GLOBAL EDITION

Abnormal Psychology

SIXTEENTH EDITION

James N. Butcher • Jill M. Hooley • Susan Mineka

ALWAYS LEARNING

PEARSON

abnormal psychology

sixteenth edition

GLOBAL 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
Head of Learning Asset Acquisition, Global Edition: Laura Dent
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
Acquisitions Editor, Global Edition: Vrinda Malik
Associate Project Editor, Global Edition: Binita Roy
Project Manager, Production: Sherry Lewis
Senior Operations Specialist: Diane Peirano
Senior Manufacturing Controller, Production, Global Edition: Trudy Kimber
Art Director: Leslie Osher
Text Designer: Anne DeMarinis, DEMARINIS DESIGN LLC
Cover Image: © Chamille White/Shutterstock
Cover Designer: Lumina Datamatics, Inc.
Media Project Manager: Pamela Weldin
Full-Service Project Management: Saraswathi Muralidhar/ Lumina Datamatics, Inc.

Credits and acknowledgments borrowed from other sources and reproduced, with permission, in this textbook appear on appropriate page within text and pages 736–741.

Pearson Education Limited
Edinburgh Gate
Harlow
Essex CM20 2JE
England

and Associated Companies throughout the world

Visit us on the World Wide Web at: www.pearsonglobaleditions.com

© Pearson Education Limited 2015

The rights of James N. Butcher, Jill M. Hooley, and Susan Mineka to be identified as the authors of this work have been asserted by them in accordance with the Copyright, Designs and Patents Act 1988.

Authorized adaptation from the United States edition, entitled Abnormal Psychology, 16th edition, ISBN 978-0-205-94428-6, by James N. Butcher, Jill M. Hooley, and Susan Mineka, published by Pearson Education © 2014.

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without either the prior written permission of the publisher or a license permitting restricted copying in the United Kingdom issued by the Copyright Licensing Agency Ltd, Saffron House, 6–10 Kirby Street, London EC1N 8TS.

All trademarks used herein are the property of their respective owners. The use of any trademark in this text does not vest in the author or publisher any trademark ownership rights in such trademarks, nor does the use of such trademarks imply any affiliation with or endorsement of this book by such owners.

ISBN 10: 1-292-06928-7
ISBN 13: 978-1-292-06928-9

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

14 13 12 11 10 9 8 7 6 5 4 3 2 1

Typeset in 10/12 MinionPro Regular by Lumina Datamatics, Inc.

Printed and bound by Courier Kendallville in The United States of America.

brief contents

1 Introduction to Abnormal Psychology 21

2 Views of Abnormal Behavior: Then and Now 48

3 Abnormal Behavior: Causes, Viewpoints, and Perspectives 74

4 Clinical Assessment and Diagnosis 120

5 Stress and Physical and Mental Health 148

6 Mood Disorders and Suicide: Causal Factors, Theories, and Treatment 182

7 Panic, Anxiety, Obsessions, and Their Disorders 234

8 Somatic Symptom and Dissociative Disorders: Characteristics and Treatment 283

9 Schizophrenia: Clinical Picture, Causes, and Treatment 313

10 Eating Disorders and Obesity 352

11 Substance-Related Disorders: Characteristics, Treatment, and Outcome 386

12 Sexual Variants, Abuse, and Dysfunctions 423

13 Personality Disorders: Clinical Features and Treatment 462

14 Disorders of Childhood and Adolescence (Neurodevelopmental Disorders) 502

15 Neurocognitive Disorders: Clinical Features, Causes, and Treatment 542

16 Treatment Approaches 568

17 Contemporary and Legal Issues in Abnormal Psychology 602

contents

Features 12 Preface 15 About the Authors 19

1 Introduction to Abnormal Psychology 21

What Do We Mean by Abnormality? 23

The *DSM-5* and the Definition of Mental Disorder 25

the WORLD around us
Extreme Generosity or Pathological Behavior? 26

Why Do We Need to Classify Mental Disorders? 27

THINKING CRITICALLY about *DSM-5*:
What Is the *DSM* and Why Was It Revised? 27

What Are the Disadvantages of Classification? 28

How Can We Reduce Prejudicial Attitudes Toward the Mentally Ill? 28

the WORLD around us
Mad, Sick, Head Nuh Good: Mental Illness and Stigma in Jamaica 29

How Does Culture Affect What Is Considered Abnormal? 30

Culture-Specific Disorders 31

How Common Are Mental Disorders? 32

Prevalence and Incidence 32

Prevalence Estimates for Mental Disorders 32

Treatment 33

Mental Health Professionals 34

Research Approaches in Abnormal Psychology 34

Sources of Information 35

Case Studies 35

Self-Report Data 35

Observational Approaches 36

Forming and Testing Hypotheses 37

Sampling and Generalization 37

Internal and External Validity 38

Criterion and Comparison Groups 38

Research Designs 39

Studying the World as It Is: Correlational Research Designs 39

Measuring Correlation 39

Statistical Significance 39

Effect Size 40

Meta-Analysis 41

Correlations and Causality 41

Retrospective Versus Prospective Strategies 41

Manipulating Variables: The Experimental Method in Abnormal Psychology 42

Studying the Efficacy of Therapy 42

Single-Case Experimental Designs 43

developments in RESEARCH:
Do Magnets Help with Repetitive-Stress Injury? 44

Animal Research 45

UNRESOLVED issues
Are We All Becoming Mentally Ill? The Expanding Horizons of Mental Disorder 46

summary 47 key terms 47

2 Views of Abnormal Behavior: Then and Now 48

Historical Views of Abnormal Behavior 49

Demonology, Gods, and Magic 49

Hippocrates' Early Medical Concepts 50

developments in THINKING:
Melancholia Through the Ages 51

Early Philosophical Conceptions of Consciousness 51

Later Greek and Roman Thought 52

Early Views of Mental Disorders in China 52

Views of Abnormality During the Middle Ages 53

Toward Humanitarian Approaches 55

The Resurgence of Scientific Questioning in Europe 55

The Establishment of Early Asylums 55

Humanitarian Reform 56

Nineteenth-Century Views of the Causes and Treatment of Mental Disorders 60

Changing Attitudes Toward Mental Health in the Early Twentieth Century 60

the WORLD around us
Chaining Mental Health Patients 61

Mental Hospital Care in the Twentieth Century 61

The Emergence of Contemporary Views of Abnormal Behavior 63

Biological Discoveries: Establishing the Link Between the Brain and Mental Disorder 63

The Development of a Classification System 64

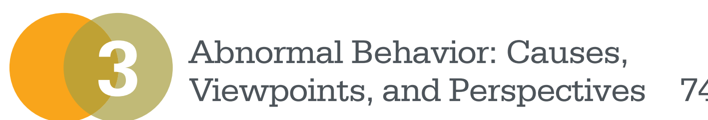
Development of the Psychological Basis of Mental Disorder 64

developments in RESEARCH:
The Search for Medications to Cure Mental Disorders 65

The Evolution of the Psychological Research Tradition: Experimental Psychology 67

UNRESOLVED issues
Interpreting Historical Events 71

summary 72 key terms 73



3 Abnormal Behavior: Causes, Viewpoints, and Perspectives 74

Causes and Risk Factors for Abnormal Behavior 75

Necessary, Sufficient, and Contributory Causes 75

Feedback and Bidirectionality in Abnormal Behavior 76

Diathesis-Stress Models 77

Viewpoints for Understanding the Causes of Abnormal Behavior 79

The Biological Viewpoint and Biological Causal Factors 80

Imbalances of Neurotransmitters and Hormones 80

Genetic Vulnerabilities 83

developments in THINKING: Nature, Nurture, and Psychopathology: A New Look at an Old Topic 86

Temperament 87

Brain Dysfunction and Neural Plasticity 88

The Impact of the Biological Viewpoint 89

The Psychological Viewpoints 90

The Psychodynamic Perspectives 90

The Behavioral Perspective 95

developments in THINKING: The Humanistic and Existential Perspectives 97

The Cognitive-Behavioral Perspective 99

What the Adoption of a Perspective Does and Does Not Do 102

Psychological Causal Factors 103

Early Deprivation or Trauma 103

Inadequate Parenting Styles 106

Marital Discord and Divorce 108

Maladaptive Peer Relationships 109

The Sociocultural Viewpoint 111

Uncovering Sociocultural Factors Through Cross-Cultural Studies 111

Sociocultural Causal Factors 113

Low Socioeconomic Status and Unemployment 114

Prejudice and Discrimination in Race, Gender, and Ethnicity 114

the WORLD around us Culture and Attachment Relationships 115

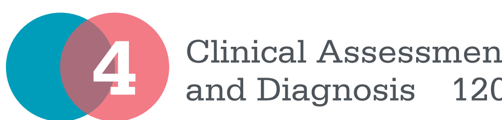
Social Change and Uncertainty 116

Urban Stressors: Violence and Homelessness 116

The Impact of the Sociocultural Viewpoint 116

UNRESOLVED issues Theoretical Viewpoints and the Causes of Abnormal Behavior 117

summary 118 key terms 119



4 Clinical Assessment and Diagnosis 120

The Basic Elements in Assessment 121

The Relationship Between Assessment and Diagnosis 122

Taking a Social or Behavioral History 122

Ensuring Culturally Sensitive Assessment Procedures 123

The Influence of Professional Orientation 123

Reliability, Validity, and Standardization 124

Trust and Rapport Between the Clinician and the Client 124

Assessment of the Physical Organism 125

The General Physical Examination 125

The Neurological Examination 125

The Neuropsychological Examination 127

Psychosocial Assessment 128

Assessment Interviews 128

The Clinical Observation of Behavior 129

Psychological Tests 130

developments in PRACTICE: The Automated Practice: Use of the Computer in Psychological Testing 131

The Case of Andrea C.: Experiencing Violence in the Workplace 137

developments in PRACTICE: Computer-Based MMPI-2 Report for Andrea C. 138

The Integration of Assessment Data 140

Ethical Issues in Assessment 140

Classifying Abnormal Behavior 141

Differing Models of Classification 142

Formal Diagnostic Classification of Mental Disorders 142

Criteria for Persistent Depressive Disorder (Dysthymia) 143

THINKING CRITICALLY about *DSM-5*: Completion Does Not Assure Acceptance 145

summary 146 key terms 147

5 Stress and Physical and Mental Health 148

What Is Stress? 150

Stress and the *DSM* 150

Factors Predisposing a Person to Stress 150

Characteristics of Stressors 151

Measuring Life Stress 152

Resilience 152

Stress and the Stress Response 153

Biological Costs of Stress 154

The Mind–Body Connection 154

Understanding the Immune System 154

Stress, Depression, and the Immune System 156

STRESS AND PHYSICAL HEALTH 157

Cardiovascular Disease 158

Hypertension 158

Coronary Heart Disease 159

Risk and Causal Factors in Cardiovascular Disease 160

the WORLD around us
Racial Discrimination and Cardiovascular Health in African Americans 162

Treatment of Stress-Related Physical Disorders 163

Biological Interventions 163

Psychological Interventions 163

STRESS AND MENTAL HEALTH 165

Adjustment Disorder 165

Adjustment Disorder Caused by Unemployment 165

Posttraumatic Stress Disorder 165

Criteria for Posttraumatic Stress Disorder 166

THINKING CRITICALLY about *DSM-5*:
Changes to the Diagnostic Criteria for PTSD 167

Acute Stress Disorder 168

Clinical Description 168

Prevalence of PTSD in the General Population 168

Rates of PTSD After Traumatic Experiences 169

Causal Factors in Posttraumatic Stress Disorder 172

Individual Risk Factors 173

Sociocultural Factors 174

Long-Term Effects of Posttraumatic Stress 175

Prevention and Treatment of Stress Disorders 175

Prevention 175

the WORLD around us
Does Playing Tetris After a Traumatic Event Reduce Flashbacks? 176

Treatment for Stress Disorders 176

Psychological Debriefing 177

the WORLD around us
Virtual Reality Exposure Treatment for PTSD in Military Personnel 178

Challenges in Studying Disaster Victims 179

Trauma and Physical Health 179

UNRESOLVED issues
Why Is the Study of Trauma so Contentious? 180

summary 180 key terms 181

6 Mood Disorders and Suicide: Causal Factors, Theories, and Treatment 182

Mood Disorders: An Overview 183

Types of Mood Disorders 183

Criteria for Major Depressive Disorder 184

Criteria for Manic Episode 185

The Prevalence of Mood Disorders 185

Unipolar Depressive Disorders 185

Other Forms of Depression 186

THINKING CRITICALLY about *DSM-5*:
Was It Wise to Drop the Bereavement Exclusion for Major Depression? 186

developments in THINKING:
A New *DSM-5* Diagnosis: Premenstrual Dysphoric Disorder 187

Dysthymic Disorder (Persistent Depressive Disorder) 187

Criteria for Persistent Depressive Disorder (Dysthymia) 188

Major Depressive Disorder 189

Causal Factors in Unipolar Mood Disorders 192

Biological Causal Factors 192

Psychological Causal Factors 197

developments in RESEARCH:
Why Do Sex Differences in Unipolar Depression Emerge During Adolescence? 206

Bipolar and Related Disorders 208

Cyclothymic Disorder 209

Criteria for Cyclothymic Disorder 209

Bipolar Disorders (I and II) 210

Causal Factors in Bipolar Disorders 213

Biological Causal Factors 213

Psychological Causal Factors 215

Sociocultural Factors Affecting Unipolar and Bipolar Disorders 215

Cross-Cultural Differences in Depressive Symptoms 215

Cross-Cultural Differences in Prevalence 216

Demographic Differences in the United States 217

Treatments and Outcomes 217

Pharmacotherapy 218

Alternative Biological Treatments 220

Psychotherapy 220

Suicide: The Clinical Picture and the Causal Pattern 223

Who Attempts and Who Commits Suicide? 224

Suicide in Children 225

Suicide in Adolescents and Young Adults 225

Other Psychosocial Factors Associated with Suicide 225

the WORLD around us
Warning Signs for Student Suicide 226

Biological Causal Factors 227

Sociocultural Factors 227

Suicidal Ambivalence 228

Communication of Suicidal Intent 229

Suicide Notes 229

Suicide Prevention and Intervention 229

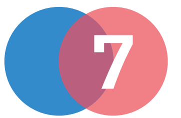
Treatment of Mental Disorders 229

Crisis Intervention 230

Focus on High-Risk Groups and Other Measures 230

UNRESOLVED issues
Is There a Right to Die? 230

summary 232 key terms 233



7 Panic, Anxiety, Obsessions, and Their Disorders 234

The Fear and Anxiety Response Patterns 236

Fear 236

THINKING CRITICALLY about *DSM-5*:
Why is OCD No Longer Considered to Be an Anxiety Disorder? 236

Anxiety 237

Overview of the Anxiety Disorders and Their Commonalities 237

Specific Phobias 238

Criteria for Specific Phobia 239
Prevalence, Age of Onset, and Gender Differences 240
Psychological Causal Factors 240
Biological Causal Factors 243
Treatments 243

Social Phobias 245

Prevalence, Age of Onset, and Gender Differences 245
Psychological Causal Factors 246
Criteria for Social Anxiety Disorder (Social Phobia) 247
Biological Causal Factors 248
Treatments 249

Panic Disorder 250
Criteria for Panic Disorder 250
Agoraphobia 251
Criteria for Agoraphobia 251
Prevalence, Age of Onset, and Gender Differences 252
Comorbidity with Other Disorders 253
The Timing of a First Panic Attack 253
Biological Causal Factors 253
Psychological Causal Factors 255

developments in RESEARCH:
Nocturnal Panic Attacks 257

Treatments 259

Generalized Anxiety Disorder 260

Criteria for Generalised Anxiety Disorder 261
Prevalence, Age of Onset, and Gender Differences 262
Comorbidity with Other Disorders 262
Psychological Causal Factors 262
Biological Causal Factors 264
Treatments 265

Obsessive-Compulsive and Related Disorders 266

Obsessive-Compulsive Disorder 266
Criteria for Obsessive-Compulsive Disorder 267
Prevalence, Age of Onset, and Gender Differences 268
Comorbidity with Other Disorders 269
Psychological Causal Factors 269
Biological Causal Factors 271
Treatments 273

Body Dysmorphic Disorder 274
Criteria for Body Dysmorphic Disorder 276
Hoarding Disorder 278
Trichotillomania 278

Cultural Perspectives 278

Cultural Differences in Sources of Worry 279
Taijin Kyofusho 279

UNRESOLVED issues
The Choice of Treatments: Medications or Cognitive-Behavior Therapy? 280

summary 281 key terms 282

8 Somatic Symptom and Dissociative Disorders: Characteristics and Treatment 283

Somatic Symptom and Related Disorders 284

Somatic Symptom Disorders 285
Hypochondriasis 285
Criteria for Somatic Symptom Disorder 285
Somatization Disorder 288
Pain Disorder 289
Conversion Disorder (Functional Neurological Symptom Disorder) 290
Criteria for Illness Anxiety Disorder 290
Criteria for Conversion disorder 291
Distinguishing Somatization, Pain, and Conversion Disorders from Malingering and Factitious Disorder 294
Criteria for Factitious Disorder 294

the WORLD around us
Factitious Disorder Imposed on Another (Munchausen's Syndrome by Proxy) 295

Dissociative Disorders 296

Depersonalization/Derealization Disorder 296
Criteria for Depersonalization/Derealization Disorder 297
Dissociative Amnesia and Dissociative Fugue 298
Criteria for Dissociative Amnesia 298
Dissociative Identity Disorder (DID) 300

THINKING CRITICALLY about *DSM-5*:
Where Does Conversion Disorder Belong? 300

Criteria for Dissociative Identity Disorder 301

the WORLD around us
DID, Schizophrenia, and Split Personality: Clearing Up the Confusion 302

Sociocultural Factors in Dissociative Disorders 308
Treatment and Outcomes in Dissociative Disorders 308

UNRESOLVED issues
DID and the Reality of "Recovered Memories" 310

summary 311 key terms 312

9 Schizophrenia: Clinical Picture, Causes, and Treatment 313

Schizophrenia 314

Origins of the Schizophrenia Construct 315
Epidemiology 315

Clinical Picture 316

Delusions 316
Criteria for Schizophrenia 317
Hallucinations 318
Disorganized Speech and Behavior 318

the WORLD around us
Stress, Caffeine, and Hallucinations 319

Positive and Negative Symptoms 320
Subtypes of Schizophrenia 320
Other Psychotic Disorders 321
Criteria for Schizoaffective Disorder 321
Criteria for Schizophreniform Disorder 321
Criteria for Delusional Disorder 322
Criteria for Brief Psychotic Disorder 322

Risk and Causal Factors 323

Genetic Factors 323

the WORLD around us
The Genain Quadruplets 324

Prenatal Exposures 328
Genes and Environment in Schizophrenia: A Synthesis 329
A Neurodevelopmental Perspective 330

THINKING CRITICALLY about *DSM-5*:
Attenuated Psychosis Syndrome 332

Structural and Functional Brain Abnormalities 332
Psychosocial and Cultural Factors 340
A Diathesis-Stress Model of Schizophrenia 343

Treatments and Outcomes 345

Clinical Outcome 345
Pharmacological Approaches 346
Psychosocial Approaches 347

UNRESOLVED issues
Why Are Recovery Rates in Schizophrenia Not Improving? 350

summary 350 key terms 351

10 Eating Disorders and Obesity 352

Clinical Aspects of Eating Disorders 354

Anorexia Nervosa 354
Criteria for Anorexia Nervosa 354
Bulimia Nervosa 356
Criteria for Bulimia Nervosa 356
Binge Eating Disorder 357
Criteria for Binge-Eating Disorder 358
Age of Onset and Gender Differences 359

THINKING CRITICALLY about *DSM-5*:
Other Forms of Eating Disorders 359

Prevalence of Eating Disorders 360
Medical Complications of Eating Disorders 360
Course and Outcome 361
Diagnostic Crossover 362
Association of Eating Disorders With Other Forms of Psychopathology 362
Eating Disorders Across Cultures 363

the WORLD around us
Ethnic Identity and Disordered Eating 364

Risk and Causal Factors in Eating Disorders 365

Biological Factors 365
Sociocultural Factors 366
Family Influences 367
Individual Risk Factors 368

Treatment of Eating Disorders 371

Treatment of Anorexia Nervosa 371
Treatment of Bulimia Nervosa 372
Treatment of Binge Eating Disorder 374

The Problem of Obesity 374

Medical Issues 374
Definition and Prevalence 375
Weight Stigma 375

the WORLD around us
Do Negative Messages About Being Overweight Encourage Overweight People to Eat More or Less? 376

Obesity and the *DSM* 376

Risk and Causal Factors in Obesity 376

The Role of Genes 376
Hormones Involved in Appetite and Weight Regulation 377
Sociocultural Influences 377
Family Influences 379
Stress and "Comfort Food" 379
Pathways to Obesity 380

Treatment of Obesity 380

Lifestyle Modifications 380
Medications 381
Bariatric Surgery 381
The Importance of Prevention 382

UNRESOLVED issues
The Role of Public Policy in the Prevention of Obesity 383

summary 384 key terms 385

11 Substance-Related Disorders: Characteristics, Treatment, and Outcome 386

Alcohol Related Disorders 388

The Prevalence, Comorbidity, and Demographics of Alcohol Abuse and Dependence 388
Criteria for Alcohol Use Disorder 389
The Clinical Picture of Alcohol Related Disorders 390

developments in RESEARCH:
Fetal Alcohol Syndrome: How Much Drinking Is Too Much? 392

Biological Causal Factors in the Abuse of and Dependence on Alcohol 394
Psychosocial Causal Factors in Alcohol Abuse and Dependence 396
the WORLD around us
Binge Drinking in College 399
Sociocultural Causal Factors 400
Treatment of Alcohol-Related Disorders 400
Drug Abuse and Dependence 405
Opium and Its Derivatives (Narcotics) 406
Cocaine and Amphetamines (Stimulants) 409
Methamphetamine 411
THINKING CRITICALLY about *DSM-5*:
Can Changes to the Diagnostic Criteria Result in Increased Drug Use? 412
Barbiturates (Sedatives) 412
Hallucinogens: LSD and Related Drugs 413
Ecstasy 414
Marijuana 415
the WORLD around us
Should Marijuana Be Marketed and Sold Openly as a Medication? 416
Stimulants: Caffeine and Nicotine 417
Gambling Disorder 419
Criteria for Gambling Disorder 419
UNRESOLVED issues
Exchanging Addictions: Is This an Effective Treatment Approach? 421
summary 421 key terms 422

12 Sexual Variants, Abuse, and Dysfunctions 423

Sociocultural Influences on Sexual Practices and Standards 425
Case 1: Degeneracy and Abstinence Theory 425
Case 2: Ritualized Homosexuality in Melanesia 426
Case 3: Homosexuality and American Psychiatry 426
Gender Dysphoria 428
The Paraphilias 428
Criteria for Several Different Paraphilic Disorders 429
Causal Factors and Treatments for Paraphilias 435
Gender Dysphoria 435
Criteria for Gender Dysphoria 436
Criteria for Gender Dysphoria in Adolescents and Adults 437
Sexual Abuse 439
Childhood Sexual Abuse 439
Pedophilic Disorder 441
THINKING CRITICALLY about *DSM-5*:
Pedophilia and Hebephilia 442
Incest 444
Rape 444
Treatment and Recidivism of Sex Offenders 447
the WORLD around us
Megan's Law 448
Sexual Dysfunctions 450
Criteria for Different Sexual Dysfunctions 451
Sexual Dysfunctions in Men 452
Male Hypoactive Sexual Desire Disorder 453
Female Sexual Interest/Arousal Disorder 455
UNRESOLVED issues
How Harmful Is Childhood Sexual Abuse? 459
summary 460 key terms 461

13 Personality Disorders: Clinical Features and Treatment 462

Clinical Features of Personality Disorders 463
Difficulties Doing Research on Personality Disorders 465
Difficulties in Diagnosing Personality Disorders 465
THINKING CRITICALLY about *DSM-5*:
Why Were No Changes Made to the Way Personality Disorders Are Diagnosed? 466
Difficulties in Studying the Causes of Personality Disorders 467
Cluster A Personality Disorders 468
Paranoid Personality Disorder 468
Criteria for Paranoid Personality Disorder 469
Schizoid Personality Disorder 470
Criteria for Schizoid Personality Disorder 471
Schizotypal Personality Disorder 471
Criteria for Schizotypal Personality Disorder 472
Cluster B Personality Disorders 473
Histrionic Personality Disorder 473
Narcissistic Personality Disorder 474
Criteria for Histrionic Personality Disorder 474
Criteria for Narcissistic Personality Disorder 475
Antisocial Personality Disorder 476
Borderline Personality Disorder 477
Criteria for Borderline Personality Disorder 477
THINKING CRITICALLY about *DSM-5*:
Nonsuicidal Self-Injury: Distinct Disorder or Symptom of Borderline Personality Disorder? 478
Cluster C Personality Disorders 480
Avoidant Personality Disorder 480
Criteria for Avoidant Personality Disorder 481
Dependent Personality Disorder 482
Obsessive-Compulsive Personality Disorder 483
Criteria for Dependent Personality Disorder 483
Criteria for Obsessive-Compulsive Personality Disorder 484

General Sociocultural Causal Factors for Personality Disorders 485

Treatments and Outcomes for Personality Disorders 485

Adapting Therapeutic Techniques to Specific Personality Disorders 486

Treating Borderline Personality Disorder 486

Treating Other Personality Disorders 487

Criteria for Antisocial Personality Disorder 488

Antisocial Personality Disorder and Psychopathy 488

Psychopathy and Antisocial Personality Disorder 488

The Clinical Picture in Psychopathy and Antisocial Personality Disorder 489

Causal Factors in Psychopathy and Antisocial Personality 492

the WORLD around us
"Successful" Psychopaths 494

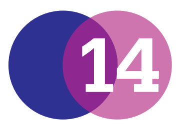
A Developmental Perspective on Psychopathy and Antisocial Personality 495

Treatments and Outcomes in Psychopathic and Antisocial Personality 498

developments in PRACTICE:
Prevention of Psychopathy and Antisocial Personality Disorder 499

UNRESOLVED issues
DSM-5: How Can We Improve the Classification of Personality Disorders? 500

summary 500 key terms 501



Disorders of Childhood and Adolescence (Neurodevelopmental Disorders) 502

Maladaptive Behavior in Different Life Periods 504

Varying Clinical Pictures 504

Special Psychological Vulnerabilities of Young Children 504

The Classification of Childhood and Adolescent Disorders 505

Common Disorders of Childhood 505

Attention-Deficit/Hyperactivity Disorder 505

Criteria for Attention-Deficit/Hyperactivity Disorder 506

Disruptive, Impulse-control and Conduct Disorder 509

Criteria for Conduct Disorder 509

Anxiety and Depression in Children and Adolescents 512

Anxiety Disorders of Childhood and Adolescence 512

Criteria for Separation Anxiety Disorder 513

Childhood Depression and Bipolar Disorder 515

developments in RESEARCH:
Bipolar Disorder in Children and Adolescents: Is There an Epidemic? 517

Elimination Disorders (Enuresis, Encopresis), Sleepwalking, and Tics 518

Enuresis 519

Encopresis 519

Sleepwalking 520

Tic Disorders 520

Neurodevelopmental Disorders 521

Autism Spectrum Disorder 521

Criteria for Autism Spectrum Disorder 522

developments in PRACTICE:
Can Virtual Reality Video Games Improve Treatment of Children with Neurodevelopmental Disorders? 525

Specific Learning Disorders 526

Causal Factors in Learning Disorder 527

Treatments and Outcomes 527

THINKING CRITICALLY about *DSM-5*:
Changes to the Diagnostic System are Nominal for Some Disorders 527

Intellectual Disability 528

Levels of Intellectual Disability 528

Causal Factors in Intellectual Disability 529

Organic Retardation Syndromes 530

Treatments, Outcomes, and Prevention 533

Planning Better Programs to Help Children and Adolescents 535

Special Factors Associated with Treatment of Children and Adolescents 535

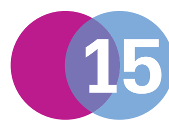
the WORLD around us
The Impact of Child Abuse on Psychological Adjustment 536

Family Therapy as a Means of Helping Children 537

Child Advocacy Programs 537

UNRESOLVED issues
Can Society Deal with Delinquent Behavior? 538

summary 540 key Terms 541



Neurocognitive Disorders: Clinical Features, Causes, and Treatment 542

Brain Impairment in Adults 544

THINKING CRITICALLY about *DSM-5*:
Is the Inclusion of Mild Neurocognitive Disorder a Good Idea? 544

Clinical Signs of Brain Damage 544

Diffuse Versus Focal Damage 545

The Neurocognitive/Psychopathology Interaction 547

Delirium 548

Clinical Picture 548

Criteria for Delirium 549

Treatments and Outcomes 549

Major Neurocognitive Disorder (Dementia) 549

Criteria for Major Neurocognitive Disorder (Dementia) 550

Parkinson's Disease 550

Huntington's Disease 551

Alzheimer's Disease 551

developments in RESEARCH: Depression Increases the Risk of Alzheimer's Disease 555
the WORLD around us Exercising Your Way to a Healthier Brain? 558
Neurocognitive Disorder Associated with HIV-1 Infection 559
Neurocognitive Disorder Associated with Vascular Disease 560
Amnestic Disorder 560
Disorders Involving Head Injury 561
Clinical Picture 562
the WORLD around us Brain Damage in Professional Athletes 564
Treatments and Outcomes 565
UNRESOLVED issues Should Healthy People Use Cognitive Enhancers? 566
summary 566 key terms 567

16 Treatment Approaches 568
An Overview of Treatment 569
Why Do People Seek Therapy? 569
Who Provides Psychotherapeutic Services? 570
The Therapeutic Relationship 571
Measuring Success in Psychotherapy 572
Objectifying and Quantifying Change 572
Would Change Occur Anyway? 573
Can Therapy Be Harmful? 573
the WORLD around us When Therapy Harms 574
What Therapeutic Approaches Should Be Used? 574
Evidence-Based Treatment 574
Medication or Psychotherapy? 575
Combined Treatments 575
Psychosocial Approaches to Treatment 576
Behavior Therapy 576
Cognitive and Cognitive-Behavioral Therapy 579
Humanistic-Experiential Therapies 581
Psychodynamic Therapies 583
Couple and Family Therapy 586
Eclecticism and Integration 587
Sociocultural Perspectives 588
Social Values and Psychotherapy 588
Psychotherapy and Cultural Diversity 589
Biological Approaches to Treatment 589
Antipsychotic Drugs 589
Antidepressant Drugs 590
Antianxiety Drugs 593
THINKING CRITICALLY about *DSM-5*: What Are Some of the Clinical Implications of the Recent Changes? 594
Lithium and Other Mood-Stabilizing Drugs 595
Electroconvulsive Therapy 596
Neurosurgery 597
the WORLD around us Deep Brain Stimulation for Treatment-Resistant Depression 598
UNRESOLVED issues Do Psychiatric medications Help or Harm? 599
summary 600 key terms 601

17 Contemporary and Legal Issues in Abnormal Psychology 602
Perspectives on Prevention 603
Universal Interventions 604
Selective Interventions 605
Indicated Interventions 608
Inpatient Mental Health Treatment in Contemporary Society 608
The Mental Hospital as a Therapeutic Community 608
Aftercare Programs 609
Deinstitutionalization 610
Controversial Legal Issues and the Mentally Ill 611
Civil Commitment 611
the WORLD around us Important Court Decisions for Patient Rights 612
Assessment of "Dangerousness" 613
the WORLD around us Controversial Not Guilty Pleas: Can Altered Mind States or Personality Disorder Limit Responsibility for a Criminal Act? 614
The Insanity Defense 616
Competence to Stand Trial 620
Does Having Mental Health Problems Result in Convicted Felons Being Returned to Prison After Being Released? 620
Organized Efforts for Mental Health 621
U.S. Efforts for Mental Health 621
International Efforts for Mental Health 623
Challenges for the Future 623
The Need for Planning 624
The Individual's Contribution 624
UNRESOLVED issues The HMOs and Mental Health Care 625
summary 627 key terms 627

Glossary 628
References 649
Credits 736
Name Index 742
Subject Index 771

features

developments in THINKING

Melancholia Through the Ages 51
Nature, Nurture, and Psychopathology: A New Look at an Old Topic 86
The Humanistic and Existential Perspectives 97
A New *DSM-5* Diagnosis: Premenstrual Dysphoric Disorder 187

developments in PRACTICE

The Automated Practice: Use of the Computer in Psychological Testing 131
Computer-Based MMPI-2 Report for Andrea C. 138
Prevention of Psychopathy and Antisocial Personality Disorder 499
Can Virtual Reality Video Games Improve Treatment of Children with Neurodevelopmental Disorders? 525

the WORLD around us

Extreme Generosity or Pathological Behavior? 26
Mad, Sick, Head Nuh Good: Mental Illness and Stigma in Jamaica 29
Chaining Mental Health Patients 61
Culture and Attachment Relationships 115
Racial Discrimination and Cardiovascular Health in African Americans 162
Does Playing Tetris After a Traumatic Event Reduce Flashbacks? 176
Virtual Reality Exposure Treatment for PTSD in Military Personnel 178
Warning Signs for Student Suicide 226
Factitious Disorder Imposed on Another (Munchausen's Syndrome by Proxy) 295
DID, Schizophrenia, and Split Personality: Clearing Up the Confusion 302
Stress, Caffeine, and Hallucinations 319
The Genain Quadruplets 324
Ethnic Identity and Disordered Eating 364
Do Negative Messages About Being Overweight Encourage Overweight People to Eat More or Less? 376
Binge Drinking in College 399
Should Marijuana Be Marketed and Sold Openly as a Medication? 416
Megan's Law 448
"Successful" Psychopaths 494
The Impact of Child Abuse on Psychological Adjustment 536
Exercising Your Way to a Healthier Brain? 558
Brain Damage in Professional Athletes 564
When Therapy Harms 574
Deep Brain Stimulation for Treatment-Resistant Depression 598
Important Court Decisions for Patient Rights 612
Controversial Not Guilty Pleas: Can Altered Mind States or Personality Disorder Limit Responsibility for a Criminal Act? 614

UNRESOLVED issues

Are We All Becoming Mentally Ill? The Expanding Horizons of Mental Disorder 46
Interpreting Historical Events 71
Theoretical Viewpoints and the Causes of Abnormal Behavior 117
Why Is the Study of Trauma so Contentious? 180
Is There a Right to Die? 230
The Choice of Treatments: Medications or Cognitive-Behavior Therapy? 280
DID and the Reality of "Recovered Memories" 310
Why are recovery rates in schizophrenia not improving? 350
The Role of Public Policy in the Prevention of Obesity 383
Exchanging Addictions: Is This an Effective Treatment Approach? 421
How Harmful Is Childhood Sexual Abuse? 459
DSM-5: How Can We Improve the Classification of Personality Disorders? 500
Can Society Deal with Delinquent Behavior? 538
Should Healthy People Use Cognitive Enhancers? 566
Do Psychiatric Medications Help or Harm? 599
The HMOs and Mental Health Care 625

DSM-5 Boxes

Criteria for Persistent Depressive Disorder (Dysthymia) 143
Criteria for Posttraumatic Stress Disorder 166
Criteria for Major Depressive Disorder 184
Criteria for Manic Episode 185
Criteria for Persistent Depressive Disorder (Dysthymia) 188
Criteria for Cyclothymic Disorder 209
Criteria for Specific Phobia 239
Criteria for Social Anxiety Disorder (Social Phobia) 247
Criteria for Panic Disorder 250
Criteria for Agoraphobia 251

Criteria for Generalized Anxiety Disorder 261
Criteria for Obsessive-Compulsive Disorder 267
Criteria for Body Dysmorphic Disorder 276
Criteria for Somatic Symptom Disorder 285
Criteria for Illness Anxiety Disorder 290
Criteria for Conversion Disorder 291
Criteria for Factitious Disorder 294
Criteria for Depersonalization/Derealization Disorder 297
Criteria for Dissociative Amnesia 298
Criteria for Dissociative Identity Disorder 301
Criteria for Schizophrenia 317
Criteria for Schizoaffective Disorder 321
Criteria for Schizophreniform Disorder 321
Criteria for Delusional Disorder 322
Criteria for Brief Psychotic Disorder 322
Criteria for Anorexia Nervosa 354
Criteria for Bulimia Nervosa 356
Criteria for Binge-Eating Disorder 358
Criteria for Alcohol Use Disorder 389
Criteria for Gambling Disorder 419
Criteria for Several Different Paraphilic Disorders 429
Criteria for Gender Dysphoria 436
Criteria for Gender Dysphoria in Adolescents and Adults 437
Criteria for Different Sexual Dysfunctions 451
Criteria for Paranoid Personality Disorder 469
Criteria for Schizoid Personality Disorder 471
Criteria for Schizotypal Personality Disorder 472
Criteria for Histrionic Personality Disorder 474
Criteria for Narcissistic Personality Disorder 475
Criteria for Borderline Personality Disorder 477
Criteria for Avoidant Personality Disorder 481
Criteria for Dependent Personality Disorder 483
Criteria for Obsessive-Compulsive Personality Disorder 484
Criteria for Antisocial Personality Disorder 488
Criteria for Attention-Deficit/Hyperactivity Disorder 506
Criteria for Conduct Disorder 509
Criteria for Separation Anxiety Disorder 513
Criteria for Autism Spectrum Disorder 522
Criteria for Delirium 549
Criteria for Major Neurocognitive Disorder (Dementia) 550

THINKING CRITICALLY about *DSM-5*

What Is the *DSM* and Why Was It Revised? 27
Completion does not assure acceptance 145
Changes to the Diagnostic Criteria for PTSD 167
Was It Wise to Drop the Bereavement Exclusion for Major Depression? 186
Why is OCD No Longer Considered to be an Anxiety Disorder? 236
Where Does Conversion Disorder Belong? 300
Attenuated Psychosis Syndrome 332
Other Forms of Eating Disorders 359
Can Changes to the diagnostic criteria result in increased drug use? 412
Pedophilia and Hebephilia 442
Why Were No Changes Made to the Way Personality Disorders Are Diagnosed? 466
Nonsuicidal Self-Injury: Distinct Disorder or Symptom of Borderline Personality Disorder? 478
Changes to the Diagnostic System are Nominal for Some Disorders 527
Is the Inclusion of Mild Neurocognitive Disorder a Good Idea? 544
What Are Some of the Clinical Implications of the Recent Changes? 594

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 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.
- 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.

Speaking Out: Interviews with People Who Struggle with Psychological Disorders

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

Instructor's Manual

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.pearsonglobaleditions.com/Butcher.

Test Bank

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.pearsonglobaleditions.com/Butcher.

Lecture PowerPoint Slides

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.pearsonglobaleditions.com/Butcher.

PowerPoint Slides for Photos, Figures, and Tables contain only the photos, figures, and line art from the textbook. Available for download on the Instructor's Resource Center at www.pearsonglobaleditions.com/Butcher.

CourseSmart

CourseSmart Learn Smart. Choose Smart. * 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.co.uk.

*This product may not be available in all markets. For more details, please visit www.coursesmart.co.uk or contact your local Pearson representative.

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 Almpoura 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; 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

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.

Pearson wishes to thank and acknowledge the following people for their work on the Global Edition:

Contributors

Ashum Gupta, University of Delhi

Malavika Kapur, National Institute of Mental Health and Neurosciences, Bangalore

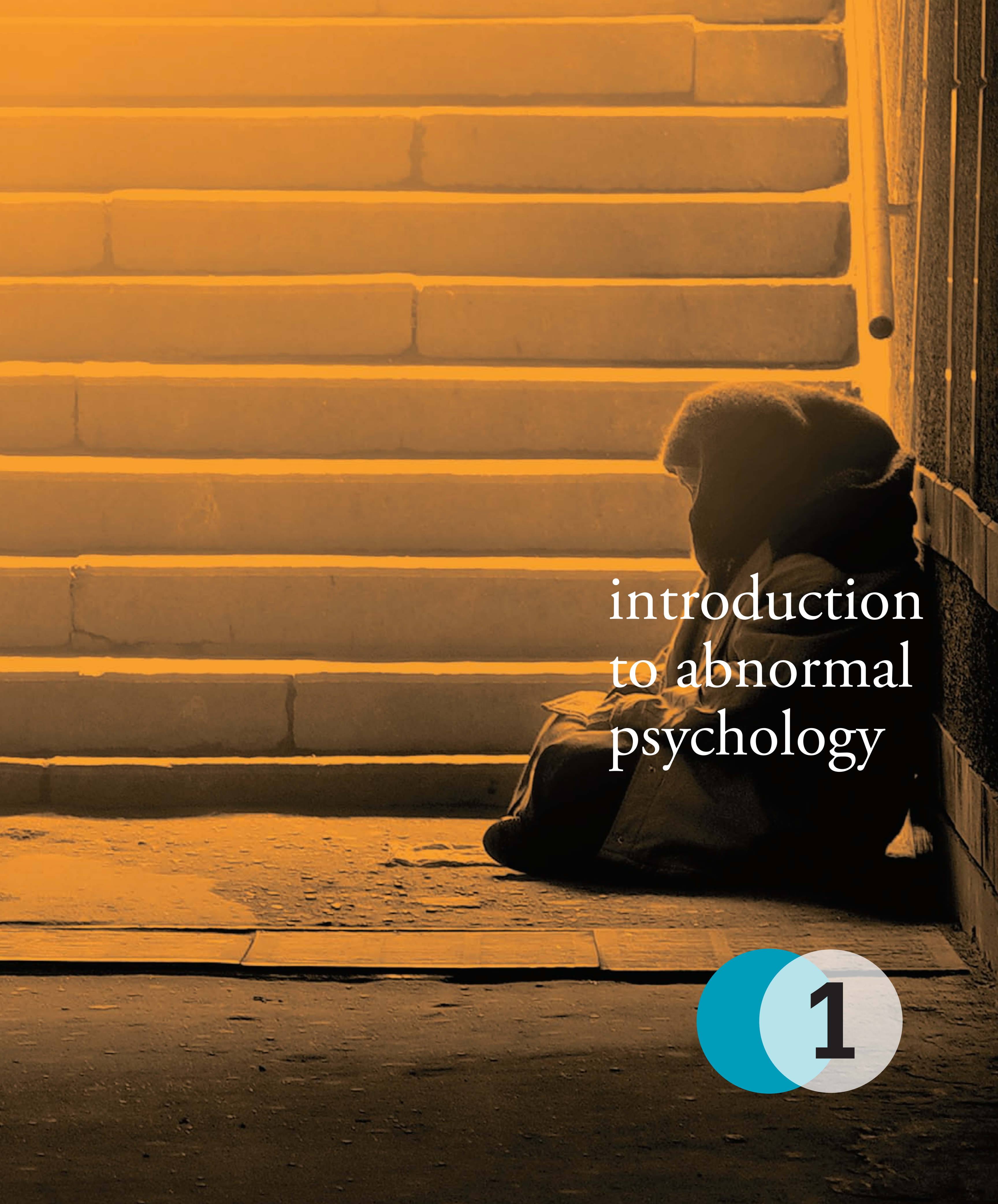
Reviewers

Iliana Magiati, National University of Singapore

Jayanti Banerjee, University of Calcutta

Azizuddin Khan, Indian Institute of Technology Bombay

Gregor Lange, National University of Singapore



1

introduction to abnormal psychology

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 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 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 antipsychotic 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.

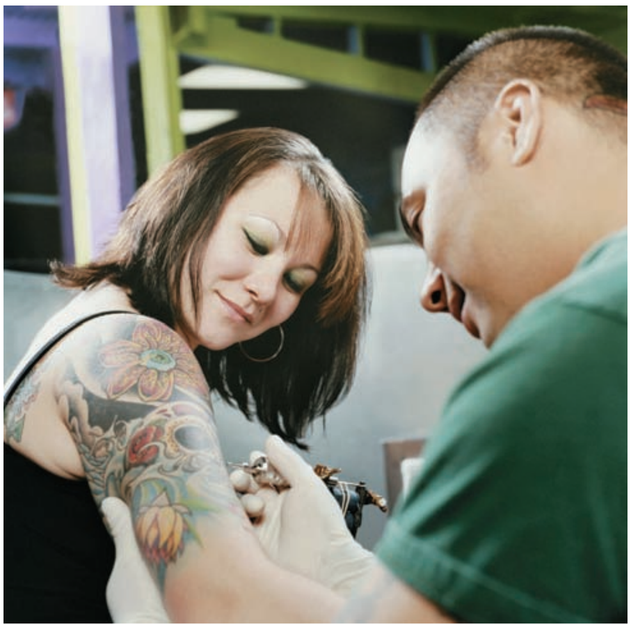
5. ***Social Discomfort:*** When someone violates a social rule, those around him or her may experience a sense of discomfort or unease. Imagine that you are sitting in an almost empty movie theater. There are rows and rows of unoccupied seats. Then someone comes in and sits down right next to you. How 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?



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

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 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 26. 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 27 we explain more about the *DSM* and discuss why a revision was necessary.