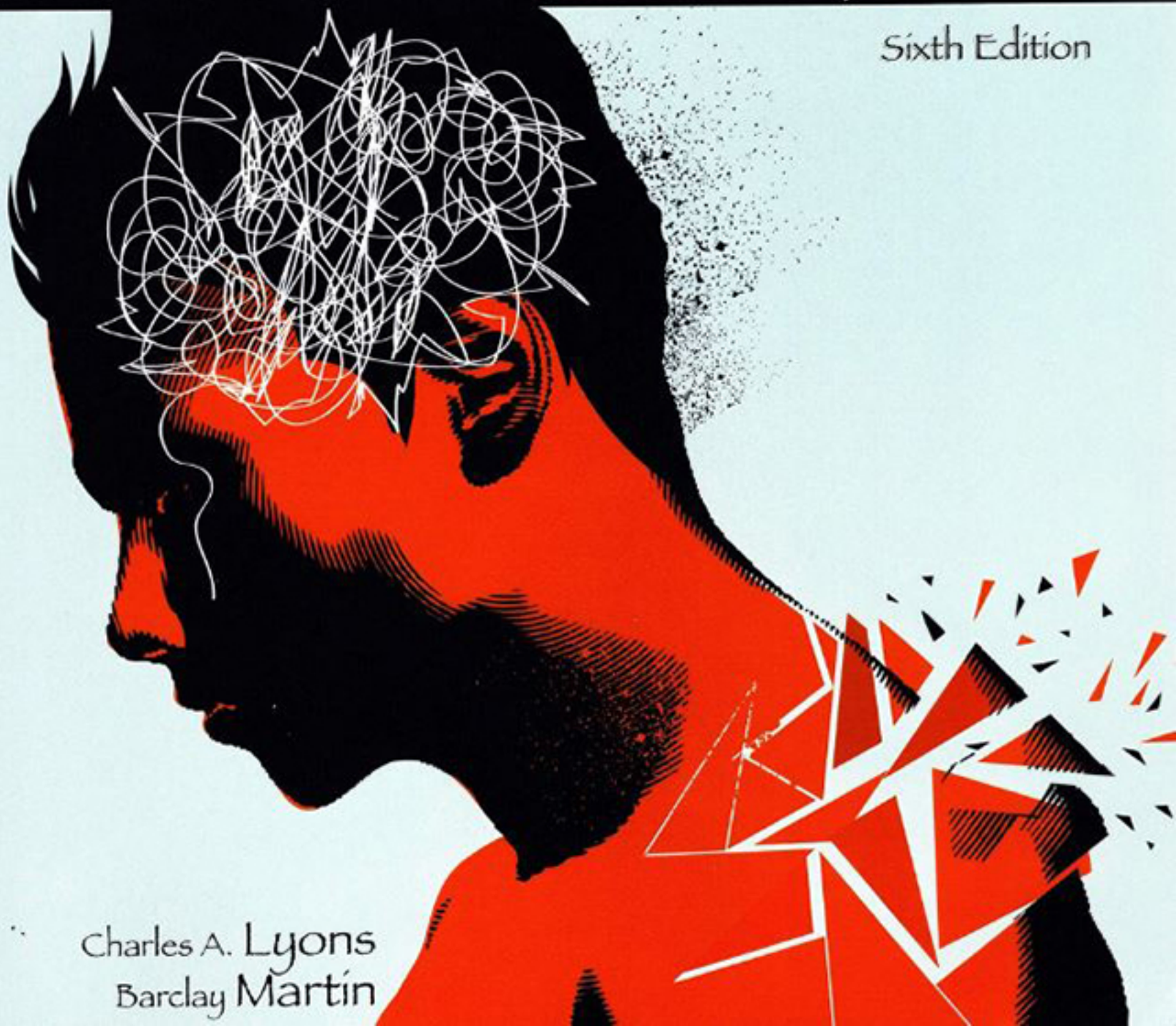
# Abnormal PSYCHOLOGY

## Clinical and Scientific Perspectives

Sixth Edition



Charles A. Lyons
Barclay Martin

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Sixth Edition

Charles A. Lyons • Barclay Martin

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# About the Authors

Charles A. Lyons is Professor of Psychology at Eastern Oregon University, where he teaches courses in abnormal psychology, behavior analysis, clinical interventions, evolution and behavior, human sexuality, and psychological assessment. He earned his PhD from Utah State University, with a specialization in the analysis of behavior. As a licensed clinical psychologist, he worked for several years with inpatient populations at a large state psychiatric facility, where he provided treatment, assessment, and forensic evaluations. As a researcher, he has published articles on animal behavior, basic learning processes, language, and addictive behaviors. His most recent research interests include social and compulsive gambling and large-scale public lotteries.

Barclay Martin is professor emeritus at the University of North Carolina at Chapel Hill. After receiving his PhD in psychology from Stanford University, he taught at the University of Wisconsin at Madison before joining the faculty at UNC. The author of numerous articles and books, he enjoys his retirement in Chapel Hill.

# Brief Contents

# Contents

# Preface

The United States spends more money on mental disorders than on any other health condition, with heart disease and cancer trailing far behind (Roehrig, 2016). As important as that statistic is, it is not the main reason that it is incumbent upon us to understand more about these conditions. We all have friends or family members who have battled with mental health in some way. It is therefore important to learn what we can about mental disorders, including how they are identified, how they develop, how they can be treated, and, ultimately, how they can be prevented.

As in the previous editions of *Abnormal Psychology: Clinical and Scientific Perspectives*, this sixth edition was prepared with the goal of producing a readable, useful, inexpensive referenced resource that could serve as a primary text for students in undergraduate abnormal psychology courses. It provides a thorough (and critical) overview of the official system for classifying mental disorders—the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*)—describing the many ways in which the DSM-5 differs from its predecessors. As this text reviews both past and present treatment approaches and their supporting research, it also encourages students to think critically and to evaluate the strength of evidence.

This edition incorporates several features, including:

- Thorough description of *DSM-5* classification, with frequent examples of diagnostic criteria and highlighted changes from the *DSM-IV*
- Extensive attention to diagnostic reliability and validity
- Coverage of continued controversies within psychiatry and psychology
- Many new and updated references from the professional literature
- Expanded glossary and index
- End-of-chapter reviews, key terms, questions for study, and pop quizzes.
- Student study materials, including practice quizzes, instructor's test banks, and lecture slides at www.BVTLab.com

It is also available in a variety of formats, ranging from eBook to bound textbook.

The original framework of Barclay Martin's *Abnormal Psychology: Clinical and Scientific Perspectives* reflected the substantial changes taking place in clinical psychology and psychiatry in the early 1980s. At that time, a new diagnostic system for psychopathology (the *DSM-III*) had appeared and Martin recognized the implications of the shift from a more subjective and analytic era in abnormal psychology to the less theory-dependent, more objective *DSM-III* model. The value of a science of clinical psychology was becoming apparent and issues such as diagnostic reliability, validity, and empirical outcome data began to drive the classification and treatment of mental disorders.

The present text, built on that framework, reviews the extensive subsequent developments in research and practice since the *DSM-III*. In the past 36 years, the *DSM* has undergone four revisions—new diagnostic categories have been added, others have been proposed, and still others modified or removed. Thousands of research studies have been published, exploring the biological, genetic, social, cognitive, and behavioral foundations of psychopathology; the effectiveness of various psychological and biological interventions; the incidence of disorders among populations; and the usefulness of different classifications. A strongly biomedical model of abnormal behavior became dominant within psychiatry, enabling the proliferation of pharmacological interventions for nearly every *DSM*-identified condition. Still, many of the questions about etiology and treatment considered in Martin's text remain unanswered. In nearly all cases of mental disorder, no biological markers or laboratory tests can identify or confirm any *DSM* diagnosis. Many contributory factors have been identified, but any necessary or sufficient causes of mental disorders remain elusive. Medications can offer some symptom relief; as of yet, however, they provide no cures, nor do they correct any presumed underlying biological abnormalities. Indeed, for many conditions, psychological interventions have been developed that are at least as effective as medication, with fewer side effects and lower risk of relapse.

The history of abnormal psychology contains many conceptual blind alleys and mistaken assumptions.

Adopting a scientific perspective does not prevent such errors, but it does allow us to eventually recognize them. The current state of the science reminds us that we have often been too quick to oversimplify and too slow to think skeptically about both causes and treatments. Inevitably, mental disorders are defined within a social and cultural context, diagnosed within an interpersonal behavioral exchange, and treated within a biological-environmental interaction; thus, they are bio-psycho-social developments. Therefore, I have endeavored to avoid the use of the common terms *mental illness* or *mental disease*—which may imply that we know more than we actually do; instead, I refer to these conditions more accurately as *mental disorders*. It should be noted that this informed skepticism does not discount the very real distress and disability associated with many *DSM* conditions, nor the importance of prompt, effective treatment.

In such an environment, there is always a danger that pseudoscience can masquerade as an acceptable alternative. There are dozens, if not hundreds, of competing therapies for common disorders such as depression and anxiety. The high level of nonspecific (or placebo) response in treatment increases the risk of promoting ineffective therapies and medications and fosters conceptual confusion. Fortunately, such problems are ultimately solved by the scientific method itself through careful comparisons, empirical testing, and evaluation of outcomes. I have highlighted research involving direct treatment comparisons or the use of randomized controlled trials that provides empirical support for any particular therapeutic intervention over others.

Because the *DSM* model is so widely accepted, I have provided a careful description of the *DSM-5*, tracing the evolution of diagnosis and treatment within various categories of mental disorders, while also providing data on the reliability and validity of these diagnoses whenever possible. The professional literature on psychopathology is enormous and continually expanding. I have given preference to reviewing the more empirical and evaluative publications; as a result, articles from medical science, neuroscience, behavioral psychology, and cognitive psychology are overrepresented in the bibliography. I readily admit to a bias in favor of the scientific method over all other approaches in the field. However, I also accept that outcomes and consequences drive the selective process, and I realize that what may appear to be today's truth may be tomorrow's folly. We can expect continued shaping and revision of the content and structure of our diagnostic system, as well as our treatments, as some investigative pathways prove fruitful and others do not. I hope to have correctly reported the current state of affairs within this fascinating subject, without minimizing the many disputes, controversies, and unresolved issues that exist.

Charles A. Lyons
January 2018
La Grande, Oregon

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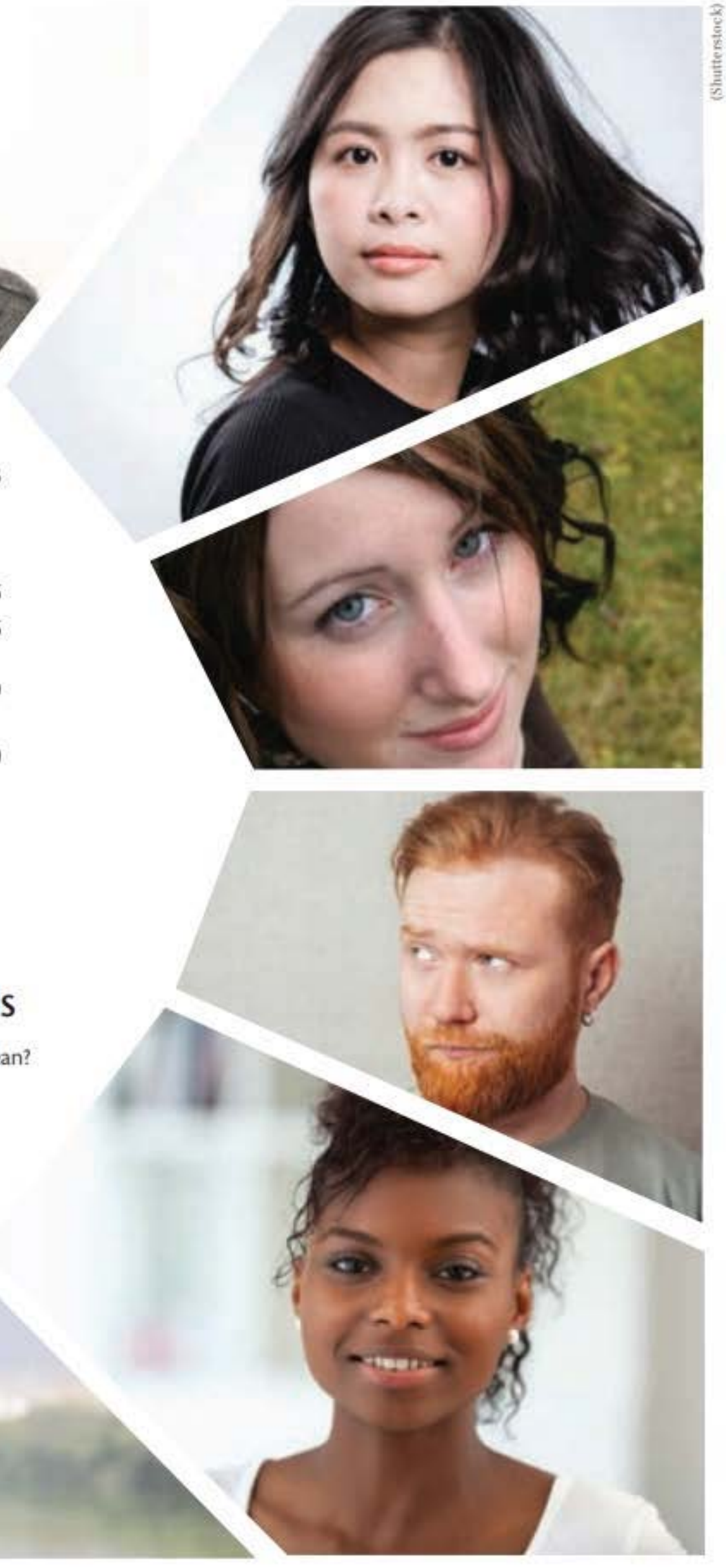

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## CHAPTER OVERVIEW



## CHAPTER OPENER QUESTIONS

What does the term *abnormal behavior* mean?

What is a psychological disability?

Is there a sharp dividing line between normal and abnormal?

How can we study abnormal behavior scientifically?

chapter 1

# Introduction and Methods of Research

Humans engage in a vast range of activities, emotions, beliefs, perceptions, and memories. These types of behaviors (both overt and covert) can be viewed as adaptations to the world around us and to the requirements of life, and different people find very different ways of expressing them. All humans share many similarities; but even within the boundaries of our biology, our culture, and our experience, great variety exists in what people do.

Societies differ to some extent over which variations of behavior are acceptable, but they also share the tendency to identify certain patterns as something other than "normal." Sometimes, people act and feel in ways that we could call *maladjusted* or *disturbed*: Their behaviors cause distress or harm to themselves or to others. They may act in ways that other people would consider unusual and objectionable. How have strange and puzzling behaviors been explained in different cultures, in different historical periods, and by different theorists? What techniques can be used to help individuals overcome such difficulties? This book will address those important questions. First, however, a more fundamental issue is at hand: What is abnormal behavior?

## 1.1 What Is Abnormal Behavior?

The term **abnormal behavior** implies behavior that is different, unusual, or deviant. Distinctiveness alone, of course, is not sufficient to imply abnormality. Olympic athletes, Nobel laureates, gifted musicians, and investors who make a killing on the stock market—all deviate considerably from the norm. Yet we are not inclined to consider them abnormal as the term is generally used. Although abnormal behavior does, for the most part, deviate from cultural norms, only certain kinds of deviant behaviors are likely to be called abnormal—namely, behavior that is culturally inappropriate, is accompanied by subjective distress, and involves a psychological impairment (an inability to cope with life's demands).

What does the term *abnormal behavior* mean?

### 1.1a Cultural Inappropriateness

The key concept here is that the behavior seems at odds with cultural expectations of appropriateness and propriety: The behavior is something that others find disturbing, puzzling, or irrational.

Ordinarily, a specific behavior is not judged strange in itself, only in the context of a particular situation. When sports fans (a term, incidentally, derived from the word *fanatic*) shout and shake their fists at a football game, there will be few lifted eyebrows; doing the same thing in church or in the public library, however, may be seen as unusual and troubling by others who witness these acts. Similarly, those who smear their faces in fake blood, dress up as dead people, and go door-to-door asking for treats would be viewed as very strange indeed—except in the United States on October 31.

Anthropologists have convincingly made the point that judgment of another person's normality will depend on the values and traditions of the culture in which he or she lives.

**Abnormal behavior**
Behavior that is culturally inappropriate, is accompanied by subjective distress, and involves a psychological impairment (inability to cope with life's demands)

For example, hearing voices and going into a trance are likely to be labeled abnormal in our society; and yet, among the Plains Indians of North America, such behaviors were highly valued as evidence of special talent for communication with the spirit world. Prestige and status would often accrue to the person having these experiences. What, however, would be the response today if a young woman from New Jersey announced that she heard divine voices instructing her to take over the position of chair of the Joint Chiefs of Staff of the U.S. Armed Forces in order to protect this country from foreign dangers? No doubt she would find a few followers, but it is unlikely that she would be as successful as Joan of Arc in accomplishing her mission. Even in Joan's case, not everyone bought her story.

When sport fans shout and shake their fist at a football game, there will be few lifted eyebrows, but doing the same thing in church or in the public library may be seen as strange. (Shutterstock)

When Ruth Benedict (1934) made her study of the Melanesian culture of the Dobu people, she found the society was characterized by a degree of suspicion and mistrust that would be labeled **paranoia** in North American culture. There was universal preoccupation with poisoning. No woman left her cooking pot untended for a moment; and because all others' food was considered to be deadly poison, community stores were out of the question. Their polite phrase at the acceptance of a gift was, "And if you now poison me, how shall I repay you for this present?" There was one man in this Dobu society who had a sunny, kindly disposition and liked to be helpful. Others laughed at him and thought him silly, simple, and a little crazy. Prevailing cultural beliefs, then, will influence how strange or inappropriate a given behavior is perceived to be.

Prevailing cultural beliefs influence how strange or inappropriate a given behavior, such as that of a shaman, is perceived to be. (Library of Congress/ Public Domain)

Anthropologists (for example, Kiev [1969] and Murphy [1964]), however, point out that we must not take too simple a view of the **cultural relativity** of abnormal behavior. For example, the trance states of shamans (priest-doctors such as voodoo priests and medicine men) show some similarities to psychopathological reactions in our society, but there are also important differences. Primarily, the shaman appears to be more in control of the trance state, deciding on which occasions to enter it and, most important, appears to be behaving according to cultural expectations while in it. A person who goes into trance states at inappropriate times and behaves in unpredictable ways might well be considered strange or "crazy" by the community. Marvin Harris (1989) notes that all known societies identify individuals (like shamans) who "have a special aptitude for obtaining help from the spirit world" (p. 411). Social rules probably dictate the "normal" methods for appealing for spiritual help in all of them. Indeed, by selecting which symptoms are legitimate, shamans, priests, and healers shape the definitions of mental disorders in culturally specific ways (Watters, 2010).

The question still remains: Can abnormality be defined largely in terms of cultural inappropriateness? There are some problems with such an approach. Take, for example, an individual in Nazi Germany who might, in belief and action, have differed from the prevailing anti-Semitic views and other aspects of the Nazi philosophy. Such a person would clearly have been deviating from acceptable cultural views and, by this definition, would have been considered abnormal. In the late 20th century, some dissidents in the Soviet Union were labeled mentally ill and placed in institutions because they voiced opposition to the Soviet dictatorship. Even now, women in some Islamic countries are considered deviant because of their wish to complete an education. Do we want to label this kind of behavior abnormal? On the contrary, it might be argued that standing up in this way against prevailing viewpoints takes considerable psychological strength.

**Paranoia**
Unfounded, irrational, or exaggerated suspicion or mistrust of others

**Cultural relativity**
The perspective that different cultures may use different standards in defining abnormality

There are other problems with cultural inappropriateness as the major criterion of abnormality. Many individuals in our society conform almost slavishly to the customs and laws of the community and yet experience inhibitions, anxieties, and great personal unhappiness. Although their overt behavior is not culturally inappropriate, their reactions may be considered, in some sense, abnormal. Other individuals (for example, professional criminals) defy societal laws but otherwise function quite well as spouses, parents, colleagues, and friends. Their behavior might more accurately be defined as criminal rather than abnormal. Cultural inappropriateness, although a characteristic of most abnormal behavior in all societies, is not entirely satisfying as the sole criterion of abnormality.


Jeff Hall, a neo-Nazi supporter, helped lead demonstrations in Riverside and Los Angeles, California, where white supremacists waved swastika flags, chanted "white power," and gave stiff-armed Nazi salutes while surrounded by hundreds of counterprotesters. (AP Wide World Photo)

## 1.1b Subjective Distress

**Subjective distress** refers to internal emotions or experiences that are real to the person but cannot be observed directly by other people. Unhappiness, fear, apathy, terrifying visual and auditory experiences, and physical aches and pains are examples. Reports of subjective distress commonly accompany abnormal reactions and may include a variety of unpleasant emotions such as guilt, nervous tension, depression, and the pain of migraine headaches.

The individual's distress is an important dimension of abnormality that should be included as one aspect of an overall definition. Once again, however, there are exceptions. Some individuals, especially those with *manic disorders*, may deny any subjective distress and maintain that they feel wonderful. Individuals labeled *sociopathic* experience little remorse or distress associated with their antisocial behavior. In these cases, reports about the degree of subjective distress would not be an accurate indication of the presence of abnormality.

## 1.1c Psychological Disability

When persons are unable to function adequately in their roles as students, workers, parents, spouses, or friends, they can be considered to have a **psychological disability**, impairment, or dysfunction. They are unable to cope adequately with life's stresses and demands. Sometimes they are not able to function effectively as parents. When depressed or having a migraine headache, they are hardly able to get through the day and may frequently take to bed. Their interpersonal relationships are hampered by an inability to assert themselves appropriately.

One way of viewing the concept of psychological disability or dysfunction is to say that individuals with such handicaps have fewer alternative ways of behaving and thinking open to them. In this sense, psychological impairments are analogous to physical impairments; indeed, many of the terms used interchangeably with abnormality (such as *psychopathology*, *behavior pathology*, *behavior disorder*, *mental illness*, and *mental disease*) imply a parallel with physical disease. For example, persons with a broken leg or pneumonia are handicapped by those conditions and cannot do things they normally could. Although some writers, such as Szasz (1960), have severely criticized the idea that mental illness is similar to physical illness, the disease metaphor is widely employed today in psychiatry and psychology. As we shall see in later chapters, disease models of mental disorders have both strengths and weaknesses. In addition, alternative perspectives propose that individuals may acquire certain mental disorders on the basis of life experiences. The concept of psychological disability or impairment, however, need not imply any particular theory of how abnormality develops.

What is a psychological disability?

**Subjective distress**
Emotion or internal experience that is distressing to the individual but cannot be directly observed by others

**Psychological disability**
Inability to cope with life's demands and stresses, or difficulty in functioning in important daily social and interpersonal roles

It is important to note that the person with a psychological impairment is *unable* to do certain things, as opposed to the person who simply does not do them because of personal values, lack of interest, or similar reasons. It is not always possible to tell from the behavior itself whether it stems from a psychological impairment; instead, one must make a judgment as to whether the person is able to do otherwise. A succession of short-lived marriages does not in itself indicate a handicap; however, when a person wants a lasting marriage, is physically healthy, and yet seems to be involved in one disastrous marriage after another, a psychological disability might be suspected.

In sum, then, most but not all forms of abnormal behavior are likely to be culturally inappropriate and accompanied by subjective distress. In addition, all forms of abnormality might be conceived as reflecting a psychological impairment: a restriction in response alternatives that makes it difficult to cope with life's demands and stresses. These considerations form the basis for current definitions of the mental disorders addressed in this book.

## 1.2 Abnormality Is a Continuum

The conception of abnormality may be clarified further by viewing it as a continuum, with extreme abnormality at one end and positive mental health at the other. In extreme forms of abnormal behavior, the person is severely handicapped, suffers much subjective distress, and is so culturally inappropriate as to evoke intense fear or revulsion in others. From these extreme instances, in which most observers would agree that something is wrong, we move by imperceptible steps to the range of behaviors that we call normal.

Milder forms of psychological impairments include the boy who is too timid to ask a girl on a date, the homemaker who feels vaguely dissatisfied and unfulfilled, the alienated student who finds nothing of interest in the world of the establishment, or the young person who feels acutely irritated whenever confronted by anyone in authority. Mild impairments are experienced from time to time by the vast majority of people in the middle range of this hypothetical continuum. Who among us does not have some occasional reaction that impairs work efficiency, disrupts interpersonal relationships, or otherwise hampers our ability to meet life's demands? Some of us feel anxious about speaking before an audience, some have minor irrational fears, and some get a little disorganized under the pressure of a course examination.

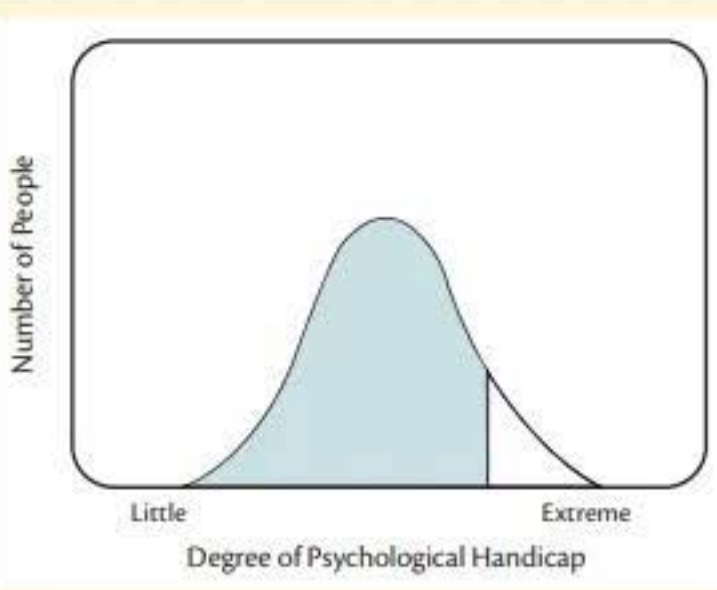
Is there a sharp dividing line between normal and abnormal?

There is, then, no single point at which one can draw a line separating normal from abnormal; there are only varying degrees of psychological disability, subjective distress, and cultural inappropriateness (Figure 1-1). Let us consider for a moment what is meant by the other end of the continuum—that is, the psychologically healthy person.

*Figure 1-1 Psychological Disability Seen as a Continuum Along Which People Vary*

Most of us fall in the middle range with only mild to moderate handicaps. Any exact border between normal and abnormal, such as the line separating the unshaded area above, is arbitrary.






## 1.3 What Is Mental Health?

Psychologically healthy persons do not necessarily escape the stresses and strains of life. From time to time they wrestle with conflicting impulses, encounter crises in interpersonal relationships, and experience unpleasant emotions such as grief, anger, or fear. In general, however, they are able to function effectively and to find satisfaction in life. They can have lasting and emotionally gratifying relations with friends, spouses, parents, and children; they can work effectively and productively; and they can laugh, play, relax, and have

fun. They are likely to make a realistic appraisal of their own talents and shortcomings, or at least they do not resort to extreme forms of denial or distortion of those aspects of themselves that they wish were different. Basically, they view themselves as worthy members of the human race.

This idealized description of mental health in no way implies that such persons have to be conformists, adjusting passively to the demands of their culture. In the present definition of mental health, freedom from psychological disability is emphasized. Mentally healthy persons are able to pursue with effectiveness and satisfaction any number of life goals. They have weighed the value and desirability of the specific uses to which they put their psychological energies. A salesperson who enjoys selling, has mutually satisfying relationships with others, plays golf on Saturday, and drinks beer while watching the Sunday afternoon pro football game on TV would, by most criteria, be leading a conventional, middle-class life—and, by our definition, be enjoying mental health. A member of a rural commune who likewise has satisfying interpersonal relationships, enjoys organic farming, and relaxes by playing the guitar may have an equal degree of mental health. Persons who try to reform society, such as political or religious leaders, may create a much more stressful life situation for themselves than either of the other two examples; yet to the extent that they successfully cope with these stresses, they also enjoy mental health. An individual with the necessary abilities and relative freedom from psychological handicaps should be able to choose among these and other lifestyles. Good mental health leaves a person open to many alternative ways of behaving. It is not some idealized and unattainable state but is, instead, that end of the dimension where individuals have relatively few psychological disabilities.

## 1.3a By What Name Shall We Call It?

Many terms have been used to refer to abnormal behavior, including *psychopathology*, *mental illness*, *behavior disorder*, and *emotional disturbance*. While some use of labels is inescapable, it is reasonable to ask about the value in applying such general labels to people. Such terms refer to a broad and complex range of phenomena, which, as previously suggested, can be seen as a continuum on which there is no sharp dividing line. The causes of these phenomena may be very complex and interconnected with biology, genetics, culture, and individual life history. It is easy to fall into the **naming fallacy** where, by giving something a name or label, we assume we have in some sense explained it. Regardless of how we name a disorder, we must also be able to describe objectively what the abnormal behaviors are, understand how they develop (and perhaps how they could be prevented), and consider how they might be modified to help restore a person to a healthier state. As we shall see, mental disorders are easier to label than to explain and understand.

Mental disorders are identified and labeled in the context of what people do and how they interact with others around them. (Shutterstock)

Furthermore, there is a tendency for any term used in referring to these phenomena to acquire a derogatory meaning, and that fact deserves some comment. Most people feel frightened or repelled by individuals who behave abnormally. These reactions account, in part, for the fact that abnormally behaving people have historically been the object of ridicule and abuse. Any term used to refer to such individuals seems to acquire, in time, a negative connotation. To say that a person is "mentally ill" or "sick" is likely to evoke negative reactions in many listeners, and yet use of the term *mental illness* was initially promoted by enlightened physicians seeking to reduce some of the negative attitudes associated with terms such as *lunacy* and notions such as demonic possession. To minimize the negative connotations of labeling, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (or more simply, the

**Naming fallacy**
The incorrect assumption that by applying a label or name to something, we have in some sense explained it

*DSM-IV*), published by the American Psychiatric Association (2000), noted that it is preferable to refer to someone we might call a "schizophrenic" as "a person with schizophrenia." While helping prevent the application of inevitably pejorative labels to individual people, this solution may also have the unfortunate effect of separating the behavioral disability from the person and giving it an existence of its own (rather like a virus), apart from the individual. We should not forget, however, that we can only identify and label these disorders in the context of what people do and how they interact with others around them.

## What Is a Mental Disorder?

According to the current version of the *DSM* series, the *DSM-5*, a mental disorder is a "syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental function" (American Psychiatric Association, 2013, p. 20). The disturbance usually involves significant personal distress or disruption in important activities in a person's life, such as occupational or social functions (see Table 1-1 *DSM-5*: Definition of a Mental Disorder). To be "clinically significant," the behavioral or psychological syndrome would have to be considered important and serious enough to presume that the individual is usually not able to manage the condition alone—although the manual notes that a diagnosis is not equivalent to the need for treatment.

**Table 1-1** *DSM-5* Definition of a Mental Disorder

| A mental disorder is a clinically significant syndrome reflecting a dysfunction in psychological, biological, or developmental processes, usually involving: | **Excluded from the definition:** |
|---|---|
| A. Disturbance in cognition, emotion regulation, or behavior<br>B. Significant personal distress<br>C. Disability in social, occupational, or other important activities | A. Expected or culturally approved responses to common stressors or loss, such as death of a loved one<br>B. Deviant political, religious, or sexual behavior<br>C. Conflicts that are primarily between the individual and society |

Source: American Psychiatric Association, 2013.

Certain types of significant syndromes or patterns of behavior are excluded from the definition of a mental disorder in the *DSM-5*. Culturally appropriate and acceptable reactions to important events, like the death of a loved one, usually include strong responses such as grief, depression, sleep disturbance, loss of appetite, and social withdrawal. Within each culture, members expect and accept these reactions as normal events; in fact, it may appear abnormal if these reactions *don't* occur. Even though grief (for example) involves present distress and impairment in functioning for the bereaved, it is not a mental disorder within the limits of cultural expectations. Among current cultures, however, the sorts of sanctioned responses to the death of a loved one can vary widely. In some American Indian cultures in the Pacific Northwest, for example, it is not unusual to wear certain types of clothing or to continue setting a place at the table for the lost loved one for a year after the loss. In the larger society, most North Americans would not consider it unusual if the mourner's social and occupational involvements were disrupted for weeks or even a few months. At some point, however, cultures expect grief to subside and the intense reactions to lessen. If that does not happen, then a diagnosis of mental disorder becomes possible.

Other potentially distressing and harmful patterns or syndromes are also excluded from the definition. We tolerate a very large range of religious beliefs and practices. Political goals, motives, and means can take many forms. There is great diversity in our sexual desires and practices. Although these patterns of behavior may at times seem very much out of the norm, they are not—by that virtue alone—considered mental disorders. Similarly, some persons find themselves in conflict with their culture or their government. Some people instigate rebellions; protest the actions of businesses, governments, and religions; or violate the laws of a nation or a community. Some people engage in terrorist acts to intentionally create fear and havoc and to kill or maim unsuspecting victims. These syndromes can be called subversive or criminal, but they are not mental disorders for those reasons alone.

It may seem obvious that there will be instances in which professionals might disagree as to whether a person is suffering from a mental disorder. Thus, the **diagnostic reliability** of mental disorders is a very important issue for the *DSM* system, as we shall consider later. Complicating the matter further, some people diagnosed with mental disorders also commit deviant political, religious, sexual, or criminal activities. The extent to which the mental disorder accounts for those acts may be unclear.

## 1.4 The Prevalence of Abnormality

The looseness of definition should not in any way obscure the existence of abnormal behavior—which is both real and pervasive, as a number of studies have shown. In an early study, Srole, Langner, Michael, Opler, and Rennie (1962) interviewed and administered a questionnaire to a random sample of 1,660 individuals living on Manhattan's East Side. Symptoms indicative of mental disorder were measured, and the percentage of individuals falling into six categories representing degree of impairment was as follows:

| | |
|---|---|
| Well | 18.5% |
| Mild | 36.3% |
| Moderate | 21.8% |
| Marked | 13.2% |
| Severe | 7.5% |
| Incapacitated | 2.7% |

If the last three categories were combined, 23.4% of the sample was considered to have at least a marked degree of psychological handicap. Similar results were obtained in studies involving rural as well as urban populations (Warheit, Holzer III, & Arey, 1975). An interview of a random sample of adults in an area of New Haven, Connecticut, concluded that 15% were experiencing a psychiatric disorder and 18% of the people interviewed had experienced a depressive disorder of at least a moderate degree sometime during the past year (Weissman & Myers, 1978).

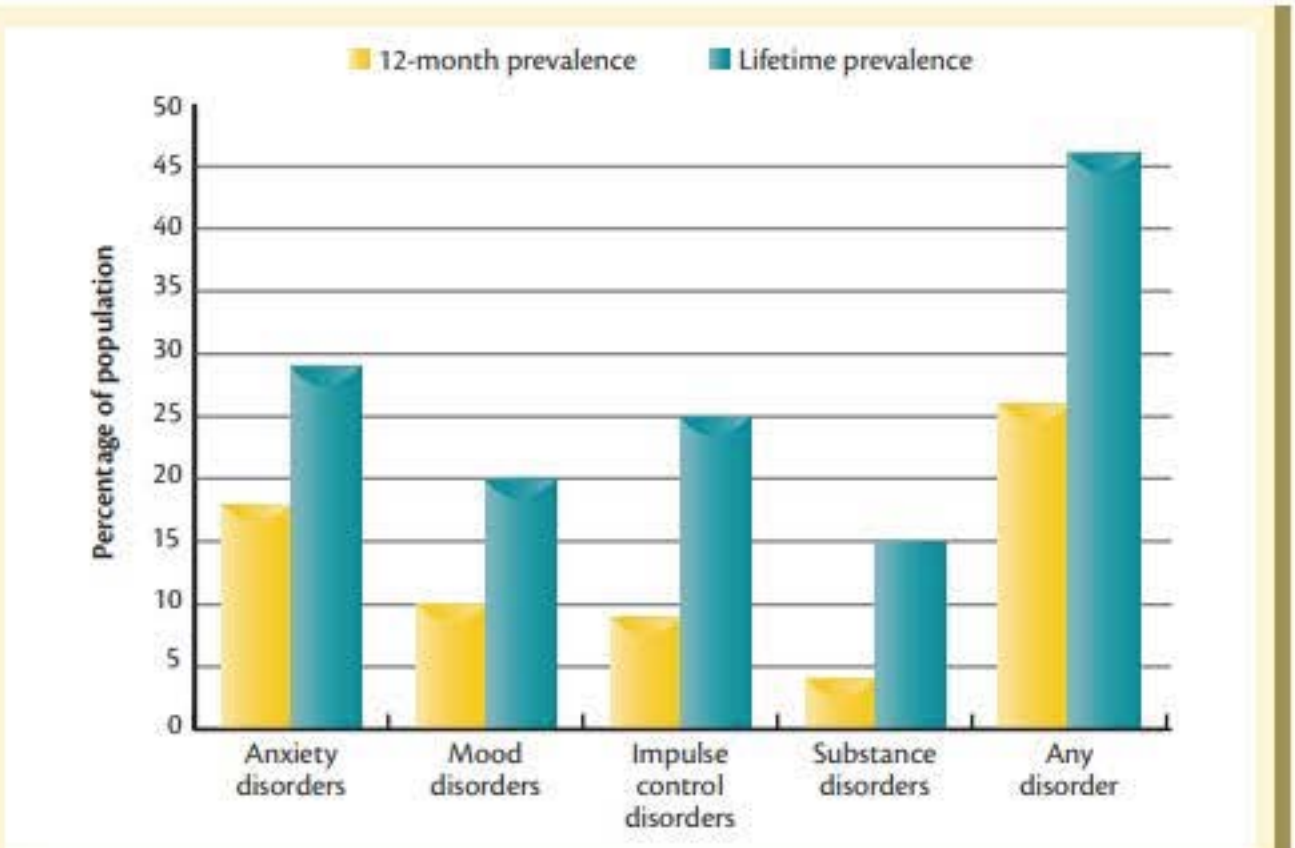
More recently, Kessler and colleagues estimated the prevalence of some of the more common mental disorders among the U.S. population in terms of whether a disorder had been experienced in the previous year (12-month prevalence; Kessler, Chiu, Demler, & Walters, 2005) or had ever been experienced by a person (lifetime prevalence; Kessler, Berglund, et al., 2005). The most common mental disorders were anxiety disorders with a 12-month prevalence of 18.1% of the population and a lifetime prevalence of 28.8% of the population (see Figure 1-2). Following anxiety disorders were mood disorders (such as depression), impulse-control disorders, and substance disorders. If all disorders are combined, about 26.6% of people in the United States experienced a defined disorder in the past 12 months. Over the course of our lifetimes, nearly half (46.4%) of us will experience at least one of the disorders.

**Diagnostic reliability**
Consistency and agreement between clinicians in use of a diagnostic label

### *Figure 1-2* Prevalence of Mental Disorders

Prevalence of mental disorders within the population, during the previous 12-month period and over the course of a person's lifetime

Sources: Lifetime data from "Lifetime Prevalence and Age-of-onset Distributions of *DSM-IV* Disorders in the National Comorbidity Survey Replication," by R. C. Kessler, P. Berglund, O. Demler, R. Jin, K. R. Merikangas, and E. E. Walters, 2005, *Archives of General Psychiatry, 62*, 593. 12-month data from "Prevalence, Severity, and Comorbidity of 1 Twelve-month *DSM-IV* Disorders in the National Comorbidity Survey Replication (NCS-R)," by R. C. Kessler, W. T. Chiu, O. Demler, and E. E. Walters, 2005, *Archives of General Psychiatry, 62*, 617.




## 1.5 The Scientific Study of Abnormal Behavior

Only recently have we attempted to study ourselves with the same objectivity that we have used in trying to understand the inanimate world and other living organisms. Abnormal behavior, especially, has lent itself to beliefs and superstitions that have yielded only slowly to the advance of scientific understanding. The history of changing conceptions of abnormality will be traced in subsequent chapters. First, consideration of common methodologies used in the scientific study of abnormal behavior and the advantages and disadvantages associated with them is warranted.

### 1.5a The Case Study

Carefully documented **case studies** of individuals have played an important role historically in the study of abnormal behavior. Typically, the investigator derives information from talking with a person who displays abnormal behavior (or those who know the person) and describing, in narrative form, the behavior of interest, related environmental circumstances, and past events that might make the present behavior intelligible. The intensive study of individuals and of the changes in symptoms that occur during therapy has been a rich source of ideas about the nature and causation of abnormal behavior.

Although case studies are useful in illustrating different forms of abnormal behavior and in generating theories, they are not proper scientific methods, and they cannot be used to "prove" a theory. For one thing, there is a tendency to select, as evidence, cases that support one's theory while ignoring those cases that are embarrassingly inconsistent with it. Furthermore, the information used in a case study report is highly

**Case study**
The in-depth examination of an individual clinical case

How can we study abnormal behavior scientifically?

selective, and one rarely has any way of knowing how much information was omitted or never sought in the first place. By simply tracking the changes that take place in a person's condition, we cannot distinguish causal influences from simple coincidence. Finally, even when the findings for a given case are accurate, they cannot be generalized to anyone other than the person being studied unless, as discussed in the following section, similar information was obtained from a sample of individuals. We should be careful, then, not to be led into believing that a general proposition has been demonstrated by a case study, no matter how persuasive and sensible the material seems to be. As William James (1897) said, "There is really no scientific or other method by which men can steer safely between the opposite dangers of believing too little or of believing too much. To face such dangers is apparently our duty, and to hit the right channel between them is the measure of our wisdom as men."

## 1.5b Epidemiological Research

It can be useful to have certain descriptive information about abnormal behavior—for example, the frequency of different forms of psychopathology among different socioeconomic classes, genders, ethnic groups, age groups, and so forth. Research aimed at getting this kind of information is called normative or **epidemiological research**. The study of the prevalence of depression in the New Haven area, cited earlier, is an example of this kind of research, as is the more current work of Kessler and his colleagues (Kessler, Chiu, et al., 2005; Kessler, Berglund, et al., 2005). Epidemiology often involves the study of the incidence of a disorder in a population (that is, the number of new cases within a specific period) or the prevalence of a disorder (that is, the number of people who show the disorder at any one time). The data produced by epidemiological research can provide important information about public health trends and risks across different elements of the population. Basic requirements for good epidemiological research, as well as for other kinds of research, are **random sampling** and the reliability and validity of measurement. Let us look at what is meant by these terms.

## 1.5c Sampling and Generalization

Weissman and Myers (1978), in their epidemiological study of depression, randomly sampled 1 out of every 14 households in the New Haven area and then randomly selected an adult from each household. Such an approach ensures that, within a certain range of chance variation, estimates of the incidence of depression will fairly accurately reflect the actual incidence in the larger population. Kessler and colleagues calculated 12-month and lifetime prevalence rates of different disorders from information collected in structured face-to-face interviews with a nationally representative sample of households, including over 9,200 persons (Kessler, Chiu, et al., 2005; Kessler, Berglund, et al., 2005). If these investigators had instead relied on statistics based on individuals who had sought treatment for mental disorders, their results would be incomplete due to the omission of untreated cases of depression.

The nature of the population randomly sampled is important in determining to what groups of people a given finding can be generalized. Thus, generalizations about the incidence of disorders can be safely made only to those populations that resemble the selected sample in terms of ethnic, socioeconomic, and other factors. Most research on psychopathology is not aimed at estimating rates of incidence in the general population; rather, it is aimed at understanding something about the nature or treatment of a given disorder. In this case, too, it is important to know to what populations the results can be generalized. Thus, Mosher and Menn (1978) assessed the effectiveness of a special treatment facility with schizophrenic patients. The patients used in this study were young, had not had more than one brief hospitalization previously, and were unmarried. Paul and Lentz (1977) evaluated the effectiveness of another approach to rehabilitating schizophrenic patients. Their patients averaged 45 years of age, had been hospitalized for an average of 17 years, and had recently been found unacceptable for transfer to an extended-care facility outside the hospital. Clearly, it cannot be assumed that results obtained in one of these studies can be generalized to the population of individuals sampled in the other study.

**Epidemiological research**
The study of the incidence of a disorder in a population

**Random sampling**
Selecting subjects by chance from some larger population

## 1.5d Reliability and Validity of Measurement

BVT Lab

Visit www.BVTLab.com to explore the student resources available for this chapter.

**Reliability** of measurement refers to the extent to which a measure consistently yields the same result on repeated trials. In physical measurements, reliability tends to be quite high. If several people measured the width of a table with a yardstick, their measurements would differ only by small amounts, perhaps 1/16 inch. Such a measure is highly reliable for most purposes, although for some endeavors, such as fine machine tool work, it would not be. Psychological measurement is never as precise as physical measurement. One reason for this imprecision is that when physical attributes (such as height or weight) are measured, we assess the entire domain of the attribute in question: We measure all of a person's height or all of a person's weight. The same is never true when we measure behavior; we can only sample a small part of the domain of how a person acts, thinks, or feels. To determine whether a person is depressed, for example, we must rely on reports of how that person feels most of the time, under most circumstances. All of us show variations in our psychological states, so the application of a diagnostic label is a judgment call. Therefore, diagnostic reliability is an important problem to consider in the measurement of abnormality.

One type of reliability that is particularly important in psychological research is **interobserver reliability**, or the extent to which different observers (or raters) agree on the way they categorize, or in some way quantify, a given observation. Suppose, for example, that an investigator wished to measure the aggressive behavior of mental patients. One method would be to count the instances of aggressive behavior among the patients. For this information to be useful, however, the investigator must demonstrate that two or more independent observers agree on their ratings or counts of aggression. Thus, it is usually necessary for observers to undergo preliminary training in which they practice making ratings until they can agree on which behaviors they are going to label a certain way—in this case, as aggressive. The careful researcher will always report in some fashion the degree of agreement between independent observers. Similarly, clinicians interviewing clients have been trained in the application of a diagnostic label; interobserver reliability is shown when the same patient receives a consistent diagnosis from two or more different clinicians.

**Reliability**
The extent to which a measure consistently yields the same results on repeated trials

**Interobserver reliability**
The extent to which different observers (or raters) agree on the way they categorize or in some way quantify a given observation

An assessment tool or method is valid if it measures what it purports to measure. When measuring certain clearly defined behaviors, such as the number of times a person talks to or hits another person, there is little problem of **validity**. The problem arises when one must, in order to obtain a measurement, make an inference about a psychological trait or process that is itself not directly definable in terms of specific, observable behaviors. If, for example, raters are asked to judge the degree of aggressiveness shown by a person, we want to know if the resulting score really measures aggression or something else. This is not always an easy issue to resolve. Ordinarily, the best procedure is to provide a detailed description of what observable behaviors were used to make an inference about aggression (such as hitting and verbal insults). When we define our target behavior in terms of how it is measured, we provide an **operational definition** of the behavior, which allows others to measure the target in the same way and thus compare results.

**Validity**
The extent to which a measure assesses what it is purported to assess

**Operational definition**
A definition of a target behavior in terms of how it is measured.

The problem of validity becomes especially acute when certain behaviors are considered "signs" of some underlying and unobservable process. For example, fear of small, enclosed places might be interpreted as a fear of death or excessive consumption of alcohol as a sign of fixation at the oral stage of development (see Chapter 3). Unobservable states or characteristics—such as oral fixations or dispositions to be hostile, fearful, and so on—are frequently referred to as **constructs**; and the term **construct validity** is used to refer to the degree to which an assessment measures the hypothetical construct that it claims to measure.

**Construct**
Hypothetical or theoretical concept that cannot be measured directly

**Construct validity**
The degree to which an assessment measures the hypothetical construct that it claims to measure

High reliability does not guarantee high validity. Two observers might agree that one person punching another lightly in the ribs indicated aggression, when in fact the behavior was meant in a friendly way. Similarly, clinicians might agree that a person's report of visual and auditory hallucinations points to a diagnosis of schizophrenia, but their agreement does not necessarily make it so. (Perhaps the person has recently ingested a drug, such as LSD, that

produces hallucinations.) Construct validity is usually determined by the way that a given measure relates to other measures and conditions. If a given measure of the construct "disposition to be aggressive" predicts aggressive behavior in other situations, and if subjects high on this measure show more aggression than those low on it, we would conclude that there is some positive evidence for the measure's construct validity.

Some psychologists have proposed that hypothetical constructs like "fixation at the oral stage" may help account for excessive drinking. (Shutterstock)

## 1.5e Correlational Research

Another method used to obtain knowledge about abnormal behavior is **correlational research**. In a correlational study, the investigator attempts to demonstrate an association or correlation between two or more measures. For example, people's height and weight tend to be correlated. If we measure these characteristics in 100 people, we would find, in general, that taller people are heavier. The correlation would not be perfect; some tall people would weigh less than some short people, but the general association would be positive. A descriptive statistic called the **correlation coefficient**, which varies between –1.00 and +1.00, is one way of quantifying the strength of the relationship. As the correlation coefficient moves closer to a perfect +1.00, the two measures move up or down together in a very predictable way. For example, as the weight of a vehicle increases, its fuel consumption increases as well; there is a strong positive correlation between weight and fuel use. A correlation coefficient approaching a perfect –1.00 indicates that as one measure increases, the other decreases in a very predictable way. For example, increasing income is negatively correlated with financial aid; as income goes up, aid goes down. A zero correlation indicates that two measures are not related in any predictable way; no association is apparent. A scatter plot graphically portrays the correlation between two measures.

Correlations can tell researchers something about the strength and direction of a relationship, but correlations do not demonstrate causation. In the 1950s, medical scientists began to find a correlation between cigarette smoking and lung cancer. Studies showed that the more cigarettes people smoked per day, the more likely they were to have lung cancer (Doll & Hill, 1954). The tobacco companies, their scientific zeal perhaps enhanced by the prospect of decreased profits, were quick to point out that such correlations did not prove that cigarette smoking caused lung cancer. They argued that it was quite possible that lung cancer and cigarette smoking were both influenced by some unknown third factor. For example, a person with certain physiological characteristics might be predisposed to both tobacco smoking and lung cancer. In such a case, it would not matter whether or not the person smoked since the occurrence of lung cancer would depend on the unknown physiological variable and not on smoking. Another possibility considered was that people experiencing chronic nervous tension were more likely to smoke and develop lung cancer and that lung cancer was caused by nervous tension, not smoking. As is frequently the case with correlational findings, one can go on at some length thinking up alternative explanations. In Figure 1-3, for example, we see scatter plots of correlations of different magnitudes between two variables, X and Y.

Correlational research, however, should not be discarded too lightly. It does make a difference whether there is a strong positive correlation or no correlation since a positive finding is consistent with the *possibility* of a causative relationship. No relationship, causative or otherwise, is likely to be associated with a zero correlation. It is possible, also, to rule out certain factors as the complete explanation (or cause) by controlling these factors. Thus, to return to the smoking example, we could divide our sample of cigarette smokers into a number of subgroups in which the individuals all show about the same amount of nervous tension—individuals very high in nervous tension would be in one group, those with moderate nervous

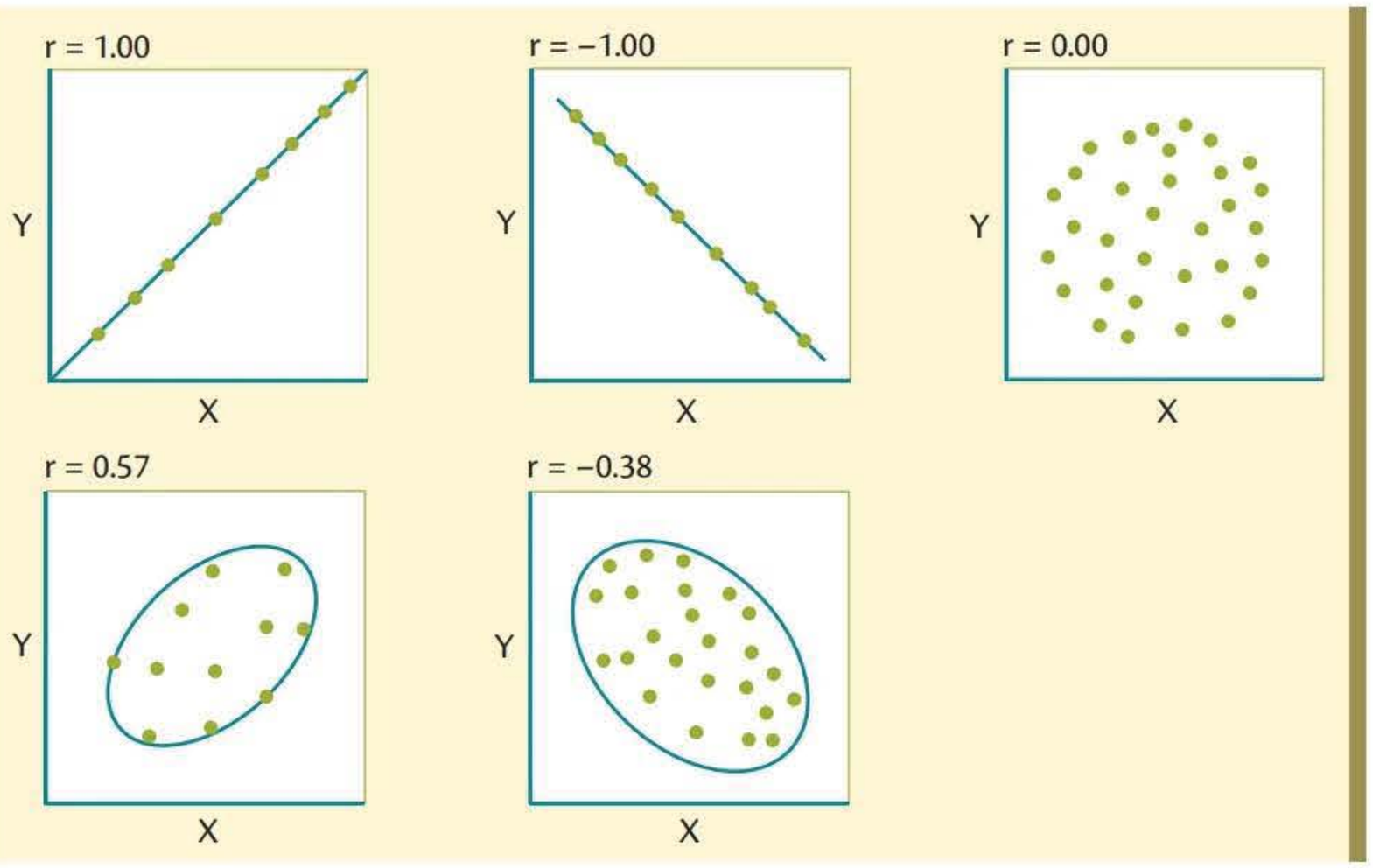
**Correlational research**
When the investigator attempts to demonstrate an association or correlation between two or more measurements

**Correlation coefficient**
A measure of the direction and strength of the relationship between variables

***Figure 1-3*** ***Scatter Plots Showing Correlations of Different Magnitudes Between Two Variables, X and Y***

Each person is represented by a point that reflects scores on the two dimensions. The correlation of +0.57, for example, could be the relationship between height and weight for a sample of 11 individuals.

Data from *Fundamentals of Behavioral Statistics, 2nd ed.*, by R. P. Runyon and A. Haber, 1971. Reading, MA: Addison-Wesley. Copyright 1971 by Addison-Wesley.




**Experimental method**
Research method in which conditions are manipulated in order to test the effects of manipulations on various measures

**Experimental group**
Group on which manipulation of interest is performed in an experimental design

**Control group**
Group that is treated similarly to the experimental group in an experimental design, except that no manipulation is performed

tension would be in another group, and so on. If one still found a correlation between smoking and lung cancer within each group of people who have the same degree of nervous tension, then it would be difficult to explain the correlation by this particular variable. The problem is that an unknown number of other variables might be contributing to the observed relationship. As for lung cancer and smoking, subsequent experimental research with animals—aided by correlational research that controlled for a number of other variables—has demonstrated that smoking, indeed, is a leading cause of lung cancer, as well as other serious diseases. The correlational research was valuable in leading to later, confirmatory experimental research that produced important information of great significance for public health.

Much of the subject matter of abnormal psychology must be studied by correlational methods for practical and ethical reasons. For example, we cannot ethically manipulate brain neurochemistry or family environments in an effort to produce schizophrenic offspring. If we are aware of and can avoid the interpretive pitfalls associated with correlational research, a great deal of understanding can be achieved by this method.

Although preliminary studies did show a correlation between lung cancer and the number of cigarettes smoked per day, the correlation alone did not prove causation. (Shutterstock)

## 1.5f Experimental Research

The most powerful way of shedding light on factors that affect human behavior is the **experimental method**. The essence of the psychological experiment is that the people to be studied are randomly assigned to two or more groups—in the simplest case, to an **experimental group** and a **control group**. The experimental group experiences some special condition (a manipulation or treatment), while the control group does not. The logic of this approach is that