SEVENTEENTH EDITION

ABNORMAL PSYCHOLOGY

JILL M. HOOLEY

JAMES N. BUTCHER

MATTHEW K. NOCK

SUSAN MINEKA

Abnormal Psychology

Seventeenth Edition

Jill M. Hooley
Harvard University

James N. Butcher
University of Minnesota

Matthew K. Nock
Harvard University

Susan Mineka
Northwestern University

PEARSON

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

VP, Product Development: Dickson Musslewhite
Senior Acquisitions Editor: Amber Chow
Director of Development: Brita Nordin
Sponsoring Editor: Carrie Brandon
Development Editor: Stephanie Ventura
Editorial Assistant: Stephany Harrington
Director of Product Marketing: Maggie Moylan
Director of Field Marketing: Jonathan Cottrell
Director, Program and Project Management: Lisa Iarkowski
Project Management Team Lead: Denise Forlow
Senior Project Manager: Sherry Lewis
Program Management Team Lead: Amber Mackey
Program Manager: Cecilia Turner
Field Marketing Manager: Kate Mitchell
Product Marketing Manager: Lindsey Prudhomme Gill
Marketing Assistant: Frank Alarcon
Operations Manager: Mary Fischer
Senior Operations Specialist: Carol Melville
Associate Director of Design: Blair Brown
Interior Design and Director: Kathryn Foot
Cover Art Director and Designer: Janet Slowik
Cover Art: (tl) Fritz Cohen/Corbis; (tc) Masterfile/Corbis; (tr) Patrik Giardino/Corbis; (l) Tony Anderson/Corbis; (cl) Kate Kunz/Corbis; (cr) Eugenio Marongiu/Corbis; (r) JAG Images/Corbis; (bl) Marnie Burkhart/Corbis; (bcl) Becky Yee/Corbis; (bcr) John Smith/Corbis; (br) Blue Images/Corbis
Digital Studio Team Lead: Peggy Bliss
Digital Studio Project Manager: Christopher Fegan
Media Project Managers: Pamela Weldin and Elissa Senra-Sargent
Full-Service Project Management and Composition: iEnergizer Aptara®, Ltd.
Printer/Binder: Courier Kendallville
Cover Printer: Phoenix Color/Hagerstown

Acknowledgements of third-party content appear on page 730, which constitutes an extension of this copyright page.

Library of Congress Cataloging-in-Publication Data

Names: Hooley, Jill M., author. | Butcher, James Neal, author. | Nock, Matthew, author. | Mineka, Susan, author.
Title: Abnormal psychology.
Description: Seventeenth edition / Jill M. Hooley, James N. Butcher, Matthew K. Nock, Susan Mineka. | Boston : Pearson, [2017] | Revision of: Abnormal psychology / James N. Butcher, University of Minnesota, Susan Mineka, Northwestern University, Jill M. Hooley, Harvard University. Sixteenth edition. | Includes bibliographical references and index.
Identifiers: LCCN 2015041946 | ISBN 9780133852059 | ISBN 0133852059
Subjects: LCSH: Psychology, Pathological—Textbooks. | Psychiatry—Textbooks

Student Edition:
ISBN-10: 0-13-385205-9
ISBN-13: 978-0-13-385205-9

Books a la Carte:
ISBN-10: 0-13-422578-3
ISBN-13: 978-0-13-422578-4

10 9 8 7 6 5 4 3 2 1

PEARSON

Brief Contents

Contents

Features

DSM-5 Boxes

Thinking Critically About DSM-5

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

Many changes occurred from *DSM-IV-TR* 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 reorganized 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 on 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 dysregulation 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-TR* 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.
- Posttraumatic 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 posttraumatic 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-TR*.
- Dissociative fugue is no longer listed as a separate diagnosis. Instead, it is listed as a form of dissociative amnesia.
- The *DSM-IV-TR* 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-TR* 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-TR* diagnoses of dementia and amnestic 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, although an alternative model is now offered as a guide for future research.
- 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, nonsuicidal self-injury disorder, Internet gaming disorder, and caffeine use disorder.

Preface

We are so excited about this course and hope that you are too! We (the authors) all took this course when we were undergraduate students because we were curious about abnormal aspects of human behavior. Why do some people become so depressed they can't get out of bed? Why do others have trouble controlling their use of alcohol and drugs? Why do some people become violent toward others, and in other cases toward themselves? We continue to be intensely curious about, and fascinated by, the answers to these and many other questions about abnormal human behavior. The purpose of this book is to provide a comprehensive (and hopefully engaging) introduction to the primary psychological disorders studied within abnormal psychology.

As you will learn, there are many different types of psychological disorders, and each is caused by the interaction of many different factors and can be considered from many different perspectives. We thought a lot about how best to present this information in a way that will be clear and engaging and will allow you to gain a solid, fundamental understanding of psychological disorders. As such, we use a biopsychosocial approach to provide a sophisticated appreciation of the total context in which abnormalities of behavior occur. This means that we present and describe the wide range of biological, psychological, and social factors that work together to lead to the development of psychological disorders. In addition, we discuss treatment approaches that target each of these different factors.

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 heavy 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.

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. This is very much the case with this new edition. Perhaps the most exciting change, however, is the addition of Harvard Professor Matthew Nock to the author team. Matt, a recent MacArthur Award (aka, "Genius Grant") recipient, brings his brilliance, scholarship, and wry sense of humor to the book, providing fresh approaches and new perspectives. We are delighted that he has joined the author team and welcome him with great enthusiasm!

The Hooley-Butcher-Nock-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 text. We are committed to excellence. We are also committed to making our text accessible to a broad audience. 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. 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 a clear 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?

The book you are reading is the seventeenth edition of *Abnormal Psychology*. Why so many revisions? And why not just use an old copy of the fifteenth or sixteenth edition? The reason is that our field is constantly making advances in our understanding of abnormal psychology. New research is being published all the time. As authors, it is important to us that these changes and new ways of thinking about the etiology, assessment, and treatment of psychological disorders are accurately presented in this text. Although many of the ideas and diagnostic concepts in the field of abnormal psychology have persisted for hundreds of years, changes in thinking often occur. And, at

some point, events occur that force a rethinking of familiar topics. A major example here is the revision of the manual that is used to classify mental disorders (called the *DSM-5*). This new edition of *Abnormal Psychology* includes the most up-to-date information about *DSM-5* 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.

If you're wondering what exactly is so new in this edition of *Abnormal Psychology*, here are seven big revisions that we have made.

1. We have a new author! Matt Nock brings a fresh and new perspective to this authoritative and established text.
2. The seventeenth 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 a comprehensive and balanced biopsychosocial approach to understanding abnormal behavior.
3. As a result of the publication of *DSM-5*, the diagnostic criteria for many disorders have changed. This edition includes detailed boxes listing the current *DSM-5* diagnostic criteria for all the disorders covered in the book. Specific highlight boxes and discussions in the text also alert you to some of the most important changes in *DSM-5*.
4. 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 text we also provide readers with different perspectives on the likely implications that these changes will have (or are having) for clinical diagnosis and research in psychopathology.
5. Reflecting the ever-changing field of abnormal psychology, hundreds of new references have been added, highlighting the newest and most important research findings.
6. Changes have been made in many chapters to improve the flow of the writing and enhance learning. The presentation of material in many chapters has also been reorganized to provide a more logical and coherent narrative.
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. These learning objectives also appear again in the specific sections to which they apply. This makes it easier for readers to identify what they should be learning in each section. At the end of each chapter a summary of the learning objectives is also 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

This new edition of *Abnormal Psychology* has been redesigned to reflect the newest and most relevant research findings, presented in a way that is engaging to the newest generation of students. We've done a lot of updating! Our focus has been on streamlining material throughout the book to decrease the length of each chapter while retaining all of the important information that students should be learning.

We have also done our best to include the most exciting changes and advances occurring in our field. For example, throughout the text, we have significantly increased the focus on the manifestation and treatment of psychological disorders around the globe, using data from a recently completed cross-national series of studies in more than 20 different countries. In Chapter 3, we have added a new and more accessible description of why correlation does not equal causation—and what does! In Chapter 5, we now adopt a more broad and integrative approach to the health consequences of stress, including a focus on the *mechanisms* through which stress is thought to cause physical health problems. Chapter 7 has been updated substantially and now includes more information about some of the problems most relevant to college students, such as suicide and self-injury.

New case studies have also been added throughout the book. Chapter 8, for example, has four new case studies, as well as two new highlight boxes. These illustrate recent neuroimaging research on patients with conversion disorder, as well as a very creative new approach to the treatment of this fascinating disorder. Chapter 11 has significant new material on how alcohol and drugs affect the brain, what causes hangovers, and information on new synthetic drugs that have recently hit the streets. In Chapter 13, the most current genetic findings concerning schizophrenia are described, and new developments in our understanding of the nature of dopamine abnormality in schizophrenia are discussed. A new Developments in Thinking highlight box also presents new ideas about the possibility that schizophrenia might be an immune function disorder. Chapter 15 has been reorganized and updated throughout; for instance, it now includes cutting-edge findings on the potential causes and most effective treatments for autism spectrum disorders. And throughout the book we have included information about some of the newest ways in which researchers and clinicians are

treating psychological disorders, such as via the use of new smartphone apps, brain stimulation treatments, and assistive therapeutic robots! These are just a handful of the many changes we have made to give readers the most current perspectives possible. We want students to stay ahead of the curve and to provide them with the most up-to-date information we can. We also want to give students a sense of how and in what ways various fields are likely moving.

This edition also retains features that were very well received in the last edition. To assist both instructors and students, we continue to feature specialized boxes, highlighting many of the key changes that were made in *DSM-5.* In this edition, however, we also provide a detailed but accessible description of the RDoC approach.

As before, chapters begin with learning objectives. These orient the reader to the material that will be presented in each specific chapter. Learning objectives are also repeated by the section they apply to and summarized at the end of each chapter. Most chapters also begin with a case study (many of which are new) 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 references, photographs, and illustrations have also been added. In short, outdated material has been replaced, current findings have been included, and new developments have been identified. Importantly, all of this has been accomplished without adding length to the book! We hope you enjoy this new edition.

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 Many of the revisions to *DSM-5* were highly contentious and controversial. A 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.

Pedagogy

LEARNING OBJECTIVES Each chapter begins with learning objectives. These orient the reader to the material that will be presented in each specific chapter. Learning objectives are also repeated by the section they apply to and summarized at the end of each chapter. 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 Review 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 text.

Supplements Package

REVEL™

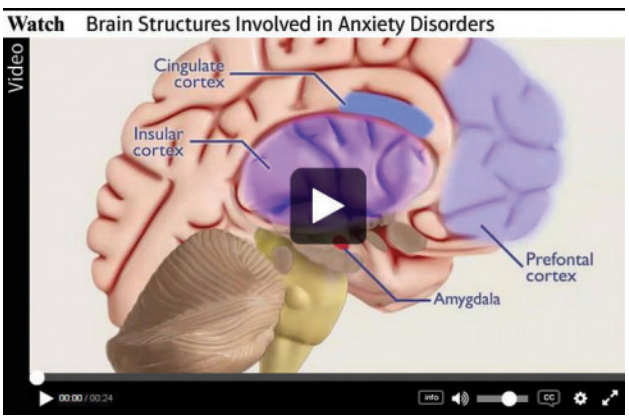
EXPERIENCE DESIGNED FOR THE WAY TODAY'S STUDENTS READ, THINK, AND LEARN When students are engaged deeply, they learn more effectively and perform better in their courses. This simple fact inspired the creation of REVEL: an immersive learning experience designed for the way today's students read, think,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

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

Learn more about REVEL

www.pearsonhighered.com/revel

The seventeenth edition includes integrated videos and media content throughout, allowing students to explore topics more deeply at the point of relevancy.



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

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.

Volume 1: ISBN 0131933329

Volume 2: ISBN 0136003036

Volume 3: ISBN 0132308916

MyPsychLab (0205952372)

Available at www.MyPsychLab.com, 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:

Customizable—MyPsychLab is customizable. Instructors choose what students' course looks like. Homework, applications, and more can easily be turned on and off.

Blackboard Single Sign-on—MyPsychLab can be used by itself or linked to any course management system. Blackboard single sign-on provides deep linking to all New MyPsychLab resources.

Pearson eText and Chapter Audio—Like the printed text, students can highlight relevant passages and add notes. The Pearson eText can be accessed through laptops, iPads, and tablets. Download the free Pearson eText app to use on tablets. Students can also listen to their text with the Audio eText.

Assignment Calendar & Gradebook—A drag and drop assignment calendar makes assigning and completing work easy. The automatically graded assessment provides instant feedback and flows into the gradebook, which can be used in the MyPsychLab or exported.

Personalized Study Plan—Students' personalized plans promote better critical thinking skills. The study plan organizes students' study needs into sections, such as Remembering, Understanding, Applying, and Analyzing.

Instructor's Manual (0134319451)

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 (0134474767)

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 (0134319478)

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 the corresponding text discussion. For more information, go to www.PearsonMyTest.com.

Lecture PowerPoint Slides (0134319443)

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 (0134474791) have been embedded with select Speaking Out video pertaining to each disorder chapter, enabling instructors to show videos within the context of their lecture.

PowerPoint Slides for Photos, Figures, and Tables (013447483X) contain only the photos, figures, and line art from the text. Available for download on the Instructor's Resource Center at www.pearsonhighered.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 acknowledgment in a preface do little to compensate those close to us for all the inconveniences and absences they have endured. Nonetheless, 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 wishes to thank Tina Chou for her help with producing an image for Chapter 10. 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. Matthew Nock would like to thank his wife, Keesha, and their children Matt Jr., Maya, and Georgina, for their patience (and tolerance). He is also grateful to Franchesca Ramirez and Nicole Murman for their assistance in the preparation of this edition. Finally, Susan Mineka thanks her graduate students, friends, and family for their patience and support.

The authors would like to express our most extreme gratitude, respect, and appreciation to our amazing development editor, Stephanie Ventura. Her insightful recommendations, editorial excellence, and all-around awesomeness made her a delight to work with. (*Note:* If they had let her edit this section, she would have caught that we just ended a sentence with a preposition. She's that good.) A big thank you also goes to Amber Chow, our acquisitions editor, for her leadership, guidance, advice, and support of this book. Without Amber's ability to manage every challenge that arose, this book might still be in the production stages. In addition, we are grateful to Carrie Brandon for all of her hard work, support, and especially for her instrumental role in creating new video for this edition. Another special thank you goes to Cecilia Turner, our program manager, for her expert coordination of all aspects of this project as well as to Donna Simons and Sherry Lewis for their skillful management of the production of this book. We also thank Laura Chadwick 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 are also especially grateful to the many reviewers who have given us invaluable feedback on this and previous editions of *Abnormal Psychology*: Joe Davis, CSU/SWC; Dan Fox, University of Houston; Marvin Lee, Tennessee State University; Stevie McKenna, Rutgers University; Loreto Prieto, Iowa State University; Hugh Riley, Baylor University; Edward Selby, Rutgers University; Tasia Smith, University of Florida; Stephanie Stein, Central Washington University; David Topor, Harvard University; Anthony Zoccolillo, Texas A&M; 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; Alexandrea 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; Lizabeth 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

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 BSc 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 DPhil. 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 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*. In 2015 Dr. Hooley received the Zubin Award for Lifetime Achievement in Psychopathology Research from the Society for Research in Psychopathology.

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.

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.

Matthew K. Nock
Harvard University

Matthew Nock was born and raised in New Jersey. Matt received his BA from Boston University (1995), followed by two masters (2000, 2001) and a PhD from Yale University (2003). He also completed a clinical internship at Bellevue Hospital and the New York University Child Study Center (2003). Matt joined the faculty of Harvard University in 2003 and has been there ever since, currently serving as a Professor in the Department of Psychology. While an undergraduate, Matt became very interested in the question of why people do things to intentionally harm themselves and he has been conducting research aimed at answering this question ever since. His research is multidisciplinary in nature and uses a range of methodological approaches (e.g., epidemiologic surveys, laboratory-based experiments, and clinic-based studies) to better understand how these behaviors develop, how to predict them, and how to prevent their occurrence. His work is funded by research grants from the National Institutes of Health, Department of Defense, and several private foundations. Matt's research has been published in over 100 scientific papers and book chapters and has been recognized through the receipt of awards from the American Psychological Association, the Association for Behavioral and Cognitive Therapies, and the American Association of Suicidology. In 2011 he received a MacArthur Fellowship (aka, "Genius Grant") in recognition of his research on suicide and self-harm. At Harvard, Matt teaches courses on various topics including psychopathology, statistics, research methods, and cultural diversity. He has received numerous teaching and mentoring awards including the Roslyn Abramson Teaching Award and the Petra Shattuck Prize.

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.

Chapter 1

Abnormal Psychology: Overview and Research Approaches

Learning Objectives

1.1 Explain how we define abnormality and classify mental disorders.

1.2 Describe the advantages and disadvantages of classification.

1.3 Explain how culture affects what is considered abnormal and describe two different culture-specific disorders.

1.4 Distinguish between incidence and prevalence and identify the most common and prevalent mental disorders.

1.5 Discuss why abnormal psychology research can be conducted in almost any setting.

1.6 Describe three different approaches used to gather information about mental disorders.

1.7 Explain why a control (or comparison group) is necessary to adequately test a hypothesis.

1.8 Discuss why correlational research designs are valuable, even though they cannot be used to make causal inferences.

1.9 Explain the key features of an experimental design.

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 read 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. All too often, some celebrity is in the news because of a drug or alcohol problem, a suicide attempt, 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 worrisomely 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 several 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.

Scott

Scott was born into an affluent family. There were no problems when he was born and he seemed to develop normally when he was a child. He went to a prestigious college and completed his degree in mathematics. Shortly afterwards, however, he began to isolate himself from his family and he abandoned his plans for graduate studies. He traveled to San Francisco, took an apartment in a run-down part of the city, became increasingly suspicious of people around him, and developed strange ideas about brain transfer technology. Shortly before Christmas, he received a package from a friend. As he opened the package, he reported that his "head exploded" and he began to hear voices, even though no one was around. The voices began to tell him what to do and what not to do. His concerned parents came out to visit him, but he refused to seek any help or return home to live with them. Shortly after, he left the city and, living as a homeless person, moved around the country, eventually making his way back to the East Coast. Throughout that time he was hearing voices every day—sometimes as many as five or six different ones. Eventually Scott's worried family located him and persuaded him to seek treatment. Although he has been hospitalized several times and been on many different medications in the intervening years, Scott still has symptoms of psychosis. His voices have never entirely gone away and they still dictate his behavior to a considerable extent. Now age 49, he lives in a halfway house, and works part-time shelving books in a university library.

Perhaps you found yourself asking questions as you read about Monique and Scott. For example, because Monique doesn't drink in the mornings, you might have

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

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 Scott and why he is hearing voices. Questions about the age of onset of his symptoms as well as predisposing factors may have occurred to you. Scott has schizophrenia, a disorder that often strikes in late adolescence or early adulthood. Also, as Scott's case illustrates, it is not especially unusual for someone who develops schizophrenia to develop in a seemingly normal manner before suddenly becoming ill.

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 Scott 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 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.

The second part of this chapter is devoted to research. We make every effort to convey to you 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?

1.1 Explain how we define abnormality and classify mental disorders.

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 et al., 2013; Stein et al., 2010).

Indicators of Abnormality

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 et al., 2013; 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. **Subjective distress:** If people suffer or experience psychological pain we are inclined to consider this as indicative of abnormality. People with depression clearly report being distressed, 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 experiencing any distress. 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 exceedingly worried. But we would hardly label your subjective distress abnormal. Although subjective distress 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. But 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).

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?

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 preceding example, 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:** Not all rules are explicit. And not all rules bother us when they are violated. Nonetheless, when someone violates an implicit or unwritten social rule, those around him or her may experience a sense of discomfort or unease. Imagine that you are sitting in an almost empty bus. There are rows of unoccupied seats. Then someone comes in and sits down right next to you. How do you feel? Is the person's behavior abnormal? Why? The person is not breaking any formal rule. He or she has paid for a ticket and is permitted to sit anywhere he or she likes. But your sense of social discomfort ("Why did this person sit right next to me when there are so many empty seats available?") will probably incline you to think that this is an example of abnormal behavior. In other words, social discomfort is another potential way that we can recognize abnormality. But again, much depends on circumstances. If the person who gets on the bus is someone you know well, it might be more unusual if he or she did not join you.

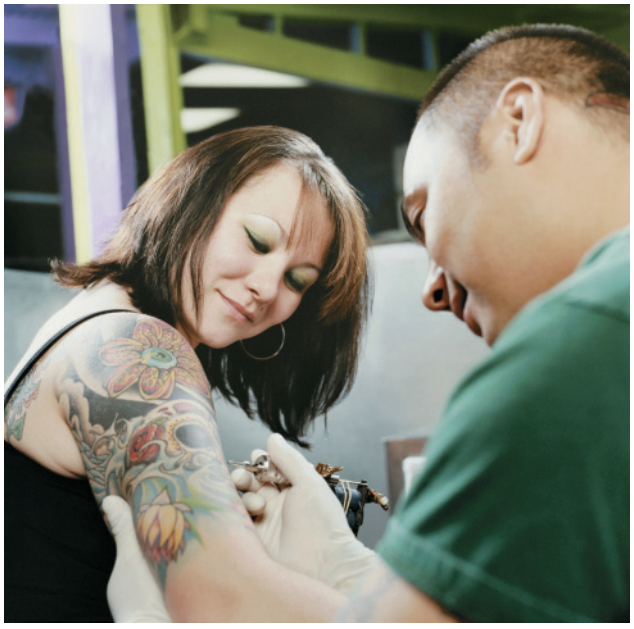
6. **Irrationality and unpredictability:** As we have already noted, we expect people to behave in certain ways. Although a little unconventionality may add some spice to life, there is a point at which we are likely to consider a given unorthodox behavior abnormal. If a person sitting next to you suddenly 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. 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 people with mental illness 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 the rule (Corrigan & Watson, 2005).

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?

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. 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 (it was removed from the formal classification system in 1974). 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 and attract little attention. What other behaviors can you think of that are now considered normal but were regarded as deviant in the past?



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

As you think about these issues, consider the person described in the World Around Us box. He is certainly an unusual human being. But is his behavior abnormal? Do you think everyone will agree about this?

The World Around Us

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 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."

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

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 bought his family a larger home. (Taken from I. Parker, 2004.)

Is Zell Kravinsky a courageous man of profound moral commitment? Or is his behavior abnormal and indicative of a mental disorder? Explain how you reached the conclusion you did.

DSM-5 Thinking Critically about *DSM-5*

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

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. In addition, providing descriptive information about the type and number of symptoms needed for each diagnosis helps ensure diagnostic accuracy and consistency (reliability). The *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-I* 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.

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. It is 947 pages long and contains a total of 541 diagnostic categories (Blashfield et al., 2014). This recent revision of the *DSM* has been the topic of much debate and controversy. In the Thinking Critically about *DSM-5* box we explain more about the *DSM* and discuss why a revision was necessary.

Although the *DSM* is widely used, it is not the only psychiatric classification system. The *International Classification of Diseases* (called *ICD-10* because it is now in its 10th revision) is produced by the World Health Organization (WHO). Chapter V of this document covers mental and behavioral disorders (WHO, 2015b). Although the *ICD-10* has much in common with *DSM-5*, it also many differences, with similar disorders having different names, for example. The *ICD-10* is used in many countries outside the United States and *ICD-11* is currently in development.

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* work groups 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 even closer to a good working

Watch What Does it Mean to Have a Mental Disorder?

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, with regular updates and modifications 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.

in review

- Why is abnormality so difficult to define?
- What characteristics help us recognize abnormality?

Classification and Diagnosis

1.2 Describe the advantages and disadvantages of classification.

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). This gives clinicians and researchers both a *common language* and *shorthand terms* for complex clinical conditions. Without having a common set of terms to describe specific clinical conditions, clinicians would have to talk at length about each patient individually to provide an overview of the patient's problems. But if there is a shared understanding of what the term "schizophrenia" means, for example, communication across professional boundaries is simplified and facilitated.

Another advantage of classification systems is that they enable us to *structure information* in a more helpful manner. Classification systems shape the way information is organized. For example, most classification systems typically place diagnoses that are thought to be related in some way close together. In *DSM-5*, the section on anxiety disorders includes disorders (such as panic disorder, specific phobia, and agoraphobia) that share the common features of fear and anxiety.

Organizing information within a classification system also allows us to study the different disorders that we classify and therefore to learn new things. In other words, *classification facilitates research,* which gives us more information and facilitates greater understanding, not only about what causes various disorders 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 Scott has schizophrenia. Knowing what disorder each of them has is clearly very helpful, because Scott's treatment would be very different from Monique's.

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 Keeley et al., 2015; 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.

What Are the Disadvantages of Classification?

Of course, a number of potential disadvantages are associated with the use 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** (disgrace) associated with having a psychiatric diagnosis. Stigma, of course, is hardly the fault of the diagnostic system itself. But even today, people are generally far more comfortable disclosing that they have a physical illness such as diabetes than they are 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 one 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).

Stigma is a deterrent to seeking treatment for mental health problems. This is especially true for younger people, for men, and for ethnic minorities (Clement et al., 2015). Stigma is also a disproportionately greater deterrent to treatment seeking for two other groups: military personnel and (ironically) mental health professionals. Would you have predicted this? Why do you think this is the case?

Related to stigma is the problem of **stereotyping**. Stereotypes are automatic beliefs concerning other people that

we unavoidably learn as a result of growing up in a particular culture (e.g., people who wear glasses are more intelligent; New Yorkers are rude). 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. Negative stereotypes about psychiatric patients are also perpetuated in movies. If you have ever seen a horror movie you know that a common dominant theme involves the homicidal maniac. And an analysis of 55 horror films made between 2000 and 2012 has shown that it is people with psychosis who are most often portrayed as murderers (Goodwin, 2014). Stereotyping is also 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)

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*. And stigma may be less a consequence of the diagnostic label than a result of the disturbed behavior that got the person the diagnosis in the first place. In some situations, a diagnosis may even reduce stigma because it provides at least a partial explanation for a person's otherwise inexplicable behavior (Ruscio, 2004). Nonetheless, 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 use what is called person-first language and say, "a person with schizophrenia," or "a person with bipolar disorder." Simply put, the person is not the diagnosis.

How Can We Reduce Prejudicial Attitudes Toward People Who Are Mentally Ill?

Negative reactions to people with mental illness are common and may be a fairly widespread phenomenon throughout the world. 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 those with mental illnesses. 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 people who are 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

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