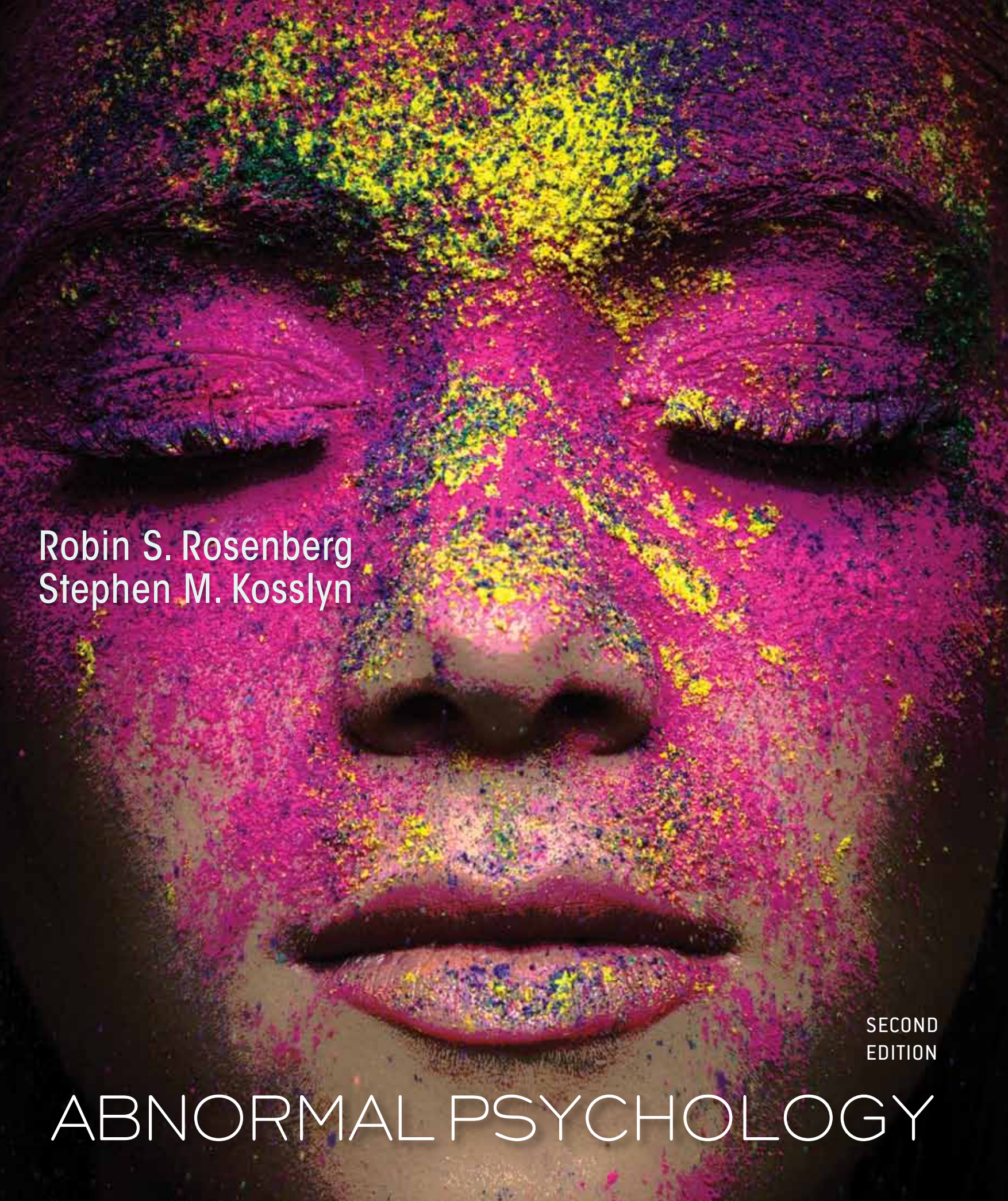
Robin S. Rosenberg
Stephen M. Kosslyn
SECOND
EDITION
ABNORMAL PSYCHOLOGY

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SECOND
EDITION

# ABNORMAL PSYCHOLOGY

Robin S. Rosenberg
University of California at San Francisco

Stephen M. Kosslyn
Minerva Schools at the Keck Graduate Institute

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To our families

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**Robin S. Rosenberg** is a clinical psychologist in private practice in both Menlo Park and San Francisco, California. She is board certified in clinical psychology by the American Board of Professional Psychology, and has been certified in clinical hypnosis.

Courtesy of Robin Apple

Dr. Rosenberg is a fellow of the American Academy of Clinical Psychology, member of the Academy for Eating Disorders, President of the Santa Clara County Psychological Association, member of the California Psychological Association Ethics Committee, and assistant clinical professor at the University of California at San Francisco. She has taught psychology classes at Lesley University and Harvard University.

Dr. Rosenberg received her B.A. in psychology from New York University, and her M.A. and Ph.D. in clinical psychology from the University of Maryland, College Park. She completed her clinical internship at Massachusetts Mental Health Center, had a postdoctoral fellowship at Harvard Community Health Plan, and was a staff member at Newton-Wellesley Hospital's Outpatient Services. Dr. Rosenberg specializes in treating people with anxiety disorders, eating disorders, depression, and sexual dysfunctions.

In addition, Dr. Rosenberg writes about fictional popular culture figures and the psychological phenomena their stories reveal. She is author of *Superhero Origins: What Makes Superheroes Tick and Why We Care* and *What's the Matter with Batman? An Unauthorized Clinical Look Under the Mask of the Caped Crusader*, as well as college-level psychology textbooks. She is the editor of *The Psychology of the Girl With the Dragon Tattoo; The Psychology of Superheroes; Our Superheroes, Ourselves;* and *What Is a Superhero?* Dr. Rosenberg is also a blogger at *Psychology Today* and the *Huffington Post*.

**Stephen M. Kosslyn** is the Founding Dean of the Minerva Schools at KGI (Keck Graduate Institute). Previously, he served as Director of the Center for Advanced Study in the Behavioral Sciences and as Professor of Psychology at Stanford University.

Courtesy of Mark Estes

Kosslyn also is the former chair of the Department of Psychology, Dean of Social Science, and John Lindsley Professor of Psychology at Harvard University. He received a B.A. from UCLA and a Ph.D. from Stanford University, both in psychology.

Kosslyn's research has focused primarily on the nature of visual cognition, visual communication, and individual differences; he has authored or coauthored 14 books and over 300 papers on these topics. Kosslyn has received the following accolades: the American Psychological Association's Boyd R. McCandless Young Scientist Award, the National Academy of Sciences Initiatives in Research Award, the Cattell Award, a Guggenheim Fellowship, and the J-L. Signoret Prize (France). He has honorary Doctorates from the University of Caen, the University of Paris Descartes, and University of Bern. Kosslyn has been elected to Academia Rodinensis pro Remediatione (Switzerland), the Society of Experimental Psychologists, and the American Academy of Arts and Sciences.

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# PREFACE

This is an exciting time to study psychopathology. Research on the entire range of psychological disorders has blossomed during the last several decades, producing dramatic new insights about psychological disorders and their treatments. However, the research results are outpacing the popular media's ability to explain them. We've noticed that when study results are explained in a news report or an online magazine article, "causes" of mental illness are often reduced to a single factor, such as genes, brain chemistry, irrational thoughts, or social rejection. But that is not an accurate picture. Research increasingly reveals that psychopathology arises from a confluence of three types of factors: neurological (brain and body, including genes), psychological (thoughts, feelings, and behaviors), and social (relationships, communities, and culture). Moreover, these three sorts of factors do not exist in isolation, but rather mutually influence each other. It's often tempting to seek a single cause of psychopathology, but this effort is fundamentally misguided.

We are a clinical psychologist (Rosenberg) and a cognitive neuroscientist (Kosslyn) who have been writing collaboratively for many years. Our observations about the state of the field of psychopathology—and the problems with how it is sometimes portrayed—led us to envision an abnormal psychology textbook that is guided by a central idea, which we call the *neuropsychosocial approach*. This approach allows us to conceptualize the ways in which neurological, psychological, and social factors interact to give rise to mental disorders. These interactions take the form of feedback loops in which each type of factor affects every other type. Take depression, for instance, which we discuss in Chapter 5: Someone who attributes the cause of a negative event to his or her own personal characteristics or behavior (such attributions are a psychological factor) is more likely to become depressed. But this tendency to attribute the cause of negative events to oneself is influenced by social experiences, such as being criticized or abused. In turn, such social factors can alter brain functioning (particularly if one has certain genes), and abnormalities in brain functioning affect one's thoughts and social interactions, and so on—round and round.

The neuropsychosocial approach grew out of the venerable biopsychosocial approach—but instead of focusing broadly on biology, we take advantage of the bountiful harvest of findings about the brain that have filled the scientific journals over the past two decades. Specifically, the name change signals a focus on the brain itself; we derive much insight from the findings of neuroimaging studies, which reveal how brain systems function normally and how they have gone awry with mental disorders, and we also learn an enormous amount from findings regarding neurotransmitters and genetics.

Although mental disorders cannot be fully understood without reference to the brain, neurological factors alone cannot explain these disorders; rather, mental disorders develop through the complex interaction of neurological factors with psychological and social factors. Without question, psychopathology cannot be reduced to "brain disease," akin to a problem someone might have with his or her liver or lungs. Instead, we show that the effects of neurological factors can only be understood in the context of the other two types of factors addressed within the neuropsychosocial approach. (In fact, an understanding of a psychological disorder cannot be reduced to any single type of factor, whether genetics, irrational thoughts, or family interaction patterns.) Thus, we present cutting-edge neuroscience research results and put them in context, explaining how they illuminate issues in psychopathology.

Our emphasis on feedback loops among neurological, psychological, and social factors led us to reconceptualize and incorporate the classic diathesis-stress model (which posits a precondition that makes a person vulnerable and an environmental trigger—the diathesis and stress, respectively). In the classic view, the diathesis was almost always treated as a biological state, and the stress was viewed as a result of environmental

events. In contrast, after describing the conventional diathesis-stress model in Chapter 1, we explain how the neuropsychosocial approach provides a new way to think about the relationship between diathesis and stress. Specifically, we show how one can view *any* of the three sorts of factors as a potential source of either a diathesis or a stressor. For example, living in a dangerous neighborhood, which is a social factor, creates a diathesis for which psychological events can serve as the stressor, triggering an episode of depression. Alternatively, being born with a very sensitive amygdala (a brain structure involved in fear and other strong emotions) may act as a diathesis for which social events—such as observing someone else being mugged—can serve as a stressor that triggers an anxiety disorder.

Thus, the neuropsychosocial approach is not simply a change in terminology ("bio" to "neuro"), but rather a change in basic orientation: We do not view any one sort of factor as "privileged" over the others, but regard the interactions among the factors—the feedback loops—as paramount. In our view, this approach incorporates what was best about the biopsychosocial approach and the diathesis-stress model.

Our new approach should lead students who use this textbook to think critically about theories and research on etiology, diagnosis and treatment of mental disorders. We want students to come away from the course with the knowledge and skills to understand why no single type of findings alone can explain psychopathology, and to have compassion for people suffering from psychological disorders. One of our goals is to put a "human face" on mental illness, which we do by using case studies to illustrate and make concrete each disorder. These goals are especially important because this course will be the last psychology course many students take—and this might be the last book about psychology they read.

The new approach we have adopted led naturally to a set of unique features, as we outline next.

## Unique Coverage

By integrating cutting-edge neuroscience research and more traditional psychosocial research on psychopathology and its treatment, this textbook provides students with a sense of the field as a coherent whole, in which different research methods illuminate different aspects of abnormal psychology. Our integrated neuropsychosocial approach allows students to learn not only how neurological factors affect mental processes (such as executive functions) and mental contents (such as distorted beliefs), but also how neurological factors affect emotions, behavior, social interactions, and responses to environmental events—and vice versa.

The 16 chapters included in this book span the traditional topics covered in an abnormal psychology course. The neuropsychosocial theme is reflected in both the overall organization of the text and the organization of its individual chapters. We present the material in a decidedly contemporary context that infuses both the foundational chapters (Chapters 1–4) as well as the chapters that address specific disorders (Chapters 5–15).

In Chapter 2, we provide an overview of explanations of abnormality and discuss neurological, psychological, and social factors. Our coverage is not limited merely to categorizing causes as examples of a given type of factor; rather, we explain how a given type of factor influences and creates feedback loops with other factors. Consider depression again: The loss of a relationship (social factor) can affect thoughts and feelings (psychological factors), which—given a certain genetic predisposition (neurological factor)—can trigger depression. Using the neuropsychosocial approach, we show how disparate fields of psychology and psychiatry (such as neuroscience and

clinical practice) are providing a unified and overarching understanding of abnormal psychology.

Our chapter on diagnosis and assessment (Chapter 3) uses the neuropsychosocial framework to organize methods of assessing abnormality. We discuss how abnormality may be assessed through measures that address the different types of factors: neurological (e.g., neuroimaging data or certain types of blood tests), psychological (e.g., clinical interviews or questionnaires), and social (e.g., family interviews or a history of legal problems).

The research methods chapter (Chapter 4) also provides unique coverage. We explain the general scientific method, but we do so within the neuropsychosocial framework. Specifically, we consider methods used to study neurological factors (e.g., neuroimaging), psychological factors (e.g., self-reports of thoughts and moods), and social factors (e.g., observational studies of dyads or groups or of cultural values and expectations). We show how the various measures themselves reflect the interactions among the different types of factors. For instance, when researchers ask participants to report family dynamics, they are relying on psychological factors—participants' memories and impressions—to provide measures of social factors. Similarly, when researchers use the number of items checked on a stressful-life events scale to infer the actual stress experienced by a person, social factors provide a proxy measure of the psychological and neurological consequences of stress. We also discuss research on treatment from the neuropsychosocial framework.

AP Photo/Winslow Townson

During times of political unrest, violence, or terrorism, rates of trauma-related disorders are likely to increase.

The clinical chapters (Chapters 5–15), which address specific disorders, also rely on the neuropsychosocial approach to organize the discussions of both etiology and treatment of the disorders. Moreover, when we discuss a particular disorder, we address the three basic questions of psychopathology: What exactly constitutes this psychological disorder? What neuropsychosocial factors are associated with it? How is it treated?

# Pedagogy

All abnormal psychology textbooks cover a lot of ground: Students must learn many novel concepts, facts, and theories. We want to make that task easier, to help students come to a deeper understanding of what they learn and to consolidate that material effectively. The textbook uses a number of pedagogical tools to achieve this goal.

## Feedback Loops Within the Neuropsychosocial Approach

This textbook highlights and reinforces the theme of feedback loops among neurological, psychological, and social factors in several ways:

- In each clinical chapter, we include a section on "Feedback Loops in Understanding," which specifically explores how disorders result from interactions among the neuropsychosocial factors. We also include a section on "Feedback Loops in Treating," which specifically explores how successful treatment results from interactions among the neuropsychosocial factors.
- We include neuropsychosocial "Feedback Loop" diagrams as part of these sections. For example, in Chapter 7 we provide a Feedback Loop diagram for understanding posttraumatic stress disorder and another for treating posttraumatic stress disorder.

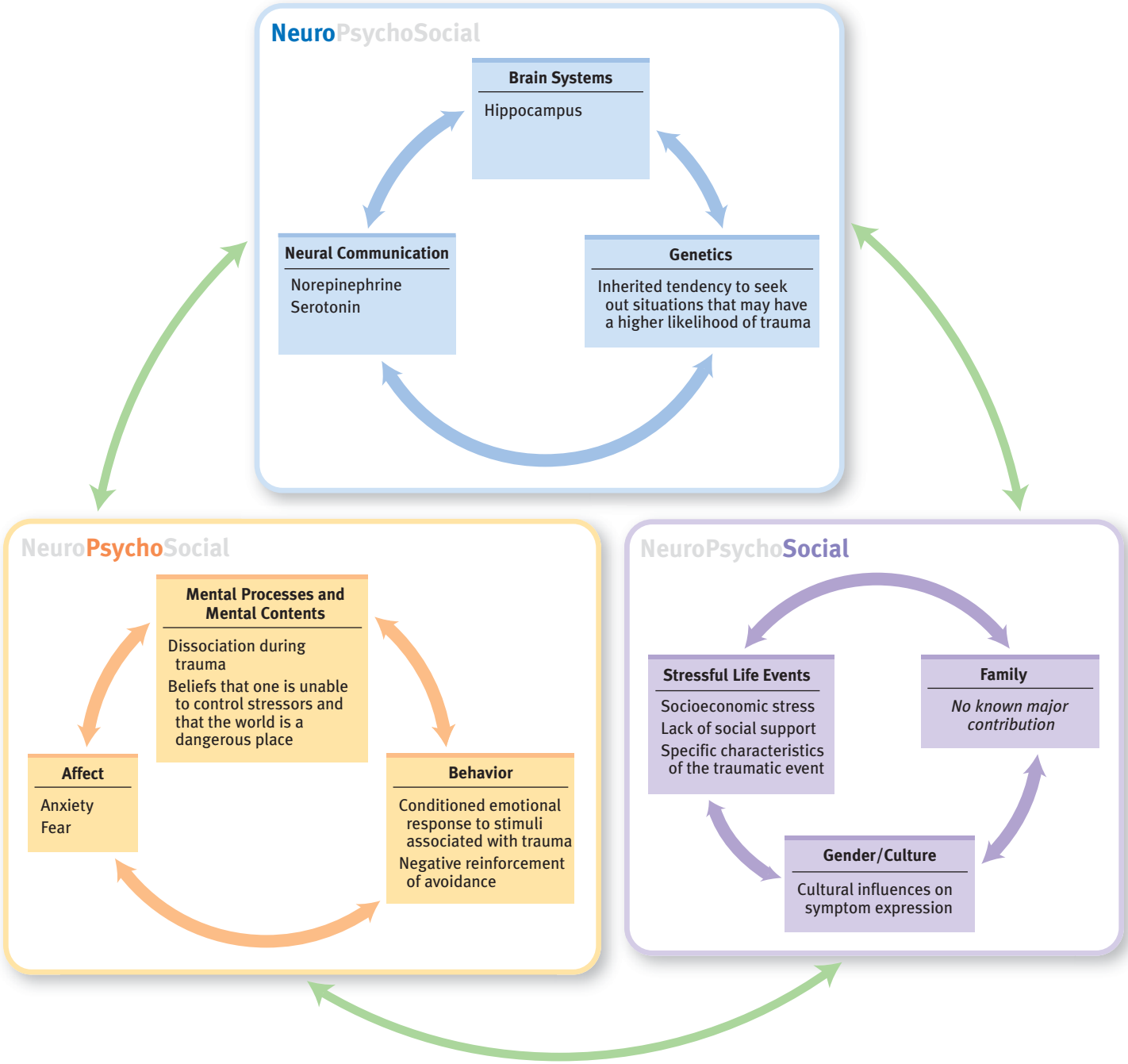



**FIGURE 7.2 • Feedback Loops in Understanding PTSD**

These diagrams illustrate the feedback loops among the neurological, psychological, and social factors. Additional feedback loop diagrams can be found on the book's website at: www.worthpublishers.com/launchpad/rkabpsych2e.

- The Feedback Loops in Understanding diagrams serve several purposes: (1) they provide a visual summary of the most important neuropsychosocial factors that contribute to various disorders; (2) they illustrate the interactive nature of the factors; (3) because their overall structure is the same for each disorder, students can compare and contrast the specifics of the feedback loops across disorders.

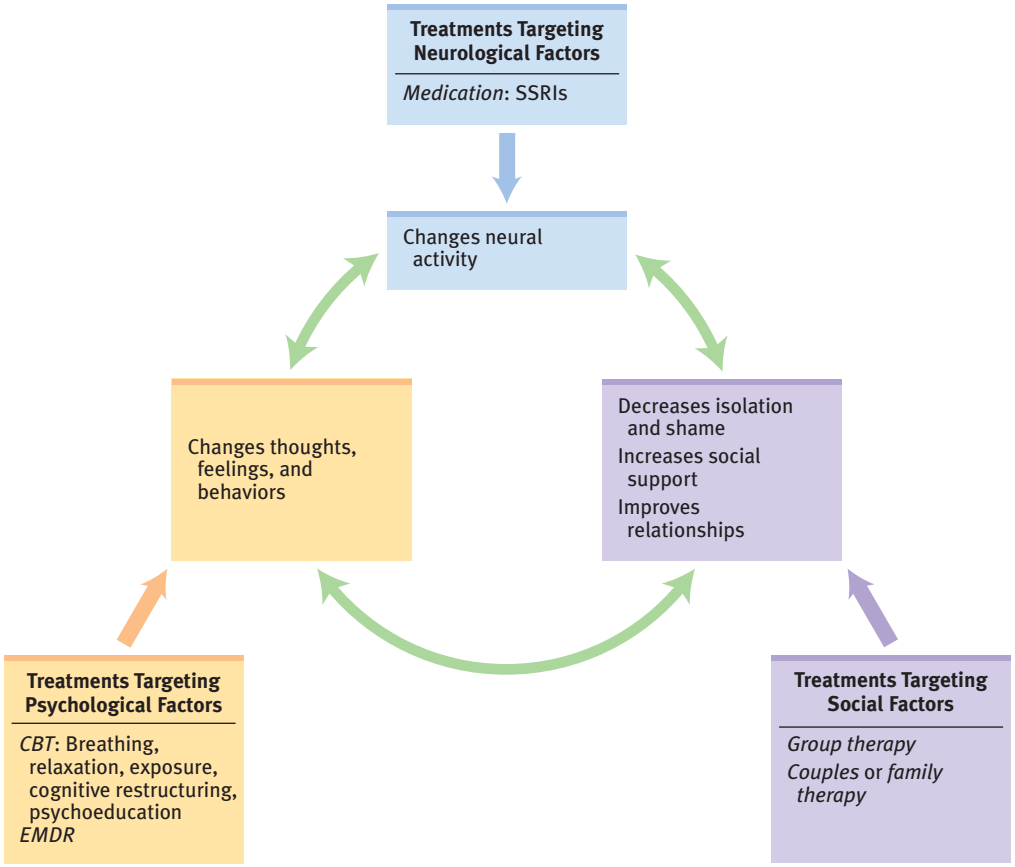



**FIGURE 7.3 • Feedback Loops in Treating PTSD**

- Like the Feedback Loops in Understanding diagrams, the Feedback Loops in Treating diagrams serve several purposes: (1) they provide a visual summary of the treatments for various disorders; (2) they illustrate the interactive nature of successful treatment (the fact that a treatment may directly target one type of factor, but changes in that factor in turn affect other factors); (3) because their overall structure is the same for each disorder, students can compare and contrast the specifics of the feedback loops across disorders.

# Clinical Material

Abnormal psychology is a fascinating topic, but we want students to go beyond fascination; we want them to understand the human toll of psychological disorders—what it's like to suffer from and cope with such disorders. To do this, we've incorporated several pedagogical elements. The textbook includes three types of clinical material: *chapter stories*—each chapter has a story woven through, traditional third-person cases (*From the Outside*), and first-person accounts (*From the Inside*).

## Chapter Stories: Illustration and Integration

Each chapter opens with a story about a person (or, in some cases, several people) who has symptoms of psychological distress or dysfunction. Observations about the person or people are then woven throughout the chapter. These chapter stories illustrate the common threads that run throughout the chapter (and thereby integrate the material), serve as retrieval cues for later recall of the material, and show students how the theories and research presented in each chapter apply to real people in the real world; the stories

Tom Wargacki/WireImage/Getty Images

Using this book's definition of a psychological disorder, did either of the Beales have a disorder? Big Edie exhibited distress that was inappropriate to her situation; both women appeared to have an impaired ability to function. The risk of harm to the women, however, is less clear-cut.

humanize the clinical descriptions and discussions of research presented in the chapters.

The chapter stories present people as clinicians and researchers often find them—with sets of symptoms in context. It is up to the clinician or researcher to make sense of the symptoms, determining which of them may meet the criteria for a particular disorder, which may indicate an atypical presentation, and which may arise from a comorbid disorder. Thus, we ask the student to see situations from the point of view of clinicians and researchers, who must sift through the available information to develop hypotheses about possible diagnoses and then obtain more information to confirm or disconfirm these hypotheses.

In the first two chapters, the opening story is about a mother and daughter—Big Edie and Little Edie Beale—who were the subject of a famous documentary in the 1970s and whose lives have been portrayed more recently in the play and HBO film *Grey Gardens*. In these initial chapters, we offer a description of the Beales' lives and examples of their very eccentric behavior to address two questions central to psychopathology: How is abnormality defined? Why do psychological disorders arise?

The stories in subsequent chapters focus on different examples of symptoms of psychological disorders, drawn from the lives of other people. For example, in Chapter 6 we discuss football star Earl Campbell (who suffered from symptoms of anxiety); in Chapter 7 we discuss the reclusive billionaire Howard Hughes (who suffered from symptoms of obsessive-compulsive disorder and who experienced multiple traumatic events); and in Chapter 12 we discuss the Genain quadruplets—all four of whom were diagnosed with schizophrenia.

We return often to these stories throughout each chapter in an effort to illustrate the complexity of mental disorders and to show the human side of mental illness, how it can affect people throughout a lifetime, rather than merely a moment in time.

## From the Outside

The feature called *From the Outside* provides third-person accounts (typically case presentations by mental health clinicians) of disorders or particular symptoms of disorders. These accounts provide an additional opportunity for memory consolidation of the material (because they mention symptoms the person experienced), an additional set of retrieval cues, and a further sense of how symptoms and disorders affect real people; these cases also serve to expose students to professional case material. The *From the Outside* feature covers an array of disorders, such as cyclothymic disorder, panic disorder, transvestic disorder, and separation anxiety disorder. Often several *From the Outside* cases are included in a chapter.

## From the Inside

In every chapter in which we address a disorder in depth, we present at least one first-person account of what it is like to live with that disorder or particular symptoms of it. In addition to providing high-interest personal narratives, these *From the Inside* cases help students to consolidate memory of the material, provide additional retrieval cues, and are another way to link the descriptions of disorders and research findings to real people's experiences. The *From the Inside* cases illuminate what it is like to live with disorders such as agoraphobia, obsessive-compulsive disorder, illness anxiety disorder, alcohol use disorder, gender dysphoria, and schizophrenia, among others.

# Learning About Disorders: Consolidated Tables to Consolidate Learning

In the clinical chapters, we provide two types of tables to help students organize and consolidate information related to diagnosis: DSM-5 diagnostic criteria tables, and Facts at a Glance tables.

## DSM-5 Diagnostic Criteria Tables

The American Psychiatric Association's manual of psychiatric disorders—the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)—provides tables of the diagnostic criteria for each of the listed disorders. For each disorder that we discuss at length, we present the DSM-5 diagnostic criteria table; we also explain and discuss the criteria—and criticisms of them—in the body of the chapters themselves.

## Facts at a Glance Tables for Disorders

Another important innovation is our summary tables for each disorder, which provide key facts about prevalence, comorbidity, onset, course, and gender and cultural factors. These tables are clearly titled with the name of the disorder, which is followed by the term "Facts at a Glance" (for instance, *Obsessive-Compulsive Disorder Facts at a Glance*). These tables give students the opportunity to access this relevant information in one place and to compare and contrast the facts for different disorders.

# New Features

This edition has two new features: *Current Controversy* boxes and *Getting the Picture* critical thinking photo sets.

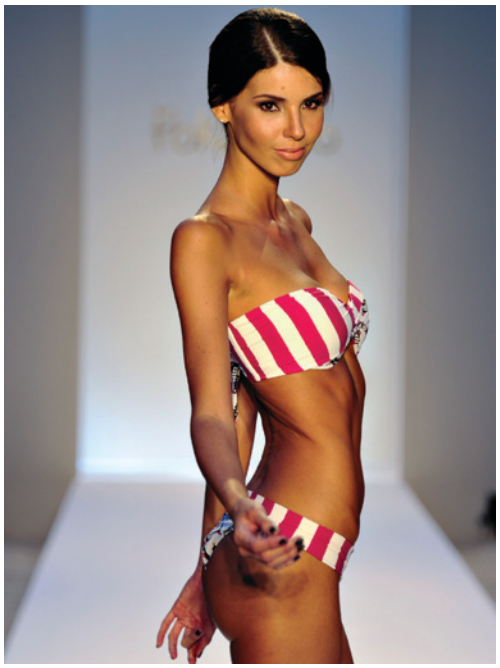
## Current Controversies

New to this edition, each clinical chapter includes a brief discussion about a current controversy related to a disorder—its diagnosis or its treatment. Examples include whether the new diagnoses in DSM-5 of mild and major neurocognitive disorders are net positive or negative changes from DSM-IV, and whether eye movement desensitization and reprocessing (EMDR) provides additional benefit beyond that of other treatments for posttraumatic stress disorder. These discussions help students understand the iterative and sometimes controversial nature of classifying "problems" and symptoms as disorders, and whether and when treatments might be appropriate. Many of these discussions were contributed by instructors who teach Abnormal Psychology—including: Ken Abrams, Carleton College; Randy Arnau, University of Southern Mississippi; Glenn Callaghan, San Jose State University; Richard Conti, Kean University; Patrice Dow-Nelson, New Jersey City University; James Foley, College of Wooster; Rick Fry, Youngstown State University; Farrah Hughes, Francis Marion University; Meghana Karnik-Henry, Green Mountain College; Kevin Meehan, Long Island University; Jan Mendoza, Golden West College; Meera Rastogi, University of Cincinnati, Clermont College; Harold Rosenberg, Bowling Green State University; Anthony Smith, Baybath College; and Janet Todaro, Salem State University.

## Getting the Picture

Also new to this edition are brief visual features that help to consolidate learning, which we call *Getting the Picture*: We offer two photos and ask students to decide which one

**GETTING THE PICTURE**



Arun Nevader/FilmMagic/Getty Images

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Imagine that you know that both of these women are afraid of getting fat and believe themselves to be overweight. If you had to guess based on their appearance, which of these models would you think didn't meet all the criteria for anorexia nervosa and instead had a partial case? The woman on the right is more likely to have a partial case because, based on these photos, she does not appear to be significantly underweight.

best illustrates a clinical phenomenon described in the chapter. Each chapter contains several of these features.

# Summarizing and Consolidating

We include two more key features to help students learn the material: end-of-section application exercises and end-of-chapter summaries (called *Summing Up*).

## *Thinking Like a Clinician*: End-of-Section Application Exercises

At the end of each major section in the clinical chapters, we provide *Thinking Like a Clinician* questions. These questions ask students to apply what they have learned to other people and situations. These questions allow students to test their knowledge of the chapter's material; they may be assigned as homework or used to foster small-group or class discussion.

## End-of-Chapter Review: *Summing Up*

The end-of-chapter review is designed to help students further consolidate the material in memory:

- Section Summaries: These summaries allow students to review what they have learned in the broader context of the entire chapter's material.
- Key Terms: At the end of each chapter we list the key terms used in that chapter—the terms that are presented in boldface in the text and are defined in the marginal glossaries—with the pages where the definitions can be found.

- At the very end of *Summing Up*, students are directed to the online study aids and resources pertinent to the chapter.

## Integrated Gender and Cultural Coverage

We have included extensive culture and gender coverage, and integrated it throughout the entire textbook. You'll find a complete list of this coverage on the book's catalog page. Some of our coverage of culture and gender include:

- *Facts at a Glance* tables provide relevant cultural and gender data for each specific disorder
- Cultural differences in evaluating symptoms of disorders in psychological research, 63, 66
- Cultural differences in assessing social factors in psychological assessment, 75, 103–104
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## Media and Supplements

The second edition of our book features a wide array of multimedia tools designed to meet the needs of both students and teachers. For more information about any of the items below, visit Worth Publishers' online catalog at www.worthpublishers.com.

**LAUNCHPAD WITH LEARNINGCURVE QUIZZING** A comprehensive Web resource for teaching and learning psychology, LaunchPad combines rich media resources and an easy-to-use platform. For students, it is the ultimate online study guide with videos, e-Book, and the LearningCurve adaptive quizzing system. For instructors, LaunchPad is a full course space where class documents can be posted, quizzes are easily assigned and graded, and students' progress can be assessed and recorded. The LaunchPad for our second edition can be previewed at: www.worthpublishers.com/launchpad/rkabpsych2e. You'll find the following in our LaunchPad:

The **LearningCurve** quizzing system was designed based on the latest findings from learning and memory research. It combines adaptive question selection, immediate and valuable feedback, and a game-like interface to engage students in a learning experience that is unique to them. Each LearningCurve quiz is fully integrated with other resources in LaunchPad through the Personalized Study Plan, so students will be able to review with Worth's extensive library of videos and activities. State-of-the-art question analysis reports allow instructors to track the progress of individual students as well as the class as a whole. The many questions in LearningCurve have been prepared by a talented team of instructors including Kanoa Meriwether from the University of Hawaii, West Oahu, Danielle Gunraj from the State University of New York at Binghamton, and Anna Aulette Root from the University of Capetown.

- **Diagnostic Quizzing** developed by Diana Joy of Denver Community College and Judith Levine from Farmingdale State College includes more than 400 questions for every chapter that help students identify their areas of strength and weakness.
- An **interactive e-Book** allows students to highlight, bookmark, and make their own notes, just as they would with a printed textbook. Digital enhancements include full-text search and in-text glossary definitions.


- **Student Video Activities** include more than 60 engaging and gradeable video activities, including archival footage, explorations of current research, case studies, and documentaries.
- **The *Scientific American* Newsfeed** delivers weekly articles, podcasts, and news briefs on the very latest developments in psychology from the first name in popular science journalism.

***COURSESMART E-BOOK*** The CourseSmart e-Book offers the complete text in an easy-to-use, flexible format. Students can choose to view the CourseSmart e-Book online or download it to a personal computer or a portable media player, such as a smart phone or iPad. The CourseSmart e-Book for *Abnormal Psychology*, Second Edition, can be previewed and purchased at www.coursesmart.com.

## Also Available for Instructors

The *Abnormal Psychology* video collection on Flash Drive and DVD. This comprehensive collection of more than 130 videos includes a balanced set of cases, experiments, and current research clips. Instructors can play clips to introduce key topics, to illustrate and reinforce specific core concepts, or to stimulate small-group or full-classroom discussions. Clips may also be used to challenge students' critical thinking skills—either in class or via independent, out-of-class assignments.

***INSTRUCTOR'S RESOURCE MANUAL,*** by Kanoa Meriwether, University of Hawaii, West Oahu and Meera Rastogi, University of Cincinnati: The manual offers chapter-by-chapter support for instructors using the text, as well as tips for explaining to students

the neuropsychosocial approach to abnormal psychology. For each chapter, the manual offers a brief outline of learning objectives and a list of key terms. In addition, it includes a chapter guide, including an extended chapter outline, point-of-use references to art in the text, and listings of class discussions/activities, assignments, and extra-credit projects for each section.

***TEST BANK,*** by James Rodgers from Hawkeye Community College, Joy Crawford, University of Washington, and Judith Levine, Farmingdale State College: The test bank offers over 1700 questions, including multiple-choice, true/false, fill-in, and essay questions. The Diploma-based CD version makes it easy for instructors to add, edit, and change the order of questions.

***PRESENTATION SLIDES*** are available in three formats that can be used as they are or can be customized. One set includes all the textbook's illustrations and tables. The second set consists of lecture slides that focus on key themes and terms in the book and include text illustrations and tables. A third set of PowerPoint slides provides an easy way to integrate the supplementary video clips into classroom lectures. In addition, we have lecture outline slides correlated to each chapter of the book created by Pauline Davey Zeece from University of Nebraska-Lincoln.

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We want to thank the following people, who generously gave of their time to review one or more—in some cases all—of the chapters in this book. Their feedback has helped make this a better book.

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# ABNORMAL PSYCHOLOGY

CHAPTER 1

# The History of Abnormal Psychology

"Big Edie" (Edith Bouvier Beale, 1894–1977) and her daughter, "Little Edie" (Edith Beale, 1917–2002), lived together as adults for 29 years. Their home was a 28-room mansion, called Grey Gardens, in the chic town of East Hampton, New York. But the Beales were not rich society women, entertaining in grand style. They had few visitors, other than people who delivered food to them daily, and they lived in impoverished circumstances. For the most part, they inhabited only two of the second-floor rooms and an upstairs porch of a house that was falling apart. These intelligent women were not simply poor recluses, though. They were unconventional, eccentric women who flaunted the rules of their time and social class.

Let's consider Big Edie first. In her later years, Big Edie had difficulty walking, and her bedroom was the hub of the Beale women's lives and full of squalor. It contained a small refrigerator, a hot plate on which food was heated or cooked, and up to 52 cats. The room had two twin beds, one for Little Edie, the other for Big Edie. Big Edie made her bed into an unusual nest of blankets (no sheets). Cats constantly walked across the bed or rested on it; because the women didn't provide the cats with a litter box, the bed was one of the spots the cats left their droppings. Big Edie's mattress was so soiled that the grime and the cat droppings were indistinguishable.

Big Edie hadn't left the house in decades (except for one occasion; Sheehy, 1972) and would let Little Edie out of her sight for only a few minutes before yelling for her to return to the bedroom. When Big Edie fell off a chair and broke her leg at the age of 80, she refused to leave the house to see a doctor, and refused to allow a doctor to come to the house to examine her leg. As a result, she developed bedsores that became infected and she died at Grey Gardens 7 months later (Wright, 2007).

CHAPTER OUTLINE



Wildcard Images/Glasshouse. Photo for illustrative purposes only; any individual depicted is a model.

**Abnormal psychology**
The subfield of psychology that addresses the causes and progression of psychological disorders; also referred to as *psychopathology*.

**Psychological disorder**
A pattern of thoughts, feelings, or behaviors that causes significant personal *distress*, significant *impairment* in daily life, and/or significant *risk of harm*, any of which is unusual for the context and culture in which it arises.

Little Edie was also unusual, most obviously in her style of dress. Little Edie always covered her head, usually with a sweater that she kept in place with a piece of jewelry. She professed not to like women in skirts, but invariably wore skirts herself, typically wearing them upside down so that the waistband was around her knees or calves and the skirt hem bunched around her waist. She advocated wearing stockings *over* pants, and she suggested that women "take off the skirt, and use it as a cape" (Maysles & Maysles, 1976).

**ALTHOUGH BOTH OF THESE WOMEN WERE ODD,** could their behavior be chalked up to eccentricity or did one or both of them have a psychological disorder? It depends on how *psychological disorder* is defined.

The sort of psychologist who would evaluate Big Edie and Little Edie would specialize in **abnormal psychology** (or *psychopathology*), the subfield of psychology that addresses the causes and progression of psychological disorders (also referred to as *psychiatric disorders*, *mental disorders*, or *mental illness*). How would a mental health clinician—a mental health professional who evaluates or treats people with psychological disorders—determine whether Big Edie or Little Edie (or both of them) had a psychological disorder? The clinician would need to evaluate whether the women's behavior and experience met three general criteria for psychological disorders.

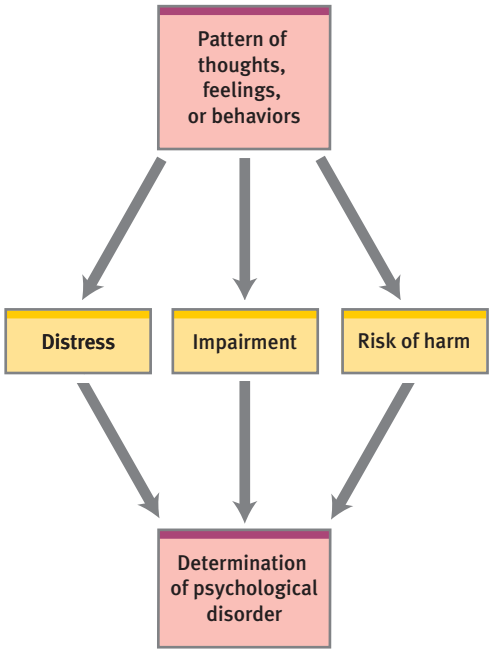



**FIGURE 1.1 • Determining a Psychological Disorder: Three Criteria** The severity of a person's distress, impairment in daily life, and/or risk of harm determine whether he or she is said to have a psychological disorder. All three elements don't need to be present at a significant level: When one or two elements are present to a significant degree, this may indicate a psychological disorder, provided that the person's behavior and experience are not normal for the context and culture in which they arise.

## The Three Criteria for Determining Psychological Disorders

Big Edie and Little Edie came to public attention in 1971, when their unusual living situation was described in the national press. Health Department inspectors had raided their house and found the structure to be in violation of virtually every regulation. "In the dining room, they found a 5-foot mountain of empty cans; in the upstairs bedrooms, they saw human waste. The story became a national scandal. Health Department officials said they would evict the women unless the house was cleaned" (Martin, 2002). The Beales were able to remain in their house after Big Edie's niece (Jacqueline Kennedy Onassis, the former first lady) paid to have the dwelling brought up to the Health Department's standards.

To determine whether Big Edie or Little Edie had a psychological disorder, we must first define **psychological disorder**: a pattern of thoughts, feelings, or behaviors that causes significant personal *distress*, significant *impairment* in daily life, and/or significant *risk of harm*, any of which is unusual for the context and culture in which it arises (American Psychiatric Association, 2013). Notice the word *significant* in the definition, which indicates that the diagnosis of psychological disorder is applied only when the symptoms have a substantial effect on a person's life. As we shall see shortly, all three elements (distress, impairment, and risk of harm) do not need to be present; if two (or even one) of the elements are present to a severe enough degree, then the person's condition may merit the diagnosis of a psychological disorder (see Figure 1.1). Let's consider these three elements in more detail.

### Distress

*Distress* can be defined as anguish or suffering, and all of us experience distress at different times in our lives. However, when a person with a psychological disorder experiences distress, it is often *out of proportion* to a situation. The state of being

distressed, in and of itself, does not indicate a psychological disorder—it is the degree of distress or the circumstances in which the distress arises that mark abnormality. Some people with psychological disorders exhibit their distress: They may cry in front of others, share their anxieties, or vent their anger on those around them. But other people with psychological disorders contain their distress, leaving family and friends unaware of their emotional suffering. For example, a person may worry excessively but not talk about the worries, or a depressed person may cry only when alone, putting on a mask to convince others that everything is all right.

Archive Photos/Getty Images

Big Edie and Little Edie Beale were clearly unconventional and eccentric. But did either of them have a psychological disorder? Psychological disorders involve significant distress, impairment in daily life, and/or risk of harm.

Severe distress, by itself, doesn't necessarily indicate a psychological disorder. The opposite is also true: The absence of distress doesn't necessarily indicate the absence of a psychological disorder. A person can have a psychological disorder without experiencing distress, although it is uncommon. For instance, someone who chronically abuses stimulant medication, such as amphetamines, may not feel distress about misusing the drug, but that person nonetheless has a psychological disorder (specifically, a type of *substance use disorder*).

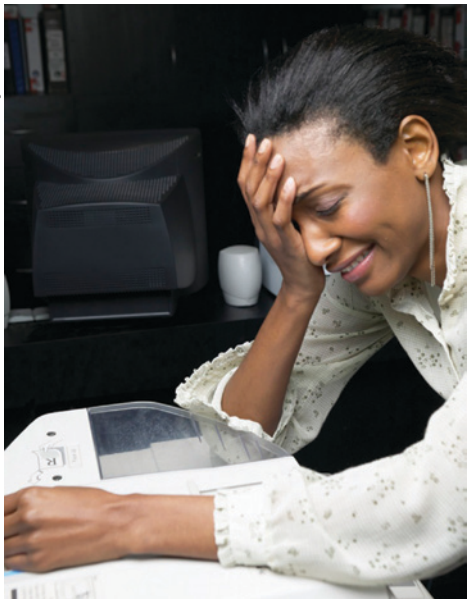
Did either Big Edie or Little Edie exhibit distress? People who knew them describe the Beale women as free spirits, making the best of life. Like many other people, they were distressed about their financial circumstances; but they in fact had real financial difficulties, so these worries were not unfounded. Little Edie did show significant distress in other ways, though. She was angry and resentful about having to be a full-time caretaker for her mother, and the documentary film *Grey Gardens* (as well as the HBO film and Broadway play of the same name) clearly portrays this: When Big Edie yells for Little Edie to return to her side, Little Edie says in front of the camera, "I've been a subterranean prisoner here for 20 years" (Maysles & Maysles, 1976).

Although Little Edie appears to have been significantly distressed, her distress was reasonable *given the situation*. Being the full-time caretaker to an eccentric and demanding mother for decades would undoubtedly distress most people. Because her distress made sense in its context, it is not an element of a psychological disorder. Big Edie, in contrast, appears to have become significantly distressed when she was alone for more than a few minutes, and this response is unusual for the context. We can consider Big Edie's distress as meeting this criterion for a psychological disorder.

## Impairment in Daily Life

*Impairment* is a significant reduction of a person's ability to function in some important area of life. A person with a psychological disorder may be impaired in functioning at school, at work, in taking adequate care of himself or herself, or in relationships. For example, a woman's drinking problem may interfere with her ability to do her job or to attend to her bills; a middle-aged, married man's continually worrying about his increasing baldness—spending hours and hours each day "fixing" his hair—might impair his ability to get to work on time.

Where do mental health clinicians draw the line between normal functioning and impaired functioning? It is the *degree* of impairment that indicates a psychological disorder. When feeling "down" or nervous, we are all likely to function less well—for example, we may feel irritable or have difficulty concentrating. With a psychological disorder, though, the degree of impairment is atypical for the context—the person is impaired to a greater degree than most people in a similar situation. For instance, after a relationship breakup, most people go through a difficult week or two, but they still go to school or to work. They may not accomplish much, but they soon





We don't know why this woman is so upset, but being persistently upset at work might qualify as an impairment—a significant reduction in a person's ability to function in some important area of life, such as work. Researchers have attempted to measure the effects of impairment associated with psychological disorders on the ability to function at work: For every 100 workers, an average of 37 work days per month are lost because of reduced productivity or absences due to psychological disorders (Kessler & Frank, 1997).

begin to bounce back. Some people, however, are more impaired after a breakup—they may not make it out of the house or even out of bed; they may not bounce back after a few weeks. These people are significantly impaired.

One type of impairment directly reflects a particular pattern of mental events: A **psychosis** is an impaired ability to perceive reality to the extent that normal functioning is difficult or not possible. The two forms of psychotic symptoms are hallucinations and delusions. **Hallucinations** are sensations that are so vivid that the perceived objects or events seem real, although they are not. Hallucinations can occur in any of the five senses, but the most common type is auditory hallucinations, in particular, hearing voices. However, a hallucination—in and of itself—does not indicate psychosis or a psychological disorder. Rather, this form of psychotic symptom must arise in a context that renders it unusual and impairs functioning.

The other psychotic symptom is **delusions**—persistent false beliefs that are held despite evidence that the beliefs are incorrect or exaggerate reality. The content of delusions can vary across psychological disorders. Common themes include a person's belief that:

- other people or organizations—the FBI, aliens, the neighbor across the street—are after the person (*paranoid* or *persecutory delusions*);
- his or her intimate partner is dating or interested in another person (*delusional jealousy*);
- he or she is more powerful, knowledgeable, or influential than is true in reality and/or that he or she is a different person, such as the president or Jesus (*grandiose delusions*);
- his or her body—or a part of it—is defective or functioning abnormally (*somatic delusion*).

Were the Beale women impaired? The fact that they lived in such squalor implies an inability to function normally in daily life. They knew about hygienic standards but didn't live up to them. Whether the Beales were impaired is complicated by the fact that they viewed themselves as bohemians, set their own standards, and did not want to conform to mainstream values (Sheehy, personal communication, December 29, 2006). However, their withdrawal from the world can be seen as clear evidence that they were impaired. Perhaps they couldn't function in the world and so retreated to Grey Gardens.

The women also appear to have been somewhat paranoid: In the heat of summer, they left the windows nailed shut (even on the second floor) for fear of possible intruders. The women's social functioning was impaired to the extent that their paranoid beliefs led to strange behaviors that isolated them. In addition, their beliefs led them to behave in ways that made the house so uncomfortable—extreme temperatures and fleas—that relatives wouldn't visit. And Big Edie's distress at being alone for even a few minutes indicates that her ability to function independently was impaired. It seems, then, that a case could be made that both of them—Big Edie more so than Little Edie—were impaired and not functioning normally.

**Psychosis**
An impaired ability to perceive reality to the extent that normal functioning is difficult or not possible. The two types of psychotic symptoms are hallucinations and delusions.

**Hallucinations**
Sensations that are so vivid that the perceived objects or events seem real, although they are not. Hallucinations can occur in any of the five senses.

**Delusions**
Persistent false beliefs that are held despite evidence that the beliefs are incorrect or exaggerate reality.

## Risk of Harm

Some people take more risks than others. They may drive too fast or drink too much. They may diet too strenuously, exercise to an extreme, gamble away too much money, or have unprotected sex with multiple partners. For such behavior to indicate a psychological disorder, it must be outside the normal range. The criterion of danger, then, refers to symptoms of a psychological disorder that lead to life or property being put at risk, either accidentally or intentionally. For example, a person with a psychological disorder may be in danger when:

- depression and hopelessness lead him or her to attempt suicide;
- hallucinations interfere with normal safety precautions, such as checking for cars before crossing the street;

- a distorted body image and other psychological disturbances lead the person to refuse to eat enough food to maintain a healthy weight, which in turn leads to malnutrition and medical problems.

Psychological disorders can also lead people to put other people's lives at risk. Examples of this type of danger include:

- auditory hallucinations that command the person to harm another person;
- suicide attempts that put the lives of other people at risk, such as driving a car into oncoming traffic;
- paranoia so extreme that a parent kills his or her children in order to "save" them from a greater evil.

The house in which Little Edie and Big Edie lived had clearly become dangerous. Wild animals—raccoons and rats—roamed the house, and the ceiling was falling down. But having too little money to make home repairs doesn't mean that someone has a psychological disorder. Some might argue that perhaps the Beale women simply weren't aware of the danger. The women were, however, aware of *some* dangers: When their heat stopped working, they called a heating company to repair it, and ditto for the electricity. They had a handyman come in regularly to repair fallen ceilings and walls, and to fill holes that rats might use to enter (Wright, 2007). It's hard to say, however, whether they realized the extent to which their house itself had become dangerous.

On at least one occasion in her early 30s, Little Edie appears to have been a danger to herself. Her cousin John told someone about "a summer afternoon when he watched Little Edie climb a catalpa tree outside Grey Gardens. She took out a lighter. He begged her not to do it. She set her hair ablaze" (Sheehy, 2006). From then on, her head was at least partially bald, explaining her ever-present head covering.

Aside from Little Edie's single episode with the lighter, it's not clear how much the Beale women's behavior led to a significant risk of harm. Big Edie recognized most imminent dangers and took steps to ensure her and her daughter's safety. The women were not overtly suicidal nor did they harm others. The only aspect of their lives that suggests a significant risk of harm was the poor hygienic standards they maintained.


Tom Wargacki/WireImage/Getty Images

Using this book's definition of a psychological disorder, did either of the Beales have a disorder? Big Edie exhibited distress that was inappropriate to her situation; both women appeared to have an impaired ability to function. The risk of harm to the women, however, is less clear-cut.

## Context and Culture

As we noted earlier, what counts as a significant level of distress, impairment, or risk of harm depends on the context in which it arises. That human waste was found in an empty room at Grey Gardens might indicate abnormal behavior, but the fact that the plumbing was out of order for a period of time might provide a reasonable explanation. Of course, knowing that the human waste was allowed to remain in place after the plumbing was fixed would probably decide the question of whether the behavior was abnormal.

In addition, the Beales appeared to have delusions—that people wanted to break into the house or kidnap them, and that then-President Nixon might have been responsible for the 1971 "raid" on their house by the town health inspectors (Wright, 2007). But these delusions aren't necessarily as farfetched as they might

**TABLE 1.1 • Psychological Disorders: Facts at a Glance**

- Psychological disorders are a leading cause of disability and death, ranked second after heart disease (Murray & Lopez, 1996).
- About half of all Americans will likely develop at least one of 30 common psychological disorders, such as those related to depression, anxiety, or substance abuse, over the course of their lives; in half of the cases, symptoms will begin by age 14 (Kessler, Berglund, et al., 2005).
- Those born more recently have a higher likelihood of developing a psychological disorder than those born earlier (Kessler, Berglund, et al., 2005).
- Within a given year, about 25% of Americans experience a diagnosable or diagnosed mental disorder; of these cases, almost one quarter are severe (Kessler, Chiu, et al., 2005).
- Disadvantaged ethnic groups—Hispanics and Blacks—do not have a higher risk than others for psychological disorders overall (Breslau et al., 2005).

Eco Images/Getty Images

How do we define "risk" or "danger" in different cultural environments? How does culture impact our understanding of abnormal behavior?

sound. Their house *was* broken into in 1968, and, as relatives of Jackie Kennedy, they had cars with Secret Service agents posted outside their house while John F. Kennedy was president.

Behavior that seems inappropriate in one context may make sense in another. Having a psychological disorder isn't merely being different—we wouldn't say that someone was abnormal simply because he or she was avant-garde or eccentric or acted on unusual social, sexual, political, religious, or other beliefs (American Psychiatric Association, 2013). And as we've seen with the Beales, the effects of context can blur the line between being different and having a disorder. Table 1.1 provides additional information about psychological disorders.

Culture, too, can play a crucial role in how mental illness is diagnosed. To psychologists, **culture** is the shared norms and values of a society; these norms and values are explicitly and implicitly conveyed to members of the society by example and through the use of reward and punishment. Different societies and countries have their own cultures, each with its own view of what constitutes mental health and mental illness—even what constitutes distress and how to communicate that distress. For example, in some cultures, distress may be conveyed by complaints of fatigue or tiredness rather than by sadness or depressed mood. Some sets of symptoms that are recognized as disorders in other parts of the world are not familiar to most Westerners. One example, described in Case 1.1, is *koro*, a disorder that arises in some people from countries in Southeast Asia. Someone with *koro* rapidly develops an intense fear that his penis—or her nipples and vulva—will retract into the body and possibly cause death (American Psychiatric Association, 2013). This disorder may break out in clusters of people, like an epidemic (Bartholomew, 1998; Sachdev, 1985). Similar genital-shrinking fears have been reported in India and in West African countries (Dzokoto & Adams, 2005; Mather, 2005).

**Culture**
The shared norms and values of a society that are explicitly and implicitly conveyed to its members by example and through the use of reward and punishment.

**CASE 1.1 • FROM THE OUTSIDE: Cultural Influence on Symptoms**

Although most cases of *koro* appear to resolve quickly, in a minority of cases, symptoms may persist.

> A 41-year-old unmarried, unemployed male from a business family, presented with the complaints of gradual retraction of penis and scrotum into the abdomen. He had frequent panic attacks, feeling that the end had come. The symptoms had persisted more than 15 years with a waxing and waning course. During exacerbations he spent most of his time measuring the penis by a scale and pulling it in order to bring it out of [his] abdomen. He tied a string around it and attached it to a hook above to prevent its shrinkage during [the] night. . . . He did not have regular work and was mostly dependent on the family.
>
> (Kar, 2005, p. 34)

In addition, cultural norms about psychopathology are not set in stone but can shift. Consider that, in 1851, Dr. Samuel Cartwright of Louisiana wrote an essay in which he declared that slaves' running away was evidence of a serious mental disorder that he called "drapetomania" (Eakin, 2000). More recently, homosexuality was officially considered a psychological disorder in the United States until 1973, when it was removed from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the manual used by mental health clinicians to classify psychological disorders.

Let's examine the behavior of the Beales within their context and culture. Big Edie's father claimed that his ancestors were prominent French Catholics; she and her siblings grew up financially well off. Big Edie was a singer and a performer, but, as a product of her time, she was expected to marry well (McKenna, 2004). Her father arranged for her to wed New York lawyer Phelan Beale, from a socially prominent Southern family (Rakoff, 2002). Little Edie was born about a year later, followed by two brothers. Big Edie was very close to her daughter, even keeping her out of school when Little Edie was 11 and 12, ostensibly for "health reasons." However, Little Edie was well enough to go to the movies with her mother every day and on a shopping trip to Paris (Sheehy, 2006).

After she was married, Big Edie continued to sing, to write songs with her accompanist, and even to record some of those songs. At that time, however, cultural conventions required a woman of Big Edie's social standing to stop performing after marrying, even if such performances generally were limited to social functions. Big Edie's need to perform was almost a compulsion, though, and she would head straight to the piano at family gatherings.

In 1934, when Little Edie was 16, Big Edie and her husband divorced; divorce back then was much less common and much less socially acceptable than it is today. This event marked the start of Big Edie's life as a recluse (Davis, 1969). By 1936, the house and grounds began to suffer from neglect (Davis, 1996). In 1942, Big Edie's husband stopped supporting her financially after she showed up late for their son's wedding, dressed inappropriately—another time when Big Edie's behavior was unusual for the context and culture. Big Edie's father set up a trust fund for her, which provided a small monthly allowance, barely enough to pay for food and other necessities.

Like her mother, Little Edie was artistically inclined. She aspired to be an actress, dancer, and poet. In 1946, she left home to live in New York City and work as a model, but her father disapproved of this, as he had disapproved of his wife's musical performances (Sheehy, 2006).

### GETTING THE PICTURE

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Which photo shows a person more likely to have a psychological disorder based on the voluntary changes made to his/her skin? Answer: It depends on the cultural context. The scarring of the man in the left is intentional and common in his West African tribe, and hence would not be considered a sign of abnormality—but such scarring might be a sign of something abnormal in some Western cultures. However, cultures shift over time, and what is abnormal in one time and place may not be in another. For example, ear gauging (shown on the right) used to be found in African tribes but not in the West, but recently some young people in Western culture have adopted this practice.