanding human behavior requires integration of brain *and* behavior and includes data from scientists *and* insights from clinicians and patients. As in the first three editions, a scientist-practitioner approach integrates biological data with research from social and behavioral sciences to foster the perspective that abnormal behavior is complex and subject to many different forces. Furthermore, these variables often interact reciprocally. Psychotherapy was built in part on the assumption that behavior could be changed by changing the environment, but science has revealed that environmental

factors can also change the brain. Scientific advances in molecular genetics have expanded our understanding of how genes influence behavior. Virtual reality treatment systems have provided new insights, raised new questions, and unlocked new areas of exploration. As this fourth edition illustrates, we remain firm in our conviction that the integration of leading-edge biological and behavioral research, known as the *translational approach*, or *from cell to society*, is needed to advance the study of abnormal psychology. As in previous editions, we reach beyond the old clichés of nature or nurture, clinician or scientist, genes or environment, and challenge the next generation of psychologists and students to embrace the complexity inherent in replacing these historical “ors” with contemporary “ands.”

What’s New in the Fourth Edition

- **A completely new chapter on obsessive-compulsive and impulse control disorders:** Integrating attention disorders characterized by repetitive behaviors, including obsessive-compulsive disorder (OCD), OC related disorders (trichotillomania, body dysmorphic disorder, hoarding disorder, excoriation disorder) and impulsive control disorders (pyromania, kleptomania).
- **Coverage of disorders expanded to include the following, based on their inclusion in DSM-5:** premenstrual dysphoric disorder, binge-eating disorder, illness anxiety disorder, gender dysphoria, autism spectrum disorder, substance use disorder, compulsive gambling added to addiction and related disorders, and others.
- **New and updated content throughout, including new topics for these special features:** “Real People, Real Disorders,” “Examining the Evidence,” “Research Hot Topic,” and “Real Science: Real Life.”
- **Current research:** Hundreds of new research citations throughout reflect the ever-advancing field of abnormal psychology.
- **Additional emphasis and in-depth analysis of ethics and responsibility** in the Revel version of this text.
- **New videos** including coverage of OCD and trichotillomania.

The Scientist–Practitioner Approach

We subtitled this book *A Scientist–Practitioner Approach* because understanding abnormal psychology rests on knowledge generated through scientific studies and clinical

practice. Many psychologists are trained in the scientist-practitioner model and adhere to it to some degree in their professional work. We live and breathe this model. In addition to our roles as teachers at the undergraduate, graduate, and postdoctoral levels, we are all active clinical researchers and clinical practitioners. However, the scientist-practitioner model means more than just having multiple roles; it is a philosophy that guides all of the psychologist's activities. Those who are familiar with the model know this quote well: "Scientist-practitioners embody a research orientation in their practice and a practice relevance in their research" (Belar & Perry, 1992). This philosophy reflects our guiding principles, and we wrote this text to emphasize this rich blend of science and practice. Because we are scientist-practitioners, all of the cases described throughout this text are drawn from our own practices with the exception of a few quotations and newspaper stories designed to highlight a specific point. We have endeavored to "bring to life" the nature of these conditions by providing vivid clinical descriptions. In addition to the clinical material that opens each chapter and the short clinical descriptions that are used liberally throughout each chapter, a fully integrated case study drawn from one of our practices is presented at the end of each chapter, again illustrating the interplay of biological, psychosocial, and emotional factors. Of course, details have been changed and some cases may represent composites in order to protect the privacy of those who have shared their life stories with us throughout our careers.

The goal of our textbook is to avoid a dense review of the scientific literature but to maintain a strong scientific focus. Similarly, we wanted to avoid "pop" psychology, an overly popularized approach that we believe presents easy answers that do not truly reflect the essence of psychological disorders. Having now used the book with our own undergraduate classes, we find that students respond positively to material and features that make these conditions more understandable and vivid. Our goal is to "put a face" on these sometimes perplexing and unfamiliar conditions by using rich clinical material such as vignettes, case histories, personal accounts, and the feature "Real People, Real Disorders." We hope that these illustrations will entice students to learn more about abnormal psychology while acquiring the important concepts. Thus, although the book represents leading-edge science, our ultimate goal is to portray the human face of these conditions.

A Developmental Trajectory

It has become increasingly clear that many types of abnormal behaviors either begin in childhood or have childhood precursors. Similarly, without treatment, most disorders do not merely disappear with advancing age, and in fact, new disorders may emerge. Quite simply, as we grow, mature, and age, our physical and cognitive capacities affect how symptoms

are expressed. Without this developmental perspective, it is easy to overlook behaviors that indicate the presence of a specific disorder at a particular phase of life. We are proud that we embraced a developmental perspective before its introduction in the DSM-5. Now that DSM-5 has shifted to a developmental focus, students and instructors will find that certain disorders are not in the same chapters as in previous editions. In each chapter where we discuss psychological disorders, we also include a section called "Developmental Considerations," which highlights what is known about the developmental trajectory of each condition. Failure to understand the various manifestations of a disorder means that theories of etiology may be incorrect or incomplete and that interventions may be inappropriately applied.

Sex, Race, and Ethnicity

In each chapter, we describe the current literature regarding the effect of sex, race, or ethnicity on a disorder's clinical presentation, etiology, and treatment. We carefully considered the terms used in the text to refer to these concepts. Indeed, the terms used to refer to sex, gender, race, and ethnicity are continually evolving, and the words that we use vary throughout the text. When we describe a particular study, we retain the labels that were used in the publication (e.g., Afro-Caribbean, Caucasian, Pacific Islander). To create some consistency throughout the text, when we discuss general issues regarding race and ethnicity, we use standard terms (e.g., *whites*, *African Americans*, *Hispanics*). Although we are admittedly uncomfortable with calling groups by any labels, whether they refer to race, ethnicity, or diagnosis (e.g., *blacks*, *whites*, *schizophrenics*), for clarity of presentation and parsimony in the case of race and ethnicity, we opted for these categorical labels rather than the more cumbersome "individuals of European-American ancestry" approach. Throughout the book, however, we have not labeled individuals who have psychological disorders by their diagnosis because people are far more rich and complex than any diagnostic label could ever capture. Moreover, referring to a patient or patient group by a diagnostic label (e.g., *bulimics*, *depressives*, *schizophrenics*) is fundamentally disrespectful. People have disorders, but their disorders do not define them.

Ethics and Responsibility

We continue our feature titled "Ethics and Responsibility," with additional in-depth ethical situations and analysis in Revel. The discussion of ethics and responsibility varies with respect to the individual chapter, but in each case, we have attempted to select a topic that is timely and illustrates how psychologists consider the impact of their behavior on those with whom they work and on society in general. We hope that this feature will generate class discussion and impress on students the impact of one's behavior upon others.

Clinical Features

Consistent with our belief that the clinical richness of this text will bring the subject matter to life, each chapter begins with a clinical vignette that introduces and illustrates the topic of the chapter. These descriptions are not extensive case studies but provide the reader a global “feel” for each disorder. Additionally, short case vignettes are used liberally throughout the text to illustrate specific clinical elements. Another important clinical element is the “Dimensions of Behavior: From Adaptive to Maladaptive,” in which we illustrate the dimensionality of human emotions (such as elation or mania). We include these descriptions in each chapter devoted to an area of abnormal behavior to emphasize that psychological disorders are not simply the presence of emotions or specific behaviors but whether the emotions or behaviors create distress or impair daily functioning.

Each chapter discussion concludes with a case study titled “Real Science, Real Life,” a clinical presentation, assessment, and treatment of a patient with a particular disorder, again drawn from our own clinical files. Each concluding case study illustrates much of the material covered in the chapter and uses the scientist–practitioner approach to understanding, assessing, and treating the disorder. Furthermore, this concluding case study demonstrates how the clinician considers biological, psychological, environmental, and cultural factors to understand the patient’s clinical presentation. Finally, we describe the treatment program and outcome, highlighting how all of the factors are addressed in treatment. In Revel, we take this engagement even further with interactive journal prompts for student participation. Through this process, the case study allows the student to view firsthand the scientist–practitioner approach to abnormal behavior, dispelling myths often propagated through the media about how psychologists think, work, and act.

Special Features

We draw the reader’s attention to three specific features that appear in each chapter. The first, “Examining the Evidence,” presents a current controversy related to one of the disorders in the chapter. However, we do not simply present the material; rather, to be consistent with the scientist–practitioner focus, we present both sides of the controversy and lead students through the data, allowing them to draw their own conclusions. Thus, “Examining the Evidence” features do not just present material but also foster critical thinking skills about issues in abnormal psychology. By considering both sides of the issues, students will become savvy consumers of scientific literature.

The second feature is “Research Hot Topic,” which presents topical, leading-edge research at the time of

publication. Consistent with the focus of this text, the “Research Hot Topic” features illustrate how science informs our understanding of human behavior in a manner that is engaging to students (e.g., “Virtual Reality Therapy for the Treatment of Anxiety Disorders”). As teachers and researchers who open our clinical research centers to undergraduate students, we have seen their excitement as they participate in the research enterprise.

The third feature, “Real People, Real Disorders,” presents a popular figure who has suffered from a condition discussed in the chapter. Many people, including undergraduate students, suffer from these disorders, and they often feel that they are alone or “weird.” We break down the stereotypes that many undergraduate students have about people with psychological disorders. Using well-known figures to humanize these conditions allows students to connect with the material on an emotional as well as an intellectual level.

Learning Objective Summaries and Critical Thinking Questions

Finally, we would like to draw the reader’s attention to the “Learning Objective Summaries” and “Critical Thinking Questions” that are found throughout the chapter. The “Learning Objective Summaries” provide quick reviews at the end of chapter sections, allowing students to be sure that they have mastered the material before proceeding to the next section. Instructors can use the “Learning Objective Summaries” and “Critical Thinking Questions” to challenge students to think “outside the box” and critically examine the material presented within that section.

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Supplemental Teaching Materials

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Finally, we hope the students and instructors who used the previous three editions and who will use this new text experience the joy and wonder that comes with learning about the challenging and intriguing topic of abnormal psychology. We are passionate about our science and compassionate with our patients. We are also dedicated educators. As such, we encourage you to contact us with comments, questions, or suggestions on how to improve this book. No textbook is perfect, but with your help, we will continue to strive for that goal.

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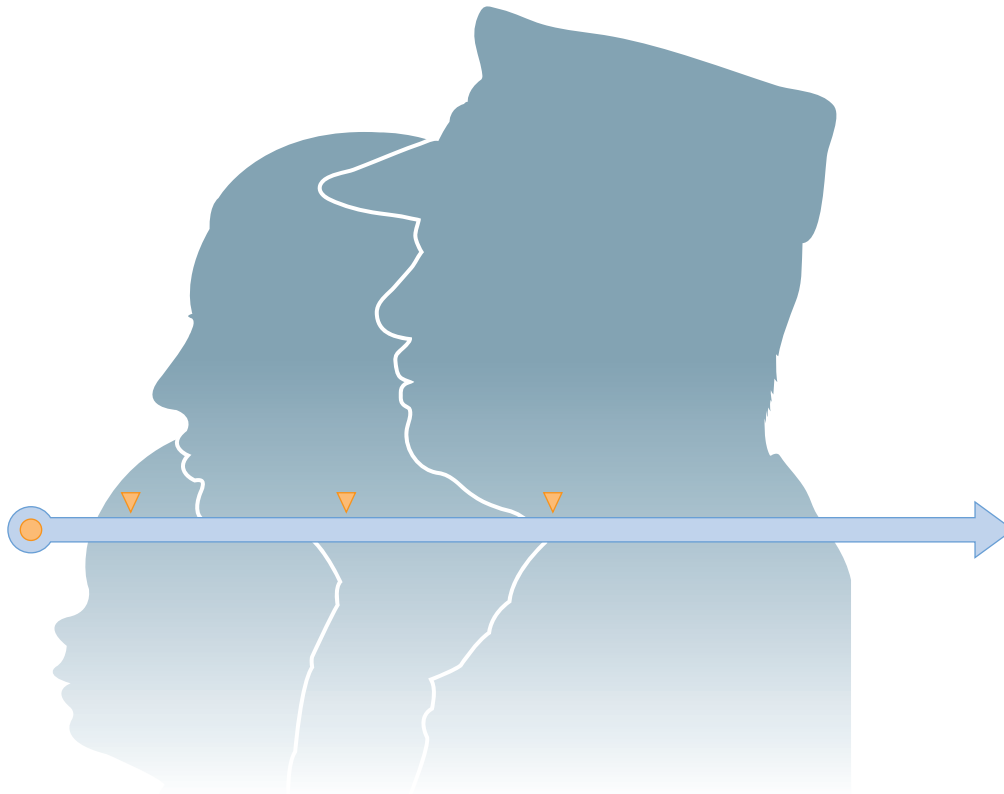
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Chapter 1

Abnormal Psychology: Historical and Modern Perspectives



Chapter Learning Objectives

Normal vs. Abnormal Behavior

- LO 1.1** Understand why simply being different does not mean abnormality.
- LO 1.2** Understand why simply behaving differently is not the same as behaving abnormally.
- LO 1.3** Understand why simply behaving dangerously does not always equal abnormality.
- LO 1.4** Explain the difference between behaviors that are different, deviant, dangerous, and dysfunctional.
- LO 1.5** Identify at least two factors that need to be considered when determining whether a behavior is abnormal.

The History of Abnormal Behavior and Its Treatment

- LO 1.6** Discuss ancient spiritual and biological theories of the origins of abnormal behavior.

- LO 1.7** Discuss spiritual, biological, and environmental theories of the origins of abnormal behavior in classical Greek and Roman periods.
- LO 1.8** Discuss the spiritual, biological, and environmental theories of the origins of abnormal behavior from the Middle Ages to the Renaissance.
- LO 1.9** Discuss the spiritual, biological, psychological, and sociocultural theories of the origins of abnormal behavior in the nineteenth century.
- LO 1.10** Identify the psychological, biological, and sociocultural models that characterize the twentieth-century models of abnormal behavior.

Current Views of Abnormal Behavior and Treatment

- LO 1.11** Identify at least two biological mechanisms that are considered to play a role in the onset of abnormal behavior.
- LO 1.12** Identify at least two psychological models that may account for the development of abnormal behavior.
- LO 1.13** Explain the sociocultural mode of behavior and how it differs from the biological and psychological models.
- LO 1.14** Explain how the biopsychosocial model accounts for the limitations in the three unidimensional models (biological, psychological, sociocultural).
-

Steve was a member of the U.S. Marine Corps who served during the Vietnam War. One night, the Viet Cong attacked his squad. During the firefight, the marine next to him lost his arm. Steve got his buddy to the medic, but the horrific image never left him. He felt helpless and out of control. After returning from Vietnam, Steve had difficulty sleeping, lost interest in his hobbies, isolated himself from family and friends, and felt helpless and sad. Even 45 years later, he can still see himself in the rice paddy, watching in horror as the grenade hits his friend, amputating his arm. Every night he wakes in yet another cold sweat and with a racing heart—unable to breathe as the nightmare occurs again.

Malcom is 9 years old. He lived in New Orleans with his family. One day Hurricane Katrina ripped through town. Malcom's family thought they were safe—the floodwalls would protect them. But they were wrong. Trapped in their house, they escaped to the attic. Luckily, his father grabbed an axe and cut a hole through the roof. After 8 hours, soaking wet and hungry, they were rescued by a helicopter. They now live in another state. But Malcom has had difficulties

adjusting. He has nightmares about being trapped on the roof. He wants to move to “Iowa—they don’t have hurricanes in Iowa.” His grades have slipped; he refuses to go to school. He insists that he has to sleep with his parents or his older brother.

Rosa is a freshman in college. When she was 6 years old, her family crossed the Mexican border to reach the United States. During the crossing, Rosa was sexually molested by the coyote—the man who helped the family navigate the border crossing. Her family settled in New York, but a year later, both parents, who were working as janitorial staff inside the World Trade Center, were killed in the 9/11 attack. Rosa went to live with her aunt, who assisted her in obtaining U.S. citizenship. Rosa grew up as a shy and very intelligent person. Her transition to college was difficult. It was hard to be separated from her aunt. She has difficulty concentrating and has started to miss classes when feeling depressed and anxious. She has trouble getting out of bed. Rosa gets panicky feelings and has premonitions that something bad might happen to her aunt. At times, she abruptly runs out of classes to check on her.

The physical, cognitive, and behavioral symptoms that Steve, Malcom, and Rosa displayed represent common mental health problems. These behaviors are considered abnormal because most people do not run out of class to check on someone, and they sleep more than 4 hours a night. Most children do not cry when they hear a helicopter. Although often unrecognized, psychological disorders exist in substantial numbers of people across all ages, races, ethnic groups, and cultures and in both sexes. Furthermore, they cause great suffering and impair academic, occupational, and social functioning.

Defining abnormality is challenging because behaviors must be considered in context. For example:

Donna and Matthew were very much in love. They had been married for 25 years and often remarked that they were not just husband and wife but also best friends. Then Matthew died suddenly, and Donna felt overwhelming sadness. She was unable to eat, cried uncontrollably at times, and started to isolate herself from others. Her usually vivacious personality disappeared.

When a loved one dies, feelings of grief and sadness are common, even expected. Donna's reaction at her husband's death would not be considered abnormal; rather, its *absence* at such a time might be considered abnormal. A theme throughout this book is that *abnormal behavior must always be considered in context*.

Normal vs. Abnormal Behavior

Sometimes it is fairly easy to identify behavior as abnormal, as when someone is still deeply troubled by events that happened 45 years ago or is feeling so hopeless that he or she cannot get out of bed. But sometimes identifying behavior as abnormal is not clear-cut. Put simply, *abnormal* means “away from normal,” but that is a circular definition. By this standard, normal becomes the statistical average and any deviation becomes “abnormal.” For example, if the average weight for a woman living in the United States is 140 pounds, then women who weigh less than 100 pounds or more than 250 pounds deviate significantly from the average. Their weight would be considered abnormally low or high. For abnormal psychology, defining abnormal behavior as merely being away from normal assumes that deviations on both sides of average are negative and in need of alteration or intervention. This assumption is often incorrect. Specifically, we must first ask whether simply being different is abnormal.

Is Being Different Abnormal?

LO 1.1 Understand why simply being different does not mean abnormality.

Many people deviate from the average in some way. LeBron James is 6 feet 8 inches tall and weighs 262 pounds—far above average in both height and weight. However, his deviant stature does not affect him negatively. To the contrary, he is a successful basketball player in the National Basketball Association. Mariah Carey has an abnormal vocal range—she is one of a few singers whose voice spans five octaves. Because of her different ability, she has sold millions of songs. Professor Stephen Hawking, one of the world's most brilliant scientists, has an intellectual capacity that exceeds that of virtually everyone else, yet he writes best-selling and popular works about theoretical physics and the universe and appears on popular television shows like *The Big Bang Theory*. He does this despite suffering from amyotrophic lateral sclerosis (ALS, also known as *Lou Gehrig's disease*), a debilitating and progressive neurological disease. Each of these individuals has abilities that distinguish him or her from the general public; that is, they are away from normal. However, their “abnormalities” (unusual abilities) are not negative; rather, they result in positive contributions to society. Furthermore, their unusual abilities do not cause distress or appear to impair their daily functioning (as appears to be the case for Steve, Malcom, and Rosa). In summary, being different is not the same as being psychologically abnormal.

Is Behaving Deviantly (Differently) Abnormal?

LO 1.2 Understand why simply behaving differently is not the same as behaving abnormally

When the definition of abnormal behavior broadens from simply *being* different to *behaving* differently, we often use the term *deviance*. Deviant behaviors differ from prevailing societal standards.



LeBron James, Mariah Carey, and Stephen Hawking differ from most people (in height, vocal range, and intelligence, respectively). However, these differences are not abnormalities and have resulted in positive contributions to society.

On February 9, 1964, four young men from Liverpool, England, appeared on *The Ed Sullivan Show* and created quite a stir. Their hair was “long,” their boots had “high (Cuban) heels,” and their “music” was loud. Young people loved them, but their parents were appalled.

The Beatles looked, behaved, and sounded deviant in the context of the prevailing cultural norms. In 1964, they were considered outrageous. Today, their music, dress, and behavior appear rather tame. Was their behavior abnormal? They looked different and acted differently, but their looks and behavior did no harm to themselves or others. The same behavior, outrageous and different in 1964 but tame by today’s standards, illustrates an important point: *deviant behavior* violates societal and cultural norms, but those norms are always changing.

Derek is 7 years old. From the time he was an infant, he was always “on the go.” He has a hard time paying attention and has boundless energy. His parents compensate for his high level of energy by involving him in lots of physical activities (soccer, Tiger Cub Scouts, karate). Derek had an understanding first-grade teacher. Because he could not sit still, the teacher accommodated him with “workstations” so that he could move around the classroom. But now Derek is in second grade, and the new teacher does not allow workstations. She believes that he must learn to sit like all the other children. He visits the principal’s office often for “out-of-seat behavior.”

Understanding behavior within a specific context is known as **goodness of fit** (Chess & Thomas, 1991). Simply put, a behavior can be problematic or not problematic depending on the environment in which it occurs. Some people change an environment to accommodate a behavior in the same way that buildings are modified to ensure accessibility by everyone. Derek’s situation illustrates the goodness-of-fit concept. At home and in first grade, his parents and teacher changed the environment to meet his high activity level. They did not see his activity as a problem but simply as behavior that needed to be accommodated. In contrast, his second-grade teacher expected Derek to fit into a nonadaptable environment. In first grade, Derek was considered “lively,” but in second grade, his behavior was considered abnormal. When we attempt to understand behavior, it is critical to consider the context in which the behavior occurs.

GROUP EXPECTATIONS The expectations of family, friends, neighborhood, and culture are consistent and pervasive influences on why people act the way they do.

Sometimes the standards of one group are at odds with those of another group. Adolescents, for example, often deliberately behave very differently than their parents do (they violate expected standards or norms) as a result of their need to *individuate* (separate) from their parents and be part of their peer group. In this instance, deviation from the norms of one group involves conformity to those of another group. Like family norms, cultural traditions and practices also affect behavior in many ways. For example, holiday celebrations usually include family and cultural traditions. As young people mature and leave their family of origin, new traditions from extended family, marriage, or friendships often blend into former customs and traditions, creating a new context for holiday celebrations.

Often, these different cultural traditions are unremarkable, but sometimes they can cause misunderstanding:

Maleah is 12 years old. Her family recently moved to the United States from the Philippines. Her teacher insisted that Maleah's mother take her to see a psychologist because of "separation anxiety." The teacher was concerned because Maleah told the teacher that she had always slept in a bed with her grandmother. However, a psychological evaluation revealed that Maleah did not have any separation fears. Rather, children sleeping with parents and/or grandparents is what people normally do (what psychologists call normative) in Philippine culture.

Culture refers to shared behavioral patterns and lifestyles that differentiate one group of people from another. Culture affects an individual's behavior but also is reciprocally changed by the behaviors of its members (Tseng, 2003). We often behave in ways that reflect the values of the culture in which we were raised. For example, in some cultures, children are expected to be "seen and not heard," whereas in other cultures, children are encouraged to freely express themselves. **Culture-bound syndrome** is a term that originally described abnormal behaviors that were specific to a particular location or group (Yap, 1967); however, we now know that some of these behavioral patterns extend across ethnic groups and geographic areas. How culture influences behavior will be a recurring theme throughout this book. Maleah's behavior is just one example of how a single behavior can be viewed differently in two different cultures.

DEVELOPMENT AND MATURITY Another important context that must be taken into account when considering behavioral abnormality is age. As a child matures (physically, mentally, and emotionally), behaviors previously considered developmentally appropriate and therefore normal can become abnormal.

I Nick is 4 years old and insists on using a night-light to keep the monsters away.

At age 4, children do not have the *cognitive*, or mental, capacity to understand fully that monsters are not real. However, at age 12, a child should understand the difference between imagination and reality. Therefore, if at age 12 Nick still needs a night-light to keep the monsters away, his behavior would be considered abnormal and perhaps in need of treatment. Similarly, very young children do not have the ability to control their bladder; bed-wetting is common in toddlerhood. However, after the child achieves a certain level of physical and cognitive maturity, bed-wetting becomes an abnormal behavior and is given the diagnostic label of *enuresis* (see Chapter 13).

Eccentricity What about the millionaire who wills his entire estate to his dog? This behavior violates cultural norms, but it is often labeled eccentric rather than abnormal. Eccentric behavior may violate societal norms but is not always negative or harmful to others. Yet sometimes behaviors that initially appear eccentric cross the line into dangerousness (see "Real People, Real Disorders: James Eagan Holmes").

REAL People REAL Disorders

James Eagan Holmes

On July 20, 2012, James Eagan Holmes walked into a Colorado movie theater and bought a ticket to the midnight showing of the Batman movie *The Dark Knight Rises*. After the movie began, he left the theater through an emergency exit, came back, and set off gas/smoke canisters and opened fire on the audience, killing 12 people and wounding 58 others. He was quickly arrested, and he warned the police not to go to his apartment. They did but found that he had booby-trapped it before leaving for the theater. At his first legal hearing, he appeared in court with his hair dyed orange, appearing dazed and confused, looking bug-eyed, and spitting on the officers who were escorting him. He called himself The Joker. In August 2015, Holmes was sentenced for his crimes, receiving 12 life sentences plus 3,318 years.

Holmes graduated from the University of California, Berkeley, in the top 1% of his class, with a 3.94 GPA and a degree in neuroscience. Described by some as socially inept and uncommunicative, he described himself as quiet and easygoing on an apartment rental application. He applied to graduate school at the University of Illinois at Urbana-Champaign, and the application included a picture of himself with a llama. The choice of such a picture on something as important as a graduate school application certainly could qualify as eccentric behavior, but does that mean that he was psychologically disturbed?

In 2011, Holmes enrolled as a Ph.D. student in neuroscience at the University of Colorado Anschutz Medical Campus in Aurora. In 2012, his grades declined and he failed

his comprehensive examination. Although the university did not plan to dismiss him, he started the process to withdraw from the university. At the same time, he purchased large quantities of guns and more than 6,000 rounds of ammunition. Is this irrational behavior? Is it potentially dangerous behavior?



He asked someone if he or she had ever heard of a disorder called dysphoric mania and told a graduate student to stay away from him because he was “bad news.” His answering machine recording was described as “freaky, guttural sounding, incoherent, and rambling.” He dyed his hair orange, called himself The Joker, and went to the movie theater. Does this behavior prove that Holmes had a psychological disorder?

From all accounts, Holmes evolved from being a brilliant if socially awkward neuroscience student to a mass murderer. Whatever label is applied, he evolved from behaving differently to behaving dangerously (perhaps as a result of disordered thinking). In this instance, his behavior was extremely harmful to others and could no longer be considered merely eccentric. It is also important to point out that most people who have psychological disorders are not dangerous and do not commit crimes or attempt to harm other people.

Is Behaving Dangerously Abnormal?

LO 1.3 Understand why simply behaving dangerously does not always equal abnormality

The police arrive at the emergency room of a psychiatric hospital with a man and a woman in handcuffs. Jon is 23 years old. He identifies himself as the chauffeur for Melissa, who is age 35 and also in handcuffs. They are both dressed in tight leather pants and shirts, have unusual “spiked” haircuts, and wear leather “dog collars” with many silver spikes. Jon and Melissa live in the suburbs but spent a day in the city buying clothes and getting their hair cut. As they were leaving the parking garage to return home, Melissa began to criticize Jon’s hair. Jon became angry and ran the car (which belonged to Melissa) into the wall of the parking garage—several times. When a clinician asked the police officer why they were brought to the psychiatric emergency room, the officer replied, “Well, would a sane person keep ramming a car into the wall of a parking garage?” Neither Jon nor Melissa had any previous history of psychological disorders. An interview revealed that Jon’s behavior was the result of a lover’s quarrel, and although their relationship was often volatile, they denied any incidents of physical aggression toward each other or anyone else.

Certainly, repeatedly ramming a car into the wall of a parking garage is dangerous, is outside of societal norms, and could be labeled abnormal. Dangerous behavior can result from intense emotional states, and in Jon’s case, the behavior was directed outwardly (toward another person or an inanimate object). In other cases, dangerous behavior such as suicidal thoughts may be directed toward oneself. However, it is important to understand that most people with psychological disorders do not engage in dangerous behavior (Linaker, 2000;

Monahan, 2001). Individuals with seriously disordered thinking rarely present any danger to society even though their behaviors may appear dangerous to others. Therefore, behavior that is dangerous may signal the presence of a psychological disorder, but dangerous behavior alone is not necessary or sufficient for the label of abnormality to be assigned.

Is Behaving Dysfunctionally Abnormal?

LO 1.4 Explain the difference between behaviors that are different, deviant, dangerous, and dysfunctional.

Thus far, simply being different, behaving differently, or behaving dangerously clearly does not constitute abnormal behavior. A final consideration when attempting to define abnormal behavior is whether that behavior causes *distress* or *dysfunction* for the individual or others. Consider the examples of Robert and Stan (see “Side-by-Side Case Studies”).

Both Robert and Stan engage in checking behaviors, but Robert’s behavior falls into the category of what is called “normal checking” (Rachman & Hodgson, 1980). Stan’s routine of checking the house before he leaves for work or goes to bed is *different* from the way in which most people lock up their house before going to work, so his behavior *deviates* from the norm. Even though simple deviance is not abnormal, Stan’s behavior differs from Robert’s in another way: Stan’s checking occurs more frequently. Frequency alone does not mean a behavior is maladaptive, but frequency can lead to two other conditions: distress and dysfunction. Specifically, Stan’s worries are so frequent and pervasive that they cause him to feel anxious and lose sleep at night. In this case, maladaptive behavior results in *distress*; Stan’s worries result in a negative mood (anxiety) and cause him to lose sleep. Frequently, they also cause him to arrive late for work or for social engagements. Thus, his behaviors create occupational and social *dysfunction*. When one of these conditions is evident, the presence of a psychological disorder must be considered.

A Definition of Abnormal Behavior

LO 1.5 Identify at least two factors that need to be considered when determining whether a behavior is abnormal.

To summarize, to define abnormal behavior, we need to consider several factors. Merely being different or behaving differently is not enough, although the latter certainly might

SIDE by SIDE Case Studies

Dimensions of Behavior: From Adaptive to Maladaptive

Adaptive Behavior Case Study

Example A

Robert is a very cautious person. He does not like to make mistakes and believes that the behavior standards that he sets for himself are high but fair. He is concerned about safety and worried that other people might take advantage of him if he makes a mistake. Before leaving his house or going to sleep, he walks through the house, checking to make sure that every door and window is locked and the oven and stove are turned off. This usually takes about 5 minutes.

Maladaptive Behavior Case Study

Example B

Stan also is cautious and very concerned. When away from home, he worries that he forgot to lock a door and that his house has been robbed. Often he returns home to check that the house is locked. But even after he checks, he remains doubtful and spends hours each day checking and rechecking. He has an elaborate system of checking the locks, the doors, the garage door, and the burglar alarm system. He checks the stove seven times to make sure that the oven and the burners are off. Thoughts of a burglar in his house or his house burning down cause him great distress, sometimes interfering with his sleep. He is often late for work or for social engagements because he needs to go back to the house to check and recheck.

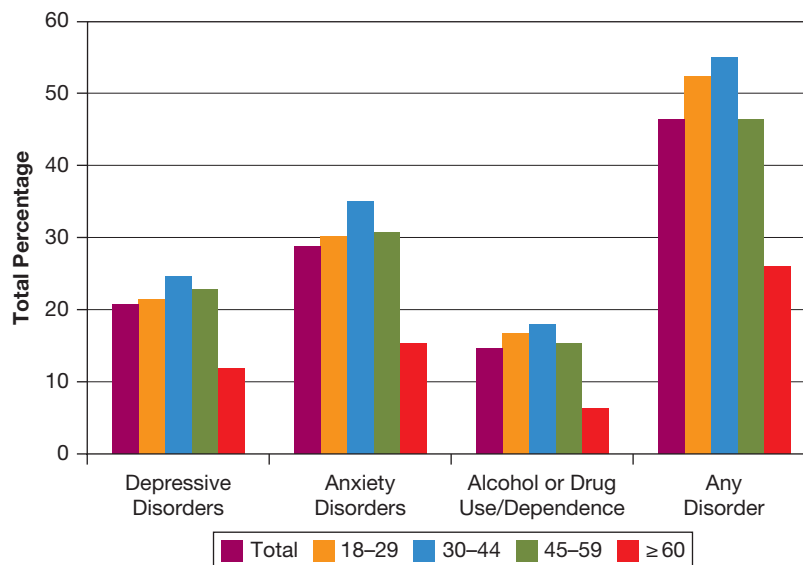
be a signal that something is wrong. Some abnormal behaviors are dangerous, but dangerousness is not necessary for a definition of abnormality. In this book, we define **abnormal behavior** as behavior that is inconsistent with the individual's developmental, cultural, and societal norms and creates emotional distress or interferes with daily functioning.

The following chapters will examine many different types of abnormal behavior. As a guide, the behaviors are considered using the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association, 2013), commonly known as the *DSM-5*. This diagnostic system uses an approach that focuses on symptoms and the scientific basis for the disorders, including their *clinical presentation* (what specific symptoms cluster together?), *etiology* (what causes the disorder?), *developmental stage* (does the disorder look different in children than it does in adults?), and *functional impairment* (what are the immediate and long-term consequences of having the disorder?). The DSM system uses a *categorical approach* to defining abnormal behavior. A categorical approach assumes that a person either has a disorder or does not, just as one is pregnant or not pregnant. Although this method is somewhat controversial (see “Research Hot Topic: Categorical vs. Dimensional Approaches to Abnormal Behavior”), it remains the most widely accepted diagnostic system in the United States.

ABNORMAL BEHAVIOR IN THE GENERAL POPULATION Psychological disorders are common in the general population. Approximately 47% of adults in the United States have suffered from a psychological disorder at some time in their lives (Kessler, Berglund, Demler, Jin, et al., 2005). The most commonly reported disorders in the United States are anxiety disorders and depressive disorders (see Figure 1.1). More than 20% of adults will suffer from major depression, and more than 14% will struggle with alcohol dependence at some point in their lives. Anxiety disorders are also common, affecting more than 28% of adults during their lifetimes. What most people do not know is that mental disorders rank as one of the most substantial causes of death (Walker et al., 2015). People with mental disorders have a mortality rate that is 2.2 times higher than people without mental disorders, and the median years of potential life loss is 10 years. Clearly, many people suffer from serious psychological disorders; this emphasizes the need for more understanding of these conditions and the development of effective treatments.

Figure 1.1 Lifetime Prevalence of Various DSM-IV Psychiatric Disorders at Different Ages in Adulthood.

SOURCE: Data from Kessler et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593–603.



FACTORS INFLUENCING THE EXPRESSION OF ABNORMAL BEHAVIORS

Contextual factors play an important role when considering if and when abnormal behaviors may develop. Some factors include personal characteristics such as sex and race or ethnicity. For example, women are more likely to suffer from anxiety disorders (see Chapter 4) and mood disorders (see Chapter 7), and men are more likely to suffer from alcohol and drug abuse (see Chapter 10; Kessler et al., 2005a). With respect to race and ethnicity, whites and African Americans suffer equally from most types of psychological disorders. Hispanics are more likely to have mood disorders such as depression than are non-Hispanic whites. In addition, as we shall see throughout this book, culture may influence how symptoms are expressed.

Socioeconomic status (SES), defined by family income and educational achievement, is another important factor that affects the prevalence of psychological disorders in the general population. Except for drug and alcohol abuse, which occurs more often among people with the middle education level (a high school graduate but no college degree), psychological disorders occur most frequently among those with the lowest incomes and the least education. A continuing debate is whether psychological disorders are the result of lower SES. Do more education and higher income serve to protect someone against psychological disorders by providing more supportive resources? An alternative hypothesis is that the impairment that *results* from a psychological disorder (inability to sleep, addiction to alcohol) leads to job loss or limited educational achievement, a phenomenon known as *downward drift*. Another alternative is that a third factor, such as genetic predisposition, contributes both to the onset of a psychiatric disorder and to the inability to achieve academically or occupationally.

Few studies address the relationship of SES to psychological disorders specifically, but one study of the development of psychological disorders in children does help us understand this relationship. In this study, children were interviewed at yearly intervals, in some cases for 9 consecutive years. During that time, children from all SES groups *developed*

Research HOT Topic

Categorical vs. Dimensional Approaches to Abnormal Behavior

The current diagnostic system, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), presents a primarily *categorical* approach to understanding psychological disorders. The DSM assumes that a person either has a disorder or does not, just as one is pregnant or not pregnant. The current DSM is superior to previous diagnostic systems, which were tied to theory but not necessarily to data. However, two issues continue to present problems for a categorical approach: (1) symptoms rarely fall neatly into just one category and (2) symptoms often are not of sufficient severity to determine that they represent a psychological disorder despite distress and impairment.

In fact, people in psychological distress rarely have only one psychological disorder (Nathan & Langenbucher, 1999). A woman struggling with an eating disorder often feels depressed as well. Does she have two distinct disorders, or is her depression merely part of her abnormal eating pattern? Making these distinctions is more than just an academic exercise—it affects whether someone receives treatment. It may, for example, determine whether a psychologist decides to refer a depressed patient for medication treatment or just

monitors her sadness to see whether it disappears when the eating disorder is successfully treated.

The second issue—deciding when one has “enough” of a symptom to have a diagnosis—can be illustrated through the following example. Shyness and sadness are two behaviors that may be personality dimensions rather than a distinct category. When is one “sad enough” or “shy enough” to be diagnosed with a psychological disorder? Is shyness a personality feature or a psychological disorder? Currently, one is considered to have a psychological disorder when the distress is severe enough or when functional impairment results. However, in many instances, this is an artificial distinction and may deny people with moderate distress the opportunity to seek services. Scientifically, a **dimensional approach** would allow an understanding of how abnormal behavior varies in severity over time, perhaps increasing and decreasing, or how behaviors change from one disorder to another.

Researchers continue to investigate the most accurate way to describe abnormal behavior. The DSM-5 emphasizes the need to consider not just the presence of symptoms but also whether those symptoms affect functioning when attempting to understand abnormal behavior.