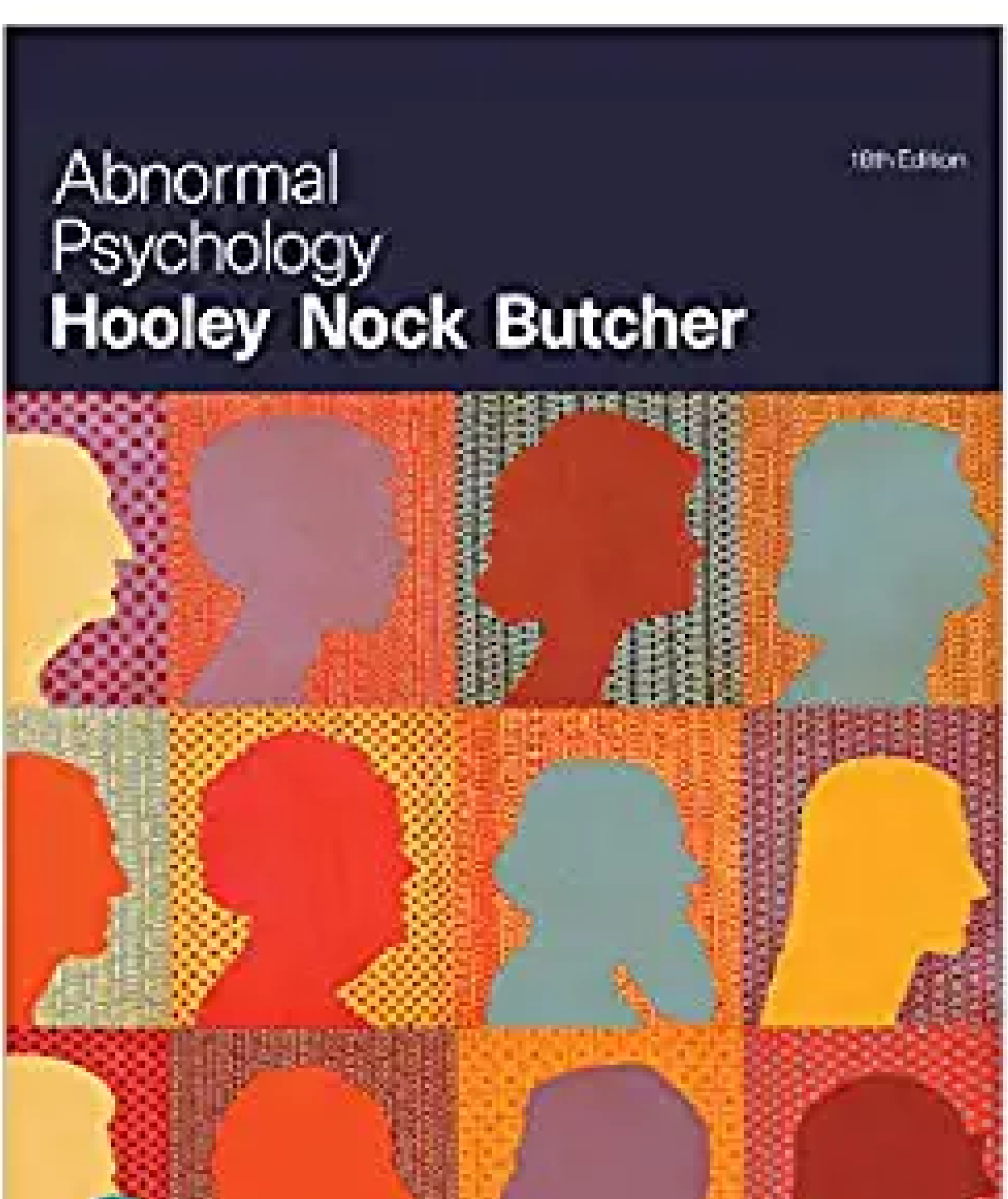

# Contents

### DSM-5 Boxes



### Thinking Critically About *DSM-5*

# *DSM-5*: A Quick Guide

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

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

- No changes have been made to the diagnostic criteria for personality disorders, although an alternative model is now offered as a guide for future research.
- Substance-related disorders are divided into two separate groups: substance use disorders and substance-induced disorders.
- A new disorder, gambling disorder, has been included in substance-related and addictive disorders.
- Included for the first time in Section III of *DSM-5* are several new disorders regarded as being in need of further study. These include attenuated psychosis syndrome, nonsuicidal self-injury disorder, Internet gaming disorder, and caffeine use disorder.

# Preface

Welcome to the 18th edition of *Abnormal Psychology*! We are excited to bring you this new revision. *Abnormal Psychology* (this specific book!) has a long and distinguished tradition as an undergraduate text. Ever since James Coleman wrote the first edition in 1948, this title has been considered the most comprehensive in the field. Along the way there have been many changes. This is very much the case with this new edition. Jim Butcher, who has guided the book so well for so long, remains with us as an author. However, with this edition and for the future, Harvard Professors Jill Hooley and Matthew Nock assume primary authorship. Both Jill and Matt are committed to excellence and to providing students with an integrated and comprehensive understanding of abnormal psychology.

Each author on the Hooley, Nock, and Butcher team is a noted researcher, an experienced teacher, and a licensed clinician. Each brings different areas of expertise and diverse research interests to the text. And please don't hold the fact that two of us teach at Harvard against us! We are passionate about abnormal psychology and we are committed to making our text as accessible as possible to a broad range of students. 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.

There are many different types of psychological disorders, and each is caused by the interaction of many different factors and can be considered from multiple different perspectives. We use a biopsychosocial approach to provide a sophisticated appreciation of the total context in which abnormalities of behavior occur. This means that we present and describe the wide range of biological, psychological, and social factors that work together to lead to the development of psychological disorders. In addition, we discuss treatment approaches that target each of these different factors.

For ease of understanding we 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. We also want students to remember that behind every diagnosis is a *person*. To keep this in the forefront, we try to integrate as much case material as we can into each chapter. Our book also continues to have a heavy focus on treatment. Treatment is discussed in every chapter in the context of specific disorders. Additionally, we 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.

We continue to be intensely curious about, and fascinated by, abnormal human behavior. With this new edition, we seek to open up the world of abnormal psychology to another generation of students, providing comprehensive and up-to-date knowledge about the most central disorders in a clear and engaging way. We hope that this newest edition conveys some of the excitement and enthusiasm for the topic that we experience every day.

## Why Do You Need This New Edition?

The book you are reading is the 18th edition of *Abnormal Psychology*. Why is a revision needed, and why is an old copy of an earlier edition not good enough? If the field of abnormal psychology never advanced and never changed, old editions would surely be fine. But new research is being published all the time. As authors, it is important to us that these changes and new ways of thinking about the etiology, assessment, and treatment of psychological disorders are accurately presented in this text. Although some ideas and diagnostic concepts have persisted for hundreds of years, changes in thinking routinely occur. A key example here is the developing field of immunopsychiatry. Advances in areas such as genetics, brain imaging, behavioral observation, and classification, as well as changes in social and government policy and in legal decisions, also add to our knowledge base and stimulate new treatments for those whose lives are touched by mental disorders. Every time we work on a revision of *Abnormal Psychology* we are reminded of how dynamic and vibrant our field is (not to mention how hard it is to keep up with all the new research!). This edition reflects the newest and most relevant research findings, presented in ways designed to be as engaging as possible to the next generation of students.

# So What's New?

True to form, we've done a lot of updating! This means hundreds of new studies/citations, dozens of new videos, images, and much more! We also continue to focus on streamlining material throughout the book, decreasing the length of chapters where possible while retaining all of the key information that students should know.

In this edition, Chapters 2, 4, 12, and 17 have received particular attention, updates, and revisions. But every other chapter has also been updated, and new features have been added throughout. To give just a few examples, in Chapter 4, we now describe new assessment methods increasingly being used by psychologists to understand human behavior, such as smartphones and wearable biosensors. In Chapter 7, we describe how psychologists can now use brain imaging techniques to identify which people are thinking about suicide and which are not. In Chapter 11, we provide updated information about what is known about the effects of some recreational drugs, such as ecstasy. Chapter 12 has been revised significantly to include updated information about sexual dysfunctions, gender dysphoria, and paraphilic disorders. And in Chapter 17, we now discuss the Goldwater Rule, which has long prohibited mental health professionals from commenting on the mental health of people they have not formally assessed. We'll stop there so as to not to give too much away. But suffice it to say, there is lots of exciting new information in the 18th edition!

Importantly, this edition retains features that were well received in the previous edition. To assist both instructors and students, we continue to feature specialized boxes, highlighting many of the key changes that were made in *DSM-5.* We also provide a detailed but accessible description of the new National Institute of Mental Health Research Domain Criteria (or "RDoC") approach because this is now playing a central role in research on abnormal psychology. In addition, as before, chapters begin with learning objectives. These orient the reader to the material that will be presented in each specific chapter. Learning objectives are also repeated by the section they apply to and summarized at the end of each chapter. Most chapters also begin with a case study that illustrates the mental health problems to be addressed in the chapter. As noted, numerous new references, photographs, and illustrations have also been added. In short, outdated material has been replaced, current findings have been included, and new developments have been identified. Especially important for students, all of this has been accomplished without adding length to the book! We hope you enjoy this latest edition.

# Features and Pedagogy

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

## Features

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

**CRITICAL THINKING** Many of the revisions to *DSM-5* were highly contentious and controversial. A feature box called "Thinking Critically about *DSM-5*" introduces students to the revised *DSM* and encourages them to think critically about the implications of these changes.

**UNRESOLVED ISSUES** All chapters include end-of-chapter sections that demonstrate how far we have come and how far we have yet to go in our understanding of psychological disorders. The topics covered here provide insight into the future of the field and expose students to some controversial subjects.

## Pedagogy

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

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

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

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

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

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

# Revel™

Revel is an interactive learning environment that deeply engages students and prepares them for class. Media and assessment integrated directly within the authors' narrative lets students read, explore interactive content, and practice in one continuous learning path. Thanks to the dynamic reading experience in Revel, students come to class prepared to discuss, apply, and learn from instructors and from each other.

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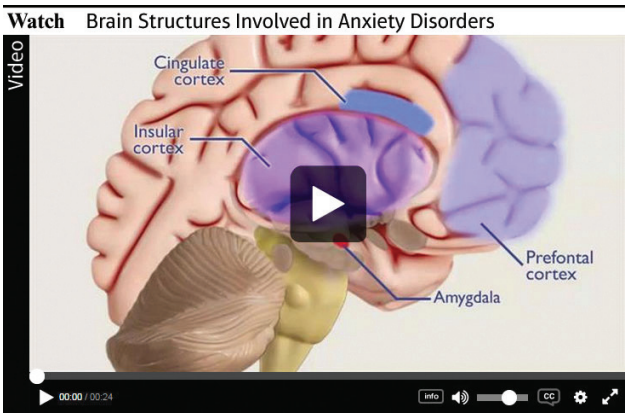
www.pearson.com/revel

The 18th edition includes a wealth of new interactive content. We know that students are especially interested in clinical case material and want to be as immersed as possible in the clinical experience. To help with this, we have included a new feature that involves patient–clinician interactions. The material in these "Clinical Interviews" is designed to help students appreciate some of the nuances associated with making a diagnosis. We hope that this new feature engages students while also increases their understanding about clinical symptoms.

In addition, to introduce students to hot new areas of research in abnormal psychology, we created a new "#TrendingTopics" currency feature in almost every chapter. This new material covers a range of topics, including increasing awareness of the importance of replication in science (Chapter 1), mindfulness-based stress reduction (Chapter 5), the development of newer types of antidepressant agents such as ketamine (Chapter 7), the current opioid epidemic in the U.S. (Chapter 11), new gene-editing techniques such as CRISPR-Cas9 (Chapter 13), and the controversial use of psychedelic drugs as therapeutic agents (Chapter 16). We also consider whether there is an epidemic of narcissism in young people (Chapter 10), explain why distracted driving is so dangerous (Chapter 14), and highlight the problems that social media may create for people at risk of eating disorders (Chapter 9). We hope that these topics engage students while also giving them an appreciation for new directions and trends in the ever-changing field of mental health research.

Throughout the text, we include case studies of individuals with various disorders. These cases are brought to life in Revel with images that accompany each case and questions that encourage students to think critically.

The 18th edition also includes integrated videos and media content throughout. More than 35 new videos have been added, allowing students to explore topics more deeply at the point of relevancy.




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

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# Supplement Package

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

## Test Bank (013519105X)

The Test Bank is composed of over 1,100 fully referenced multiple-choice, completion, short-answer, and concise essay questions. Each question is accompanied by a page reference, difficulty level, skill type (factual, conceptual, or applied), topic, and a correct answer. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

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A powerful assessment-generation program that helps instructors easily create and print quizzes and exams. Questions and tests can be authored online, allowing instructors ultimate flexibility and the ability to efficiently manage assessments anytime, anywhere. Instructors can easily access existing questions and edit, create, and store questions using a simple drag-and-drop technique and Word-like controls. Data on each question provides information on difficulty level and the page number of the corresponding text discussion. For more information, go to www.PearsonMyTest.com.

## Lecture PowerPoint Slides (0135190991)

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

**Video PowerPoint Slides (0135190975)** have been embedded with select video pertaining to each disorder chapter, enabling instructors to show videos within the context of their lecture.

**Art PowerPoint Slides (0135190983)** contain only the photos, figures, and line art from the text. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

# Acknowledgments

It takes each member of the author team more than a year of focused work to produce a new edition of this textbook. During this time, family and friends receive much less attention than they deserve. We are aware that a few lines of acknowledgment in a preface do little to compensate those close to us for all the inconveniences and absences they have endured (and they would surely agree!). Nonetheless, Jill Hooley is ever grateful to Kip Schur for his patience, love, support, and ability to retain a sense of humor throughout the revision process. She also wishes to thank Shirley Wang for her helpful comments on Chapter 9, Patrícia Alexandra Carreiros Evans for her comments on Chapter 2, as well as other members of her research lab for their feedback and insights. Matthew Nock would like to thank his wife, Keesha, and their children, Matt Jr., Maya, and Georgina, for their patience (and tolerance). He is also grateful to Franchesca Ramirez and Evan Kleiman for their assistance in the preparation of this edition. 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.

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# About the Authors

**Jill M. Hooley**
*Harvard University*

Jill M. Hooley is a professor of psychology at Harvard University. She is also the head of the experimental psychopathology and clinical psychology program at Harvard and, in addition, serves as Director of Undergraduate Studies for the Psychology Department. Dr. Hooley was born in England and received a BSc in psychology from the University of Liverpool. This was followed by research work at Cambridge University. She then attended Magdalen College, Oxford, where she completed her 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 for longer than she can remember.

Dr. Hooley has a long-standing interest in psychosocial predictors of psychiatric relapse in patients with severe psychopathology such as schizophrenia and depression. Other research interests center around nonsuicidal self-injury (skin-cutting or burning) as well as emotion regulation—particularly in people who are vulnerable to depression or who have borderline personality disorder. Her research has been supported by grants from the National Institute of Mental Health and by the Borderline Personality Disorder Research Foundation.

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 served as Associate Editor for *Clinical Psychological Science* from 2012 to 2016. She also serves on the editorial boards of journals including *Family Process* and *Personality Disorders: Theory, Research and Treatment*. In 2015 Dr. Hooley received the Zubin Award for Lifetime Achievement in Psychopathology Research from the Society for Research in Psychopathology.

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

**Matthew K. Nock**
*Harvard University*

Matthew Nock was born and raised in New Jersey. Matt received his BA from Boston University (1995), followed by two masters (2000, 2001) and a PhD from Yale University (2003). He also completed a clinical internship at Bellevue Hospital and the New York University Child Study Center (2003). Matt joined the faculty of Harvard University in 2003 and has been there ever since, currently serving as the Edgar Pierce Professor of Psychology in the Department of Psychology.

While an undergraduate, Matt became very interested in the question of why people do things to intentionally harm themselves and he has been conducting research aimed at answering this question ever since. His research is multidisciplinary in nature and uses a range of methodological approaches (e.g., epidemiologic surveys, laboratory-based experiments, and clinic-based studies) to better understand how these behaviors develop, how to predict them, and how to prevent their occurrence. His work is funded by research grants from the National Institutes of Health, Department of Defense, and several private foundations. Matt's research has been published in over 250 scientific papers and book chapters and has been recognized through the receipt of awards from the American Psychological Association, the Association for Behavioral and Cognitive Therapies, and the American Association of Suicidology. In 2011 he received a MacArthur Fellowship (aka, "Genius Grant") in recognition of his research on suicide and self-harm.

At Harvard, Matt teaches courses on various topics including psychopathology, statistics, research methods, and cultural diversity. He has received numerous teaching and mentoring awards including the Roslyn Abramson Teaching Award and the Petra Shattuck Prize.

**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 more than 60 books and more than 250 articles in the fields of abnormal psychology, cross-cultural psychology, and personality assessment.

Chapter 1

# Abnormal Psychology: Overview and Research Approaches

Brand X Pictures/Getty Images

## Learning Objectives

**1.1** Explain how we define abnormality and classify mental disorders.

**1.2** Describe the advantages and disadvantages of classification.

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

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

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

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

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

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

**1.9** Explain the key features of an experimental design.

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

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

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

### Monique

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

### Scott

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

Perhaps you found yourself asking questions as you read about Monique and Scott. For example, because Monique doesn't drink in the mornings, you might have wondered whether she could really have a serious

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

alcohol problem. She does. This is a question that concerns the criteria that must be met before someone receives a particular diagnosis. Or perhaps you wondered whether other people in Monique's family likewise have drinking problems. They do. This is a question about what we call **family aggregation**—that is, whether a disorder runs in families.

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

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

Asking questions is an important aspect of being a psychologist. Psychology is a fascinating field, and abnormal psychology is one of the most interesting areas of psychology (although we are undoubtedly biased). Psychologists are trained to ask questions and to conduct research. Though not all people who are trained in abnormal psychology (this field is sometimes called psychopathology) conduct research, they still rely heavily on their scientific skills and ability both to ask questions and to put information together in coherent and logical ways. For example, when a clinician first sees a new client or patient, he or she asks many questions to try and understand the issues or problems related to that person. The clinician will also rely on current research to choose the most effective treatment. The best treatments of 20, 10, or even 5 years ago are not invariably the best treatments of today. Knowledge accumulates and advances are made—and research is the engine that drives all of these developments.

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

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

# What Do We Mean by Abnormality?

**1.1 Explain how we define abnormality and classify mental disorders.**

It may come as a surprise to you that there is still no universal agreement about what is meant by *abnormality* or *disorder*. This is not to say we do not have definitions; we do. However, a truly satisfactory definition will probably always remain elusive (Lilienfeld et al., 2017; Stein et al., 2010).

## Indicators of Abnormality

Why does the definition of a mental disorder present so many challenges? A major problem is that there is no one behavior that makes someone abnormal. However, there are some clear elements or indicators of abnormality (Lilienfeld et al., 2017; Stein et al., 2010). No single indicator is sufficient in and of itself to define or determine abnormality. Nonetheless, the more that someone has difficulties in the following areas, the more likely he or she is to have some form of mental disorder:

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

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

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

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

Paul Cookney/Professional Sport/Topham/The Image Works

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

4. **Violation of the standards of society:** All cultures have rules. Some of these are formalized as laws. Others form the norms and moral standards that we are taught to follow. Although many social rules are arbitrary to some extent, when people fail to follow the conventional social and moral rules of their cultural group, we may consider their behavior abnormal. For example, driving a car or watching television would be considered highly abnormal for the Amish of Pennsylvania. However, both of these activities reflect normal everyday behavior for most other Pennsylvania residents.

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

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

6. **Irrationality and unpredictability:** As we have already noted, we expect people to behave in certain ways. Although a little unconventionality may add some spice to life, there is a point at which we are likely to consider a given unorthodox behavior abnormal. If a person sitting next to you suddenly began to scream and yell obscenities at nothing, you would probably regard that behavior as abnormal. It would be unpredictable, and it would make no sense to you. The disordered speech and the disorganized behavior of patients with schizophrenia are often irrational. Such behaviors are also a hallmark of the manic phases of bipolar disorder. Perhaps the most important factor, however, is our

evaluation of whether the person can control his or her behavior. Few of us would consider a roommate who began to recite speeches from *King Lear* to be abnormal if we knew that he was playing Lear in the next campus Shakespeare production—or even if he was a dramatic person given to extravagant outbursts. On the other hand, if we discovered our roommate lying on the floor, flailing wildly, and reciting Shakespeare, we might consider calling for assistance if this was entirely out of character and we knew of no reason why he should be behaving in such a manner.

7. **Dangerousness:** It seems quite reasonable to think that someone who is a danger to him- or herself or to another person must be psychologically abnormal. Indeed, therapists are required to hospitalize suicidal clients or contact the police (as well as the person who is the target of the threat) if they have a client who makes an explicit threat to harm another person. But, as with all of the other elements of abnormality, if we rely only on dangerousness as our sole feature of abnormality, we will run into problems. Is a soldier in combat mentally ill? What about someone who is an extremely bad driver? Both of these people may be a danger to others. Yet we would not consider them to be mentally ill. Why not? And why is someone who engages in extreme sports or who has a dangerous hobby (such as free diving, race car driving, or keeping poisonous snakes as pets) not immediately regarded as mentally ill? Just because we may be a danger to ourselves or to others does not mean we are mentally ill. Conversely, we cannot assume that someone diagnosed with a mental disorder must be dangerous. Although people with mental illness do commit serious crimes, serious crimes are also committed every day by people who have no signs of mental disorder. Indeed, research suggests that in people with mental illness, dangerousness is more the exception than the rule (Corrigan & Watson, 2005).

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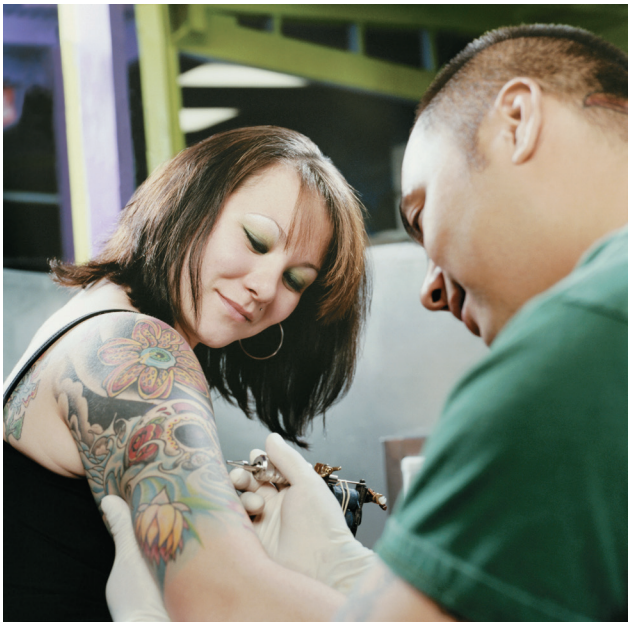
How important is dangerousness to the definition of mental illness? If we are a risk to ourselves or to others, does this mean we are mentally ill?

One final point bears repeating. Decisions about abnormal behavior always involve social judgments and are based on the values and expectations of society at large. This means that culture plays a role in determining what is and is not abnormal. In addition, because society is constantly shifting and becoming more or less tolerant of certain behaviors, what is considered abnormal or deviant in one decade may not be considered abnormal or deviant a decade or two later. At one time, homosexuality was classified as a mental disorder. But this is no longer the case (it was removed from the formal classification system in 1974). A generation ago, pierced noses and navels were regarded as highly deviant and prompted questions about a person's mental health. Now, however, such adornments are commonplace and attract little attention. What other behaviors can you think of that are now considered normal but were regarded as deviant in the past?



Digital Vision/Getty Images

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

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

# The World Around Us

## Extreme Generosity or Pathological Behavior?

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

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

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

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

For Kravinsky, however, the burden of refusing to help alleviate the suffering of someone in need was almost unbearable, even if it meant sacrificing his very own organs. He called the Albert Einstein Medical Center and spoke to a transplant coordinator. He met with a surgeon and then with a psychiatrist. Kravinsky told the psychiatrist that his wife did not support his desire to donate one of his kidneys. When the psychiatrist told him that he was doing something he did not have to do, Kravinsky's response was that he did need to make this sacrifice: "You're missing the whole point. It's as much a necessity as food, water, and air."

Three months later, Kravinsky left his home in the early hours of the morning, drove to the hospital, and donated his right kidney. He informed his wife after the surgery was over. In spite of the turmoil that his kidney donation created within his family,

Jon Adams/UPI Photo Service/Newscom

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

Kravinsky's mind turned back to philanthropy almost immediately. "I lay there in the hospital, and I thought about all my other good organs. When I do something good, I feel that I can do more. I burn to do more. It's a heady feeling." By the time he was discharged, he was wondering about giving away his one remaining kidney.

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

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

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

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

In the United States, the accepted standard for defining various types of mental disorders is the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. This manual, commonly referred to as the *DSM*, is revised and updated from time to time. The current version, called *DSM-5*, was published in 2013. It is 947 pages long and contains a total of 541 diagnostic categories (Blashfield et al., 2014). This recent revision of the *DSM* has been the topic of much debate and controversy. In the *Thinking Critically about DSM-5* box we explain more about the *DSM* and discuss why a revision was necessary.

Although the *DSM* is widely used, it is not the only psychiatric classification system. The World Health Organization (WHO) produces a document with the rather macabre title of the *International Classification of Diseases.* The 11th revision of this (called *ICD-11*) has just been published. Chapter V of this document covers mental and behavioral disorders (WHO, 2018). Although the *ICD-11* has much in common with *DSM-5*, it also has many differences, with similar disorders having different names, for example. The *ICD-11* is used in many countries outside the United States. ICD code numbers (which are provided next to the various diagnoses in the *DSM*) are also used in hospital settings in the United States because the U.S. is a member country of the WHO.

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

The *DSM-5* definition of mental illness was based on input from various *DSM-5* work groups as well as other sources (Broome & Bortolotti, 2010; First & Wakefield, 2010; Stein et al., 2010). Although this definition will still not satisfy everyone, it brings us even closer to a good working description. Keep in mind that any definition of abnormality

**Watch** What Does It Mean to Have a Mental Disorder?


## DSM-5 Thinking Critically about *DSM-5*

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

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

Since *DSM-I* was first published in 1952, the *DSM* has been revised from time to time. Revisions are important because they allow new scientific developments to be incorporated into how we think about mental disorders. The revision process for *DSM-5* had the goals of maintaining continuity with the previous edition (*DSM-IV*) as well as being guided by new research findings. But another guiding principle was that no constraints should be placed on the level of change that could be made. If this strikes you as a little contradictory, you are correct. Striking the right balance between change and continuity presented considerable challenges. It also created a great deal of controversy. As part of the revision process, experts in specific disorders were invited to join special *DSM-5* work groups and make specific recommendations for change. In some cases, the debates were so heated that people resigned from their work groups! Now that *DSM-5* is here, not everyone is happy with some of the changes that have been made. On the other hand, many of the revisions that have been made make a lot of sense. In the chapters that follow we highlight key changes in *DSM-5*. We also try to help you think critically about the reasons behind the specific modifications that were proposed and understand why they were accepted.

or mental disorder must be somewhat arbitrary. Rather than thinking of the *DSM* as a finished product, it should always be regarded as a work in progress, with regular updates and modifications to be expected. Although earlier versions of the *DSM* used Roman numerals to refer to each specific edition (e.g., *DSM-IV*), Arabic numerals are now being used instead of Roman numerals (5 versus V) to facilitate updating (e.g., *DSM-5.1, DSM-5.2*) in the future.

# Classification and Diagnosis

**1.2 Describe the advantages and disadvantages of classification.**

If defining abnormality is so contentious and so difficult, why do we try to do it? One simple reason is that most sciences rely on classification (e.g., the periodic table in chemistry and the classification of living organisms into kingdoms, phyla, classes, and so on in biology). At the most fundamental level, classification systems provide us with a **nomenclature** (a naming system). This gives clinicians and researchers both a *common language* and *shorthand terms* for complex clinical conditions. Without having a common set of terms to describe specific clinical conditions, clinicians would have to talk at length about each patient individually to provide an overview of the patient's problems. But if there is a shared understanding of what the term "schizophrenia" means, for example, communication across professional boundaries is simplified and facilitated.

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

Organizing information within a classification system also allows us to study the different disorders that we classify and therefore to learn new things. In other words, *classification facilitates research,* which gives us more information and facilitates greater understanding, not only about what causes various disorders but also how they might best be treated. For example, thinking back to the cases you read about, Monique has alcohol and drug use disorders, and Scott has schizophrenia. Knowing what disorder each of them has is clearly very helpful, because Scott's treatment would be very different from Monique's.

A final effect of classification system usage is somewhat more mundane. As others have pointed out, the classification of mental disorders has social and political implications (see Keeley et al., 2015; Kirk & Kutchins, 1992). Simply put, *defining the domain* of what is considered to be pathological establishes the range of problems that the mental health profession can address. As a consequence, on a purely pragmatic level, it furthermore delineates which types of psychological difficulties warrant insurance reimbursement and the extent of such reimbursement.

## What Are the Disadvantages of Classification?

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

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

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

Related to stigma is the problem of **stereotyping**. Stereotypes are automatic beliefs concerning other people that we unavoidably learn as a result of growing up in a particular culture (e.g., people who wear glasses are more intelligent; New Yorkers are rude). Because we may have

heard about certain behaviors that can accompany mental disorders, we may automatically and incorrectly infer that these behaviors will also be present in any person we meet who has a psychiatric diagnosis. Negative stereotypes about psychiatric patients are also perpetuated in movies. If you have ever seen a horror movie you know that a common dominant theme involves the homicidal maniac. And an analysis of 55 horror films made between 2000 and 2012 has shown that it is people with psychosis who are most often portrayed as murderers (Goodwin, 2014). Stereotyping is also reflected in the comment "People like you don't go back to work" in the case example of James McNulty.

### James McNulty

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

At this point I had my most powerful experience with stigma. I was 38 years old. I had recently been discharged after a psychiatric hospitalization for a suicide attempt, I had no place to live, my savings were exhausted, and my only possession was a 4-year-old car. I contacted the mental health authorities in the state where I then lived and asked for assistance in dealing with my mental illness. I was told that to qualify for assistance I would need to sell my car and spend down the proceeds. I asked how I was supposed to get to work when I recovered enough to find a job. I was told, "Don't worry about going back to work. People like you don't go back to work."[1]

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

It is important to keep in mind, however, that diagnostic classification systems do not classify people. Rather, *they classify the disorders that people have*. And stigma may be less a consequence of the diagnostic label than a result of the disturbed behavior that got the person the diagnosis in the first place. In some situations, a diagnosis may even reduce stigma because it provides at least a partial explanation for a person's otherwise inexplicable behavior (Ruscio, 2004).

[1]McNulty JP; Mental Illness, Society, Stigma, and Research, *Schizophrenia Bulletin 2004; 30*(3): 573–575, doi:10.1093/oxfordjournals.schbul.a007101. Reproduced by permission of Oxford University Press on behalf of the Maryland Psychiatric Research Center.

Nonetheless, when we note that someone has an illness, we should take care not to define him or her by that illness. Respectful and appropriate language should instead be used. At one time, it was quite common for mental health professionals to describe a given patient as "a schizophrenic" or "a manic-depressive." Now, however, it is widely acknowledged that it is more accurate (not to mention more considerate) to use what is called person-first language and say "a person with schizophrenia," or "a person with bipolar disorder." Simply put, the person is not the diagnosis.

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

Negative reactions to people with mental illness are common and may be a fairly widespread phenomenon throughout the world. Using focus groups, Arthur and colleagues (2010) asked community residents in Jamaica about the concept of stigma. Some participants came from rural communities, others from more urban areas. Regardless of their gender, level of education, or where they lived, most participants described highly prejudicial attitudes toward those with mental illnesses. One middle-class male participant said, "We treat them as in a sense second class citizens, we stay far away from them, ostracize them, we just treat them bad" (see Arthur et al., 2010, p. 263). Fear of people who are mentally ill was also

Joshua Baker/Alamy Stock Photo

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

commonly expressed. A rural-dwelling middle-class man described a specific situation in the following way: "There is a mad lady on the road named […]. Even the police are afraid of her because she throws stones at them. She is very, very terrible" (p. 261). Moreover, even when more kindly attitudes were expressed, fear was still a common response. One person put it simply: "You are fearful even though you may be sympathetic" (p. 262). In short, the results of this study suggest that stereotyping, labeling, and stigma toward people with mental illness are not restricted to industrialized countries. Although we might wish that it were otherwise, prejudicial attitudes are common. This highlights the need for anti-stigma campaigns.

For a long time, it was thought that educating people that mental illnesses were "real" brain disorders might be the solution. Sadly, however, this does not seem to be the case. Although there have been impressive increases in the proportion of people who now understand that mental disorders have neurobiological causes, this increased awareness has not resulted in decreases in stigma. In one study, Pescosolido and colleagues (2010) asked people in the community to read a vignette (brief description) about a person who showed symptoms of mental illness. Some people read a vignette about a person who had schizophrenia. Others read a vignette about someone with clinical depression or alcohol dependence. Importantly, no diagnostic labels were used to describe these people. The vignettes simply provided descriptive information. Nonetheless, the majority of the people who were surveyed in this study expressed an unwillingness to work with the person described in the vignette. They also did not want to have to socialize with them and did not want them to marry into their family. Moreover, the level of rejection that was shown was just as high as it was in a similar survey that was done 10 years earlier. Over that same 10-year period, however, many more people embraced a neurobiological understanding about the causes of mental illness. So what this study tells us is that just because people understand that mental illness is caused by problems in the brain doesn't mean that they are any less prejudiced toward those with mental illness. This is a disappointing conclusion for everyone who hoped that more scientific research into the biology of mental illness would lead to the elimination of stigma.

Stigma does seem to be reduced by having more contact with people in the stigmatized group (Corrigan et al., 2014; Couture & Penn, 2003). However, there may be barriers to this. Simply imagining interacting with a person who has a mental disorder can lead to distress and also to unpleasant physical reactions. In an interesting study, Graves and colleagues (2005) asked college students enrolled in a psychology course to imagine interacting with a person whose image was shown to them on a slide. As the slide was being presented, subjects were given some scripted biographical information that described the person. In some scripts, the target person was described as having been diagnosed with schizophrenia, although it was also mentioned that he or she was "doing much better now." In other trials, the biographical description made no mention of any mental illness when the person on the slide was being described. Students who took part in the study reported more distress and had more muscle tension in their brows when they imagined interacting with a person with schizophrenia than when they imagined interacting with a person who did not have schizophrenia. Heart rate changes also suggested they were experiencing the imagined interactions with the patients as being more unpleasant than the interactions with the nonpatients. Finally, research participants who had more psychophysiological reactivity to the slides of the patients reported higher levels of stigma toward these patients. These findings suggest that people may tend to avoid those with mental illness because the psychophysiological arousal these encounters create is experienced as unpleasant.

# Culture and Abnormality

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

Just as we must consider changing societal values and expectations in defining abnormality, so too must we consider differences across cultures. In fact, this is explicitly acknowledged in the *DSM-5* definition of *disorder.* Within a given culture, many shared beliefs and behaviors exist that are widely accepted and that may constitute one or more customary practices. For instance, many people in Christian countries believe that the number 13 is unlucky. The origins of this may be linked to the Last Supper, at which 13 people were present. Many of us try to be especially cautious on Friday the 13th. Some hotels and apartment buildings avoid having a 13th floor altogether. Similarly, there is frequently no bed numbered 13 in hospital wards.

The Japanese, in contrast, are not worried about the number 13. Rather, they attempt to avoid the number 4. This is because in Japanese the sound of the word for "four" is similar to the sound of the word for "death" (see Tseng, 2001, pp. 105–106).

There is also considerable variation in the way different cultures describe psychological distress. For example, there is no word for "depressed" in the languages of certain Native Americans, Alaska Natives, and Southeast

Asian cultures (Manson, 1995). Of course, this does not mean that members from such cultural groups do not experience clinically significant depression. As the accompanying case illustrates, however, the way some disorders present themselves may depend on culturally sanctioned ways of articulating distress.

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There is no word for "depressed" in the languages of certain Native American tribes. Members of these communities tend to describe their symptoms of depression in physical rather than emotional terms.

### Depression in a Native American Elder

JGH is a 71-year-old member of a Southwestern tribe who has been brought to a local Indian Health Service hospital by one of his granddaughters and is seen in the general medical outpatient clinic for multiple complaints. Most of Mr. GH's complaints involve nonlocalized pain. When asked to point to where he hurts, Mr. GH indicates his chest, then his abdomen, his knees, and finally moves his hands "all over." Barely whispering, he mentions a phrase in his native language that translates as "whole body sickness." His granddaughter notes that he "has not been himself" recently. Specifically, Mr. GH, during the past 3 or 4 months, has stopped attending or participating in many events previously important to him and central to his role in a large extended family and clan. He is reluctant to discuss this change in behavior as well as his feelings. When questioned more directly, Mr. GH acknowledges that he has had difficulty falling asleep, sleeps intermittently through the night, and almost always awakens at dawn's first light. He admits that he has not felt like eating in recent months but denies weight loss, although his clothes hang loosely in many folds. Trouble concentrating and remembering are eventually disclosed as well. Asked why he has not participated in family and clan events in the last several months, Mr. GH describes himself as "too tired and full of pain" and "afraid of disappointing people." Further pressing by the clinician is met with silence. Suddenly the patient states, "You know, my sheep haven't been doing well lately. Their coats are ragged; they're thinner. They just wander aimlessly; even the ewes don't seem to care about the little ones." Physical examination and laboratory tests are normal. Mr. GH continues to take two tablets of acetaminophen daily for mild arthritic pain. Although he describes himself as a "recovering alcoholic," Mr. GH reports not having consumed alcohol during the last 23 years. He denies any prior episodes of depression or other psychiatric problems. (Manson, 1995, p. 488)

As is apparent in the case of JGH, culture can shape the clinical presentation of disorders like depression, which are present across cultures around the world (see Draguns & Tanaka-Matsumi, 2003). In China, for instance, individuals with depression frequently focus on physical concerns (fatigue, dizziness, headaches) rather than verbalizing their feelings of melancholy or hopelessness (Kleinman, 1986; Parker et al., 2001). This focus on physical pain rather than emotional pain is also noteworthy in Mr. GH's case.

Despite progressively increasing cultural awareness, we still know relatively little concerning cultural interpretation and expression of abnormal psychology (Arrindell, 2003). The vast majority of the psychiatric literature originates from Euro-American countries—that is, Western Europe, North America, and Australia/New Zealand (Patel & Kim, 2007; Patel & Sumathipala, 2001). To exacerbate this underrepresentation, research published in languages other than English tends to be disregarded (Draguns, 2001).

As noted, prejudice toward people with mental illness seems to be found worldwide. However, some types of psychopathology appear to be highly culture specific: They are found only in certain areas of the world and seem to be highly linked to culturally bound concerns. A case in point is *taijin kyofusho*. This syndrome, which is an anxiety disorder, is quite prevalent in Japan. It involves a marked fear that one's body, body parts, or body functions may offend, embarrass, or otherwise make others feel uncomfortable. Often, people with this disorder are afraid of blushing or upsetting others by their gaze, facial expression, or body odor (Levine & Gaw, 1995).

Another culturally rooted expression of distress, found in people of Latino descent, especially those from the Caribbean, is *ataque de nervios* or an "attack of nerves" (Lizardi et al., 2009; Lopez & Guarnaccia, 2005). This is a clinical syndrome that does not seem to correspond to any specific diagnosis within the *DSM*. The symptoms of an *ataque de nervios*, which is often triggered by a stressful

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Some disorders are highly culture specific. For example, *taijin kyofusho* is a disorder that is prevalent in Japan. It is characterized by the fear that one may upset others by one's gaze, facial expression, or body odor.

event such as divorce or bereavement, include crying, trembling, and uncontrollable screaming. There is also a sense of being out of control. Sometimes the person may become physically or verbally aggressive. Alternately, the person may faint or experience a seizure-like fit. Once the *ataque* is over, the person may promptly resume his or her normal manner, with little or no memory of the incident.

As previously mentioned, abnormal behavior is behavior that deviates from the norms of the society in which the person lives. Experiences such as hearing the voice of a dead relative might be regarded as normative in one culture (e.g., in many Native American tribes) yet abnormal in another cultural milieu. Nonetheless, certain unconventional actions and behaviors are almost universally considered to be the product of mental disorder.

Many years ago, the anthropologist Jane Murphy (1976) studied abnormal behavior in the Yoruba of Africa and the Yupik-speaking Eskimos living on an island in the Bering Sea. Both societies had words that were used to denote abnormality or "craziness." In addition, the clusters of behaviors that were considered to reflect abnormality in these cultures were behaviors that most of us would also regard as abnormal. These included hearing voices, laughing at nothing, defecating in public, drinking urine, and believing things that no one else believes. Why do you think these behaviors are universally considered to be abnormal?

# How Common Are Mental Disorders?

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

How many and what sort of people have diagnosable psychological disorders today? This is a significant question for a number of reasons. First, such information is essential when planning and establishing mental health services. Mental health planners require a precise understanding of the nature and extent of the psychological difficulties within a given area, state, or country because they are responsible for determining how resources such as funding of research projects or services provided by community mental health centers may be most effectively allocated. It would make little practical sense to have a treatment center filled with clinicians skilled in the treatment of anorexia nervosa (a very severe but relatively rare clinical problem) if there were few clinicians skilled in treating anxiety or depression, which are much more prevalent disorders.

Second, estimates of the frequency of mental disorders in different groups of people may provide valuable clues as to the causes of these disorders. For example, data from the United Kingdom have shown that schizophrenia is about three times more likely to develop in ethnic minorities than in the white population (Kirkbridge et al., 2006). Rates of schizophrenia in southeast London are also high relative to other parts of the country. This is prompting researchers to explore why this might be. Possible factors may be social class and neighborhood deprivation, as well as diet or exposure to infections or environmental contaminants.

## Prevalence and Incidence

Before we can further discuss the impact of mental disorders upon society, we must clarify the way in which psychological problems are counted. **Epidemiology** is the study of the distribution of diseases, disorders, or health-related behaviors in a given population. Mental health epidemiology is the study of the distribution of mental disorders. A key component of an epidemiological survey is determining the frequencies of mental disorders. There are several ways of doing this. The term **prevalence** refers to the number of active cases in a population during any given period of time. Prevalence figures are typically expressed as percentages (i.e., the percentage of the population that has the disorder). Furthermore, there are several different types of prevalence estimates that can be made.

**Point prevalence** refers to the estimated proportion of actual, active cases of a disorder in a given population at a given point in time. For example, if we were to conduct a study and count the number of people who have major depressive disorder (i.e., clinical depression) on January 1 of next year, this would provide us with a point prevalence estimate of active cases of depression. A person who experienced depression during the months of November and December but who managed to recover by January 1 would not be included in our point prevalence calculation. The same is true of someone whose depression did not begin until January 2.