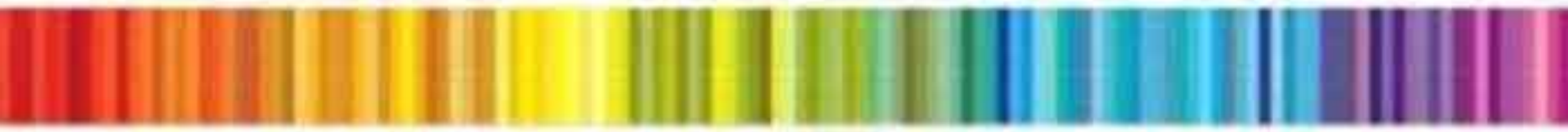


sixteenth edition

abnormal psychology



JAMES M. BUTCHER • SUSAN HOOLEY • MINEKA



abnormal psychology sixteenth edition

JAMES N.
BUTCHER
University of Minnesota

JILL M.
HOOLEY
Harvard University

SUSAN
MINEKA
Northwestern University

PEARSON

Boston Columbus Indianapolis New York San Francisco Upper Saddle River
Amsterdam Cape Town Dubai London Madrid Milan Munich Paris Montréal Toronto
Delhi Mexico City São Paulo Sydney Hong Kong Seoul Singapore Taipei Tokyo

Executive Editor: Erin Mitchell
Director of Development: Sharon Geary
Development Editor: LeeAnn Doherty
Editorial Assistant: Sarah Henrich
Director of Marketing: Brandy Dawson
Marketing Manager: Jeremy Intal
Marketing Assistant: Frank Alarcon
Team Lead: Amber Mackey
Senior Managing Editor: Linda Behrens
Project Manager, Production: Sherry Lewis
Senior Operations Specialist: Diane Peirano

Art Director: Leslie Osher
Text and Cover Designer: Anne DeMarinis, DEMARINIS
DESIGN LLC
Cover Art: Soren Hald/Stone/Getty Images IS2/Masterfile
Media Project Manager: Pamela Weldin
Full-Service Project Management: Saraswathi Muralidhar/
PreMediaGlobal
Composition: PreMediaGlobal
Printer/Binder: R.R. Donnelley and Sons
Cover Printer: Lehigh-Phoenix Color/Hagerstown
Text Font: 10/12 MinionPro-Regular

Credits and acknowledgments borrowed from other sources and reproduced, with permission, in this textbook appear on appropriate page within text and pages 716–721.

Copyright © 2014, 2013, 2010, by Pearson Education, Inc. All rights reserved. Printed in the United States of America. This publication is protected by Copyright and permission should be obtained from the publisher prior to any prohibited reproduction, storage in a retrieval system, or transmission in any form or by any means, electronic, mechanical, photocopying, recording, or likewise. To obtain permission(s) to use material from this work, please submit a written request to Pearson Education, Inc., Permissions Department, One Lake Street, Upper Saddle River, New Jersey 07458 or you may fax your request to 201-236-3290.

Many of the designations by manufacturers and seller to distinguish their products are claimed as trademarks. Where those designations appear in this book, and the publisher was aware of a trademark claim, the designations have been printed in initial caps or all caps.

Library of Congress Cataloging-in-Publication Data

Butcher, James Neal.

Abnormal psychology. — 16th ed. / James N. Butcher, University of Minnesota, Jill M. Hooley, Harvard University, Susan Mineka, Northwestern University.

p. cm

Editions 1 through 11 published as: Abnormal psychology and modern life; 1st-7th under: James C. Coleman; 8th-11th under: Robert C. Carson. From 12th edition under: James Neal Butcher.

Includes bibliographical references and index.

ISBN-13: 978-0-205-94428-6

ISBN-10: 0-205-94428-0

I. Mineka, Susan. II. Hooley, Jill M. III. Title.

RC454.B87 2014

616.89—dc23

2013012128

10 9 8 7 6 5 4 3 2 1

PEARSON

Student Edition

ISBN-10: 0-205-94428-0

ISBN-13: 978-0-205-94428-6

Ala Carte

ISBN-10: 0-205-96502-4

ISBN-13: 978-0-205-96502-1

brief contents

- 1** Abnormal Psychology: An Overview 1
- 2** Historical and Contemporary Views of Abnormal Behavior 28
- 3** Causal Factors and Viewpoints 54
- 4** Clinical Assessment and Diagnosis 100
- 5** Stress and Physical and Mental Health 128
- 6** Panic, Anxiety, Obsessions, and Their Disorders 162
- 7** Mood Disorders and Suicide 211
- 8** Somatic Symptom and Dissociative Disorders 263
- 9** Eating Disorders and Obesity 293
- 10** Personality Disorders 327
- 11** Substance-Related Disorders 367
- 12** Sexual Variants, Abuse, and Dysfunctions 404
- 13** Schizophrenia and Other Psychotic Disorders 443
- 14** Neurocognitive Disorders 482
- 15** Disorders of Childhood and Adolescence
(Neurodevelopmental Disorders) 508
- 16** Therapy 548
- 17** Contemporary and Legal Issues in Abnormal Psychology 582

contents

Features xii

Preface xv

About the Authors xix

1 Abnormal Psychology: An Overview 1

What Do We Mean by Abnormality? 3

The *DSM-5* and the Definition of Mental Disorder 5

the **WORLD** around us

Extreme Generosity or Pathological Behavior? 6

Why Do We Need to Classify Mental Disorders? 7

THINKING CRITICALLY about *DSM-5*:

What Is the *DSM* and Why Was It Revised? 7

What Are the Disadvantages of Classification? 8

How Can We Reduce Prejudicial Attitudes Toward the Mentally Ill? 8

the **WORLD** around us

Mad, Sick, Head Nuh Good: Mental Illness and Stigma in Jamaica 9

How Does Culture Affect What Is Considered Abnormal? 10

Culture-Specific Disorders 11

How Common Are Mental Disorders? 12

Prevalence and Incidence 12

Prevalence Estimates for Mental Disorders 12

Treatment 13

Mental Health Professionals 14

Research Approaches in Abnormal Psychology 14

Sources of Information 15

Case Studies 15

Self-Report Data 15

Observational Approaches 16

Forming and Testing Hypotheses 17

Sampling and Generalization 17

Internal and External Validity 18

Criterion and Comparison Groups 18

Research Designs 19

Studying the World as It Is: Correlational Research Designs 19

Measuring Correlation 19

Statistical Significance 19

Effect Size 20

Meta-Analysis 21

Correlations and Causality 21

Retrospective Versus Prospective Strategies 21

Manipulating Variables: The Experimental Method in Abnormal Psychology 22

Studying the Efficacy of Therapy 22

Single-Case Experimental Designs 23

developments in **RESEARCH**:

Do Magnets Help with Repetitive-Stress Injury? 24

Animal Research 25

UNRESOLVED issues

Are We All Becoming Mentally Ill? The Expanding Horizons of Mental Disorder 26

summary 27 key terms 27

2 Historical and Contemporary Views of Abnormal Behavior 28

Historical Views of Abnormal Behavior 29

Demonology, Gods, and Magic 29

Hippocrates' Early Medical Concepts 30

developments in **THINKING**:

Melancholia Through the Ages 31

Early Philosophical Conceptions of Consciousness 31

Later Greek and Roman Thought 32

Early Views of Mental Disorders in China 32

Views of Abnormality During the Middle Ages 33

Toward Humanitarian Approaches 35

The Resurgence of Scientific Questioning in Europe 35

The Establishment of Early Asylums 35

Humanitarian Reform 36

Nineteenth-Century Views of the Causes and Treatment of Mental Disorders 40

Changing Attitudes Toward Mental Health in the Early Twentieth Century 40

the **WORLD** around us

Chaining Mental Health Patients 41

Mental Hospital Care in the Twentieth Century 41

The Emergence of Contemporary Views of Abnormal Behavior 43

Biological Discoveries: Establishing the Link Between the Brain and Mental Disorder 43

The Development of a Classification System 44

Development of the Psychological Basis of Mental Disorder 44

developments in **RESEARCH**:

The Search for Medications to Cure Mental Disorders 45

The Evolution of the Psychological Research Tradition: Experimental Psychology 47

UNRESOLVED issues

Interpreting Historical Events 51

summary 52 key terms 53



Causal Factors and Viewpoints 54

Causes and Risk Factors for Abnormal Behavior 55

- Necessary, Sufficient, and Contributory Causes 55
- Feedback and Bidirectionality in Abnormal Behavior 56
- Diathesis-Stress Models 57

Viewpoints for Understanding the Causes of Abnormal Behavior 59

The Biological Viewpoint and Biological Causal Factors 60

- Imbalances of Neurotransmitters and Hormones 60
- Genetic Vulnerabilities 63

developments in THINKING:

- Nature, Nurture, and Psychopathology: A New Look at an Old Topic 66
- Temperament 67

- Brain Dysfunction and Neural Plasticity 68
- The Impact of the Biological Viewpoint 69

The Psychological Viewpoints 70

- The Psychodynamic Perspectives 70
- The Behavioral Perspective 75

developments in THINKING:

- The Humanistic and Existential Perspectives 77
- The Cognitive-Behavioral Perspective 79
- What the Adoption of a Perspective Does and Does Not Do 82

Psychological Causal Factors 83

- Early Deprivation or Trauma 83
- Inadequate Parenting Styles 86
- Marital Discord and Divorce 88
- Maladaptive Peer Relationships 89

The Sociocultural Viewpoint 91

- Uncovering Sociocultural Factors Through Cross-Cultural Studies 91

Sociocultural Causal Factors 93

- Low Socioeconomic Status and Unemployment 94
- Prejudice and Discrimination in Race, Gender, and Ethnicity 94

the WORLD around us

- Culture and Attachment Relationships 95
- Social Change and Uncertainty 96
- Urban Stressors: Violence and Homelessness 96
- The Impact of the Sociocultural Viewpoint 96

UNRESOLVED issues

- Theoretical Viewpoints and the Causes of Abnormal Behavior 97
- summary 98 key terms 99



Clinical Assessment and Diagnosis 100

The Basic Elements in Assessment 101

- The Relationship Between Assessment and Diagnosis 102

- Taking a Social or Behavioral History 102
- Ensuring Culturally Sensitive Assessment Procedures 103
- The Influence of Professional Orientation 103
- Reliability, Validity, and Standardization 104
- Trust and Rapport Between the Clinician and the Client 104

Assessment of the Physical Organism 105

- The General Physical Examination 105
- The Neurological Examination 105
- The Neuropsychological Examination 107

Psychosocial Assessment 108

- Assessment Interviews 108
- The Clinical Observation of Behavior 109
- Psychological Tests 110

developments in PRACTICE:

- The Automated Practice: Use of the Computer in Psychological Testing 111

The Case of Andrea C.: Experiencing Violence in the Workplace 117

developments in PRACTICE:

- Computer-Based MMPI-2 Report for Andrea C. 118

The Integration of Assessment Data 120

- Ethical Issues in Assessment 120

Classifying Abnormal Behavior 121

- Differing Models of Classification 122
- Formal Diagnostic Classification of Mental Disorders 122
- Criteria for Persistent Depressive Disorder (Dysthymia) 123

THINKING CRITICALLY about DSM-5:

- Completion Does Not Assure Acceptance 125
- summary 126 key terms 127



Stress and Physical and Mental Health 128

What Is Stress? 130

- Stress and the DSM 130
- Factors Predisposing a Person to Stress 130
- Characteristics of Stressors 131
- Measuring Life Stress 132
- Resilience 132

Stress and the Stress Response 133

- Biological Costs of Stress 134
- The Mind–Body Connection 134
- Understanding the Immune System 134
- Stress, Depression, and the Immune System 136

STRESS AND PHYSICAL HEALTH 137

Cardiovascular Disease 138

- Hypertension 138
- Coronary Heart Disease 139
- Risk and Causal Factors in Cardiovascular Disease 140

the WORLD around us

Racial Discrimination and Cardiovascular Health in African Americans 142

Treatment of Stress-Related Physical Disorders 143

Biological Interventions 143

Psychological Interventions 143

STRESS AND MENTAL HEALTH 145

Adjustment Disorder 145

Adjustment Disorder Caused by Unemployment 145

Posttraumatic Stress Disorder 145

Criteria for Posttraumatic Stress Disorder 146

THINKING CRITICALLY about DSM-5:

Changes to the Diagnostic Criteria for PTSD 147

Acute Stress Disorder 148

Clinical Description 148

Prevalence of PTSD in the General Population 148

Rates of PTSD After Traumatic Experiences 149

Causal Factors in Posttraumatic Stress Disorder 152

Individual Risk Factors 153

Sociocultural Factors 154

Long-Term Effects of Posttraumatic Stress 155

Prevention and Treatment of Stress Disorders 155

Prevention 155

the WORLD around us

Does Playing Tetris After a Traumatic Event Reduce Flashbacks? 156

Treatment for Stress Disorders 156

Psychological Debriefing 157

the WORLD around us

Virtual Reality Exposure Treatment for PTSD in Military Personnel 158

Challenges in Studying Disaster Victims 159

Trauma and Physical Health 159

UNRESOLVED issues

Why Is the Study of Trauma so Contentious? 160

summary 160 key terms 161



Panic, Anxiety, Obsessions, and Their Disorders 162

The Fear and Anxiety Response Patterns 164

Fear 164

THINKING CRITICALLY about DSM-5:

Why is OCD No Longer Considered to Be an Anxiety Disorder? 164

Anxiety 165

Overview of the Anxiety Disorders and Their Commonalities 165

Specific Phobias 166

Criteria for Specific Phobia 167

Prevalence, Age of Onset, and Gender Differences 168

Psychological Causal Factors 168

Biological Causal Factors 171

Treatments 171

Social Phobias 173

Prevalence, Age of Onset, and Gender Differences 173

Psychological Causal Factors 174

Criteria for Social Anxiety Disorder (Social Phobia) 175

Biological Causal Factors 176

Treatments 177

Panic Disorder 178

Criteria for Panic Disorder 178

Agoraphobia 179

Criteria for Agoraphobia 179

Prevalence, Age of Onset, and Gender Differences 180

Comorbidity with Other Disorders 181

The Timing of a First Panic Attack 181

Biological Causal Factors 181

Psychological Causal Factors 183

developments in RESEARCH:

Nocturnal Panic Attacks 185

Treatments 187

Generalized Anxiety Disorder 188

Criteria for Generalised Anxiety Disorder 189

Prevalence, Age of Onset, and Gender Differences 190

Comorbidity with Other Disorders 190

Psychological Causal Factors 190

Biological Causal Factors 192

Treatments 193

Obsessive-Compulsive and Related Disorders 194

Obsessive-Compulsive Disorder 194

Criteria for Obsessive-Compulsive Disorder 195

Prevalence, Age of Onset, and Gender Differences 196

Comorbidity with Other Disorders 197

Psychological Causal Factors 197

Biological Causal Factors 199

Treatments 201

Body Dysmorphic Disorder 202

Criteria for Body Dysmorphic Disorder 204

Hoarding Disorder 206

Trichotillomania 206

Cultural Perspectives 206

Cultural Differences in Sources of Worry 207

Taijin Kyofusho 207

UNRESOLVED issues

The Choice of Treatments: Medications or Cognitive-Behavior Therapy? 208

summary 209 key terms 210



Mood Disorders and Suicide 211

Mood Disorders: An Overview 212

- Types of Mood Disorders 212
- Criteria for Major Depressive Disorder 213
- Criteria for Manic Episode 214
- The Prevalence of Mood Disorders 214

Unipolar Depressive Disorders 214

- Other Forms of Depression 215

THINKING CRITICALLY about *DSM-5*:

- Was It Wise to Drop the Bereavement Exclusion for Major Depression? 215

developments in THINKING:

- A New *DSM-5* Diagnosis: Premenstrual Dysphoric Disorder 216
- Dysthymic Disorder (Persistent Depressive Disorder) 216
- Criteria for Persistent Depressive Disorder (Dysthymia) 217
- Major Depressive Disorder 218

Causal Factors in Unipolar Mood Disorders 221

- Biological Causal Factors 221
- Psychological Causal Factors 226

developments in RESEARCH:

- Why Do Sex Differences in Unipolar Depression Emerge During Adolescence? 235

Bipolar and Related Disorders 237

- Cyclothymic Disorder 238
- Criteria for Cyclothymic Disorder 238
- Bipolar Disorders (I and II) 239

Causal Factors in Bipolar Disorders 242

- Biological Causal Factors 242
- Psychological Causal Factors 244

Sociocultural Factors Affecting Unipolar and Bipolar Disorders 244

- Cross-Cultural Differences in Depressive Symptoms 244
- Cross-Cultural Differences in Prevalence 245
- Demographic Differences in the United States 246

Treatments and Outcomes 246

- Pharmacotherapy 247
- Alternative Biological Treatments 249
- Psychotherapy 249

Suicide: The Clinical Picture and the Causal Pattern 252

- Who Attempts and Who Commits Suicide? 253
- Suicide in Children 254
- Suicide in Adolescents and Young Adults 254
- Other Psychosocial Factors Associated with Suicide 254

the WORLD around us

- Warning Signs for Student Suicide 255
- Biological Causal Factors 256
- Sociocultural Factors 256

Suicidal Ambivalence 257

- Communication of Suicidal Intent 258
- Suicide Notes 258

Suicide Prevention and Intervention 258

- Treatment of Mental Disorders 258
- Crisis Intervention 259
- Focus on High-Risk Groups and Other Measures 259

UNRESOLVED issues

- Is There a Right to Die? 259
- summary 261 key terms 262



Somatic Symptom and Dissociative Disorders 263

Somatic Symptom and Related Disorders 264

- Somatic Symptom Disorders 265
- Hypochondriasis 265
- Criteria for Somatic Symptom Disorder 265
- Somatization Disorder 268
- Pain Disorder 269
- Conversion Disorder (Functional Neurological Symptom Disorder) 270
- Criteria for Illness Anxiety Disorder 270
- Criteria for Conversion disorder 271
- Distinguishing Somatization, Pain, and Conversion Disorders from Malingering and Factitious Disorder 274
- Criteria for Factitious Disorder 274

the WORLD around us

- Factitious Disorder Imposed on Another (Munchausen's Syndrome by Proxy) 275

Dissociative Disorders 276

- Depersonalization/Derealization Disorder 276
- Criteria for Depersonalization/Derealization Disorder 277
- Dissociative Amnesia and Dissociative Fugue 278
- Criteria for Dissociative Amnesia 278
- Dissociative Identity Disorder (DID) 280

THINKING CRITICALLY about *DSM-5*:

- Where Does Conversion Disorder Belong? 280
- Criteria for Dissociative Identity Disorder 281

the WORLD around us

- DID, Schizophrenia, and Split Personality: Clearing Up the Confusion 282
- Sociocultural Factors in Dissociative Disorders 288
- Treatment and Outcomes in Dissociative Disorders 288

UNRESOLVED issues

- DID and the Reality of "Recovered Memories" 290
- summary 291 key terms 292



Eating Disorders and Obesity 293

Clinical Aspects of Eating Disorders 295

- Anorexia Nervosa 295
- Criteria for Anorexia Nervosa 295
- Bulimia Nervosa 297

Criteria for Bulimia Nervosa	297
Binge Eating Disorder	298
Criteria for Binge-Eating Disorder	299
Age of Onset and Gender Differences	300
THINKING CRITICALLY about DSM-5:	
Other Forms of Eating Disorders	300
Prevalence of Eating Disorders	301
Medical Complications of Eating Disorders	301
Course and Outcome	302
Diagnostic Crossover	303
Association of Eating Disorders With Other Forms of Psychopathology	303
Eating Disorders Across Cultures	304
the WORLD around us	
Ethnic Identity and Disordered Eating	305
Risk and Causal Factors in Eating Disorders	306
Biological Factors	306
Sociocultural Factors	307
Family Influences	308
Individual Risk Factors	309
Treatment of Eating Disorders	312
Treatment of Anorexia Nervosa	312
Treatment of Bulimia Nervosa	313
Treatment of Binge Eating Disorder	315
The Problem of Obesity	315
Medical Issues	315
Definition and Prevalence	316
Weight Stigma	316
the WORLD around us	
Do Negative Messages About Being Overweight Encourage Overweight People to Eat More or Less?	317
Obesity and the DSM	317
Risk and Causal Factors in Obesity	317
The Role of Genes	317
Hormones Involved in Appetite and Weight Regulation	318
Sociocultural Influences	318
Family Influences	320
Stress and “Comfort Food”	320
Pathways to Obesity	321
Treatment of Obesity	321
Lifestyle Modifications	321
Medications	322
Bariatric Surgery	322
The Importance of Prevention	323
UNRESOLVED issues	
The Role of Public Policy in the Prevention of Obesity	324
summary	325
key terms	326

Personality Disorders 327

Clinical Features of Personality Disorders	328
Difficulties Doing Research on Personality Disorders	330
Difficulties in Diagnosing Personality Disorders	330
THINKING CRITICALLY about DSM-5:	
Why Were No Changes Made to the Way Personality Disorders Are Diagnosed?	331
Difficulties in Studying the Causes of Personality Disorders	332
Cluster A Personality Disorders	333
Paranoid Personality Disorder	333
Criteria for Paranoid Personality Disorder	334
Schizoid Personality Disorder	335
Criteria for Schizoid Personality Disorder	336
Schizotypal Personality Disorder	336
Criteria for Schizotypal Personality Disorder	337
Cluster B Personality Disorders	338
Histrionic Personality Disorder	338
Narcissistic Personality Disorder	339
Criteria for Histrionic Personality Disorder	339
Criteria for Narcissistic Personality Disorder	340
Antisocial Personality Disorder	341
Borderline Personality Disorder	342
Criteria for Borderline Personality Disorder	342
THINKING CRITICALLY about DSM-5:	
Nonsuicidal Self-Injury: Distinct Disorder or Symptom of Borderline Personality Disorder?	343
Cluster C Personality Disorders	345
Avoidant Personality Disorder	345
Criteria for Avoidant Personality Disorder	346
Dependent Personality Disorder	347
Obsessive-Compulsive Personality Disorder	348
Criteria for Dependent Personality Disorder	348
Criteria for Obsessive-Compulsive Personality Disorder	349
General Sociocultural Causal Factors for Personality Disorders	350
Treatments and Outcomes for Personality Disorders	350
Adapting Therapeutic Techniques to Specific Personality Disorders	351
Treating Borderline Personality Disorder	351
Treating Other Personality Disorders	352
Criteria for Antisocial Personality Disorder	353
Antisocial Personality Disorder and Psychopathy	353
Psychopathy and Antisocial Personality Disorder	353
The Clinical Picture in Psychopathy and Antisocial Personality Disorder	354
Causal Factors in Psychopathy and Antisocial Personality	357
the WORLD around us	
“Successful” Psychopaths	359

A Developmental Perspective on Psychopathy and Antisocial Personality 360

Treatments and Outcomes in Psychopathic and Antisocial Personality 363

developments in PRACTICE:

Prevention of Psychopathy and Antisocial Personality Disorder 364

UNRESOLVED issues

DSM-5: How Can We Improve the Classification of Personality Disorders? 365

summary 365 key terms 366



11 Substance-Related Disorders 367

Alcohol Related Disorders 369

The Prevalence, Comorbidity, and Demographics of Alcohol Abuse and Dependence 369

Criteria for Alcohol Use Disorder 370

The Clinical Picture of Alcohol Related Disorders 371

developments in RESEARCH:

Fetal Alcohol Syndrome: How Much Drinking Is Too Much? 373

Biological Causal Factors in the Abuse of and Dependence on Alcohol 375

Psychosocial Causal Factors in Alcohol Abuse and Dependence 377

the WORLD around us

Binge Drinking in College 380

Sociocultural Causal Factors 381

Treatment of Alcohol-Related Disorders 381

Drug Abuse and Dependence 386

Opium and Its Derivatives (Narcotics) 387

Cocaine and Amphetamines (Stimulants) 390

Methamphetamine 392

THINKING CRITICALLY about DSM-5:

Can Changes to the Diagnostic Criteria Result in Increased Drug Use? 393

Barbiturates (Sedatives) 393

Hallucinogens: LSD and Related Drugs 394

Ecstasy 395

Marijuana 396

the WORLD around us

Should Marijuana Be Marketed and Sold Openly as a Medication? 397

Stimulants: Caffeine and Nicotine 398

Gambling Disorder 400

Criteria for Gambling Disorder 400

UNRESOLVED issues

Exchanging Addictions: Is This an Effective Treatment Approach? 402

summary 402 key terms 403



12 Sexual Variants, Abuse, and Dysfunctions 404

Sociocultural Influences on Sexual Practices and Standards 406

Case 1: Degeneracy and Abstinence Theory 406

Case 2: Ritualized Homosexuality in Melanesia 407

Case 3: Homosexuality and American Psychiatry 407

Gender Dysphoria 409

The Paraphilias 409

Criteria for Several Different Paraphilic Disorders 410

Causal Factors and Treatments for Paraphilias 416

Gender Dysphoria 416

Criteria for Gender Dysphoria 417

Criteria for Gender Dysphoria in Adolescents and Adults 418

Sexual Abuse 420

Childhood Sexual Abuse 420

Pedophilic Disorder 422

THINKING CRITICALLY about DSM-5:

Pedophilia and Hebephilia 423

Incest 425

Rape 425

Treatment and Recidivism of Sex Offenders 428

the WORLD around us

Megan's Law 429

Sexual Dysfunctions 431

Criteria for Different Sexual Dysfunctions 432

Sexual Dysfunctions in Men 433

Male Hypoactive Sexual Desire Disorder 434

Female Sexual Interest/Arousal Disorder 436

UNRESOLVED issues

How Harmful Is Childhood Sexual Abuse? 440

summary 441 key terms 442



13 Schizophrenia and Other Psychotic Disorders 443

Schizophrenia 444

Origins of the Schizophrenia Construct 445

Epidemiology 445

Clinical Picture 446

Delusions 446

Criteria for Schizophrenia 447

Hallucinations 448

Disorganized Speech and Behavior 448

the WORLD around us

Stress, Caffeine, and Hallucinations 449

Positive and Negative Symptoms 450

Subtypes of Schizophrenia 450
Other Psychotic Disorders 451
Criteria for Schizoaffective Disorder 451
Criteria for Schizophreniform Disorder 451
Criteria for Delusional Disorder 452
Criteria for Brief Psychotic Disorder 452

Risk and Causal Factors 453

Genetic Factors 453

the **WORLD** around us

The Genain Quadruplets 454
Prenatal Exposures 458
Genes and Environment in Schizophrenia: A Synthesis 459
A Neurodevelopmental Perspective 460

THINKING CRITICALLY about *DSM-5*:

Attenuated Psychosis Syndrome 462
Structural and Functional Brain Abnormalities 462
Psychosocial and Cultural Factors 470
A Diathesis-Stress Model of Schizophrenia 473

Treatments and Outcomes 475

Clinical Outcome 475
Pharmacological Approaches 476
Psychosocial Approaches 477

UNRESOLVED issues

Why Are Recovery Rates in Schizophrenia Not Improving? 480
summary 480 key terms 481



14 Neurocognitive Disorders 482

Brain Impairment in Adults 484

THINKING CRITICALLY about *DSM-5*:

Is the Inclusion of Mild Neurocognitive Disorder a Good Idea? 484
Clinical Signs of Brain Damage 484
Diffuse Versus Focal Damage 485
The Neurocognitive/Psychopathology Interaction 487

Delirium 488

Clinical Picture 488
Criteria for Delirium 489
Treatments and Outcomes 489

Major Neurocognitive Disorder (Dementia) 489

Criteria for Major Neurocognitive Disorder (Dementia) 490
Parkinson's Disease 490
Huntington's Disease 491
Alzheimer's Disease 491

developments in **RESEARCH**:

Depression Increases the Risk of Alzheimer's Disease 495

the **WORLD** around us

Exercising Your Way to a Healthier Brain? 498
Neurocognitive Disorder Associated with HIV-1 Infection 499
Neurocognitive Disorder Associated with Vascular Disease 500

Amnestic Disorder 500

Disorders Involving Head Injury 501

Clinical Picture 502

the **WORLD** around us

Brain Damage in Professional Athletes 504
Treatments and Outcomes 505

UNRESOLVED issues

Should Healthy People Use Cognitive Enhancers? 506
summary 506 key terms 507



15 Disorders of Childhood and Adolescence (Neurodevelopmental Disorders) 508

Maladaptive Behavior in Different Life Periods 510

Varying Clinical Pictures 510
Special Psychological Vulnerabilities of Young Children 510
The Classification of Childhood and Adolescent Disorders 511

Common Disorders of Childhood 511

Attention-Deficit/Hyperactivity Disorder 511
Criteria for Attention-Deficit/Hyperactivity Disorder 512
Disruptive, Impulse-control and Conduct Disorder 515
Criteria for Conduct Disorder 515

Anxiety and Depression in Children and Adolescents 518

Anxiety Disorders of Childhood and Adolescence 518
Criteria for Separation Anxiety Disorder 519
Childhood Depression and Bipolar Disorder 521

developments in **RESEARCH**:

Bipolar Disorder in Children and Adolescents:
Is There an Epidemic? 523

Elimination Disorders (Enuresis, Encopresis), Sleepwalking, and Tics 524

Enuresis 525
Encopresis 525
Sleepwalking 526
Tic Disorders 526
Neurodevelopmental Disorders 527
Autism Spectrum Disorder 527
Criteria for Autism Spectrum Disorder 528

developments in **PRACTICE**:

Can Virtual Reality Video Games Improve Treatment of Children with Neurodevelopmental Disorders? 531

Specific Learning Disorders 532

Causal Factors in Learning Disorders 533
Treatments and Outcomes 533

THINKING CRITICALLY about *DSM-5*:

Changes to the Diagnostic System are Nominal for Some Disorders 533

Intellectual Disability 534

Levels of Intellectual Disability 534

Causal Factors in Intellectual Disability 535
Organic Retardation Syndromes 536
Treatments, Outcomes, and Prevention 539

Planning Better Programs to Help Children and Adolescents 541

Special Factors Associated with Treatment of Children and Adolescents 541

the **WORLD** around us

The Impact of Child Abuse on Psychological Adjustment 542
Family Therapy as a Means of Helping Children 543
Child Advocacy Programs 543

UNRESOLVED issues

Can Society Deal with Delinquent Behavior? 544
summary 546 key Terms 547



Therapy 548

An Overview of Treatment 549

Why Do People Seek Therapy? 549
Who Provides Psychotherapeutic Services? 550
The Therapeutic Relationship 551

Measuring Success in Psychotherapy 552

Objectifying and Quantifying Change 552
Would Change Occur Anyway? 553
Can Therapy Be Harmful? 553

the **WORLD** around us

When Therapy Harms 554

What Therapeutic Approaches Should Be Used? 554

Evidence-Based Treatment 554
Medication or Psychotherapy? 555
Combined Treatments 555

Psychosocial Approaches to Treatment 556

Behavior Therapy 556
Cognitive and Cognitive-Behavioral Therapy 559
Humanistic-Experiential Therapies 561
Psychodynamic Therapies 563
Couple and Family Therapy 566
Eclecticism and Integration 567

Sociocultural Perspectives 568

Social Values and Psychotherapy 568
Psychotherapy and Cultural Diversity 569

Biological Approaches to Treatment 569

Antipsychotic Drugs 569
Antidepressant Drugs 570
Antianxiety Drugs 573

THINKING CRITICALLY about *DSM-5*:

What Are Some of the Clinical Implications of the Recent Changes? 574

Lithium and Other Mood-Stabilizing Drugs 575
Electroconvulsive Therapy 576
Neurosurgery 577

the **WORLD** around us

Deep Brain Stimulation for Treatment-Resistant Depression 578

UNRESOLVED issues

Do Psychiatric medications Help or Harm? 579
summary 580 key terms 581



Contemporary and Legal Issues in Abnormal Psychology 582

Perspectives on Prevention 583

Universal Interventions 584
Selective Interventions 585
Indicated Interventions 588

Inpatient Mental Health Treatment in Contemporary Society 588

The Mental Hospital as a Therapeutic Community 588
Aftercare Programs 589
Deinstitutionalization 590

Controversial Legal Issues and the Mentally Ill 591

Civil Commitment 591

the **WORLD** around us

Important Court Decisions for Patient Rights 592

Assessment of "Dangerousness" 593

the **WORLD** around us

Controversial Not Guilty Pleas: Can Altered Mind States or Personality Disorder Limit Responsibility for a Criminal Act? 594

The Insanity Defense 596

Competence to Stand Trial 600

Does Having Mental Health Problems Result in Convicted Felons Being Returned to Prison After Being Released? 600

Organized Efforts for Mental Health 601

U.S. Efforts for Mental Health 601
International Efforts for Mental Health 603

Challenges for the Future 603

The Need for Planning 604
The Individual's Contribution 604

UNRESOLVED issues

The HMOs and Mental Health Care 605

summary 607 key terms 607

Glossary 608

References 629

Credits 716

Name Index 722

Subject Index 751

features

developments in RESEARCH

- Do Magnets Help with Repetitive-Stress Injury? 24
- The Search for Medications to Cure Mental Disorders 45
- Nocturnal Panic Attacks 185
- Why Do Sex Differences in Unipolar Depression Emerge During Adolescence? 235
- Fetal Alcohol Syndrome: How Much Drinking Is Too Much? 373
- Depression Increases the Risk of Alzheimer's Disease 495
- Bipolar Disorder in Children and Adolescents: Is There an Epidemic? 523

developments in THINKING

- Melancholia Through the Ages 31
- Nature, Nurture, and Psychopathology: A New Look at an Old Topic 66
- The Humanistic and Existential Perspectives 77
- A New DSM-5 Diagnosis: Premenstrual Dysphoric Disorder 216

developments in PRACTICE

- The Automated Practice: Use of the Computer in Psychological Testing 111
- Computer-Based MMPI-2 Report for Andrea C. 118
- Prevention of Psychopathy and Antisocial Personality Disorder 364
- Can Virtual Reality Video Games Improve Treatment of Children with Neurodevelopmental Disorders? 531

the WORLD around us

- Extreme Generosity or Pathological Behavior? 6
- Mad, Sick, Head Nuh Good: Mental Illness and Stigma in Jamaica 9
- Chaining Mental Health Patients 41
- Culture and Attachment Relationships 95
- Racial Discrimination and Cardiovascular Health in African Americans 142
- Does Playing Tetris After a Traumatic Event Reduce Flashbacks? 156
- Virtual Reality Exposure Treatment for PTSD in Military Personnel 158
- Warning Signs for Student Suicide 255
- Factitious Disorder Imposed on Another (Munchausen's Syndrome by Proxy) 275
- DID, Schizophrenia, and Split Personality: Clearing Up the Confusion 282

- Ethnic Identity and Disordered Eating 305
- Do Negative Messages About Being Overweight Encourage Overweight People to Eat More or Less? 317
- "Successful" Psychopaths 359
- Binge Drinking in College 380
- Should Marijuana Be Marketed and Sold Openly as a Medication? 397
- Megan's Law 429
- Stress, Caffeine, and Hallucinations 449
- The Genain Quadruplets 454
- Exercising Your Way to a Healthier Brain? 498
- Brain Damage in Professional Athletes 504
- The Impact of Child Abuse on Psychological Adjustment 542
- When Therapy Harms 554
- Deep Brain Stimulation for Treatment-Resistant Depression 578
- Important Court Decisions for Patient Rights 592
- Controversial Not Guilty Pleas: Can Altered Mind States or Personality Disorder Limit Responsibility for a Criminal Act? 594

UNRESOLVED issues

- Are We All Becoming Mentally Ill? The Expanding Horizons of Mental Disorder 26
- Interpreting Historical Events 51
- Theoretical Viewpoints and the Causes of Abnormal Behavior 97
- Why Is the Study of Trauma so Contentious? 160
- The Choice of Treatments: Medications or Cognitive-Behavior Therapy? 208
- Is There a Right to Die? 259
- DID and the Reality of "Recovered Memories" 290
- The Role of Public Policy in the Prevention of Obesity 324
- DSM-5: How Can We Improve the Classification of Personality Disorders? 365
- Exchanging Addictions: Is This an Effective Treatment Approach? 402
- How Harmful Is Childhood Sexual Abuse? 440
- Why are Recovery Rates in Schizophrenia Not Improving? 480
- Should Healthy People Use Cognitive Enhancers? 506
- Can Society Deal with Delinquent Behavior? 544
- Do Psychiatric Medications Help or Harm? 579
- The HMOs and Mental Health Care 605

DSM-5 Boxes

Criteria for Persistent Depressive Disorder (Dysthymia)	123
Criteria for Posttraumatic Stress Disorder	146
Criteria for Specific Phobia	167
Criteria for Social Anxiety Disorder (Social Phobia)	175
Criteria for Panic Disorder	178
Criteria for Agoraphobia	179
Criteria for Generalized Anxiety Disorder	189
Criteria for Obsessive-Compulsive Disorder	195
Criteria for Body Dysmorphic Disorder	204
Criteria for Major Depressive Disorder	213
Criteria for Manic Episode	214
Criteria for Persistent Depressive Disorder (Dysthymia)	217
Criteria for Cyclothymic Disorder	238
Criteria for Somatic Symptom Disorder	265
Criteria for Illness Anxiety Disorder	270
Criteria for Conversion Disorder	271
Criteria for Factitious Disorder	274
Criteria for Depersonalization/Derealization Disorder	277
Criteria for Dissociative Amnesia	278
Criteria for Dissociative Identity Disorder	281
Criteria for Anorexia Nervosa	295
Criteria for Bulimia Nervosa	297
Criteria for Binge-Eating Disorder	299
Criteria for Paranoid Personality Disorder	334
Criteria for Schizoid Personality Disorder	336
Criteria for Schizotypal Personality Disorder	337
Criteria for Histrionic Personality Disorder	339
Criteria for Narcissistic Personality Disorder	340
Criteria for Borderline Personality Disorder	342
Criteria for Avoidant Personality Disorder	346
Criteria for Dependent Personality Disorder	348
Criteria for Obsessive-Compulsive Personality Disorder	349
Criteria for Antisocial Personality Disorder	353
Criteria for Alcohol Use Disorder	370
Criteria for Gambling Disorder	400
Criteria for Several Different Paraphilic Disorders	410

Criteria for Gender Dysphoria	417
Criteria for Gender Dysphoria in Adolescents and Adults	418
Criteria for Different Sexual Dysfunctions	432
Criteria for Schizophrenia	447
Criteria for Schizoaffective Disorder	451
Criteria for Schizophreniform Disorder	451
Criteria for Delusional Disorder	452
Criteria for Brief Psychotic Disorder	452
Criteria for Delirium	489
Criteria for Major Neurocognitive Disorder (Dementia)	490
Criteria for Attention-Deficit/Hyperactivity Disorder	512
Criteria for Conduct Disorder	515
Criteria for Separation Anxiety Disorder	519
Criteria for Autistic Spectrum Disorder	528

THINKING CRITICALLY about DSM-5

What Is the DSM and Why Was It Revised?	7
Completion Does Not Assure Acceptance	125
Changes to the Diagnostic Criteria for PTSD	147
Why is OCD No Longer Considered to be an Anxiety Disorder?	164
Was It Wise to Drop the Bereavement Exclusion for Major Depression?	215
Where Does Conversion Disorder Belong?	280
Other Forms of Eating Disorders	300
Why Were No Changes Made to the Way Personality Disorders Are Diagnosed?	331
Nonsuicidal Self-Injury: Distinct Disorder or Symptom of Borderline Personality Disorder?	343
Can Changes to the Diagnostic Criteria Result in Increased Drug Use?	393
Pedophilia and Hebephilia	423
Attenuated Psychosis Syndrome	462
Is the Inclusion of Mild Neurocognitive Disorder a Good Idea?	484
Changes to the Diagnostic System are Nominal for Some Disorders	533
What Are Some of the Clinical Implications of the Recent Changes?	574

What's New in *DSM-5*? A Quick Guide

Many changes occurred from *DSM-IV* to *DSM-5*. Here is a summary of some of the most important revisions. Many of these changes are highlighted in the “Thinking Critically about *DSM-5*” boxes throughout this edition.

- The chapters of the *DSM* have been re-organized to reflect a consideration of developmental and lifespan issues. Disorders that are thought to reflect developmental perturbations or that manifest early in life (e.g., neurodevelopmental disorders and disorders such as schizophrenia) are listed before disorders that occur later in life.
- The multiaxial system has been abandoned. No distinction is now made between Axis I and Axis II disorders.
- *DSM-5* allows for more gender-related differences to be taken into consideration for mental health problems.
- It is extremely important for the clinician to understand the client's cultural background in appraising mental health problems. *DSM-5* contains a structured interview that focuses upon the patient's cultural background and characteristic approach to problems.
- The term *intellectual disability* is now used instead of the term *mental retardation*.
- A new diagnosis of autism spectrum disorder now encompasses autism, Asperger's disorder, and other forms of pervasive developmental disorder. The diagnosis of Asperger's disorder has been eliminated from the *DSM*.
- Changes to the diagnostic criteria for attention deficit disorder now mean that symptoms that occur before age 12 (rather than age 7) have diagnostic significance.
- A new diagnosis, called disruptive mood regulation disorder, has been added. This will be used to diagnose children up to age 18 who show persistent irritability and frequent episodes of extreme and uncontrolled behavior.
- The subtypes of schizophrenia have been eliminated.
- The special significance afforded to bizarre delusions with regard to the diagnosis of schizophrenia has been removed.
- Bipolar and related disorders are now described in a separate chapter of the *DSM* and are no longer listed with depressive disorders.
- Premenstrual dysphoric disorder has been promoted from the appendix of *DSM-IV* and is now listed as a new diagnosis.
- A new diagnosis of persistent depressive disorder now subsumes dysthymia and chronic major depressive disorder.
- The bereavement exclusion has been removed in the diagnosis of major depressive episode.
- The diagnosis of phobia no longer requires that the person recognize that his or her anxiety is unreasonable.
- Panic disorder and agoraphobia have been unlinked and are now separate diagnoses in *DSM-5*.
- Obsessive-compulsive disorder is no longer classified as an anxiety disorder. *DSM-5* contains a new chapter that covers obsessive compulsive and related disorders.
- New disorders in the obsessive compulsive and related disorders category include hoarding disorder and excoriation (skin picking) disorder.
- Post-traumatic stress disorder is no longer considered to be an anxiety disorder. Instead, it is listed in a new chapter that covers trauma- and stressor-related disorders.
- The diagnostic criteria for post-traumatic stress disorder have been significantly revised. The definition of what counts as a traumatic event has been clarified and made more explicit. *DSM-5* now also recognizes four-symptom clusters rather than the three noted in *DSM-IV*.
- Dissociative fugue is no longer listed as a separate diagnosis. Instead, it is listed as a form of dissociative amnesia.
- The *DSM-IV* diagnoses of hypochondriasis, somatoform disorder, and pain disorder have been removed and are now subsumed into the new diagnosis of somatic symptom disorder.
- Binge eating disorder has been moved from the appendix of *DSM-IV* and is now listed as an official diagnosis.
- The frequency of binge eating and purging episodes has been reduced for the diagnosis of bulimia nervosa.
- Amenorrhea is no longer required for the diagnosis of anorexia nervosa.
- The *DSM-IV* diagnoses of dementia and amnesic disorder have been eliminated and are now subsumed into a new category called major neurocognitive disorder.
- Mild neurocognitive disorder has been added as a new diagnosis.
- No changes have been made to the diagnostic criteria for personality disorders.
- Substance-related disorders are divided into two separate groups: substance use disorders and substance-induced disorders.
- A new disorder, gambling disorder, has been included in substance-related and addictive disorders.
- Included for the first time in Section III of *DSM-5* are several new disorders regarded as being in need of further study. These include attenuated psychosis syndrome, non-suicidal self-injury disorder, Internet gaming disorder, and caffeine use disorder.

The guidelines and standards that we follow in our professional activities are not set in stone. Change is a big part of life and new research or novel new theories can impact the way mental health professionals view problems. Although many of the ideas and diagnostic concepts in the field of abnormal psychology have persisted for hundreds of years, changes in thinking do occur. And, at some point there are events that occur that force a rethinking of some issues. Most recently in abnormal psychology, the publication of the *DSM-5*, after years of development and considerable controversy, is one of those momentous changes. Reflecting this, we have revised this new edition of *Abnormal Psychology* to reflect the most up-to-date information about diagnostic categories, classifications, and criteria.

Every time we work on a revision of *Abnormal Psychology* we are reminded of how dynamic and vibrant our field is. Developments in areas such as genetics, brain imaging, behavioral observation, and classification, as well changes in social and government policy and in legal decisions, add to our knowledge base and stimulate new treatments for those whose lives are touched by mental disorders. This is exciting. But the rapid progress of our field also presents its own challenges. One of the most important is how best to provide students with an integrated perspective—one that respects new ideas and discoveries and places them into the existing body of knowledge in a way that emphasizes multiple perspectives, provokes thought, and increases awareness.

We use a biopsychosocial approach to provide a sophisticated appreciation of the total context in which abnormalities of behavior occur. For ease of understanding we also present material on each disorder in a logical and consistent way. More specifically, we focus on three significant aspects: (1) the clinical picture, where we describe the symptoms of the disorder and its associated features; (2) factors involved in the development of the disorder; and (3) treatment approaches. In each case, we examine the evidence for biological, psychosocial (i.e., psychological and interpersonal), and sociocultural (the broader social environment of culture and subculture) influences. Because we wish never to lose sight of the person, we try to integrate as much case material as we can into each chapter. An additional feature of this book is a focus on treatment. Although treatment is discussed in every chapter in the context of specific disorders, we also include a separate chapter that addresses issues in treatment more broadly. This provides students with increased understanding of a wide range of treatment approaches and permits more in-depth coverage than is possible in specific disorder-based chapters.

The Butcher–Hooley–Mineka author team is in a unique position to provide students with an integrated and comprehensive understanding of abnormal psychology. Each author is a noted researcher, an experienced teacher, and a licensed clinician.

Each brings different areas of expertise and diverse research interests to the textbook. Importantly, these different perspectives come together in a systematically integrated text that is accessible to a broad audience. The depth and breadth of the author team provides students with learning experiences that can take them to new levels of understanding. Our approach emphasizes the importance of research as well as the need to translate research findings into informed and effective clinical care for all who suffer from mental disorders.

Abnormal Psychology has a long and distinguished tradition as an undergraduate text. Ever since James Coleman wrote the first edition many years ago, this textbook has been considered the most comprehensive in the field. Along the way there have been many changes. However, the commitment to excellence in this now-classic textbook has remained ever constant. In this new edition, we seek to open up the fascinating world of abnormal psychology, providing students with comprehensive and up-to-date knowledge in an accessible and engaging way. We hope that this newest edition conveys some of the passion and enthusiasm for the topic that we still experience every day.

Why Do You Need This New Edition?

If you're wondering why you should buy this new edition of *Abnormal Psychology*, here are 7 good reasons!

1. The sixteenth edition of *Abnormal Psychology* includes the most up-to-date and in-depth information about biological influences on the entire spectrum of behavioral abnormalities, while still maintaining its comprehensive and balanced biopsychosocial approach to understanding abnormal behavior.
2. After years of planning, *DSM-5* was published in May 2013. This major revision of the diagnostic system means that the diagnostic criteria for many disorders have changed. To stay current, you need to know about the changes that have been made in *DSM-5*. Books that do not include coverage of *DSM-5* are books that are out of date.
3. Our new edition provides you with detailed tables showing the current *DSM-5* diagnostic criteria for all the disorders covered in the book.
4. New highlight boxes alert you to some of the most important changes in *DSM-5*. These include changes to the diagnostic criteria for attention-deficit hyperactivity disorder as well as new diagnoses such as binge eating disorder and premenstrual dysphoric disorder.
5. Other feature boxes provide opportunities for critical thinking by illustrating some of the controversies associated with the changes that were (or were not) made. Throughout the

book we also provide readers with different perspectives on the likely implications that these changes will have for clinical diagnosis and research in psychopathology.

6. Changes have been made in many chapters to improve the flow of the writing and enhance learning. Reflecting the ever-changing field of abnormal psychology, new references have been added and new research findings highlighted.
7. Finally, at the beginning of each chapter clearly defined Learning Objectives provide the reader with an overview of topics and issues that will be included in the chapter. At the end of each chapter a summary of answers to these Learning Objective questions are provided. In-Review Questions at the end of major sections within chapters also provide additional opportunities for self-assessment and increased learning.

What's New

A major change in the 16th edition of *Abnormal Psychology* is the focus on *DSM-5*. This important revision to the diagnostic system was published in May 2013. To assist both instructors and students, we include specialized feature boxes, highlighting many of the key changes that were made in *DSM-5*. This makes new material immediately accessible. Other important changes in *DSM-5* are also mentioned throughout the text. Providing students with this material as soon as possible after the publication of *DSM-5* reflects our commitment to staying ahead of the curve and to providing students with the most up-to-date information possible.

This new edition of *Abnormal Psychology* has been redesigned to remain visually engaging to the newest generation of students. Chapters begin with learning objective questions. These orient the reader to the material that will be presented in each specific chapter. Learning objective questions are also repeated at the end of each chapter and answers to each are provided. Most chapters also begin with a case study that illustrates the mental health problems to be addressed in the chapter. This serves to capture students' interest and attention right from the outset. Numerous new photographs and illustrations have also been added. In addition, this edition also contains updated case material, new unresolved issues (e.g., why is the study of trauma so contentious?; why are recovery rates in schizophrenia not improving?), and new feature boxes designed to be of high interest to students (e.g., non-suicidal self-injury disorder). Reflecting the ever-changing field of abnormal psychology, numerous new references have been added. Outdated material has been replaced, current findings have been included, and new developments have been identified. The 16th edition also includes the most up-to-date and in-depth information about the role of biological factors in abnormal behavior, while at the same time placing this in the context of a comprehensive biopsychosocial approach. Our coverage of cultural issues and diversity has also been strengthened. We hope readers will be

pleased to know that all of this has been accomplished without adding length to the book!

Features and Pedagogy

The extensive research base and accessible organization of this book are supported by high-interest features and helpful pedagogy to further engage students and support learning. We also hope to encourage students to think in depth about the topics they are learning about through specific highlight features that emphasize critical thinking.

Features

FEATURE BOXES

Special sections, called Developments in Research, Developments in Thinking, Developments in Practice, and The World Around Us, highlight topics of particular interest, focusing on applications of research to everyday life, current events, and the latest research methodologies, technologies, and findings.

CRITICAL THINKING

New to this edition are special highlight boxes about *DSM-5*. Many of the revisions to *DSM-5* were highly contentious and controversial. A new feature box called "Thinking Critically About *DSM-5*" introduces students to the revised *DSM* and encourages them to think critically about the implications of these changes.

UNRESOLVED ISSUES

All chapters include end-of-chapter sections that demonstrate how far we have come and how far we have yet to go in our understanding of psychological disorders. The topics covered here provide insight into the future of the field and expose students to some controversial topics. New to this edition is a discussion of the problems associated with the study of trauma. In another chapter, we raise the contentious issue of whether treatment with antipsychotic medications is helpful or harmful in the very long term.

Pedagogy

LEARNING OBJECTIVES

Each chapter begins with learning objective questions. These orient the reader to the material that will be presented in each specific chapter. Learning objective questions are also repeated at the end of each chapter, along with their answers. This provides students with an excellent tool for study and review. In this edition, sections of many chapters have also been reorganized and material has been streamlined whenever possible. All the changes that have been made are designed to improve the flow of the writing and enhance pedagogy.

CASE STUDIES

Extensive case studies of individuals with various disorders are integrated in the text throughout the book. Some are brief excerpts; others are detailed analyses. These cases bring important aspects of the disorders to life. They also remind readers that the problems of abnormal psychology affect the lives of people—people from all kinds of diverse backgrounds who have much in common with all of us.

IN REVIEW QUESTIONS

Questions appear at the end of each major section within the chapter, providing regular opportunities for self-assessment as students read and further reinforce their learning.

DSM-5 BOXES

Throughout the book these boxes contain the most up-to-date (*DSM-5*) diagnostic criteria for all of the disorders discussed. In a convenient and visually accessible form, they provide a helpful study tool that reflects current diagnostic practice. They also help students understand disorders in a real-world context.

RESEARCH CLOSE-UP TERMS

Appearing throughout each chapter, these terms illuminate research methodologies. They are designed to give students a clearer understanding of some of the most important research concepts in the field of abnormal psychology.

CHAPTER SUMMARIES

Each chapter ends with a summary of the essential points of the chapter organized around the learning objectives presented at the start of the chapter. These summaries use bulleted lists rather than formal paragraphs. This makes the information more accessible for students and easier to scan.

KEY TERMS

Key terms are identified in each chapter. Key terms are also listed at the end of every chapter with page numbers referencing where they can be found in the body of the text. Key terms are also defined in the Glossary at the end of the book.

Supplements Package

MyPsychLab® for Abnormal Psychology

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 a dynamic set of tools for gauging individual and class performance.

To order the 16th edition with MyPsychLab, use ISBN 0205965091

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 on DVD or through MyPsychLab.

Volume 1: ISBN 0131933329

Volume 2: ISBN 0136003036

Volume 3: ISBN 0132308916

Instructor's Manual (0205971946)

A comprehensive tool for class preparation and management, each chapter includes teaching objectives; a chapter overview; a detailed lecture outline; a list of key terms; teaching resources, including lecture launchers, class activities, demonstrations, assignments, teaching tips and handouts; a list of video, media, and Web resources; and a sample syllabus. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

Test Bank (0205971938)

The Test Bank is composed of approximately 2,000 fully referenced multiple-choice, completion, short-answer, and concise essay questions. Each question is accompanied by a page reference, difficulty level, skill type (factual, conceptual or applied), topic, and a correct answer. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

MyTest (020591537X)

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, 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 on each question provides information on difficulty level and the page number of corresponding text discussion. For more information, go to www.PearsonMyTest.com.

Lecture PowerPoint Slides (0205978398)

The PowerPoint slides provide an active format for presenting concepts from each chapter and feature relevant figures and tables from the text. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

Enhanced Lecture PowerPoint Slides with Embedded Videos on DVD (020597422). The lecture PowerPoint slides have been embedded with select Speaking Out video pertaining to each disorder chapter, enabling instructors to show videos within the context of their lecture. No internet connection is required to play videos.

PowerPoint Slides for Photos, Figures, and Tables

(0205988814) contain only the photos, figures, and line art from the textbook. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

CourseSmart (0205971768)

CourseSmart Textbooks Online is an exciting choice for students looking to save money. As an alternative to purchasing the print textbook, students can subscribe to the same content online and save up to 60 percent off the suggested list price of the print text. With a CourseSmart eTextbook, students can search the text, make notes online, print out reading assignments that incorporate lecture notes, and bookmark important passages for later review. For more information or to subscribe to the CourseSmart eTextbook, visit www.coursesmart.com.

Acknowledgments

It takes each member of the author team more than a year of focused work to produce a new edition of this textbook. During this time, family and friends receive much less attention than they deserve. We are aware that a few lines of acknowledgement in a preface do little to compensate those close to us for all the inconveniences and absences they have endured. Nonetheless, James Butcher would like to thank his wife, Carolyn L. Williams, and his children, Holly Butcher, Sherry Butcher, and Jay Butcher, for their patience and support during this time. Jill Hooley is ever grateful to Kip Schur for his patience, love, support, and ability to retain a sense of humor throughout the revision process. She also thanks Blake T. Haskell for providing valuable information used in Chapter 9. The efforts of graduate student Sara Masland and undergraduates Lauren Fields and Deirdre Gorman are also gratefully acknowledged. Susan Mineka wishes to thank her graduate students, friends, and family for their patience and support for the duration of this project. She also extends special thanks to J. Michael Bailey.

Singled out for special praise and endless appreciation is our wonderful development editor, LeeAnn Doherty. Her editorial expertise, insightful recommendations, and grace under pressure made her a delight to work with. A big thank you also goes to Erin Mitchell, acquisitions editor, for her advice, support, and dedication to the book. Without Erin's ability to manage every challenge that arose, this book might still be in the production stages. Another special thank you goes to Sherry Lewis for her skillful management of the production of this book as well as to Amber Mackey for her efforts to secure all the permissions necessary for the figures and photographs.

Many experts, researchers, and users of this book provided us with comments on individual chapters. We are extremely grateful for their input and feedback. Their knowledge and expertise help us keep this text current and accurate. We thank Tia Alpouira

and Mohsen Jadidi who provided valuable help. We are also especially grateful to the many reviewers who have given us invaluable feedback on this and previous editions of *Abnormal Psychology*.

Angela Bragg, Mount Hood Community College; Greg Carey, University of Colorado; Louis Castonguay, Pennsylvania State University; Richard Cavasina, California University of Pennsylvania; Dianne Chambless, University of Pennsylvania; Lee Anna Clark, The University of Iowa; Barbara Cornblatt; William Paul Deal, University of Mississippi; Raymond L. Eastman, Stephen F. Austin State University; John F. Edens, Sam Houston State University; Colleen Ehrnstrom, University of Colorado at Boulder; William Fals-Stewart, The State University of New York at Buffalo; John P. Forsyth, The State University of New York at Albany; Louis R. Franzini, San Diego State University; David H. Gleaves, Texas A&M University; Michael Green, University of California at Los Angeles; Steven Haynes, University of Hawaii at Manoa; Kathi Heffner, Ohio University; Daniel Holland, University of Arkansas at Little Rock; Steven Hollon, Vanderbilt University; Joanne Hoven Stohs, California State University Fullerton; Robert Howland, University of Pittsburgh, School of Medicine; Jean W. Hunt, Cumberland College; Alexandra Hye-Young Park, Virginia Tech; William G. Iacono, University of Minnesota; Jessica Jablonski, University of Delaware; Erick Janssen, Indiana University; Sheri Johnson, University of Miami; Ann Kane, Barnstable High; Alan Kazdin, Yale University; Lynne Kemen, Hunter College; Carolin Keutzer, University of Oregon; John F. Kihlstrom, University of California at Berkeley; Gerald Koocher, Simmons College; David Kosson, Chicago Medical School; Marvin Lee, Tennessee State University; Brett Litz, Boston University; Brendan Maher, Harvard University; Richard McNally, Harvard University; Edwin Megargee, Florida State University; William Miller, University of New Mexico; Robin Morgan, Indiana University Southeast; Michael Neboschick, College of Charleston; Matthew Nock, Harvard University; Chris Patrick, Florida State University; Marcus Patterson, University of Massachusetts; John Daniel Paxton, Lorain County Community College; Walter Penk, Memorial Veterans Hospital, Bedford, MA; Diego Pizzagalli, Harvard University; Lauren Polvere, Concordia University; Andy Pomerantz, Southern Illinois University, Edwardsville; Harvey Richman, Columbus State University; Barry J. Ries, Minnesota State University; Elizabeth Roemer, University of Massachusetts at Boston; Rick Seime, Mayo Clinic; Frances Sessa, Pennsylvania State University, Abington; Brad Schmidt, Ohio State University; Kandy Stahl, Stephen F. Austin State University; Stephanie Stein, Central Washington University; Xuan Stevens, Florida International University; Eric Stice, University of Texas at Austin; Marcus Tye, Dowling College; Beverly Vchulek, Columbia College; Michael E. Walker, Stephen F. Austin State University; Clifton Watkins, University of North Texas; Nathan Weed, Central Michigan University; and Kenneth J. Zucker, Centre for Addiction and Mental Health, Ontario, Canada.

about the authors



James N. BUTCHER

Professor Emeritus, University of Minnesota

James N. Butcher was born in West Virginia. He enlisted in the army when he was 17 years old and served in the airborne infantry for 3 years, including a 1-year tour in Korea during the Korean War. After military service, he attended Guilford College, graduating in 1960 with a BA in psychology. He received an MA in experimental psychology in 1962 and a PhD in clinical psychology from the University of North Carolina at Chapel Hill. He was awarded Doctor Honoris Causa from the Free University of Brussels, Belgium, in 1990 and an honorary doctorate from the University of Florence, Florence, Italy, in 2005. He is currently professor emeritus in the Department of Psychology at the University of Minnesota. He was associate director and director of the clinical psychology program at the university for 19 years. He was a member of the University of Minnesota Press's MMPI Consultative Committee, which undertook the revision of the MMPI in 1989. He was formerly the editor of *Psychological Assessment*, a journal of the American Psychological Association, and serves as consulting editor or reviewer for numerous other journals in psychology and psychiatry. Dr. Butcher was actively involved in developing and organizing disaster response programs for dealing with human problems following airline disasters during his career. He organized a model crisis intervention disaster response for the Minneapolis-St. Paul Airport and organized and supervised the psychological services offered following two major airline disasters: Northwest Flight 255 in Detroit, Michigan, and Aloha Airlines on Maui. He is a fellow of the Society for Personality Assessment. He has published 60 books and more than 250 articles in the fields of abnormal psychology, cross-cultural psychology, and personality assessment.



Jill M. HOOLEY

Harvard University

Jill M. Hooley is a professor of psychology at Harvard University. She is also the head of the experimental psychopathology and clinical psychology program at Harvard. Dr. Hooley was born in England and received a B.Sc. in psychology from the University of Liverpool. This was followed by research work at Cambridge University. She then attended Magdalen College, Oxford, where she completed her D.Phil. After a move to the United States and additional training in clinical psychology at SUNY Stony Brook, Dr. Hooley took a position at Harvard, where she has been a faculty member since 1985.

Dr. Hooley has a long-standing interest in psychosocial predictors of psychiatric relapse in patients with severe psychopathology such as schizophrenia and depression. Her research has been supported by grants from the National Institute of Mental Health and by the Borderline Personality Disorder Research Foundation. She uses fMRI to study emotion regulation in people who are vulnerable to depression and in people who are suffering from borderline personality disorder. Another area of research interest is nonsuicidal self-harming behaviors such as skin cutting or burning.

In 2000, Dr. Hooley received the Aaron T. Beck Award for Excellence in Psychopathology Research. She is also a past president of the Society for Research in Psychopathology. The author of many scholarly publications, Dr. Hooley was appointed as Associate Editor for Clinical Psychological Science in 2012. She is also an associate editor for *Applied and Preventive Psychology* and serves on the editorial boards of several journals including the *Journal of Consulting and Clinical Psychology*, the *Journal of Family Psychology*, *Family Process*, and *Personality Disorders: Theory, Research and Treatment*.

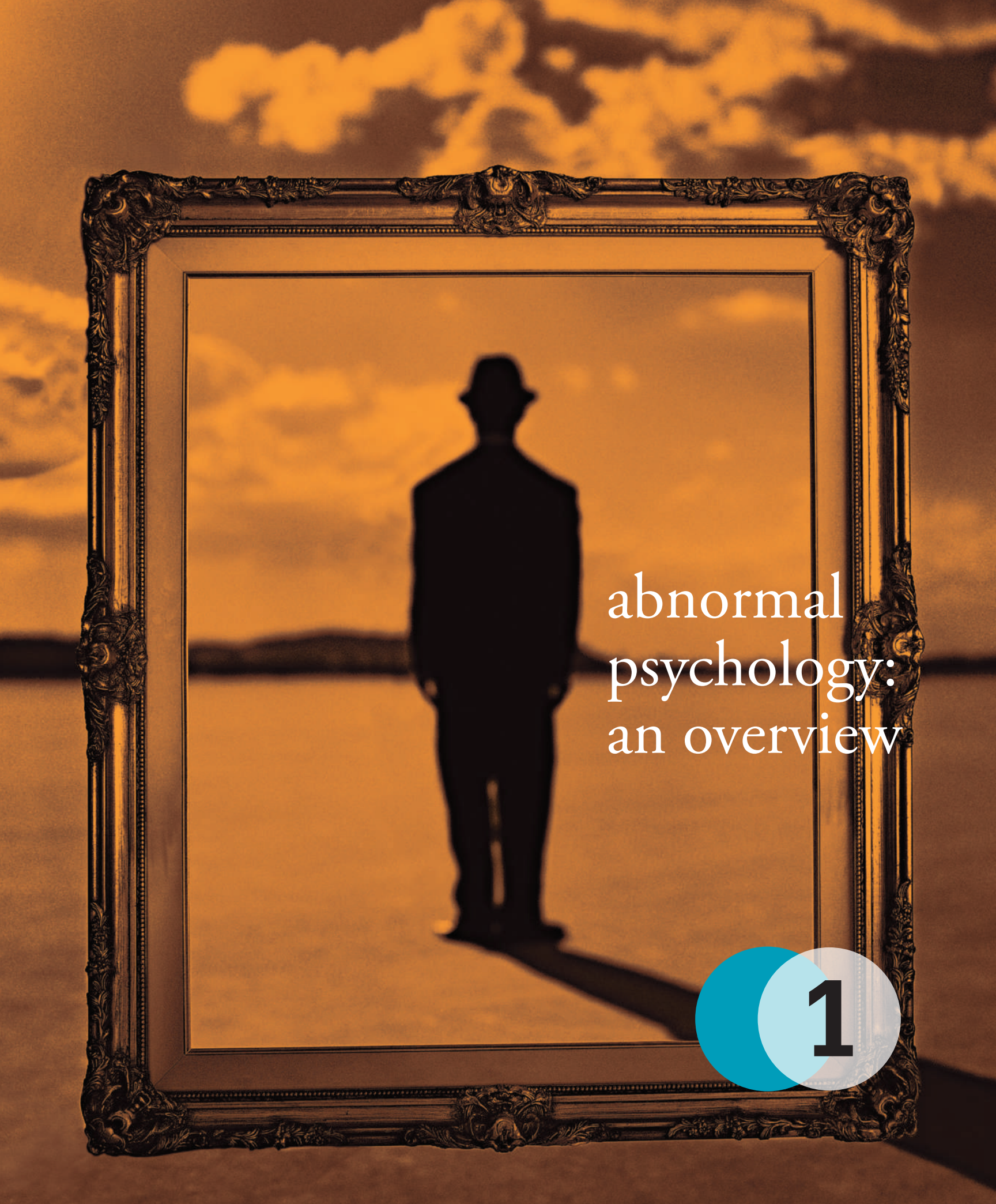
At Harvard, Dr. Hooley has taught graduate and undergraduate classes in introductory psychology, abnormal psychology, schizophrenia, mood disorders, clinical psychology, psychiatric diagnosis, and psychological treatment. Reflecting her commitment to the scientist-practitioner model, she also does clinical work specializing in the treatment of people with depression, anxiety disorders, and personality disorders.



Susan MINEKA

Northwestern University

Susan Mineka, born and raised in Ithaca, New York, received her undergraduate degree magna cum laude in psychology at Cornell University. She received a PhD in experimental psychology from the University of Pennsylvania and later completed a formal clinical retraining program from 1981 to 1984. She taught at the University of Wisconsin–Madison and at the University of Texas at Austin before moving to Northwestern University in 1987. Since 1987 she has been a professor of psychology at Northwestern, and from 1998 to 2006 she served as director of clinical training there. She has taught a wide range of undergraduate and graduate courses, including introductory psychology, learning, motivation, abnormal psychology, and cognitive-behavior therapy. Her current research interests include cognitive and behavioral approaches to understanding the etiology, maintenance, and treatment of anxiety and mood disorders. She is currently a Fellow of the American Psychological Association, the American Psychological Society, and the Academy of Cognitive Therapy. She has served as editor of the *Journal of Abnormal Psychology* (1990–1994). She also served as associate editor for *Emotion* from 2002 to 2006 and is on the editorial boards of several of the leading journals in the field. She was also president of the Society for the Science of Clinical Psychology (1994–1995) and was president of the Midwestern Psychological Association (1997). She also served on the American Psychological Association's Board of Scientific Affairs (1992–1994, chair 1994), on the Executive Board of the Society for Research in Psychopathology (1992–1994, 2000–2003), and on the Board of Directors of the American Psychological Society (2001–2004). During 1997 and 1998 she was a fellow at the Center for Advanced Study in the Behavioral Sciences at Stanford.



abnormal
psychology:
an overview

1



learning objectives

1.1

How do we define abnormality and classify mental disorders?

1.2

What are the advantages and disadvantages of classification?

1.3

How common are mental disorders? Which disorders are most prevalent?

1.4

Why do we need a research-based approach in abnormal psychology?

1.5

How do we gather information about mental disorders?

1.6

What kinds of research designs are used to conduct research in abnormal psychology?

Abnormal psychology is concerned with understanding the nature, causes, and treatment of mental disorders. The topics and problems within the field of abnormal psychology surround us every day. You have only to pick up a newspaper, flip through a magazine, surf the web, or sit through a movie to be exposed to some of the issues that clinicians and researchers deal with on a day-to-day basis. Almost weekly some celebrity is in the news because of a drug or alcohol problem, an eating disorder, or some other psychological difficulty. Countless books provide personal accounts of struggles with schizophrenia, depression, phobias, and panic attacks. Films and TV shows portray aspects of abnormal behavior with varying degrees of accuracy. And then there are the tragic news stories of mothers who kill their children, in which problems with depression, schizophrenia, or postpartum difficulties seem to be implicated.

Abnormal psychology can also be found much closer to home. Walk around any college campus, and you will see flyers about peer support groups for people with eating disorders, depression, and a variety of other disturbances. You may even know someone who has experienced a clinical problem. It may be a cousin with a cocaine habit, a roommate with bulimia, or a grandparent who is developing Alzheimer's disease. It may be a coworker of your mother's who is hospitalized for depression, a neighbor who is afraid to leave the house, or someone at your gym who works out intensely despite being worryingly thin. It

may even be the disheveled street person in the aluminum foil hat who shouts, "Leave me alone!" to voices only he can hear.

The issues of abnormal psychology capture our interest, demand our attention, and trigger our concern. They also compel us to ask questions. To illustrate further, let's consider two clinical cases.

→ **Monique** Monique is a 24-year-old law student. She is attractive, neatly dressed, and clearly very bright. If you were to meet her, you would think that she had few problems in her life; but Monique has been drinking alcohol since she was 14, and she smokes marijuana every day. Although she describes herself as "just a social drinker," she drinks four or five glasses of wine when she goes out with friends and also drinks a couple of glasses of wine a night when she is alone in her apartment in the evening. She frequently misses early-morning classes because she feels too hung over to get out of bed. On several occasions her drinking has caused her to black out. Although she denies having any problems with alcohol, Monique admits that her friends and family have become very concerned about her and have suggested that she seek help. Monique, however, says, "I don't think I am an alcoholic because I never drink in the mornings." The previous week she decided to stop smoking marijuana entirely because she was concerned that she might have a drug problem. However, she found it impossible to stop and is now smoking regularly again.

→ **John** John comes from a family with no history of mental illness. He had a normal birth and seemed to develop normally when he was a child. However, when he was 21, John began to hear voices and started to believe that there was a conspiracy against him. Since that time, he has been on various different anti-psychotic medications. Although these have helped a little, he still has symptoms of psychosis. Now aged 46, John has been unable to work since he became ill. He has also been hospitalized many times. John lives in sheltered accommodation, although he maintains contact with his parents and his older brother.

Perhaps you found yourself asking questions as you read about Monique and John. For example, because Monique doesn't drink in the mornings, you might have wondered whether she could really have a serious alcohol problem. She does. This is a question that concerns the criteria that must be met before someone receives a particular diagnosis. Or perhaps you wondered whether other people in Monique's family likewise have drinking problems. They do. This is a question about what we call **family aggregation**—that is, whether a disorder runs in families.

You may also have been curious about what is wrong with John and why he is hearing voices. Questions about the age of onset of his symptoms as well as predisposing factors may also have occurred to you. John has schizophrenia, a disorder that often strikes in late adolescence or early adulthood. Also, as



Fergie has spoken about her past struggles with substance abuse, specifically crystal meth.

John's case illustrates, it is not unusual for someone who develops schizophrenia to develop perfectly normally before suddenly becoming ill. You can read more about John's case and treatment in Valmaggia and colleagues (2008).

These cases, which describe real people, give some indication of just how profoundly lives can be derailed because of mental disorders. It is hard to read about difficulties such as these without feeling compassion for the people who are struggling. Still, in addition to compassion, clinicians and researchers who want to help people like Monique and John must have other attributes and skills. If we are to understand mental disorders, we must learn to ask the kinds of questions that will enable us to help the patients and families who have mental disorders. These questions are at the very heart of a research-based approach that looks to use scientific inquiry and careful observation to understand abnormal psychology.

Asking questions is an important aspect of being a psychologist. Psychology is a fascinating field, and abnormal psychology is one of the most interesting areas of psychology (although we are undoubtedly biased). Psychologists are trained to ask questions and to conduct research. Though not all people who are trained in abnormal psychology (this field is sometimes called psychopathology) conduct research, they still rely heavily on their scientific skills and ability both to ask questions and to put information together in coherent and logical ways. For example, when a clinician first sees a new client or patient, he or she asks many questions to try and understand the issues or problems related to that person. The clinician will also rely on current research to

choose the most effective treatment. The best treatments of 20, 10, or even 5 years ago are not invariably the best treatments of today. Knowledge accumulates and advances are made. And research is the engine that drives all of these developments.

In this chapter, we will outline the field of abnormal psychology and the varied training and activities of the people who work within its demands. First we describe the ways in which abnormal behavior is defined and classified so that researchers and mental health professionals can communicate with each other about the people they see. Some of the issues here are probably more complex and controversial than you might expect. We also outline basic information about the extent of behavioral abnormalities in the population at large.

You will notice that a large section of this chapter is devoted to research. We make every effort to convey how abnormal behavior is studied. Research is at the heart of progress and knowledge in abnormal psychology. The more you know and understand about how research is conducted, the more educated and aware you will be about what research findings do and do not mean.

What Do We Mean by Abnormality?

It may come as a surprise to you that there is still no universal agreement about what is meant by *abnormality* or *disorder*. This is not to say we do not have definitions; we do. However, a truly satisfactory definition will probably always remain elusive (Lilienfeld & Landfield, 2008; Stein et al., 2010) even though there is a great deal of general agreement about which conditions are disorders and which are not (Spitzer, 1999).

Why does the definition of a mental disorder present so many challenges? A major problem is that there is no one behavior that makes someone abnormal. However, there are some clear elements or indicators of abnormality (Lilienfeld & Marino, 1999; Stein et al., 2010). No single indicator is sufficient in and of itself to define or determine abnormality. Nonetheless, the more that someone has difficulties in the following areas, the more likely he or she is to have some form of mental disorder.

1. **Suffering:** If people suffer or experience psychological pain we are inclined to consider this as indicative of abnormality. Depressed people clearly suffer, as do people with anxiety disorders. But what of the patient who is manic and whose mood is one of elation? He or she may not be suffering. In fact, many such patients dislike taking medications because they do not want to lose their manic "highs." You may have a test tomorrow and be suffering with worry. But we would hardly label your suffering abnormal. Although suffering is an element of abnormality in many cases, it is neither a sufficient condition (all that is needed) nor even a necessary condition (a feature that all cases of abnormality must show) for us to consider something as abnormal.
2. **Maladaptiveness:** Maladaptive behavior is often an indicator of abnormality. The person with anorexia may restrict her intake of food to the point where she becomes so emaciated

that she needs to be hospitalized. The person with depression may withdraw from friends and family and may be unable to work for weeks or months. Maladaptive behavior interferes with our well-being and with our ability to enjoy our work and our relationships. However, not all disorders involve maladaptive behavior. Consider the con artist and the contract killer, both of whom have antisocial personality disorder. The first may be able glibly to talk people out of their life savings, the second to take someone's life in return for payment. Is this behavior maladaptive? Not for them, because it is the way in which they make their respective livings. We consider them abnormal, however, because their behavior is maladaptive for and toward society.

3. **Statistical Deviancy:** The word *abnormal* literally means “away from the normal.” But simply considering statistically rare behavior to be abnormal does not provide us with a solution to our problem of defining abnormality. Genius is statistically rare, as is perfect pitch. However, we do not consider people with such uncommon talents to be abnormal in any way. Also, just because something is statistically common doesn't make it normal. The common cold is certainly very common, but it is regarded as an illness nonetheless.

On the other hand, intellectual disability (which is statistically rare and represents a deviation from normal) is considered to reflect abnormality. This tells us that in defining abnormality we make value judgments. If something is statistically rare and undesirable (as is severely diminished intellectual functioning), we are more likely to consider it abnormal than something that is statistically rare and highly desirable (such as genius) or something that is undesirable but statistically common (such as rudeness).

4. **Violation of the Standards of Society:** All cultures have rules. Some of these are formalized as laws. Others form the norms and moral standards that we are taught to follow. Although

many social rules are arbitrary to some extent, when people fail to follow the conventional social and moral rules of their cultural group we may consider their behavior abnormal. For example, driving a car or watching television would be considered highly abnormal for the Amish of Pennsylvania. However, both of these activities reflect normal everyday behavior for most other Pennsylvania residents.

Of course, much depends on the magnitude of the violation and on how commonly the rule is violated by others. As illustrated in the example above, a behavior is most likely to be viewed as abnormal when it violates the standards of society and is statistically deviant or rare. In contrast, most of us have parked illegally at some point. This failure to follow the rules is so statistically common that we tend not to think of it as abnormal. Yet when a mother drowns her children there is instant recognition that this is abnormal behavior.

5. **Social Discomfort:** When someone violates a social rule, those around him or her may experience a sense of discomfort or unease. Imagine that you are sitting in an almost empty movie theater. There are rows and rows of unoccupied seats. Then someone comes in and sits down right next to you. How do you feel? In a similar vein, how do you feel when someone you met only 4 minutes ago begins to chat about her suicide attempt? Unless you are a therapist working in a crisis intervention center, you would probably consider this an example of abnormal behavior.

6. **Irrationality and Unpredictability:** As we have already noted, we expect people to behave in certain ways. Although a little unconventionality may add some spice to life, there is a point at which we are likely to consider a given unorthodox behavior abnormal. If a person sitting next to you suddenly began to scream and yell obscenities at nothing, you would probably regard that behavior as abnormal. It would be unpredictable, and it would make no sense to you. The disordered speech and the disorganized behavior of patients with schizophrenia are often irrational. Such behaviors are also a hallmark of the manic phases of bipolar disorder. Perhaps the most important factor, however, is our evaluation of whether the person can control his or her behavior. Few of us would consider a roommate who began to recite speeches from *King Lear* to be abnormal if we knew that he was playing *Lear* in the next campus Shakespeare production—or even if he was a dramatic person given to extravagant outbursts. On the other hand, if we discovered our roommate lying on the floor, flailing wildly, and reciting Shakespeare, we might consider calling for assistance if this was entirely out of character and we knew of no reason why he should be behaving in such a manner.

7. **Dangerousness:** It seems quite reasonable to think that someone who is a danger to him- or herself or to another person must be psychologically abnormal. Indeed, therapists are required to hospitalize suicidal clients or contact the police (as well as the person who is the target of the threat) if they have a client who makes an explicit threat to harm another person.



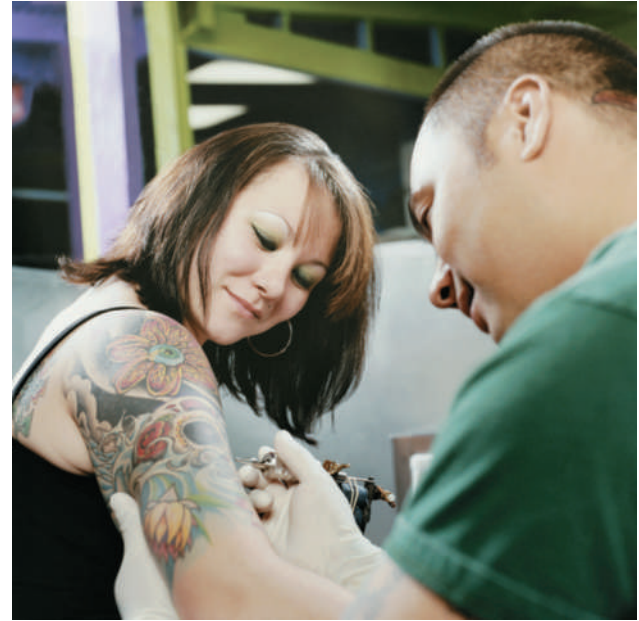
As with most accomplished athletes, Venus and Serena Williams' physical ability is abnormal in a literal and statistical sense. Their behavior, however, would not be labeled as being abnormal by psychologists. Why not?



How important is dangerousness to the definition of mental illness? If we are a risk to ourselves or to others, does this mean we are mentally ill?

But, as with all of the other elements of abnormality, if we rely only on dangerousness as our sole feature of abnormality, we will run into problems. Is a soldier in combat mentally ill? What about someone who is an extremely bad driver? Both of these people may be a danger to others. Yet we would not consider them to be mentally ill. Why not? And why is someone who engages in extreme sports or who has a dangerous hobby (such as free diving, race car driving, or keeping poisonous snakes as pets) not immediately regarded as mentally ill? Just because we may be a danger to ourselves or to others does not mean we are mentally ill. Conversely, we cannot assume that someone diagnosed with a mental disorder must be dangerous. Although mentally ill people do commit serious crimes, serious crimes are also committed every day by people who have no signs of mental disorder. Indeed, research suggests that in people with mental illness, dangerousness is more the exception than it is the rule (Corrigan & Watson, 2005).

One final point bears repeating. Decisions about abnormal behavior always involve social judgments and are based on the values and expectations of society at large. This means that culture plays a role in determining what is and is not abnormal. For example, in the United States, people do not believe that it is acceptable to murder a woman who has a premarital or an extramarital relationship. However, *karo-kari* (a form of honor killing



Tattoos, which were once regarded as highly deviant, are now quite commonplace and considered fashionable by many.

where a woman is murdered by a male relative because she is considered to have brought disgrace onto her family) is considered justifiable by many people in Pakistan (Patel & Gadit, 2008).

In addition, because society is constantly shifting and becoming more or less tolerant of certain behaviors, what is considered abnormal or deviant in one decade may not be considered abnormal or deviant a decade or two later. At one time, homosexuality was classified as a mental disorder. But this is no longer the case. A generation ago, pierced noses and navels were regarded as highly deviant and prompted questions about a person's mental health. Now, however, such adornments are commonplace, considered fashionable by many, and attract little attention. What other behaviors can you think of that are now considered normal but were regarded as deviant in the past?

As you think about these issues, consider the person described in The World Around Us box on page 6. Is he a courageous man of profound moral commitment? Or is his behavior abnormal and indicative of a mental disorder? Do others share your view about him?

The DSM-5 and the Definition of Mental Disorder

In the United States, the accepted standard for defining various types of mental disorders is the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. This manual, commonly referred to as the *DSM*, is revised and updated from time to time. The current version, called *DSM-5*, was published in 2013. Its revision has been a topic of much debate and controversy. In the box on page 7 we explain more about the *DSM* and discuss why a revision was necessary.

Extreme Generosity or Pathological Behavior?

Zell Kravinsky was a brilliant student who grew up in a working-class neighborhood in Philadelphia. He won prizes at school, and at the age of 12, he began investing in the stock market. Despite his abilities, his Russian immigrant parents were, in the words of a family friend, “steadfast in denying him any praise.” Kravinsky eventually completed two Ph.D. degrees and indulged his growing interest in real estate. By the time he was 45 years old, he was married with children. His assets amounted to almost \$45 million.

Although Kravinsky had a talent for making money, he found it difficult to spend it. He drove an old car, did not give his children pocket money, and lived with his family in a modest home. As his fortune grew, however, he began to talk to his friends about his plans to give all of his assets to charity. His philanthropy began in earnest when he and his wife gave two gifts, totaling \$6.2 million, to the Centers for Disease Control Foundation. They also donated an apartment building to a school for the disabled in Philadelphia. The following year the Kravinskys gave real estate gifts worth approximately \$30 million to Ohio State University.

Kravinsky’s motivation for his donations was to help others. According to one of his friends, “He gave away the money because he had it and there were people who needed it. But it changed his way of looking at himself. He decided the purpose of his life was to give away things.” After he had put some money aside in trust for his wife and his children, Kravinsky’s personal assets were reduced to a house (on which he had a substantial mortgage), two minivans, and around \$80,000 in stocks and cash. He had essentially given away his entire fortune.

Kravinsky’s donations did not end when his financial assets became depleted. He began to be preoccupied with the idea of nondirected organ donations, in which an altruistic person gives an organ to a total stranger. When he learned that he could live quite normally with only one kidney, Kravinsky decided that the personal costs of giving away one of his kidneys were minimal compared to the benefits received by the kidney recipient. His wife, however, did not share his view. Although she had consented to bequeathing substantial sums of money to worthwhile charities, when it came to her husband offering his kidney, she could not support him.

For Kravinsky, however, the burden of refusing to help alleviate the suffering of someone in need was almost unbearable, even if it meant sacrificing his very own organs. He called the Albert Einstein Medical Center and spoke to a transplant coordinator. He met with a surgeon and then with a psychiatrist. Kravinsky told the psychiatrist that his wife did not support his desire to donate one of his kidneys. When the psychiatrist told him that he was



Is Zell Kravinsky’s behavior abnormal, or is he a man with profound moral conviction and courage?

doing something he did not have to do, Kravinsky’s response was that he did need to make this sacrifice: “You’re missing the whole point. It’s as much a necessity as food, water, and air.”

Three months later, Kravinsky left his home in the early hours of the morning, drove to the hospital, and donated his right kidney. He informed his wife after the surgery was over. In spite of the turmoil that his kidney donation created within his family, Kravinsky’s mind turned back to philanthropy almost immediately. “I lay there in the hospital, and I thought about all my other good organs. When I do something good, I feel that I can do more. I burn to do more. It’s a heady feeling.” By the time he was discharged, he was wondering about giving away his one remaining kidney.

After the operation, Kravinsky experienced a loss of direction. He had come to view his life as a continuing donation. However, now that his financial assets and his kidney were gone, what could he provide to the less fortunate? Sometimes he imagines offering his entire body for donation. “My organs could save several people if I gave my whole body away.” He acknowledges that he feels unable to hurt his family through the sacrifice of his life.

Several years after the kidney donation, Kravinsky still remains committed to giving away as much as possible. However, his actions have caused a tremendous strain in his marriage. In an effort to maintain a harmonious relationship with his wife, he is now involved in real estate and has recently bought his family a larger home. (Taken from Parker, 2004.)

Within *DSM-5*, a mental disorder is defined as a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for mental functioning. *DSM-5* also recognizes that mental disorders are usually associated with significant distress or disability in key areas of functioning such as social, occupational or other activities. Predictable or culturally approved responses to common stressors or losses (such as death of a loved one) are excluded. It is also important that this dysfunctional pattern of behavior not stem from social deviance or conflicts that the person has with society as a whole.

This new *DSM-5* definition of mental illness was based on input from various *DSM-5* workgroups as well as other sources (Broome & Bortolotti, 2010; First & Wakefield, 2010; Stein et al., 2010). Although this definition will still not satisfy everyone, it brings us ever closer to a good working description. Keep in mind that any definition of abnormality or mental disorder must be somewhat arbitrary. Rather than thinking of the *DSM* as a finished product, it should always be regarded as a work in progress and regular updates and modifications are to be expected. Although earlier versions of the *DSM* used Roman numerals to refer to each specific edition (e.g., *DSM-IV*), Arabic numerals are now being used instead of Roman numerals (5 versus V) to facilitate updating (e.g., *DSM-5.1*, *DSM-5.2*) in the future.

Why Do We Need to Classify Mental Disorders?

If defining abnormality is so contentious and so difficult, why do we try to do it? One simple reason is that most sciences rely on classification (e.g., the periodic table in chemistry and the classification of living organisms into kingdoms, phyla, classes, and so on in biology). At the most fundamental level, classification systems provide us with a **nomenclature** (a naming system) and enable us to *structure information* in a more helpful manner.

Organizing information within a classification system also allows us to study the different disorders that we classify and therefore to learn more about not only what causes them but also how they might best be treated. For example, thinking back to the cases you read about, Monique has alcohol and drug use disorders, and John has schizophrenia. Knowing what disorder each of them has is clearly very helpful, as John's treatment would likely not work for Monique.

A final effect of classification system usage is somewhat more mundane. As others have pointed out, the classification of mental disorders has social and political implications (see Blashfield & Livesley, 1999; Kirk & Kutchins, 1992). Simply put, defining the domain of what is considered to be pathological establishes the range of problems that the mental health profession can address. As a consequence, on a purely pragmatic level, it furthermore delineates which types of psychological difficulties warrant insurance reimbursement and the extent of such reimbursement.

THINKING CRITICALLY about *DSM-5*

What Is the *DSM* and Why Was It Revised?

DSM-5

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* provides all the information necessary (descriptions, lists of symptoms) to diagnose mental disorders. As such, it provides clinicians with specific diagnostic criteria for each disorder. This creates a common language so that a specific diagnosis means the same thing to one clinician as it does to another. This also helps ensure diagnostic accuracy and consistency (reliability). *DSM* is also important for research. If patients could not be diagnosed reliably it would be impossible to compare different treatments for patients with similar conditions. Although the *DSM* does not include information about treatment, clinicians need to have an accurate diagnosis in order to select the most appropriate treatment for their patients.

Since *DSM-1* was first published in 1952, the *DSM* has been revised from time to time. Revisions are important because they allow new scientific developments to be incorporated into how we think about mental disorders. The revision process for *DSM-5*

had the goals of maintaining continuity with the previous edition (*DSM-IV*) as well as being guided by new research findings. But another guiding principle was that no constraints should be placed on the level of change that could be made. If this strikes you as a little contradictory, you are correct. Striking the right balance between change and continuity presented considerable challenges. It also created a great deal of controversy. As part of the revision process, experts in specific disorders were invited to join special *DSM-5* work groups and make specific recommendations for change. In some cases, the debates were so heated that people resigned from their work groups! Now that *DSM-5* is here, not everyone is happy with some of the changes that have been made. On the other hand, many of the revisions that have been made make a lot of sense. In the chapters that follow we highlight key changes in *DSM-5*. We also try to help you think critically about the reasons behind the specific modifications that were proposed and understand why they were accepted.

What Are the Disadvantages of Classification?

Of course, there are a number of disadvantages in the usage of a discrete classification system. Classification, by its very nature, provides information in a shorthand form. However, using any form of shorthand inevitably leads to a *loss of information*. If we know the specific history, personality traits, idiosyncrasies, and familial relations of a person with a particular type of disorder (e.g., from reading a case summary), we naturally have much more information than if we were simply told the individual's diagnosis (e.g., schizophrenia). In other words, as we simplify through classification, we inevitably lose an array of personal details about the actual person who has the disorder.

Moreover, although things are improving, there can still be some **stigma** (or disgrace) associated with having a psychiatric diagnosis. Even today, people are generally far more comfortable disclosing that they have a physical illness such as diabetes than they are in admitting to any mental disorder. This is in part due to the fear (real or imagined) that speaking candidly about having a psychological disorder will result in unwanted social or occupational consequences or frank discrimination. Be honest. Have you ever described someone as “nuts,” “crazy,” or “a psycho”? Now think of the hurt that people with mental disorders experience when they hear such words. In a recent study, 96 percent of patients with schizophrenia reported that stigma was a routine part of their lives (Jenkins & Carpenter-Song, 2008). In spite of the large amount of information that is now available about mental health issues, the level of knowledge about mental illness (sometimes referred to as mental health literacy) is often very poor (Thornicroft et al., 2007).

Related to stigma is the problem of **stereotyping**. Stereotypes are automatic beliefs concerning other people that are based on minimal (often trivial) information (e.g., people who wear glasses are more intelligent; New Yorkers are rude; everyone in the South has a gun). Because we may have heard about certain behaviors that can accompany mental disorders, we may automatically and incorrectly infer that these behaviors will also be present in any person we meet who has a psychiatric diagnosis. This is reflected in the comment, “People like you don't go back to work,” in the case example of James McNulty.

→ **James McNulty** I have lived with bipolar disorder for more than 35 years—all of my adult life. The first 15 years were relatively conventional, at least on the surface. I graduated from an Ivy League university, started my own business, and began a career in local politics. I was married, the father of two sons. I experienced mood swings during these years, and as I got older the swings worsened. Eventually, I became so ill that I was unable to work, my marriage ended, I lost my business, and I became homeless.

At this point I had my most powerful experience with stigma. I was 38 years old. I had recently been discharged after a psychiatric hospitalization for a suicide attempt, I had no place to live, my savings were exhausted, and my only possession was

a 4-year-old car. I contacted the mental health authorities in the state where I then lived and asked for assistance in dealing with my mental illness. I was told that to qualify for assistance I would need to sell my car and spend down the proceeds. I asked how I was supposed to get to work when I recovered enough to find a job. I was told, “Don't worry about going back to work. People like you don't go back to work.” (McNulty, 2004)

Take a moment to consider honestly your own attitudes toward people with mental disorders. What assumptions do you tend to make? Do you view people with mental illness as less competent, more irresponsible, more dangerous, and more unpredictable? Research has shown that such attitudes are not uncommon (see A. C. Watson et al., 2004). Can you recall movies, novels, or advertisements that maintain such stereotypes? What are some ways in which you can challenge the false assumptions that are so common in the media? Do you think reality TV shows such as *Hoarders*, *Obsessed*, or *My Strange Addiction* have a helpful or harmful impact on societal attitudes?

Finally, stigma can be perpetuated by the problem of **labeling**. A person's self-concept may be directly affected by being given a diagnosis of schizophrenia, depression, or some other form of mental illness. How might you react if you were told something like this? Furthermore, once a group of symptoms is given a name and identified by means of a diagnosis, this diagnostic label can be hard to shake even if the person later makes a full recovery.

It is important to keep in mind, however, that diagnostic classification systems do not classify people. Rather, *they classify the disorders that people have*. When we note that someone has an illness, we should take care not to define him or her by that illness. Respectful and appropriate language should instead be used. At one time, it was quite common for mental health professionals to describe a given patient as “a schizophrenic” or “a manic-depressive.” Now, however, it is widely acknowledged that it is more accurate (not to mention more considerate) to say, “a person with schizophrenia,” or “a person with manic depression.” Simply put, the person is not the diagnosis.

How Can We Reduce Prejudicial Attitudes Toward the Mentally Ill?

For a long time, it was thought that educating people that mental illnesses were “real” brain disorders might be the solution. Sadly, however, this does not seem to be the case. Although there have been impressive increases in the proportion of people who now understand that mental disorders have neurobiological causes, this increased awareness has not resulted in decreases in stigma. In a recent study, Pescosolido and colleagues (2010) asked people in the community to read a vignette (brief description) about a person who showed symptoms of mental illness. Some people read a vignette about

a person who had schizophrenia. Others read a vignette about someone with clinical depression or alcohol dependence. Importantly, no diagnostic labels were used to describe these people. The vignettes simply provided descriptive information. Nonetheless, the majority of the people who were surveyed in this study expressed an unwillingness to work with the person described in the vignette. They also did not want to have to socialize with them and did not want them to marry into their family. Moreover, the level of rejection that was shown was just as high as it was in a similar survey that was done 10 years earlier. Over that same 10-year period, however, many more people embraced a neurobiological understanding about the causes of mental illness. So what this study tells us is that just because people understand that mental illness is caused by problems in the brain doesn't mean that they are any less prejudiced toward those with mental illness. This is a disappointing conclusion for everyone who hoped that more

scientific research into the biology of mental illness would lead to the elimination of stigma.

Stigma does seem to be reduced by having more contact with people in the stigmatized group (Couture & Penn, 2003). However, there may be barriers to this. Simply imagining interacting with a person who has a mental disorder can lead to distress and also to unpleasant physical reactions. In an interesting study, Graves and colleagues (2005) asked college students enrolled in a psychology course to imagine interacting with a person whose image was shown to them on a slide. As the slide was being presented, subjects were given some scripted biographical information that described the person. In some scripts, the target person was described as having been diagnosed with schizophrenia, although it was also mentioned that he or she was "doing much better now." In other trials, the biographical description made no mention of any mental illness when the person on the slide was being described.

the **WORLD** around us

Mad, Sick, Head Nuh Good: Mental Illness and Stigma in Jamaica

Evidence suggests that negative reactions to the mentally ill may be a fairly widespread phenomenon. Using focus groups, Arthur and colleagues (2010) asked community residents in Jamaica about the concept of stigma. Some participants came from rural communities, others from more urban areas. Regardless of their gender, level of education, or where they lived, most participants described highly prejudicial attitudes toward the mentally ill. One middle-class male participant said, "We treat them as in a sense second class citizens, we stay far away from them, ostracize them, we just treat them bad" (see Arthur et al., 2010, p. 263). Fear of the mentally ill was also commonly expressed. A rural-dwelling middle-class man described a specific situation in the following way, "There is a mad lady on the road named [. . .]. Even the police are afraid of her because she throws stones at them. She is very, very terrible" (p. 261). Moreover, even when more kindly attitudes were expressed, fear was still a common response. One person put it simply, "You are fearful even though you may be sympathetic" (p. 262).

The Jamaicans in this study also made a distinction between mental illness (a term used to denote less severe conditions) and madness, which was used to describe more severe problems. Madness was invariably regarded as being a permanent condition ("once yuh mad yuh mad" or "once yuh gone yuh gone"). Moreover, homelessness was almost always taken to indicate madness. In short, the results of this study suggest that stereotyping, labeling, and stigma toward the mentally ill are not restricted to industrialized countries. Although we might wish that it were otherwise, prejudicial attitudes are common.

This highlights the need for antistigma campaigns in Jamaica, as well as everywhere else in the world.



Are attitudes toward the mentally ill in Jamaica more benign than they are in more industrialized countries?