DEBORAH C.
BEIDEL
CYNTHIA M.
BULIK
MELINDA A.
STANLEY

abnormal psychology

third edition

DSM 5

abnormal psychology

third edition

DEBORAH C.
BEIDEL
University of Central Florida

CYNTHIA M.
BULIK
University of North Carolina at Chapel Hill

MELINDA A.
STANLEY
Baylor College of Medicine

PEARSON

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

To our parents
Anthony and Jean Casamassa
Frank and Marie Bulik
Pat and Bob Stanley
Thank you for teaching us the value of education
and for providing the love and encouragement
that allowed us to achieve our dreams.

Senior Acquisitions Editor: Erin Mitchell
Editorial Assistant: Sarah Henrich
VP, Director of Marketing: Brandy Dawson
Senior Marketing Manager: Jeremy Intal
Marketing Assistant: Frank Alarcon
Director of Development: Sharon Geary
Development Editor: Amber Mackey
Director of Production: Lisa Iarkowski
Senior Managing Editor: Linda Behrens
Project Manager: Shelly Kupperman
Program Manager: Annemarie Franklin
Operations Supervisor: Mary Fischer
Operations Specialist: Diane Peirano
Creative Design Director: Leslie Osher
Interior/Cover Design: DeMarinis Design LLC
Digital Media Editor: Tom Scalzo
Digital Media Project Manager: Pam Weldin
Full-Service Project Management: Lindsay Bethoney, PreMediaGlobal
Printer/Binder: R. R. Donnelley and Sons
Cover Printer: Lehigh-Phoenix Color/Hagerstown
Text Font: 10.5/13, Adobe Garamond Pro

Library of Congress Cataloging-in-Publication Data

Beidel, Deborah C.
Abnormal psychology / Deborah C. Beidel, Cynthia M. Bulik, Melinda A. Stanley. -- Third Edition.
pages cm
Includes bibliographical references and index.
ISBN 978-0-205-96654-7
1. Psychology, Pathological. I. Bulik, Cynthia M. II. Stanley, M. A. (Melinda Anne) III. Title.
[DNLM: 1. Mental Disorders—psychology. 2. Psychopathology—methods.]
RC454.B428 2013
616.89—dc23

2013019288

10 9 8 7 6 5 4 3 2 1

Student Edition
ISBN-10: 0-205-96654-3
ISBN-13: 978-0-205-96654-7
Books à la Carte
ISBN-10: 0-205-96681-0
ISBN-13: 978-0-205-96681-3

PEARSON

brief contents

contents

preface

When the first edition was introduced, we wondered whether instructors and students would perceive the need for a new textbook, and we were pleased to find so many people who resonated with the scientist-practitioner approach. Abnormal psychology remains one of the most popular courses among undergraduate students as national and world events drive us to try to understand human behavior and the forces that shape and act on it. What factors drive someone to take a gun and shoot a member of the U.S. Congress? How could a celebrity, who seemingly has everything—wealth, family, fame—shoplift a $50.00 item of jewelry? The answers to these questions do not come easily as we see simplistic answers such as "the measles vaccine causes autism," a theory first accepted and now completely discredited.

The third edition of this textbook is another opportunity for students to see science in action. Prompted by the revision of the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), students will be exposed to the ever-changing nature of our understanding of human behavior, as research has shed new light on disorders, forced scientists and clinicians to grapple with disparate data sets and to work together to produce what is hopefully a scientific and clinically meaningful system for understanding and communicating about abnormal behavior. Because the DSM-5 has just been introduced, there are some areas of abnormal behavior where the science has not yet caught up to the new criteria and in some cases, the new diagnoses. This is particularly relevant in those chapters where revisions to the diagnostic criteria were extensive. The new criteria are there but epidemiological data for the new disorders are not available—researchers simply have not had time to conduct new studies using the new criteria. In those instances, we rely on the published data based on the DSM-IV categories, while giving appropriate caveats about the need for more research.

Despite the changing criteria, understanding human behavior requires integration of brain *and* behavior, data from scientists, *and* insights from clinicians and patients. As in the first two editions, a scientist-practitioner approach integrates biological data with research from social and behavioral sciences to foster the perspective that abnormal behavior is complex and subject to many different forces. Furthermore, these variables often interact in a reciprocal fashion. Psychotherapy was built in part on the assumption that behavior could be changed by changing the environment, but science has now shown us that environmental factors can also change the brain. Scientific advances in molecular genetics have expanded our understanding of how genes influence behavior. Virtual reality treatment systems have provided new insights, raised new questions, and unlocked new areas of exploration. As this third edition illustrates, we remain firm in our conviction that the integration of leading-edge biological and behavioral research, known as the *translational approach*, or *from bench to bedside*, is needed to advance the study of abnormal psychology. As we did in previous editions, we reach beyond the old clichés of nature or nurture, clinician or scientist, genes or environment, and challenge the next generation of psychologists and students to embrace the complexity inherent in replacing these historical "ors" with contemporary "ands."

What's New in the Third Edition

- **Complete DSM-5 Revisions:** Updated to thoroughly reflect the new DSM-5, including relevant organizational changes in some chapters.
- **DSM-5 diagnostic criteria tables:** All diagnostic criteria tables have been revised to reflect any changes in the DSM-5.
- **Coverage of disorders expanded to include the following, based on their inclusion in DSM-5:** Premenstrual Dysphoric Disorder, Binge Eating Disorder, Hoarding Disorder, Excoriation Disorder, Illness Anxiety Disorder, Gender Dysphoria, Autism Spectrum Disorder, Substance Use Disorder, Compulsive Gambling added to Addiction and Related Disorders, and others.
- **New and updated content throughout, including many new topics for these special features:** "Real People, Real Disorders," "Examining the Evidence," and "Research Hot Topic" and a new feature, "Real Science: Real Life."
- **Current research:** Hundreds of new research citations throughout reflect the ever-advancing field of abnormal psychology.
- **QR Codes:** Use of QR codes students can use to access sample video case vignettes on their smartphones or computers.

The Scientist-Practitioner Model

We subtitled this book *A Scientist-Practitioner Approach* because we know that understanding abnormal psychology rests on knowledge generated through scientific studies and clinical practice. Many psychologists are trained in the scientist-practitioner model and adhere to it to some degree in their professional work. We live and breathe this model. In addition to our roles as teachers at the undergraduate, graduate, and postdoctoral levels, we are all active clinical researchers and clinical practitioners. However, the scientist-practitioner model means more than just having multiple roles; it is a philosophy that guides all of the psychologist's activities. Those who are familiar with the model know this quote well: "Scientist-practitioners embody a research orientation in their practice and a practice relevance in their research" (Belar & Perry, 1992). This philosophy reflects our guiding principles, and we wrote this text to emphasize this

rich blend of science and practice. Because we are scientist-practitioners, all of the cases described throughout this text are drawn from our own practice with the exception of a few quotations and newspaper stories designed to highlight a specific point. We have endeavored to "bring to life" the nature of these conditions by providing vivid clinical descriptions. In addition to the clinical material that opens each chapter and the short clinical descriptions that are used liberally throughout each chapter, a fully integrated case study drawn from one of our practices is presented at the end of each chapter, again illustrating the interplay of biological, psychosocial, and emotional factors. Of course, details have been changed and some cases may represent composites in order to protect the privacy of those who have shared their life stories with us throughout our careers.

The goal of our textbook is to avoid a dense review of the scientific literature but to maintain a strong scientific focus. Similarly, we wanted to avoid "pop" psychology, an overly popularized approach that we believe presents easy answers that do not truly reflect the essence of the psychological disorders we cover. Having now used the book with our own undergraduate classes, we find that students respond positively to material and features that make these conditions more understandable and vivid. Our goal is to "put a face" on these sometimes perplexing and unfamiliar conditions by using rich clinical material such as vignettes, case histories, personal accounts, and the feature "Real People, Real Disorders." We hope that these illustrations will entice students to learn more about abnormal psychology while acquiring the important concepts. Thus, although the book represents leading-edge science, our ultimate goal is to portray the human face of these conditions.

A Developmental Trajectory

It has become increasingly clear that many types of abnormal behaviors either begin in childhood or have childhood precursors. Similarly, without treatment, most disorders do not merely disappear with advancing age and, in fact, new disorders may emerge. Quite simply, as we grow, mature, and age, our physical and cognitive capacities affect how symptoms are expressed. Without this developmental perspective, it is easy to overlook important clues that indicate the presence of a specific disorder at a particular phase of life. We are proud that we embraced this concept before its introduction in the DSM-5. Failure to understand the various manifestations of a disorder means that theories of etiology may be incorrect or incomplete, and that interventions may be inappropriately applied. Now that DSM-5 has shifted to a developmental focus, students and instructors will find that certain disorders are not in the same chapters in which they were in previous editions. In each chapter where we discuss psychological disorders, we also include a section called "Developmental Considerations," which highlights what is known about the developmental trajectory of each condition. In the margins of those pages, you will find the developmental trajectory icons, which indicate that important developmental features are discussed in that paragraph.

Sex, Race, and Ethnicity

In each chapter, we describe the current literature regarding the effect of sex, race, or ethnicity on a disorder's clinical presentation, etiology, and treatment. We carefully considered the terms used in the text to refer to these concepts. Indeed, the terms used to refer to *sex*, *gender*, *race*, and *ethnicity* are continually evolving, and the words that we use vary throughout the text. When we describe a particular study, we retain the labels that were used in the publication (e.g., Afro-Caribbean, Caucasian, Pacific Islander). To create some consistency throughout the text, when we discuss general issues regarding race and ethnicity, we use standard terms (e.g., whites, African Americans, Hispanics). Although we are admittedly uncomfortable with calling groups by any labels, whether they refer to race, ethnicity, or diagnosis (e.g., blacks, whites, schizophrenics), for clarity of presentation and parsimony in the case of race and ethnicity, we opted for these categorical labels rather than the more cumbersome "individuals of European-American ancestry" approach. Throughout the book, however, we have not labeled individuals who have psychological disorders by their diagnosis because people are far more rich and complex than any diagnostic label could ever capture. Moreover, referring to a patient or patient group by a diagnostic label (e.g., bulimics, depressives, schizophrenics) is fundamentally disrespectful. People have disorders, but their disorders do not define them.

Ethics and Responsibility

In this edition, we continue our newest feature titled "Ethics and Responsibility." The discussion of ethics and responsibility varies with respect to the individual chapter, but in each case, we have attempted to select a topic that is timely and illustrates how psychologists consider the impact of their behavior on those with whom they work and on society in general. We hope that this feature will generate class discussion and impress on students the impact of one's behavior upon others.

Clinical Features

Consistent with our belief that the clinical richness of this text will bring the subject matter to life, each chapter begins with a clinical description that introduces and illustrates the topic of the chapter. These descriptions are not necessarily extensive case studies but provide the reader a global "feel" for each disorder. Additionally, small case vignettes are used liberally throughout the text to illustrate specific clinical elements. Another important clinical element is the "Side by Side Case Studies," in which we illustrate the differences between typical human emotions (such as elation) and abnormal behavior (such as mania). We included

these descriptions in each chapter devoted to an area of abnormal behavior to emphasize that the difference between normal emotions and what we call *psychological disorders* is not simply the presence of emotion or specific behavior but whether the behavior creates distress or impairs daily functioning.

Each chapter discussion concludes with a case study "Real Science, Real Life," a clinical presentation, assessment, and treatment of a patient with a particular disorder, again drawn from our own clinical files. Each concluding case study illustrates much of the material covered in the chapter and uses the scientist-practitioner approach to understanding, assessing, and treating the disorder. Furthermore, this concluding case study demonstrates how the clinician considers biological, psychological, environmental, and cultural factors to understand the patient's clinical presentation. Finally, we describe the treatment program and outcome, highlighting how all of the factors are addressed in treatment. Through this process, the case study allows the student to view "firsthand" the scientist-practitioner approach to abnormal behavior, dispelling myths often propagated through the media about how psychologists think, work, and act.

Special Features

We draw the reader's attention to three specific features that appear in each chapter. The first, "Examining the Evidence," presents a current controversy related to the disorder under study in the chapter. However, we do not simply present the material; rather, to be consistent with the scientist-practitioner focus, we present both sides of the controversy and lead students through the data, allowing them to draw their own conclusions. Thus, "Examining the Evidence" features do not just present material but also foster critical thinking skills about issues in abnormal psychology. By considering both sides of the issues, students will become savvy consumers of scientific literature.

The second feature is "Research Hot Topic," which presents topical, leading-edge research at the time of publication. Consistent with the focus of this text, the "Research Hot Topic" features illustrate how science informs our understanding of human behavior in a manner that is engaging to students (e.g., "Virtual Reality Therapy for the Treatment of Anxiety Disorders"). As teachers and researchers who open our clinical research centers to undergraduate students, we know that many students think research is "dull." What they discover by participating in our research programs, and what students reading this text will discover, is that research is exciting.

The third feature, "Real People, Real Disorders," presents a popular figure who has suffered from the disorder discussed in the chapter. As we indicated in Chapter 1, although many people, including undergraduate students, suffer from these disorders, they often feel that they are alone or "weird." We wanted to break down the stereotypes that many undergraduate students have about people with psychological disorders. Using well-known figures to humanize these conditions allows students to connect with the material on an emotional, as well as an intellectual, level.

Intermediate and End-of-Chapter Reviews

Finally, we would like to draw the reader's attention to the "Concept Checks" that are found throughout the chapter as well as the "Test Yourself" sections at the end of each chapter. The "Concept Checks" provide quick reviews at the end of chapter sections, allowing students to be sure that they have mastered the material before proceeding to the next section. Instructors can use the "Concept Checks" and "Critical Thinking Questions" to challenge students to think "outside the box" and critically examine the material presented within that section. The "Test Yourself" provides another opportunity for students to review and master the material using the format that they will most likely find on their class examinations.

Supplemental Teaching Materials

MyPsychLab for Abnormal Psychology

MyPsychLab is an online homework, tutorial, and assessment program that truly engages students in learning. It helps students better prepare for class, quizzes, and exams—resulting in better performance in the course. It provides educators a dynamic set of tools for gauging individual and class performance. To order the third edition with MyPsychLab, use ISBN 0205968244.

SPEAKING OUT: INTERVIEWS WITH PEOPLE WHO STRUGGLE WITH PSYCHOLOGICAL DISORDERS

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

Volume 1: ISBN 0-13-193332-9
Volume 2: ISBN 0-13-600303-6
Volume 3: ISBN 0-13-230891-6

INSTRUCTOR'S MANUAL (0205978428)

A comprehensive tool for class preparation and management, each chapter includes a chapter-at-a-glance overview; key terms; teaching objectives; a detailed chapter outline including lecture starters, demonstrations and activities, and handouts; a list of

references, films and videos, and web resources; and a sample syllabus. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

TEST BANK (0205978452)

The Test Bank has been rigorously developed, reviewed, and checked for accuracy to ensure the quality of both the questions and the answers. It includes fully referenced multiple-choice, true/false, and concise essay questions. Each question is accompanied by a page reference, difficulty level, skill type (factual, conceptual, or applied), topic, and a correct answer. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

MyTest (0205978460)

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

LECTURE POWERPOINT SLIDES (0205979645)

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

ENHANCED LECTURE POWERPOINT SLIDES WITH EMBEDDED VIDEOS ON DVD (0205978436)

The lecture PowerPoint slides have been embedded with select Speaking Out video pertaining to each disorder chapter, enabling instructors to show videos within the context of their lecture. No Internet connection is required to play videos.

POWERPOINT SLIDES FOR PHOTOS, FIGURES, AND TABLES (0205979661)

These slides contain only the photos, figures, and line art from the textbook. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

CourseSmart

Learn Smart. Choose Smart.

CourseSmart Textbooks Online is an exciting choice for students looking to save money. As an alternative to purchasing the print textbook, students can subscribe to the same content online and save up to 60% off the suggested list price of the print text. With a CourseSmart eTextbook, students can search the text, make notes online, print out reading assignments that incorporate lecture notes, and bookmark important passages for later review. For more information or to subscribe to the CourseSmart eTextbook, visit www.coursesmart.com.

Acknowledgments

As we wrote in the first edition, this book began with the vision of our mentor and friend, Samuel M. Turner, Ph.D. He was the one who believed that the book could be written, convinced us to write it with him, and contributed substantially to the initial book prospectus. The success of the first edition surprised us, but we often felt that Sam would have just looked at us and said, "I told you so." We hope this edition continues to honor him and his lasting influence on us.

We met Sam and each other more than 20 years ago when the three of us were in various stages of graduate training under his tutelage at Western Psychiatric Institute and Clinic (WPIC), University of Pittsburgh School of Medicine. We want to thank David Kupfer, M.D., who was Director of Research at WPIC at that time, for creating the cross-disciplinary and fertile research environment that allowed us to learn and grow. We are also grateful to the other scientist-practitioners who mentored us at various stages of our undergraduate and graduate careers: Alan Bellack, Michel Hersen, Stephen Hinshaw, Alan Kazdin, and Sheldon Korchin.

Second, we want to thank our editor, Erin Mitchell, for her enthusiasm, support, and good humor. Her understanding of all of our other time commitments kept this revision on time and (almost) stress free—well at least for us—Erin may still be recovering. To Amber Mackey, Lindsay Bethoney, Shelly Kupperman, and Kate Cebik who put up with our attempts (and sometimes successes) to make deadlines, thank you. To Nicole Kunzman Orrechio, who has been with us from the start and has become a dear friend—your first-class professionalism and devotion to our textbook is unbelievable. Thanks also to Anne DeMarinis, our book designer, who continues to amaze us with her uncanny ability to visually translate our words into pictures. Every time we looked at a chapter opener, we used the words "visionary," "magnificent," and "cool." A special thank you to Sandra Neer, Ph.D. for carefully reading each final chapter.

Third, a big thank you goes to our students, colleagues, and friends who listened endlessly, smiled supportively, and waited patiently as we said once again "next month will be easier."

Fourth, we thank our patients and their families whose life journeys or bumps along life's road we have shared. Good psychologists never stop learning. Each new clinical experience adds to our knowledge and understanding of the illnesses we seek to treat. We thank our patients and families for sharing their struggles and their successes with us and for the unique opportunity to learn from their experience. It is an honor and a privilege to have worked with each of you.

Fifth, our thanks go to our spouses, Ed Beidel, Patrick Sullivan, and Bill Ehrenstrom, children (Brendan, Emily, Natalie, Brendan, and Jacob), and families who celebrate the publication of each edition with us and smiled

understandingly when we tell them we have to start on the next edition.

As authors, each of us feels enormous gratitude to our coauthors for their tireless work, unending support and friendship, and dedication to this project. Abnormal psychology is a broad topic, requiring ever-increasing specialization. Having colleagues who share an orientation but possess distinct areas of expertise represents a rare and joyful collaborative experience.

Finally, we hope the students and instructors who used the first and second editions and who will use this new text experience the joy and wonder that comes with learning about the challenging and intriguing topic of abnormal psychology. We are passionate about our science and compassionate with our patients. We are also dedicated educators. As such, we encourage you to contact us with comments, questions, or suggestions on how to improve this book. No textbook is perfect, but with your help, we will continue to strive for that goal.

Text and Content Reviewers

We would like to thank the following colleagues who reviewed this text at various stages and gave us a great many helpful suggestions: Bethann Bierer, Metropolitan State College of Denver; Andrew Corso, University of Pennsylvania; Joseph Davis, California State University System; Jim Haugh, Rowan University; Rob Hoff, Mercyhurst College; Robert Intrieri, Western Illinois University; Jennifer Katz, SUNY College at Geneseo; Lynne Kemen, Hunter College; Jennifer Langhinrichsen-Rohling, University of South Alabama; Robert Lawyer, Delgado Community College; Barbara Lewis, University of West Florida; Freda Liu, Arizona State University; Joseph Lowman, U. North Carolina at Chapel Hill; Kristelle Miller, University of Minnesota Duluth; Anny Mueller, Southwestern Oregon Community College; Edward O'Brien, Marywood University; Lauren Polvere, Concordia University (full time) and Clinton Community College (adjunct); Karen Rhines, Northampton Community College; Rachel Schmale, North Park University; Marianne Shablousky, Community College of Allegheny County; Mary Shelton, Tennessee State University; Nancy Simpson, Trident Technical College; George Spilich, Washington College; Mary Starke, Ramapo College of NJ; David Steitz, Nazareth College; Melissa Terlecki, Cabrini College; David Topor, Harvard Medical School.

Focus Group Participants

Thank you to the following professors for participating in a focus group: David Crystal, Georgetown University; Victoria Lee, Howard University; Jeffrey J. Pedroza, Santa Ana College; Grace Ribaudo, Brooklyn College; Brendan Rich, Catholic University of America; Alan Roberts, Indiana University; David Rollock, Purdue University. David Topor, Harvard Medical School.

about the authors

Deborah C. BEIDEL

received her B.A. from the Pennsylvania State University and her M.S. and Ph.D. from the University of Pittsburgh, completing her predoctoral internship and postdoctoral fellowship at Western Psychiatric Institute and Clinic. Before joining the faculty at the University of Central Florida where she is Pegasus Professor of Psychology and Medical Education and the Director of the Center for Trauma, Anxiety, Resilience and Prevention (C-TARP), she was on the faculty at the University of Pittsburgh, Medical University of South Carolina, University of Maryland—College Park, and Penn State College of Medicine-Hershey Medical Center. Currently, she holds American Board of Professional Psychology (ABPP) Diplomates in Clinical Psychology and Behavioral Psychology and is a Fellow of the American Psychological Association, the American Psychopathological Association, and the Association for Psychological Science. She is Chair-elect of the Council for University Directors in Clinical Psychology (CUDCP), a past Chair of the American Psychological Association's Committee on Accreditation, the 1990 recipient of the Association for Advancement of Behavior Therapy's New Researcher Award, and the 2007 recipient of the Samuel M. Turner Clinical Researcher Award from the American Psychological Association. While at the University of Pittsburgh, Dr. Beidel was twice awarded the "Apple for the Teacher Citation" by her students for outstanding classroom teaching. In 1995, she was the recipient of the Distinguished Educator Award from the Association of Medical School Psychologists. She is editor in chief of the *Journal of Anxiety Disorders*, author of over 230 scientific publications, including journal articles, book chapters, and books, including *Childhood Anxiety Disorders: A Guide to Research and Treatment* and *Shy Children, Phobic Adults: The Nature and Treatment of Social Anxiety Disorder*. Her academic, research, and clinical interests focus on child, adolescent, and adult anxiety disorders, including their etiology, psychopathology, and behavioral interventions. Her research is characterized by a developmental focus, and includes high-risk and longitudinal designs, psychophysiological assessment, treatment development, and treatment outcome. She is the recipient of numerous grants from the Department of Defense, the National Institute of Mental Health and the Autism Speaks Foundation. At the University of Central Florida, she teaches abnormal psychology at both the undergraduate and graduate level.

Cynthia M. BULIK

is the Distinguished Professor of Eating Disorders in the Department of Psychiatry in the School of Medicine at the University of North Carolina at Chapel Hill, where she is also Professor of Nutrition in the Gillings School of Global Public Health, Director of the UNC Center of Excellence for Eating Disorders, and Co-Director of the UNC Center for Psychiatric Genomics. A clinical psychologist by training, Dr. Bulik has been conducting research and treating individuals with eating disorders since 1982. She received her B.A. from the University of Notre Dame and her M.A. and Ph.D. from the University of California, Berkeley. She completed internships and postdoctoral fellowships at the Western Psychiatric Institute and Clinic in Pittsburgh, Pennsylvania. She developed outpatient, partial hospitalization, and inpatient services for eating disorders both in New Zealand and the United States. Her research has included treatment, laboratory, epidemiological, twin, and molecular genetic studies of eating disorders and body weight regulation. She integrates technology into treatment for eating disorders and obesity in order to broaden the public health reach of interventions. She is the Director of the first NIMH-sponsored Post-Doctoral Training Program in Eating Disorders. She has active research collaborations in 21 countries around the world. Dr. Bulik has written over 450 scientific papers and chapters on eating disorders and is author of the books *Eating Disorders: Detection and Treatment* (Dunmore), *Runaway Eating: The 8 Point Plan to Conquer Adult Food and Weight Obsessions* (Rodale), and *Crave: Why You Binge Eat and How to Stop, The Woman in the Mirror: How to Stop Confusing What You Look Like with Who You Are, and Midlife Eating Disorders: Your Journey to Recovery* (Walker). She is a recipient of the Eating Disorders Coalition Research Award, the Hulka Innovators Award, the Academy for Eating Disorders Leadership Award for Research, the Price Family National Eating Disorders Association Research Award, the Carolina Women's Center Women's Advocacy Award, the Women's Leadership Council Faculty-to-Faculty Mentorship Award, and the Academy for Eating Disorders Meehan-Hartley Advocacy Award. She is a past President of the Academy for Eating Disorders, past Vice-President of the Eating Disorders Coalition, and past Associate Editor of the *International Journal of Eating Disorders*. Dr. Bulik holds the first endowed professorship in eating disorders in the United States. She balances her academic life by being happily married with three children and a competitive ice dancer.

Melinda A. STANLEY

is Professor and Head of the Division of Psychology in the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine. She holds The McIngvale Family Chair in Obsessive Compulsive Disorder Research and a secondary appointment as Professor in the Department of Medicine. Dr. Stanley is a clinical psychologist and senior mental health services researcher within the Health Services Research and Development Center of Excellence, Michael E. DeBakey Veterans Affairs Medical Center, Houston, and an affiliate investigator for the South Central Mental Illness Research, Education, and Clinical Center (MIRECC). Before joining the faculty at Baylor, she was Professor of Psychiatry at the University of Texas Health Science Center at Houston, where she served as Director of the Psychology Internship program. Dr. Stanley completed an internship and postdoctoral fellowship at Western Psychiatric

Institute and Clinic, University of Pittsburgh School of Medicine. She received a Ph.D. from Texas Tech University, an M.A. from Princeton University, and a B.A. from Gettysburg College, where she was a Phi Beta Kappa and summa cum laude graduate. Dr. Stanley's research interests involve the identification and treatment of anxiety and depressive disorders in older adults. Her current focus is on expanding the reach of services for older people into primary care and underserved communities where mental health needs of the older people often remain unrecognized and undertreated. In these settings, the content and delivery of care require modifications to meet cultural, cognitive, sensory, and logistic barriers. Some of Dr. Stanley's work in this domain includes the integration of religion and spirituality into therapy to enhance engagement in care for traditionally underserved groups. Dr. Stanley and her colleagues have been awarded continuous funding from the National Institute of Mental Health (NIMH) for 14 years to support her research in late-life anxiety. In 2008, Dr. Stanley received the Excellence in Research Award from the South Central MIRECC. In 2009, she received the MIRECC Excellence in Research Education Award. She has received numerous teaching awards and has served as mentor for five junior faculty career development awards. Dr. Stanley is a Fellow of the American Psychological Association, and she has served as a regular reviewer of NIMH grants. She is the author of over 150 scientific publications, including journal articles, book chapters, and books.

chapter 1

abnormal psychology

historical and modern perspectives

learning objectives

At the end of this chapter, you should be able to:

1.1
Explain the difference between behaviors that are different, deviant, dangerous, and dysfunctional.

1.2
Identify at least two factors that need to be considered when determining whether a behavior is abnormal.

1.3
Discuss spiritual/religious, biological, psychological, and sociocultural theories of the origins of abnormal behavior in their historical context.

1.4
Discuss the scientist–practitioner model of abnormal psychology.

1.5
Describe the modern biological, psychological, sociocultural, and biopsychosocial perspectives on the origins of abnormal behavior.

Steve was a member of the United States Marine Corps who served during the Vietnam War. He spent a year on patrol, constantly on the lookout for the enemy. One night, the Viet Cong attacked his squad. During the firefight, the Marine next to him lost his arm. Steve got his buddy to the medic, but the horrific image never left him. He felt helpless and out of control. After returning from Vietnam, Steve had difficulty sleeping, lost interest in his hobbies, isolated himself from family and friends, and felt helpless and sad. Even 45 years later, he can still see himself in the rice paddy, watching in horror as the grenade hits his friend, amputating his arm. Every night he wakes in yet another cold sweat and with a racing heart—unable to breathe, as the nightmare occurs again. Steve cannot watch fireworks—he breaks out in a cold sweat and feels dizzy. He drops to the ground at the sound of a helicopter, reacting as if he were again under attack. He sleeps only 4 hours a night. Although employed for many years, he had many interpersonal conflicts with coworkers and his boss, and recently he was forced into early retirement. He has no friends except for his immediate family and other veterans who served in Vietnam.

Malcom is 9 years old. He lived in New Orleans with his family. They did not have a lot of money, but there was always food and a roof over their heads. At school, Malcom was an average and well-behaved student. One day Hurricane Katrina ripped through town. Malcom's family thought they were safe—the floodwalls would protect them. But they were wrong. Trapped in their house, they escaped to the attic. Luckily, his father grabbed an axe and cut a hole through the roof. After 8 hours, soaking wet and hungry, they were rescued by a helicopter and taken to the convention center. The situation was not much better there. People were sick and desperate. Malcom saw a dead body inside the convention center. Finally, they were able to get to another state where they had relatives so they could start their lives over. But Malcom has had difficulties adjusting. He has nightmares about once again being on the roof or in the convention center. He cries when he hears a helicopter. When the news media forecasts a hurricane, he cries and begs his parents to move to "Iowa—they don't have hurricanes in Iowa." His grades have slipped, he has difficulty making friends, and he often refuses to go to school. He will not sleep in his room, insisting that he has to sleep with his parents or his older brother.

Rosa is a freshman in college. She is seeking treatment because she has been feeling anxious and depressed and experiencing chest pain and breathing problems. When she was 6 years old, her family crossed the Mexican border to reach the United States. During the crossing, Rosa was sexually molested by the *coyote*—the man who helped the family navigate the border crossing. Her family settled in New York to live the American dream. One year later, both parents, who were working as janitorial staff inside the World Trade Center, were killed in the 9/11 attack. Rosa went to live with her aunt, who assisted her in obtaining U.S. citizenship via a special visa that is granted for someone who was a victim of a crime. Over the years, Rosa grew up as a shy and very intelligent person. Her transition to college was difficult, especially because she had to move to another city. It was the first time she had to be separated from her aunt since her parents' death. She has been having difficulty concentrating and has started to miss classes when feeling depressed and anxious. She gets panicky feelings and premonitions that something bad might happen to her aunt. Occasionally she runs out of class to call to check on her aunt.

The physical, cognitive, and behavioral symptoms that Steve, Malcom, and Rosa displayed represent common mental health problems. These behaviors are considered abnormal because most people do not run out of class to check on someone, and they sleep more than 4 hours a night. Most children do not cry when they hear a helicopter. Although often unrecognized, psychological disorders exist in substantial numbers of people across all ages, races, ethnic groups, cultures, and in both sexes. Furthermore, they cause great suffering and impair academic, occupational, and social functioning.

Defining abnormality is challenging because behaviors must be considered in context. For example,

> Donna and Matthew were very much in love. They had been married for 25 years and often remarked that they were not just husband and wife but also best friends. Then Matthew died suddenly, and Donna felt overwhelming sadness. She was unable to eat, cried uncontrollably at times, and started to isolate herself from others. Her usually vivacious personality disappeared.

When a loved one dies, feelings of grief and sadness are common, even expected. Donna's reaction at her husband's death would not be considered abnormal; rather, its *absence* at such a time might be considered abnormal. A theme throughout this book is that *abnormal behavior must always be considered in context*.

Normal vs. Abnormal Behavior

Sometimes it's fairly easy to identify behavior as abnormal, as when someone is still deeply troubled by events that happened 45 years ago or is feeling so hopeless that he or she cannot get out of bed. But sometimes identifying behavior as abnormal is not clear-cut. Put simply, *abnormal* means "away from normal," but that is a circular definition. By this standard, normal becomes the statistical average and any deviation becomes "abnormal." For example, if the average weight for a woman living in the United States is 140 pounds, then women who weigh less than 100 pounds or more than 250 pounds deviate significantly from the average. Their weight would be considered abnormally low or high. For abnormal psychology, defining abnormal behavior as merely being away from normal assumes that deviations on both sides of average are negative and in need of alteration or intervention. This assumption is often incorrect. Specifically, we must first ask whether simply being different is abnormal.

Is Being Different Abnormal?

Many people deviate from the average in some way. Yao Ming is 7 feet 5 inches tall and weighs 295 pounds—far above average in both height and weight. However, his deviant stature does not affect him negatively. To the contrary, he was a successful and highly paid

Yao Ming, Mariah Carey, and Stephen Hawking differ from most people (in height, vocal range, and intelligence, respectively). However, these differences are not abnormalities and have resulted in positive contributions to society.

basketball player in the National Basketball Association. Mariah Carey has an abnormal vocal range—she is one of a few singers whose voice spans five octaves. Because of her different ability, she has sold millions of songs. Professor Stephen Hawking, one of the world's most brilliant scientists, has an intellectual capacity that exceeds that of virtually everyone else, yet he writes best-selling and popular works about theoretical physics and the universe and appears on popular television shows like The Big Bang Theory. He does this despite suffering from amyotrophic lateral sclerosis (ALS, also known as *Lou Gehrig's disease*), a debilitating and progressive neurological disease. Each of these individuals has abilities that distinguish him or her from the general public; that is, they are away from normal. However, their "abnormalities" (unusual abilities) are not negative; rather, they result in positive contributions to society. Furthermore, their unusual abilities do not cause distress or appear to impair their daily functioning (as appears to be the case for Steve, Malcom, and Rosa). In summary, being different is not the same as being psychologically abnormal.

Is Behaving Deviantly (Differently) Abnormal?

When the definition of abnormal behavior broadens from simply *being* different to *behaving* differently, we often use the term *deviance*. Deviant behaviors differ from prevailing societal standards.

On February 9, 1964, four young men from Liverpool, England, appeared on *The Ed Sullivan Show* and created quite a stir. Their hair was "long," their boots had "high (Cuban) heels," and their "music" was loud. Young people loved them but their parents were appalled.

The Beatles looked, behaved, and sounded deviant in the context of the prevailing cultural norms. In 1964, they were considered outrageous. Today their music, dress, and behavior appear rather tame. Was their behavior abnormal? They looked different and acted differently, but their looks and behavior did no harm to themselves or others. The same behavior, outrageous and different in 1964 but tame by today's standards, illustrates an important point, *deviant behavior* violates societal and cultural norms, but those norms are always changing.

Derek is 7 years old. From the time he was an infant, he was always "on the go." He has a hard time paying attention and has boundless energy. His parents compensate for his high level of energy by involving him in lots of physical activities (soccer, Tiger Cub Scouts, karate). Derek had an understanding first-grade teacher. Because he could not sit still, the teacher accommodated him with "workstations" so that he could move around the classroom. But now Derek is in second grade, and the new teacher does not allow workstations. She believes that he must learn to sit like all the other children. He visits the principal's office often for "out-of-seat behavior."

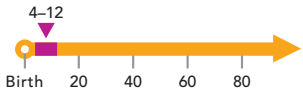
Understanding behavior within a specific context is known as **goodness of fit** (Chess & Thomas, 1991). Simply put, a behavior can be problematic or not problematic depending on the environment in which it occurs. Some people change an environment to accommodate a behavior in the same way that buildings are modified to assure accessibility by everyone. Derek's situation illustrates the goodness-of-fit concept. At home and in first grade, his parents and teacher changed the environment to meet his high activity level. They did not see his activity as a problem but simply as behavior that needed to be accommodated. In contrast, his second-grade teacher expected Derek to fit into a nonadaptable environment. In first grade, Derek was considered "lively," but in second grade, his behavior was considered abnormal. When we attempt to understand behavior, it is critical to consider the context in which the behavior occurs.

GROUP EXPECTATIONS The expectations of family, friends, neighborhood, and culture are consistent and pervasive influences on why people act the way they do. Sometimes the standards of one group are at odds with those of another group. Adolescents, for example, often deliberately behave very differently than their parents do (they violate expected standards or norms) as a result of their need to *individuate* (separate) from their parents and be part of their peer group. In this instance, deviation from the norms of one group involves conformity to those of another. Like family norms, cultural traditions and practices also affect behavior in many ways. For example, holiday celebrations usually include family and cultural traditions. As young people mature and leave their family of origin, new traditions from extended family, marriage, or friendships often blend into former customs and traditions, creating a new context for holiday celebrations.

Often, these different cultural traditions are unremarkable, but sometimes they can cause misunderstanding:

Maleah is 12 years old. Her family recently moved to the United States from the Philippines. Her teacher insisted that Maleah's mother take her to see a psychologist because of "separation anxiety." The teacher was concerned because Maleah told the teacher that she had always slept in a bed with her grandmother. However, a psychological evaluation revealed that Maleah did not have any separation fears. Rather, children sleeping with parents and/or grandparents is what people normally do (what psychologists call normative) in Philippine culture.

Culture refers to shared behavioral patterns and lifestyles that differentiate one group of people from another. Culture affects an individual's behavior but also is reciprocally changed by the behaviors of its members (Tseng, 2003). We often behave in ways that reflect the values of the culture in which we were raised. For example, in some cultures, children are expected to be "seen and not heard," whereas in other cultures, children are encouraged to freely express themselves. **Culture-bound syndrome** is a term that originally described abnormal behaviors that were specific to a particular location or group (Yap, 1967); however, we now know that some of these behavioral patterns extend across ethnic groups and geographic areas. How culture influences behavior will be a recurring theme throughout this book. Maleah's behavior is just one example of how a single behavior can be viewed differently in two different cultures.



Childhood is a period of rapid development. As children mature, behaviors once considered typical can became deviant.

DEVELOPMENT AND MATURITY Another important context that must be taken into account when considering behavioral abnormality is age. As a child matures (physically, mentally, and emotionally), behaviors previously considered developmentally appropriate and therefore normal can become abnormal.

Nick is 4 years old and insists on using a night-light to keep the monsters away.

At age 4, children do not have the *cognitive*, or mental, capacity to understand fully that monsters are not real. However, at age 12, a child should understand the difference between imagination and reality. Therefore, if at age 12 Nick still needs a night-light to keep the monsters away, his behavior would be considered abnormal and perhaps in need of treatment. Similarly, very young children do not have the ability to control their bladder; bed-wetting is common in toddlerhood. However, after the child achieves a certain level of physical and cognitive maturity, bed-wetting becomes an abnormal behavior and is given the diagnostic label of *enuresis* (see Chapter 12).

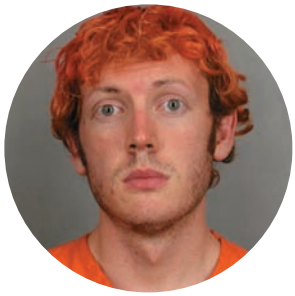
REAL people REAL disorders

James Eagan Holmes

On July 20, 2012, James Eagan Holmes walked into a Colorado movie theater and bought a ticket to the midnight showing of the Batman movie, *The Dark Knight Rises*. After the movie began, he left the theater through an emergency exit, came back, and allegedly set off gas/smoke canisters and opened fire on the audience, killing 12 people and wounding 58 others. He was quickly arrested and he warned the police not to go to his apartment. They did but found that he had booby-trapped it before leaving for the theater. At his first legal hearing, he appeared in court with his hair dyed orange, appearing dazed and confused, looking bug-eyed, and spitting on the officers who were escorting him. He called himself The Joker.

Holmes graduated from the University of California, Berkeley, in the top 1% of his class, with a 3.94 GPA, and a degree in neuroscience. Described by some as socially inept and uncommunicative, he described himself as quiet and easygoing on an apartment rental application. He applied to graduate school at the University of Illinois at Urbana-Champaign, and the application included a picture of himself with a llama. The choice of such a picture on something as important as a graduate school application certainly could qualify as eccentric behavior, but does that mean that he was psychologically disturbed?

In 2011, Holmes enrolled as a Ph.D. student in neuroscience at the University of Colorado Anschutz Medical Campus in Aurora. In 2012, his grades declined and he failed his comprehensive examination. Although the university did not plan to dismiss him, he started the process to withdraw from the university. At the same time, he purchased large quantities of guns and over 6,000 rounds of ammunition. Is this irrational behavior? Is it potentially dangerous behavior?



He asked someone if he or she had ever heard of a disorder called dysphoric mania and told a graduate student to stay away from him because he was "bad news." His answering machine recording was described as "freaky, guttural sounding, incoherent, and rambling." He dyed his hair orange, called himself The Joker, and went to the movie theater. Does this behavior prove that Holmes had a psychological disorder?

From all accounts, Holmes evolved from being a brilliant, if socially awkward neuroscience student, to a mass murderer. Whatever label is applied, his behavior evolved from behaving differently to behaving dangerously (perhaps as a result of disordered thinking). In this instance, his behavior was extremely harmful to others and could no longer be considered merely eccentric. It is also important to point out that most people who have psychological disorders are not dangerous and do not commit crimes or attempt to harm other people.

Eccentricity. What about the millionaire who wills his entire estate to his dog? This behavior violates cultural norms, but it is often labeled eccentric rather than abnormal. Eccentric behavior may violate societal norms but is not always negative or harmful to others. Yet, sometimes behaviors that initially appear eccentric cross the line into dangerousness (see "Real People, Real Disorders: James Eagan Holmes").

Is Behaving Dangerously Abnormal?

The police arrive at the emergency room of a psychiatric hospital with a man and a woman in handcuffs. Jon is 23 years old. He identifies himself as the chauffeur for Melissa, who is age 35 and also in handcuffs. They are both dressed in tight leather pants and shirts, have unusual "spiked" haircuts, and wear leather "dog collars" with many silver spikes. Jon and Melissa live in the suburbs but spent a day in the city buying clothes and getting their hair cut. As they were leaving the parking garage to return home, Melissa began to criticize Jon's hair. Jon became angry and ran the car (which belonged to Melissa) into the wall of the parking garage—several times. When a clinician asked the police officer why they were brought to the psychiatric emergency room, the officer replied, "Well, would a sane person keep ramming a car into the wall of a parking garage?" Neither Jon nor Melissa had any previous history of psychological disorders. An interview revealed that Jon's behavior was the result of a lover's quarrel, and although their relationship was often volatile, they denied any incidents of physical aggression toward each other or anyone else.

Certainly, repeatedly ramming a car into the wall of a parking garage is dangerous, is outside of societal norms, and could be labeled abnormal. Dangerous behavior can result from intense emotional states, and in Jon's case, the behavior was directed outwardly (toward another person or an inanimate object). In other cases, dangerous behavior such as suicidal thoughts may be directed toward oneself. However, it is important to understand that most people with psychological disorders do not engage in dangerous behavior (Linaker, 2000; Monahan, 2001). Individuals with seriously disordered thinking rarely present any danger to society even though their behaviors may appear dangerous to others. Therefore, behavior that is dangerous may signal the presence of a psychological disorder, but dangerous behavior alone is not necessary or sufficient for the label of abnormality to be assigned.

Is Behaving Dysfunctionally Abnormal?

1.1 Explain the difference between behaviors that are different, deviant, dangerous, and dysfunctional.

Thus far, simply being different, behaving differently, or behaving dangerously clearly does not constitute abnormal behavior. A final consideration when attempting to define abnormal behavior is whether that behavior causes *distress* or *dysfunction* for the individual or others. Consider the examples of Robert and Stan (see "Side-by-Side Case Studies").

Both Robert and Stan engage in checking behaviors, but Robert's behavior falls into the category of what is called "normal checking" (Rachman & Hodgson, 1980). Stan's routine of checking the house before he leaves for work or goes to bed is *different* from the way in which most people lock up their house before going to work, so his behavior *deviates* from the norm. Even though simple deviance is not abnormal, Stan's behavior differs from Robert's in another way: Stan's checking occurs more frequently. Frequency alone does not mean a behavior is maladaptive, but frequency can lead to two other conditions: distress and dysfunction. Specifically, Stan's worries are so frequent and pervasive that they cause him to feel anxious and lose sleep at night. In this case, maladaptive behavior results in *distress*; Stan's worries result in a negative mood (anxiety) and cause him to lose sleep. Frequently, they also cause him to arrive late for work or for social engagements. Thus, his behaviors create occupational and social *dysfunction*. When one of these conditions is evident, the presence of a psychological disorder must be considered.

SIDE by SIDE case studies Dimensions of Behavior: From Normal to Abnormal

Normal Behavior Case Study

A Cautious Person—No Disorder

Robert is a very cautious person. He does not like to make mistakes and believes that the behavior standards that he sets for himself are high but fair. He is concerned about safety and worried that other people might take advantage of him if he makes a mistake. Before leaving his house or going to sleep, he walks through the house, checking to make sure that every door and window is locked and the oven and stove are turned off. This usually takes about 5 minutes.

Abnormal Behavior Case Study

Obsessive-Compulsive Disorder

Stan also is cautious and very concerned. When away from home, he worries that he forgot to lock a door and that his house has been robbed. Often he returns home to check that the house is locked. But even after he checks, he remains doubtful and spends hours each day checking and rechecking. He has an elaborate system of checking the locks, the doors, the garage door, and the burglar alarm system. He checks the stove seven times to make sure that the oven and the burners are off. Thoughts of a burglar in his house or his house burning down cause him great distress, sometimes interfering with his sleep. He is often late for work or for social engagements because he needs to go back to the house to check and recheck.

A Definition of Abnormal Behavior

1.2 Identify at least two factors that need to be considered when determining whether a behavior is abnormal.

To summarize, to define abnormal behavior, we need to consider several factors. Merely being different or behaving differently is not enough, although the latter certainly might be a signal that something is wrong. Some abnormal behaviors are dangerous, but dangerousness is not necessary for a definition of abnormality. In this book, we define **abnormal behavior** as behavior that is inconsistent with the individual's developmental, cultural, and societal norms, and creates emotional distress or interferes with daily functioning.

The following chapters will examine many different types of abnormal behavior. As a guide, the behaviors are considered using the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (American Psychiatric Association [APA], 2013), commonly known as the *DSM-5*. This diagnostic system uses an approach that focuses on symptoms and the scientific basis for the disorders, including their *clinical presentation* (what specific symptoms cluster together?), *etiology* (what causes the disorder?), *developmental stage* (does the disorder look different in children than it does in adults?), and *functional impairment* (what are the immediate and long-term consequences of having the disorder?). The DSM system uses a *categorical approach* to defining abnormal behavior. Although this method is somewhat controversial (see "Research Hot Topic: Categorical vs. Dimensional Approaches to Abnormal Behavior"), it remains the most widely accepted diagnostic system in the United States.

ABNORMAL BEHAVIOR IN THE GENERAL POPULATION Psychological disorders are common in the general population. Approximately 47% of adults in the United States have suffered from a psychological disorder at some time in their lives (Kessler et al., 2005a). The most commonly reported disorders in the United States are anxiety disorders and depressive disorders (see Figure 1.1). More than 20% of adults will suffer from major depression, and more than 14% will struggle with alcohol dependence at some point in their lives. Anxiety disorders are also common, affecting over 28% of adults, during their lifetimes. Clearly, many people suffer from serious psychological disorders; this emphasizes the need for more understanding of these conditions and the development of effective treatments.

FACTORS INFLUENCING THE EXPRESSION OF ABNORMAL BEHAVIORS Contextual factors play an important role when considering if and when abnormal behaviors may develop. Some factors include personal characteristics such as sex and race or ethnicity.

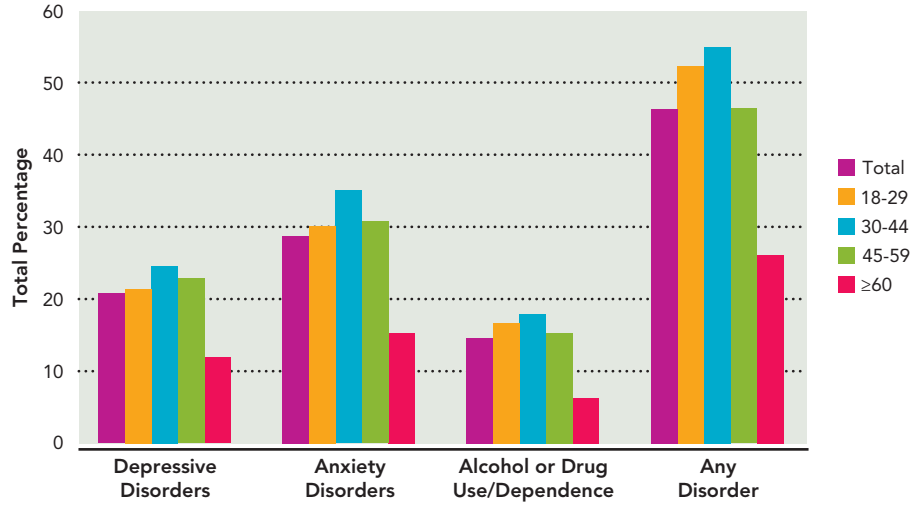


FIGURE 1.1
Lifetime Prevalence of Various DSM-IV Psychiatric Disorders at Different Ages in Adulthood. Data from Kessler et al. (2005). *Archives of General Psychiatry, 62*, 593–603.

research HOT topic

Categorical vs. Dimensional Approaches to Abnormal Behavior

The current diagnostic system, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), presents a primarily *categorical* approach to understanding psychological disorders. The DSM assumes that a person either has a disorder or does not, just as one is pregnant or not pregnant. The current DSM is superior to previous diagnostic systems, which were tied to theory but not necessarily to data. However, two issues continue to present problems for a categorical approach: (a) symptoms rarely fall neatly into just one category and (b) symptoms often are not of sufficient severity to determine that they represent a psychological disorder despite distress and impairment.

In fact, people in psychological distress rarely have only one psychological disorder (Nathan & Langenbucher, 1999). A woman struggling with an eating disorder often feels depressed as well. Does she have two distinct disorders, or is her depression merely part of her abnormal eating pattern? Making these distinctions is more than just an academic exercise—it affects whether someone receives treatment. It may, for example, determine whether a psychologist decides to refer a depressed patient for medication treatment or just monitors her sadness to see whether it disappears when the eating disorder is successfully treated.

The second issue—deciding when one has "enough" of a symptom to have a diagnosis—can be illustrated through the following example. Shyness and sadness are two behaviors that may be personality dimensions rather than a distinct category. When is one "sad enough" or "shy enough" to be diagnosed with a psychological disorder? Is shyness a personality feature or a psychological disorder? Currently, one is considered to have a psychological disorder when the distress is severe enough or when functional impairment results. However, in many instances, this is an artificial distinction and may deny people with moderate distress the opportunity to seek services. Scientifically, a **dimensional approach** would allow an understanding of how abnormal behavior varies in severity over time, perhaps increasing and decreasing, or how behaviors change from one disorder to another.

Researchers continue to investigate the most accurate way to describe abnormal behavior. The DSM-5 emphasizes the need to consider not just the presence of symptoms but also whether those symptoms affect functioning when attempting to understand abnormal behavior.

For example, women are more likely to suffer from anxiety disorders (see Chapter 4) and mood disorders (see Chapter 6), and men are more likely to suffer from alcohol and drug abuse (see Chapter 9; Kessler et al., 2005a). With respect to race and ethnicity, whites and African Americans suffer equally from most types of psychological disorders. Hispanics are more likely to have mood disorders such as depression than are non-Hispanic whites. In addition, as we shall see throughout this book, culture may influence how symptoms are expressed.

Socioeconomic status (SES), defined by family income and educational achievement, is another important factor that affects the prevalence of psychological disorders in the general population. Except for drug and alcohol abuse, which occurs more often among those with the middle education level (a high school graduate but no college degree), psychological disorders occur most frequently among those with the lowest incomes and the least education. A continuing debate is whether psychological disorders are the result of lower SES. Do more education and higher income serve to protect someone against psychological disorders by providing more supportive resources? An alternative hypothesis is that the impairment that *results* from a psychological disorder (inability to sleep, addiction to alcohol) leads to job loss or limited educational achievement, a phenomenon known as *downward drift*. Another alternative is that a third factor, such as genetic predisposition, contributes both to the onset of a psychiatric disorder and to the inability to achieve academically or occupationally.

Few studies address the relationship of SES to psychological disorders specifically, but one study of the development of psychological disorders in children does help us understand this relationship. In this study, children were interviewed at yearly intervals, in some cases for 9 consecutive years. During that time, children from all SES groups *developed* psychological disorders at the same rate (Wadsworth & Achenbach, 2005).