



Robin S. Rosenberg
Stephen M. Kosslyn

SECOND
EDITION

ABNORMAL PSYCHOLOGY

This page intentionally left blank

SECOND
EDITION

ABNORMAL PSYCHOLOGY

Robin S. Rosenberg

University of California at San Francisco

Stephen M. Kosslyn

Minerva Schools at the Keck Graduate Institute

WORTH PUBLISHERS

A Macmillan Higher Education Company

Senior Vice President, Editorial and Production: Catherine Woods
Publisher: Kevin Feyen
Associate Publisher: Jessica Bayne
Executive Marketing Manager: Katherine Nurre
Developmental Editor: Thomas Finn
Director of Print and Digital Development: Tracey Kuehn
Associate Managing Editor: Lisa Kinne
Media Editor: Anthony Casciano
Editorial Assistant: Catherine Michaelson
Photo Editor: Robin Fadool
Photo Researchers: Roman Barnes and Donna Ranieri
Project Editor: Christine Cervoni, TSI Graphics, Inc.
Art Director: Barbara Reingold
Cover Designers: Barbara Reingold and Lyndall Culbertson
Interior Designers: Charles Yuen and Lyndall Culbertson
Production Manager: Barbara Anne Seixas
Composition and Line Art: TSI Graphics, Inc.
Anatomical and Studio Art: Matthew Holt, Keith Kasnot, and Chris Notarile
Printing and Binding: Quad/Graphics
Cover Art: coloroftime/E+/Getty Images

Library of Congress Control Number: 2013955446

ISBN-13: 978-1-4292-4216-5

ISBN-10: 1-4292-4216-7

© 2014, 2011 by Worth Publishers
All rights reserved

Printed in the United States of America

First printing
Worth Publishers
41 Madison Avenue
New York, NY 10010
www.worthpublishers.com

To our families

ABOUT THE AUTHORS

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



Courtesy of Robin Apple

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

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

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

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



Courtesy of Mark Estes

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

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

LIST OF CHAPTERS

	Preface	xvii
CHAPTER 1	The History of Abnormal Psychology	3
CHAPTER 2	Understanding Psychological Disorders: The Neuropsychosocial Approach	29
CHAPTER 3	Clinical Diagnosis and Assessment	59
CHAPTER 4	Research Methods	87
CHAPTER 5	Mood Disorders and Suicide	115
CHAPTER 6	Anxiety Disorders	155
CHAPTER 7	Obsessive-Compulsive-Related and Trauma-Related Disorders	195
CHAPTER 8	Dissociative and Somatic Symptom Disorders	223
CHAPTER 9	Substance Use Disorders	257
CHAPTER 10	Eating Disorders	297
CHAPTER 11	Gender and Sexual Disorders	327
CHAPTER 12	Schizophrenia and Other Psychotic Disorders	365
CHAPTER 13	Personality Disorders	401
CHAPTER 14	Neurodevelopmental and Disruptive Behavior Disorders	443
CHAPTER 15	Neurocognitive Disorders	477
CHAPTER 16	Ethical and Legal Issues	503
	Glossary	G-1
	References	R-1
	Permissions and Attributions	P-1
	Name Index	N-1
	Subject Index	S-1

Preface xvii

CHAPTER 1 The History of Abnormal Psychology 3

The Three Criteria for Determining Psychological Disorders 4

Distress 4

Impairment in Daily Life 5

Risk of Harm 6

Context and Culture 7

Views of Psychological Disorders Before Science 10

Ancient Views of Psychopathology 10

Supernatural Forces 11

Imbalance of Substances Within the Body 11

Forces of Evil in the Middle Ages and the Renaissance 12

Rationality and Reason in the 18th and 19th Centuries 12

Asylums 13

Pinel and Mental Treatment 13

Moral Treatment 13

The Transition to Scientific Accounts of Psychological Disorders 14

Freud and the Importance of Unconscious Forces 14

Psychoanalytic Theory 15

Psychosexual Stages 16

Mental Illness, According to Freud 16

Defense Mechanisms 16

Psychoanalytic Theory Beyond Freud 17

Evaluating the Contributions of Freud and His Followers 17

The Humanist Response 18

Scientific Accounts of Psychological Disorders 19

Behaviorism 19

The Cognitive Contribution 20

Social Forces 21

Biological Explanations 22

The Modern Synthesis of Explanations of Psychopathology 23

The Diathesis-Stress Model 23

The Biopsychosocial and Neuropsychosocial Approaches 23

CHAPTER 2 Understanding Psychological Disorders: The Neuropsychosocial Approach 29

Neurological Factors in Psychological Disorders 30

Brain Structure and Brain Function 30

A Quick Tour of the Nervous System 30

Neurons 32

Chemical Signals 34

Hormones and the Endocrine System 36

The Genetics of Psychopathology 36

Behavioral Genetics 37

Feedback Loops in Understanding Genes and the Environment 39

The Environment Affects the Genes 39

The Genes Affect the Environment 40

Psychological Factors in Psychological Disorders 41

Behavior and Learning 41

Classical Conditioning 41

Operant Conditioning 42

Feedback Loops in Understanding Classical Conditioning and Operant Conditioning 44

Observational Learning 45

Mental Processes and Mental Contents 45

Mental Processes 45

Mental Contents 46

Emotion 47

Emotions and Behavior 47

Emotions, Mental Processes, and Mental Contents 48

Emotional Regulation and Psychological Disorders 48

Neurological Bases of Emotion 48

Temperament 49

Social Factors in Psychological Disorders 50

Family Matters 50

Family Interaction Style and Relapse 51

Child Maltreatment 51

Parental Psychological Disorders 52

Community Support 52

Social Stressors 52

Socioeconomic Status 53

Discrimination, Bullying, and War 54

Culture 54

A Neuropsychosocial Last Word on the Beales 56

CHAPTER 3 Clinical Diagnosis and Assessment..... 59

Diagnosing Psychological Disorders	61
Why Diagnose?	62
A Cautionary Note About Diagnosis	63
Reliability and Validity in Classification Systems	64
The Diagnostic and Statistical Manual of Mental Disorders	65
The Evolution of DSM	65
The Evolution of DSM-5	66
The People Who Diagnose Psychological Disorders	70
Clinical Psychologists and Counseling Psychologists	70
Psychiatrists, Psychiatric Nurses, and General Practitioners	71
Mental Health Professionals with Master's Degrees	71
Assessing Psychological Disorders	72
Assessing Neurological and Other Biological Factors	72
Assessing Abnormal Brain Structures with X-Rays, CT Scans, and MRIs	73
Assessing Brain Function with PET Scans and fMRI	73
Neuropsychological Assessment	74
Assessing Psychological Factors	75
Clinical Interview	75
Tests of Psychological Functioning	78
Assessing Social Factors	81
Family Functioning	81
Community	82
Culture	82
Assessment as an Interactive Process	83
Diagnosing and Assessing Rose Mary and Rex Walls?	84

CHAPTER 4 Research Methods 87

Using the Scientific Method to Understand Abnormality	88
The Scientific Method	88
Collect Initial Observations	88
Identify a Question	88
Develop and Test a Hypothesis	89
Develop a Theory	89
Test the Theory	89

Types of Scientific Research	90
Conducting Research with Experiments	90
Quasi-Experimental Design	93
Correlational Research	93
Case Studies	96
Meta-Analysis	97
Ethical Guidelines for Research	98

Research Challenges in Understanding Abnormality 100






Challenges in Researching Neurological Factors	100
Challenges in Researching Psychological Factors	101
Biases in Mental Processes That Affect Assessment	101
Research Challenges with Clinical Interviews	101
Research Challenges with Questionnaires	101
Challenges in Researching Social Factors	102
Investigator-Influenced Biases	103
Cultural Differences in Evaluating Symptoms	103

Researching Treatment 104


Researching Treatments That Target Neurological Factors	104
Drug Effect or Placebo Effect?	105
Dropouts	105
Researching Treatments That Target Psychological Factors	105
Common Factors and Specific Factors	106
Is Therapy Better Than No Treatment?	107
Is One Type of Therapy Generally More Effective Than Another?	108
The Therapy Dose–Response Relationship	109
Researching Treatments That Target Social Factors	110
Gender and Ethnicity of Patient and Therapist	111
Culturally Sanctioned Placebo Effects	111
Ethical Research on Experimental Treatments	112

CHAPTER 5 Mood Disorders and Suicide..... 115

Depressive Disorders	116
Major Depressive Episode	116
Affect: The Mood Symptoms of Depression	116
Behavioral and Physical Symptoms of Depression	116
Cognitive Symptoms of Depression	117


Major Depressive Disorder	118
Depression in Children and Adolescents	120
Persistent Depressive Disorder	120
Current Controversy: Disruptive Mood Dysregulation Disorder: Overlabeling of Tantrums?	121
Understanding Depressive Disorders	122
Neurological Factors	122
Psychological Factors	124
Social Factors	126
 Feedback Loops in Understanding Depressive Disorders	128
Treating Depressive Disorders	130
Targeting Neurological Factors	130
Targeting Psychological Factors	132
Targeting Social Factors	133
 Feedback Loops in Treating Depressive Disorders	135
Bipolar Disorders	136
Mood Episodes for Bipolar Disorders	136
Manic Episode	136
Hypomanic Episode	138
The Two Types of Bipolar Disorder	139
Cyclothymic Disorder	140
Understanding Bipolar Disorders	141
Neurological Factors	141
Psychological Factors: Thoughts and Attributions	142
Social Factors: Social and Environmental Stressors	143
 Feedback Loops in Understanding Bipolar Disorders	143
Treating Bipolar Disorders	143
Targeting Neurological Factors: Medication	144
Targeting Psychological Factors: Thoughts, Moods, and Relapse Prevention	144
Targeting Social Factors: Interacting with Others	145
 Feedback Loops in Treating Bipolar Disorder	145
Suicide	146
Suicidal Thoughts and Suicide Risks	146
Thinking About, Planning, and Attempting Suicide	146
Risk and Protective Factors for Suicide	148
Understanding Suicide	149
Neurological Factors	149
Psychological Factors: Hopelessness and Impulsivity	150
Social Factors: Alienation and Cultural Stress	150
 Feedback Loops in Understanding Suicide	150
Preventing Suicide	151
Crisis Intervention	151
Long-Term Prevention	151

 CHAPTER 6	
Anxiety Disorders.....	155
Common Features of Anxiety Disorders	155
What Is Anxiety?	156
The Fight-or-Flight Response Gone Awry	156
Comorbidity of Anxiety Disorders	157
Generalized Anxiety Disorder	158
What Is Generalized Anxiety Disorder?	158
Understanding Generalized Anxiety Disorder	159
Neurological Factors	160
Psychological Factors: Hypervigilance and the Illusion of Control	160
Social Factors: Stressors	161
 Feedback Loops in Understanding Generalized Anxiety Disorder	161
Treating Generalized Anxiety Disorder	161
Targeting Neurological Factors: Medication	161
Targeting Psychological Factors	162
Targeting Social Factors	163
 Feedback Loops in Treating Generalized Anxiety Disorder	164
Panic Disorder and Agoraphobia	165
The Panic Attack—A Key Ingredient of Panic Disorder	165
What Is Panic Disorder?	166
What Is Agoraphobia?	167
Understanding Panic Disorder and Agoraphobia	168
Neurological Factors	169
Psychological Factors	170
Social Factors: Stressors, a Sign of the Times, and “Safe People”	170
 Feedback Loops in Understanding Panic Disorder and Agoraphobia	171
Treating Panic Disorder and Agoraphobia	171
Targeting Neurological Factors: Medication	171
Targeting Psychological Factors	172
Targeting Social Factors: Group and Couples Therapy	174
 Feedback Loops in Treating Panic Disorder and Agoraphobia	174
Social Anxiety Disorder (Social Phobia)	175
What Is Social Anxiety Disorder?	176
Understanding Social Anxiety Disorder	177
Neurological Factors	177
Psychological Factors	178
Social Factors	179

 Feedback Loops in Understanding Social Anxiety Disorder	179
Treating Social Anxiety Disorder	180
Targeting Neurological Factors: Medication	180
Targeting Psychological Factors: Exposure and Cognitive Restructuring	180
Targeting Social Factors: Group Interactions	181
 Feedback Loops in Treating Social Anxiety Disorder	181
Specific Phobia	182
What Is Specific Phobia?	182
Specifics About Specific Phobia	183
Understanding Specific Phobia	184
Neurological Factors	184
Psychological Factors	185
Social Factors: Modeling and Culture	185
 Feedback Loops in Understanding Specific Phobia	186
Treating Specific Phobia	186
Targeting Neurological Factors: Medication	186
Targeting Psychological Factors	186
Targeting Social Factors: A Limited Role for Observational Learning	187
 Feedback Loops in Treating Specific Phobia	187
Separation Anxiety Disorder	188
What Is Separation Anxiety Disorder?	188
Current Controversy: Separation Anxiety Disorder: Anxiety Disorder or Developmental Difference?	190
Understanding and Treating Separation Anxiety Disorder	191
Follow-up on Earl Campbell	191

CHAPTER 7

Obsessive-Compulsive-Related and Trauma-Related Disorders 195

Obsessive-Compulsive Disorder and Related Disorders	196
What Is Obsessive-Compulsive Disorder?	196
What Is Body Dysmorphic Disorder?	199
Understanding Obsessive-Compulsive Disorder	202
Neurological Factors	202
Psychological Factors	203
Social Factors	204
 Feedback Loops in Understanding Obsessive-Compulsive Disorder	205

Treating Obsessive-Compulsive Disorder	205
Targeting Neurological Factors: Medication	205
Targeting Psychological Factors	205
Targeting Social Factors: Family Therapy	206

 Feedback Loops in Treating Obsessive-Compulsive Disorder	206
--	-----

Trauma-Related Disorders 207

What Are the Trauma-Related Disorders? 208

 What Is Posttraumatic Stress Disorder? 209

 What Is Acute Stress Disorder? 211

Understanding Trauma-Related Disorders: PTSD 213

 Neurological Factors 213

 Psychological Factors: History of Trauma, Comorbidity, and Conditioning 214

 Social Factors: Socioeconomic Factors, Social Support, and Culture 215

 Feedback Loops in Understanding Posttraumatic Stress Disorder	215
---	-----

Treating Posttraumatic Stress Disorder 216

 Targeting Neurological Factors: Medication 217

 Targeting Psychological Factors 217

Current Controversy: Eye Movement Desensitization and Reprocessing (EMDR) Treatment for Posttraumatic Stress Disorder 217

 Targeting Social Factors: Safety, Support, and Family Education 218

 Feedback Loops in Treating Posttraumatic Stress Disorder	218
--	-----

Follow-up on Howard Hughes 220

CHAPTER 8

Dissociative and Somatic Symptom Disorders 223

Dissociative Disorders 224

Dissociative Disorders: An Overview 224

 Normal Versus Abnormal Dissociation 225

 Types of Dissociative Disorders 226

Dissociative Amnesia 226

 What Is Dissociative Amnesia? 226

 Understanding Dissociative Amnesia 228

Depersonalization-Derealization Disorder 229

 What Is Depersonalization-Derealization Disorder? 229


 Understanding Depersonalization-Derealization Disorder 231

Dissociative Identity Disorder	232	Polysubstance Abuse	262
What Is Dissociative Identity Disorder?	232	Prevalence and Costs	262
Criticisms of the DSM-5 Criteria	234	Culture and Context	263
Understanding Dissociative Identity Disorder	234	Stimulants	263
Treating Dissociative Disorders	238	What Are Stimulants?	263
Targeting Neurological Factors: Medication	238	Cocaine and Crack	264
Targeting Psychological and Social Factors: Coping and Integration	238	Amphetamines	264
 Feedback Loops in Treating Dissociative Disorders	239	Methamphetamine	265
Somatic Symptom Disorders	240	Ritalin	265
Somatic Symptom Disorders: An Overview	240	MDMA (Ecstasy)	265
Somatic Symptom Disorder	241	"Bath Salts"	266
What Is Somatic Symptom Disorder?	241	Understanding Stimulants	266
Understanding Somatic Symptom Disorder	242	Brain Systems and Neural Communication: Dopamine and Abuse	267
Conversion Disorder	244	Psychological Factors: From Learning to Coping	268
What Is Conversion Disorder?	245	Social Factors	269
Criticisms of the DSM-5 Criteria	247	Depressants	271
Understanding Conversion Disorder	247	What Are Depressants?	271
Illness Anxiety Disorder	248	Alcohol	272
Current Controversy: Omission of Hypochondriasis from DSM-5: Appropriate or Overreaction?	249	Sedative-Hypnotic Drugs	274
What Is Illness Anxiety Disorder?	249	Understanding Depressants	275
Illness Anxiety Disorder, Anxiety Disorders, and OCD: Shared Features	250	Neurological Factors	275
Understanding Illness Anxiety Disorder	250	Psychological Factors	276
Treating Somatic Symptom Disorders	251	Social Factors	277
Targeting Neurological Factors	251	Other Abused Substances	278
Targeting Psychological Factors: Cognitive-Behavior Therapy	252	What Are Other Abused Substances?	278
Targeting Social Factors: Support and Family Education	252	Opioids: Narcotic Analgesics	278
 Feedback Loops in Treating Somatic Symptom Disorders	253	Hallucinogens	279
Follow-up on Anna O.	254	Dissociative Anesthetics	280
 CHAPTER 9		Understanding Other Abused Substances	281
Substance Use Disorders	257	Neurological Factors	281
Substance Use: When Use Becomes a Disorder	257	Psychological Factors	282
Substance Use Versus Intoxication	258	Social Factors	282
Substance Use Disorders	258	 Feedback Loops in Understanding Substance Use Disorders	282
Substance Use Disorder as a Category or on a Continuum?	260	Treating Substance Use Disorders	284
Use Becomes a Problem	261	Goals of Treatment	284
Comorbidity	262	Current Controversy: Once an Alcoholic, Always an Alcoholic?	285
		Targeting Neurological Factors	285
		Detoxification	285
		Medications	286

Targeting Psychological Factors	287	Dieting, Restrained Eating, and Disinhibited Eating	313
Motivation	288	Other Psychological Disorders as Risk Factors	313
Cognitive-Behavior Therapy	289	Social Factors: The Body in Context	313
Twelve-Step Facilitation (TSF)	290	The Role of Family and Peers	314
Targeting Social Factors	291	The Role of Culture	314
Residential Treatment	291	Eating Disorders Across Cultures	315
Group-Based Treatment	291	The Power of the Media	315
Family Therapy	292	Objectification Theory: Explaining the Gender Difference	316
 Feedback Loops in Treating Substance Use Disorders	292	 Feedback Loops in Understanding Eating Disorders	317
 		Treating Eating Disorders	318
 CHAPTER 10		Targeting Neurological and Biological Factors: Nourishing the Body	319
Eating Disorders.....	297	A Focus on Nutrition	319
Anorexia Nervosa	298	Medical Hospitalization	319
What Is Anorexia Nervosa?	298	Medication	319
Anorexia Nervosa According to DSM-5	298	Targeting Psychological Factors: Cognitive-Behavior Therapy	320
Two Types of Anorexia Nervosa: Restricting and Binge Eating/Purging	300	CBT for Anorexia	320
Medical, Psychological, and Social Effects of Anorexia Nervosa	300	CBT for Bulimia	320
Medical Effects of Anorexia	301	Efficacy of CBT for Treating Eating Disorders	321
Psychological and Social Effects of Starvation	301	Targeting Social Factors	321
Bulimia Nervosa	302	Interpersonal Therapy	321
What Is Bulimia Nervosa?	302	Family Therapy	321
Medical Effects of Bulimia Nervosa	304	Psychiatric Hospitalization	322
Is Bulimia Distinct From Anorexia?	305	Prevention Programs	323
Binge Eating Disorder and “Other” Eating Disorders	305	 Feedback Loops in Treating Eating Disorders	323
What Is Binge Eating Disorder?	305	Follow-up on Marya Hornbacher	324
Current Controversy: Is Binge Eating Disorder Diagnosis a Good Idea?	307	 	
Disordered Eating: “Other” Eating Disorders	307	 CHAPTER 11	
Understanding Eating Disorders	308	Gender and Sexual Disorders.....	327
Neurological Factors: Setting the Stage	309	Gender Dysphoria	328
Brain Systems	309	What Is Gender Dysphoria?	328
Neural Communication: Serotonin	310	Understanding Gender Dysphoria	331
Genetics	310	Neurological Factors	332
Psychological Factors: Thoughts of and Feelings About Food	310	Psychological Factors: A Correlation with Play Activities?	332
Thinking About Weight, Appearance, and Food	311	Social Factors: Responses From Others	332
Operant Conditioning: Reinforcing Disordered Eating	311	Treating Gender Dysphoria	333
Personality Traits as Risk Factors	312	Targeting Neurological and Other Biological Factors: Altered Appearance	333
		Targeting Psychological Factors: Understanding the Choices	334
		Targeting Social Factors: Family Support	334

Paraphilic Disorders	335	CHAPTER 12	
What Are Paraphilic Disorders?	335	Schizophrenia and Other Psychotic Disorders	365
Paraphilic Disorders Involving Nonconsenting People	336	What Are Schizophrenia and Other Psychotic Disorders?	366
Sexual Sadism Disorder and Sexual Masochism Disorder: Pain and Humiliation	340	The Symptoms of Schizophrenia	366
Paraphilic Disorders Involving Nonhuman Objects	341	Positive Symptoms	366
Assessing Paraphilic Disorders	343	Negative Symptoms	369
Criticisms of the DSM-5 Paraphilic Disorders	343	Cognitive Deficits: The Specifics	369
Understanding Paraphilic Disorders	343	Deficits in Attention	369
Neurological Factors	344	Deficits in Working Memory	369
Psychological Factors: Conditioned Arousal	344	Deficits in Executive Functioning	370
Social Factors: More Erotica?	344	Cognitive Deficits Endure Over Time	370
Treating Paraphilic Disorders	345	Limitations of DSM-5 Criteria	370
Targeting Neurological and Other Biological Factors: Medication	345	Deficit/Nondeficit Subtypes	371
Current Controversy: Sex Offenders: Is Surgical Castration an Ethical Solution?	345	Distinguishing Between Schizophrenia and Other Disorders	371
Targeting Psychological Factors: Cognitive-Behavior Therapy	346	Psychotic Symptoms in Schizophrenia, Mood Disorders, and Substance-Related Disorders	371
Targeting Social Factors	346	Other Psychotic Disorders	372
Sexual Dysfunctions	346	Current Controversy: Attenuated Psychosis Syndrome: The Diagnosis That Wasn't	375
An Overview of Sexual Functioning and Sexual Dysfunctions	346	Schizophrenia Facts in Detail	376
The Normal Sexual Response Cycle	347	Prevalence	376
Sexual Dysfunctions According to DSM-5	348	Comorbidity	376
Sexual Desire Disorders and Sexual Arousal Disorders	349	Course	377
Orgasmic Disorders	350	Gender Differences	377
Sexual Pain Disorder: Genito-Pelvic Pain/Penetration Disorder	352	Culture	377
Criticisms of the Sexual Dysfunctions in DSM-5	354	Prognosis	379
Understanding Sexual Dysfunctions	354	Understanding Schizophrenia	380
Neurological and Other Biological Factors	354	Neurological Factors in Schizophrenia	380
Psychological Factors in Sexual Dysfunctions	355	Brain Systems	380
Social Factors	356	Neural Communication	383
 Feedback Loops in Understanding Sexual Dysfunctions	356	Genetics	384
Treating Sexual Dysfunctions	358	Psychological Factors in Schizophrenia	385
Targeting Neurological and Other Biological Factors: Medications	358	Mental Processes and Cognitive Difficulties: Attention, Memory, and Executive Functions	385
Targeting Psychological Factors: Shifting Thoughts, Learning Behaviors	359	Beliefs and Attributions	386
Targeting Social Factors: Couples Therapy	360	Emotional Expression	387
 Feedback Loops in Treating Sexual Dysfunctions	360	Social Factors in Schizophrenia	387
		Understanding the Social World	388
		Stressful Environments	388

Immigration	389	Odd/Eccentric Personality Disorders	410
Economic Factors	390	Paranoid Personality Disorder	411
Cultural Factors: Recovery in Different Countries	390	Schizoid Personality Disorder	413
 Feedback Loops in Understanding Schizophrenia	391	Schizotypal Personality Disorder	414
Treating Schizophrenia	392	What Is Schizotypal Personality Disorder?	414
Targeting Neurological Factors in Treating Schizophrenia	393	Understanding Schizotypal Personality Disorder	415
Medication	393	Treating Odd/Eccentric Personality Disorders	417
Brain Stimulation: ECT	394	Dramatic/Erratic Personality Disorders	417
Targeting Psychological Factors in Treating Schizophrenia	394	Antisocial Personality Disorder	418
Cognitive-Behavior Therapy	394	Understanding Antisocial Personality Disorder and Psychopathy	419
Treating Comorbid Substance Abuse: Motivational Enhancement	395	Treating Antisocial Personality Disorder and Psychopathy	421
Targeting Social Factors in Treating Schizophrenia	395	Current Controversy: Should Psychopaths Receive Treatment?	422
Family Education and Therapy	395	Borderline Personality Disorder	422
Group Therapy: Social Skills Training	395	Understanding Borderline Personality Disorder	424
Inpatient Treatment	396	Treating Borderline Personality Disorder: New Treatments	427
Minimizing Hospitalizations: Community-Based Interventions	396	Histrionic Personality Disorder	429
 Feedback Loops in Treating Schizophrenia	397	What Is Histrionic Personality Disorder?	430
 CHAPTER 13		Distinguishing Between Histrionic Personality Disorder and Other Disorders	431
Personality Disorders401		Treating Histrionic Personality Disorder	431
Diagnosing Personality Disorders	402	Narcissistic Personality Disorder	431
What Are Personality Disorders?	403	What Is Narcissistic Personality Disorder?	431
Assessing Personality Disorders	404	Treating Narcissistic Personality Disorder	432
DSM-5 Personality Clusters	405	Fearful/Anxious Personality Disorders	433
Criticisms of the DSM-5 Category of Personality Disorders	405	Avoidant Personality Disorder	433
Understanding Personality Disorders in General	406	What Is Avoidant Personality Disorder?	433
Neurological Factors in Personality Disorders: Genes and Temperament	407	Distinguishing Between Avoidant Personality Disorder and Other Disorders	434
Psychological Factors in Personality Disorders: Temperament and the Consequences of Behavior	408	Dependent Personality Disorder	435
Social Factors in Personality Disorders: Insecurely Attached	408	Obsessive-Compulsive Personality Disorder	436
 Feedback Loops in Understanding Personality Disorders	408	What Is Obsessive-Compulsive Personality Disorder?	436
Treating Personality Disorders: General Issues	409	Distinguishing Between Obsessive-Compulsive Personality Disorder and OCD	438
Targeting Neurological Factors in Personality Disorders	409	Understanding Fearful/Anxious Personality Disorders	438
Targeting Psychological Factors in Personality Disorders	409	Treating Fearful/Anxious Personality Disorders	438
Targeting Social Factors in Personality Disorders	410	Follow-up on Rachel Reiland	440

 CHAPTER 14	
Neurodevelopmental and Disruptive Behavior Disorders.....	443
Intellectual Disability (Intellectual Developmental Disorder)	444
What Is Intellectual Disability?	444
<i>Current Controversy: Changing Mental Retardation to Intellectual Disability: Will Such a Switch Be Beneficial?</i>	446
Understanding Intellectual Disability	447
Neurological Factors: Teratogens and Genes	447
Psychological Factors: Problem Behaviors	448
Social Factors: Understimulation	448
Treating Intellectual Disability	448
Targeting Neurological Factors: Prevention	448
Targeting Psychological and Social Factors: Communication	449
Targeting Social Factors: Accommodation in the Classroom—It’s the Law	449
Autism Spectrum Disorder	449
What Is Autism Spectrum Disorder?	450
Understanding Autism Spectrum Disorder	453
Neurological Factors	453
Psychological Factors: Cognitive Deficits	453
Social Factors: Communication Problems	454
Treating Autism Spectrum Disorder	454
Targeting Neurological Factors	454
Targeting Psychological Factors: Applied Behavior Analysis	454
Targeting Social Factors: Communication	455
Specific Learning Disorder: Problems with the Three Rs	455
What Is Specific Learning Disorder?	455
Understanding Specific Learning Disorder	457
Neurological Factors	457
Psychological Factors	458
Social Factors	458
Treating Dyslexia	458
Disorders of Disruptive Behavior and Attention	459
What Is Conduct Disorder?	460
Adolescent-Onset Type	462
Childhood-Onset Type	462
What Is Oppositional Defiant Disorder?	463
What Is Attention-Deficit/Hyperactivity Disorder?	464
Understanding Disorders of Disruptive Behavior and Attention	468
Neurological Factors	468
Psychological Factors: Recognizing Facial Expressions, Low Self-Esteem	469
Social Factors: Blame and Credit	469
 Feedback Loops in Understanding Attention-Deficit/Hyperactivity Disorder	470
Treating Disorders of Disruptive Behavior and Attention: Focus on ADHD	470
Targeting Neurological Factors: Medication	470
Targeting Psychological Factors: Treating Disruptive Behavior	472
Targeting Social Factors: Reinforcement in Relationships	473
 Feedback Loops in Treating Attention-Deficit/Hyperactivity Disorder	473
 CHAPTER 15	
Neurocognitive Disorders.....	477
Normal Versus Abnormal Aging and Cognitive Functioning	478
Cognitive Functioning in Normal Aging	479
Intelligence	479
Memory	480
Processing Speed, Attention, and Working Memory	480
Psychological Disorders and Cognition	481
Depression	481
Anxiety Disorders	482
Schizophrenia	482
Medical Factors That Can Affect Cognition	482
Diseases and Illnesses	482
Stroke	483
Head Injury	484
Substance-Induced Changes in Cognition	484
Delirium	484
What Is Delirium?	484
Understanding Delirium: A Side Effect?	487
Delirium Caused by Substance Use	487
Delirium Caused by a General Medical Condition	487
Treating Delirium: Rectify the Cause	487

Dementia (and Mild Versus Major Neurocognitive Disorders)	488	The Insanity Defense: Current Issues	511
What Is Dementia?	488	Assessing Insanity for the Insanity Defense	512
Mild and Major Neurocognitive Disorders	489	States' Rights: Doing Away with the Insanity Defense	513
Current Controversy: Mild and Major Neurocognitive Disorders	490	Current Controversy: Criminal Behavior: Does Abnormal Neural Functioning Make It More Excusable?	513
Dementia and Alzheimer's Disease	490	With the Insanity Defense, Do People Really "Get Away with Murder"?	514
Understanding Dementia	492	After Committing the Crime: Competent to Stand Trial?	514
Alzheimer's Disease	492	Dangerousness: Legal Consequences	515
Vascular Dementia	494	Evaluating Dangerousness	516
Dementia Due to Other Medical Conditions	495	Actual Dangerousness	516
Treating Dementia	497	Confidentiality and the Dangerous Patient: Duty to Warn and Duty to Protect	516
Targeting Neurological Factors	498	Maintaining Safety: Confining the Dangerously Mentally Ill Patient	518
Targeting Psychological Factors	498	Criminal Commitment	518
Targeting Social Factors	499	Civil Commitment	518
Diagnosing Mrs. B.'s Problems	499	Sexual Predator Laws	521
 CHAPTER 16		Legal Issues Related to Treatment	521
Ethical and Legal Issues.....	503	Right to Treatment	522
Ethical Issues	504	Right to Refuse Treatment	522
An Ethical Principle: The Role of Confidentiality	504	Competence to Refuse Treatment	522
Ambiguities Regarding Confidentiality	505	Mental Health and Drug Courts	523
Limits of Confidentiality: HIPAA in Action	505	The Wheels of Justice: Follow-up on Andrew Goldstein	524
Legal Restrictions on Confidentiality	506	Glossary	G-1
Privileged Communication	506	References	R-1
Informed Consent to Participate in Research on Mental Illness: Can Patients Truly Be Informed?	507	Permissions and Attributions	P-1
Criminal Actions and Insanity	507	Name Index	N-1
While Committing the Crime: Sane or Insane?	508	Subject Index	S-1
From the M'Naghten Test to the Durham Test	508		
The American Legal Institute Test	509		
Insanity Defense Reform Acts	509		

This page intentionally left blank

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

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

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

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

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

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

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

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

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

Unique Coverage

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

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

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

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

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

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

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

Pedagogy

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

Feedback Loops Within the Neuropsychosocial Approach

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

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



AP Photo/Winslow Townson

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

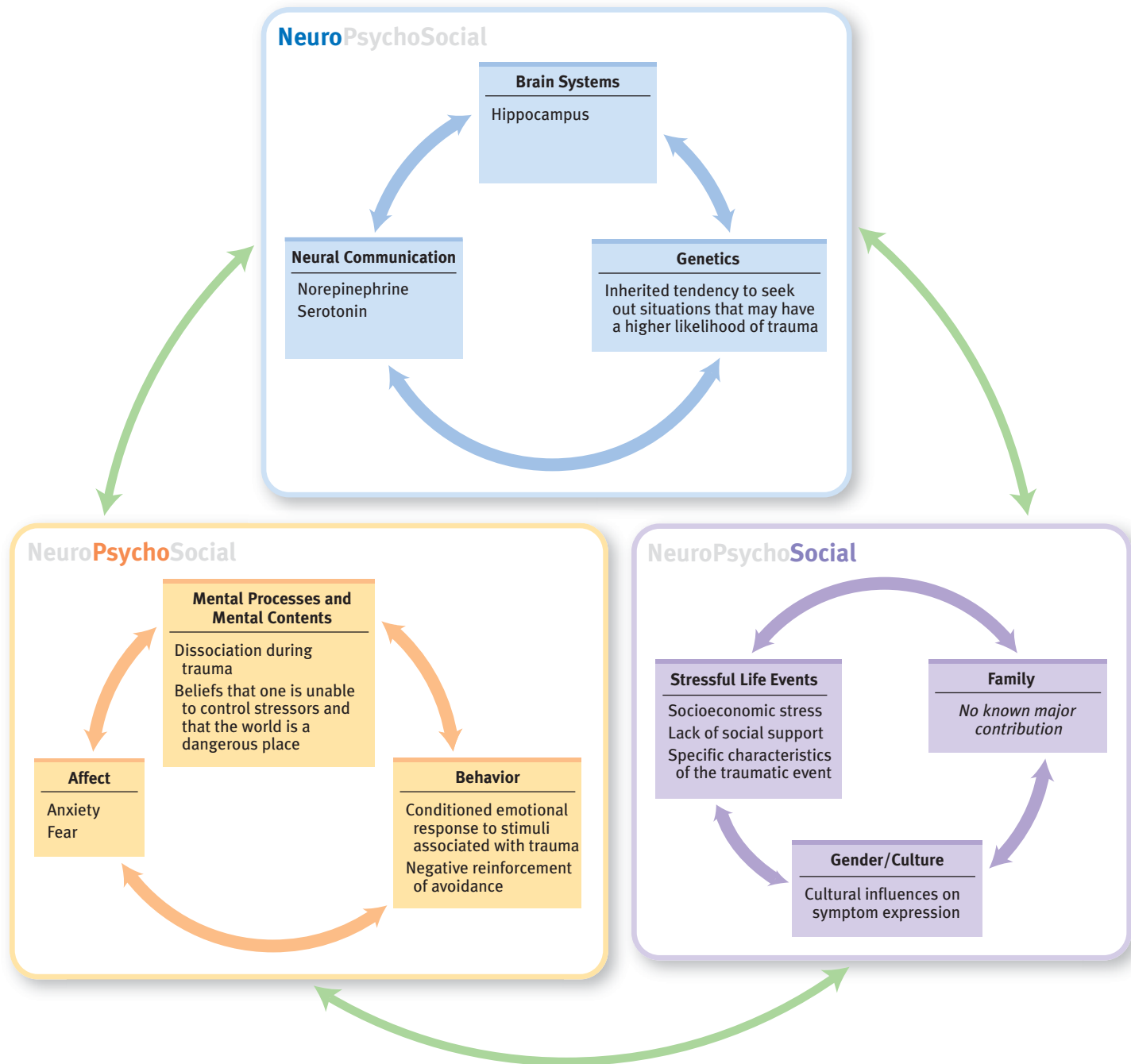


FIGURE 7.2 • Feedback Loops in Understanding PTSD

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

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

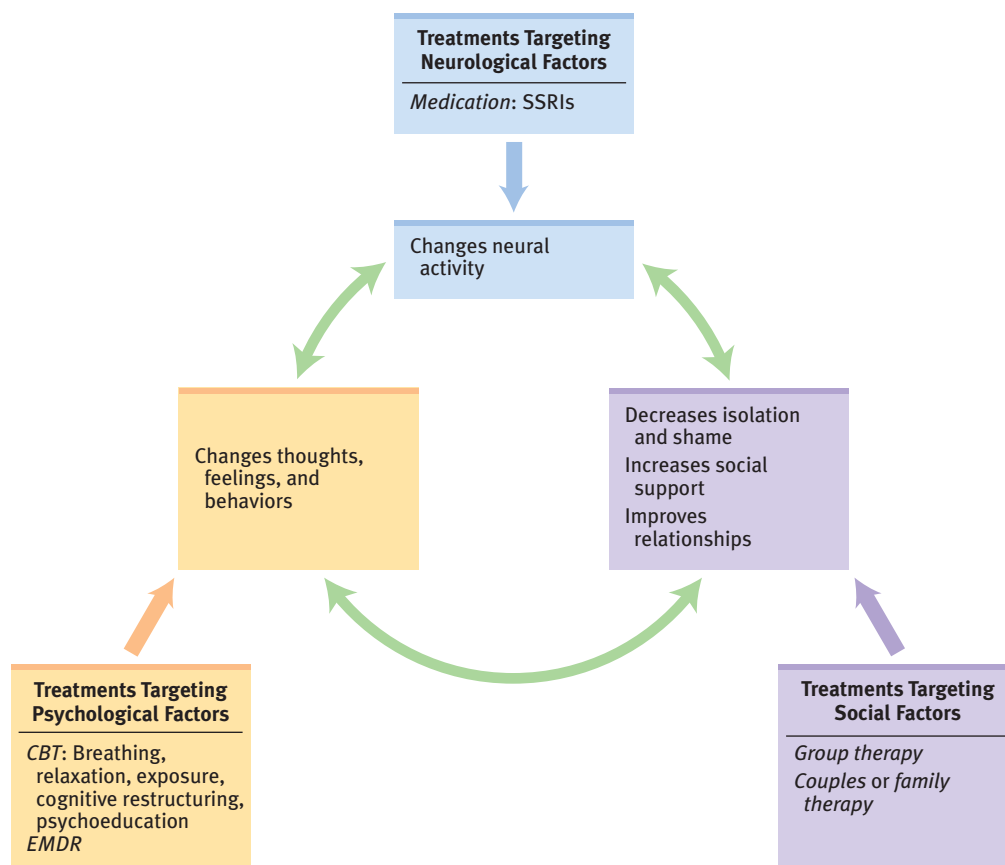


FIGURE 7.3 • Feedback Loops in Treating PTSD

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

Clinical Material

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

Chapter Stories: Illustration and Integration

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



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

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

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

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

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

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

From the Outside

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

From the Inside

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

Learning About Disorders: Consolidated Tables to Consolidate Learning

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

DSM-5 Diagnostic Criteria Tables

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

Facts at a Glance Tables for Disorders

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

New Features

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

Current Controversies

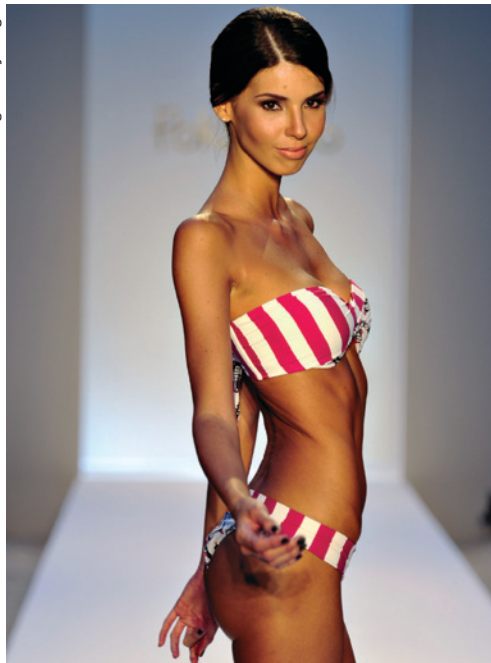
New to this edition, each clinical chapter includes a brief discussion about a current controversy related to a disorder—its diagnosis or its treatment. Examples include whether the new diagnoses in DSM-5 of mild and major neurocognitive disorders are net positive or negative changes from DSM-IV, and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

Getting the Picture

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

 GETTING THE PICTURE

Arun Nevader/FilmMagic/Getty Images



© PhotoAlto sas/Alamy

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

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

Summarizing and Consolidating

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

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

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

End-of-Chapter Review: *Summing Up*

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

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

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

Integrated Gender and Cultural Coverage

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

- *Facts at a Glance* tables provide relevant cultural and gender data for each specific disorder
- Cultural differences in evaluating symptoms of disorders in psychological research, 63, 66
- Cultural differences in assessing social factors in psychological assessment, 75, 103–104
- Gender and cultural consideration in depressive disorders, 127
- Suicide—cultural factors, 150
- Cultural influence of substance abuse, 263
- Alcoholism rate variations by gender and culture, 271–273, 411
- Gender and culture differences in schizophrenia, 377
- Oppositional defiant disorder—cultural considerations for diagnosis, 468
- Gender differences in different types of dementia (Table 15.9), 501

Media and Supplements

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

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

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

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

The screenshot shows the LaunchPad website for 'Abnormal Psychology'. At the top, the 'LaunchPad' logo is prominently displayed in blue, with the 'macmillan HIGHER EDUCATION' logo to its right. Below the logo, the navigation bar includes 'Home > What is LaunchPad?' and a 'Share' button. A vertical sidebar on the left contains menu items: 'What is LaunchPad?', 'Why LaunchPad Works', 'Testimonials', 'Find Your LaunchPad', 'Feature Overviews', and 'User Guides'. A large red 'Show Me More' button is at the bottom of this sidebar. The main content area features a central video player showing a course interface with a large '1' in a blue circle. To the right of the video, a text box reads: 'LaunchPad ...because technology should never get in the way. LaunchPad is an intuitive course space with curated, pre-built lessons. Watch the video to learn more.' Below the video and text are four buttons: 'TRY... LEARNINGCurve Adaptive Quizzing', 'LMS Integration', and 'Find Your Rep'.

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

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

Also Available for Instructors

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

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

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

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

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

Acknowledgments

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

REVIEWERS OF THE FIRST EDITION

Eileen Achorn, University of Texas at San Antonio
Tsippa Ackerman, Queens College
Paula Alderette, University of Hartford
Richard Alexander, Muskegon Community College
Leatrice Allen, Prairie State College
Liana Apostolova, University of California, Los Angeles
Hal Arkowitz, University of Arizona
Randolph Arnau, University of Southern Mississippi
Tim Atchison, West Texas A&M University
Linda Bacheller, Barry University
Yvonne Barry, John Tyler Community College
David J. Baxter, University of Ottawa
Bethann Bierer, Metropolitan State College of Denver
Dawn Bishop Mclin, Jackson State University
Nancy Blum, California State University, Northridge
Robert Boland, Brown University
Kathryn Bottonari, University at Buffalo/SUNY
Joan Brandt Jensen, Central Piedmont Community College
Franklin Brown, Eastern Connecticut State University
Eric Bruns, Campbellsville University
Gregory Buchanan, Beloit College
Jeffrey Buchanan, Minnesota State University–Mankato
NiCole Buchanan, Michigan State University
Danielle Burchett, Kent State University



Glenn M. Callaghan, San Jose State University
Christine Calmes, University at Buffalo/SUNY
Rebecca Cameron, California State University, Sacramento
Alastair Cardno, University of Leeds
Kan Chandras, Fort Valley State University
Jennifer Cina, University of St. Thomas
Carolyn Cohen, Northern Essex Community College
Sharon Cool, University of Sioux Falls
Craig Cowden, Northern Virginia Community College
Judy Cusumano, Jefferson College of Health Sciences
Daneen Deptula, Fitchburg State College
Dallas Dolan, The Community College of Baltimore County
Mitchell Earleywine, University at Albany/SUNY
Christopher I. Eckhardt, Purdue University
Diane Edmond, Harrisburg Area Community College
James Eisenberg, Lake Erie College
Frederick Ernst, University of Texas–Pan American
John P. Garofalo, Washington State University–Vancouver
Franklin Foote, University of Miami
Sandra Jean Foster, Clark Atlantic University
Richard Fry, Youngstown State
Murray Fullman, Nassau Community College
Irit Gat, Antelope Valley College
Marjorie Getz, Bradley University
Andrea Goldstein, South University
Steven Gomez, Harper College
Carol Globiana, Fitchburg State University
Cathy Hall, East Carolina University
Debbie Hanke, Roanoke Chowan Community College
Sheryl Hartman, Miami Dade College
Wanda Haynie, Greenville Technical College
Brian Higley, University of North Florida
Debra Hollister, Valencia Community College
Kris Homan, Grove City College
Farrah Hughes, Francis Marion University
Kristin M. Jacquin, Mississippi State University
Annette Jankiewicz, Iowa Western Community College
Paul Jenkins, National University
Cynthia Kalodner, Towson University
Richard Kandus, Mt. San Jacinto College
Jason Kaufman, Inver Hills Community College
Jonathan Keigher, Brooklyn College
Mark Kirschner, Quinnipiac University
Cynthia Kreutzer, Georgia Perimeter College, Clarkston
Thomas Kwapil, University of North Carolina at Greensboro

Kristin Larson, Monmouth College
Dean Lauterbach, Eastern Michigan University
Robert Lichtman, John Jay College of Criminal Justice
Michael Loftin, Belmont University
Jacquelyn Loupis, Rowan-Cabarrus Community College
Donald Lucas, Northwest Vista College
Mikhail Lyubansky, University of Illinois, Urbana-Champaign
Eric J. Mash, University of Calgary
Janet Matthews, Loyola University
Dena Matzenbacher, McNeese State University
Timothy May, Eastern Kentucky University
Paul Mazeroff, McDaniel University
Dorothy Mercer, Eastern Kentucky University
Paulina Mulhaupt, Macomb Community College
Mark Nafziger, Utah State University
Craig Neumann, University of North Texas
Christina Newhill, University of Pittsburgh
Bonnie Nichols, Arkansas NorthEastern College
Rani Nijjar, Chabot College
Janine Ogden, Marist College
Randall Osborne, Texas State University–San Marcos
Patricia Owen, St. Mary's University
Crystal Park, University of Connecticut
Karen Pfof, Illinois State University
Daniel Philip, University of North Florida
Skip Pollack, Mesa Community College
William Price, North Country Community College
Linda Raasch, Normandale Community College
Christopher Ralston, Grinnell College
Lillian Range, Our Lady of Holy Cross College
Judith Rauenzahn, Kutztown University
Jacqueline Reihman, State University of New York at Oswego
Sean Reilley, Morehead State University
David Richard, Rollins College
Harvey Richman, Columbus State University
J.D. Rodgers, Hawkeye Community College
David Romano, Barry University
Sandra Rouce, Texas Southern University
David Rowland, Valparaiso University
Lawrence Rubin, St. Thomas University
Stephen Rudin, Nova Southeastern University
Michael Rutter, Canisius College
Thomas Schoeneman, Lewis and Clark College
Stefan E. Schulenberg, University of Mississippi
Christopher Scribner, Lindenwood University

Russell Searight, Lake Superior State University
Daniel Segal, University of Colorado at Colorado Springs
Frances Sessa, Pennsylvania State University, Abington
Fredric Shaffer, Truman State University
Eric Shiraev, George Mason University
Susan J. Simonian, College of Charleston
Melissa Snarski, University of Alabama
Jason Spiegelman, Community College of Beaver County
Michael Spiegler, Providence College
Barry Stennett, Gainesville State College
Carla Strassle, York College of Pennsylvania
Nicole Taylor, Drake University
Paige Telan, Florida International University
Carolyn Turner, Texas Lutheran University
MaryEllen Vandenberg, Potomac State College of West Virginia
Elaine Walker, Emory University
David Watson, MacEwan University
Karen Wolford, State University of New York at Oswego
Shirley Yen, Brown University
Valerie Zurawski, St. John's University
Barry Zwibelman, University of Miami

REVIEWERS OF THE SECOND EDITION

Mildred Cordero, Texas State University
Brenda East, Durham Technical Community College
Jared F. Edwards, Southwestern Oklahoma State University
Rick Fry, Youngstown State University
Kelly Hagan, Bluegrass Community & Technical College
Jay Kosegarten, Southern New Hampshire University
Katherine Lau, University of New Orleans
Linda Lelii, St. Josephs University
Tammy L. Mahan, College of the Canyons
David McAllister, Salem State University
Kanoa Meriwether, University of Hawaii, West Oahu
Bryan Neighbors, Southwestern University
Katherine Noll, University of Illinois–Chicago
G. Michael Poteat, East Carolina University
Kimberly Renk, University of Central Florida
JD Rodgers, Hawkeye Community College
Eric Rogers, College of Lake County
Ty S. Schepis, Southwest Texas State University
Gwendolyn Scott-Jones, Delaware State University
Jason Shankle, Community College of Denver
Jeff Sinkele, Anderson University
Marc Wolpoff, Riverside Community College

Many thanks also go to our Advisory Board for the helpful insights and suggestions:

Randy Arnau, University of Southern Mississippi
Carolyn Cohen, Northern Essex Community College
Christopher Dyszelski, Madison Area Technical College
Brenda East, Durham Technical Community College
Rick Fry, Youngstown State University
Jeff Henriques, University of Wisconsin
Katherine Noll, University of Illinois at Chicago
Marilee Ogren, Boston College
Linda Raasch, Normandale Community College
Judith Rauenzahn, Kutztown University
Susan Simonian, College of Charleston

For double checking our DSM-5 information, we want to give a loud shout out of thanks to:

Rosemary McCullough, New England Counseling Associates
Jim Foley, College of Wooster

Although our names are on the title page, this book has been a group effort. Special thanks to a handful of people who did armfuls of work in the early stages of bringing the book to life in the first edition: Nancy Snidman, Children's Hospital Boston, for help with the chapter on developmental disorders; Shelley Greenfield, McLean Hospital, for advice about the etiology and treatment of substance abuse; Adam Kissel, for help in preparing the first draft of some of the manuscript; Lisa McLellan, senior development editor, for conceiving the idea of "Facts at a Glance" tables; Susan Clancy for help in gathering relevant literature; and Lori Gara-Matthews and Anne Perry for sharing a typical workday of a pediatrician and a school psychologist, respectively.

To the people at Worth Publishers who have helped us bring this book from conception through gestation and birth, many thanks for your wise counsel, creativity, and patience. Specifically, for the second edition, thanks to: Jessica Bayne, our acquisitions editor and rock; Thomas Finn, our development editor who went over and over and over each chapter with good humor, patience, and a needed "outside" eye; Jim Strandberg, our pre-development editor, whose advice, support, and amazing attention to detail were sorely appreciated; Christine Cervoni and her crew at TSI Graphics for getting the manuscript ready to become a book; Babs Reingold (again), art director, for her out-of-the-box visual thinking. We'd also like to thank Roman Barnes and Robin Fadool for their help with photo research; Eileen Lang and Catherine Michaelson for helping prepare the manuscript for turnover; Anthony Casciano for helping to wrangle our supplements and media packages; and Kate Nurre for marketing our book. And a special note of thanks to Carlise Stembridge for organizing and helping us with our advisory board.

On the personal side, we'd like to thank our children—Neil, David, and Justin—for their unflagging love and support during this project and for their patience with our foibles and passions. We also want to thank: our mothers—Bunny and Rhoda—for allowing us to know what it means to grow up with supportive and loving parents; Steven Rosenberg, for numerous chapter story suggestions; Merrill Mead-Fox, Melissa Robbins, Jeanne Serafin, Amy Mayer, Kim Rawlins, and Susan Pollak, for sharing their clinical and personal wisdom over the last three decades; Michael Friedman and Steven Hyman, for answering our esoteric pharmacology questions; and Jennifer Shephard and Bill Thompson, who helped track down facts and findings related to the neurological side of the project.

Robin S. Rosenberg
Stephen M. Kosslyn

This page intentionally left blank

ABNORMAL PSYCHOLOGY



The History of Abnormal Psychology

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

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

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

The Three Criteria for Determining Psychological Disorders

- Distress
- Impairment in Daily Life
- Risk of Harm
- Context and Culture

Views of Psychological Disorders Before Science

- Ancient Views of Psychopathology
- Forces of Evil in the Middle Ages and the Renaissance
- Rationality and Reason in the 18th and 19th Centuries

The Transition to Scientific Accounts of Psychological Disorders

- Freud and the Importance of Unconscious Forces
- The Humanist Response

Scientific Accounts of Psychological Disorders

- Behaviorism
- The Cognitive Contribution
- Social Forces
- Biological Explanations
- The Modern Synthesis of Explanations of Psychopathology



Abnormal psychology

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

Psychological disorder

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

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

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

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

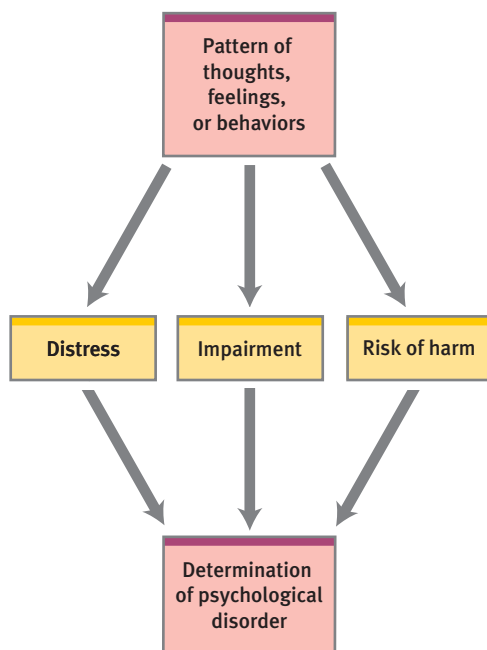


FIGURE 1.1 • Determining a Psychological Disorder: Three Criteria

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

The Three Criteria for Determining Psychological Disorders

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

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

Distress

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

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

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

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

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

Impairment in Daily Life

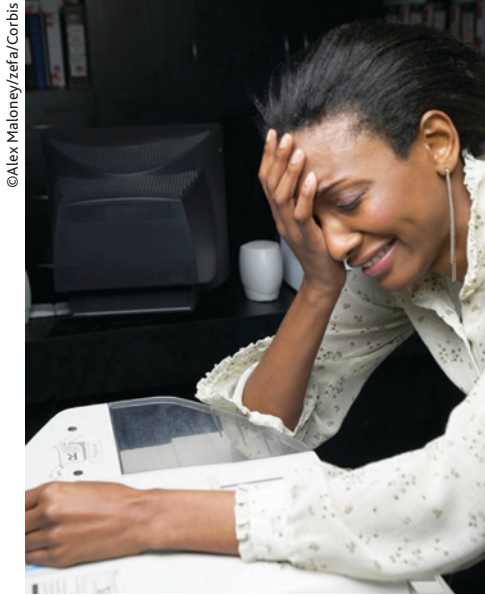
Impairment is a significant reduction of a person's ability to function in some important area of life. A person with a psychological disorder may be impaired in functioning at school, at work, in taking adequate care of himself or herself, or in relationships. For example, a woman's drinking problem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

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



Archive Photos/Getty Images

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



©Alex Maloney/Zetefal/Corbis

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

Psychosis

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

Hallucinations

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

Delusions

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

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

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

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

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

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

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

Risk of Harm

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

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

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

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

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

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

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

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

Context and Culture

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

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



Tom Wargacki/WireImage/Getty Images

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

TABLE 1.1 • Psychological Disorders: Facts at a Glance

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



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

Culture

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

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

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

Culture, too, can play a crucial role in how mental illness is diagnosed. To psychologists, **culture** is the shared norms and values of a society; these norms and values are explicitly and implicitly conveyed to members of the society by example and through the use of reward and punishment. Different societies and countries have their own cultures, each with its own view of what constitutes mental health and mental illness—even what constitutes distress and how to communicate that distress. For example, in some cultures, distress may be conveyed by complaints of fatigue or tiredness rather than by sadness or depressed mood. Some sets of symptoms that are recognized as disorders in other parts of the world are not familiar to most Westerners. One example, described in Case 1.1, is *koro*, a disorder that arises in some people from countries in Southeast Asia. Someone with *koro* rapidly develops an intense fear that his penis—or her nipples

and vulva—will retract into the body and possibly cause death (American Psychiatric Association, 2013). This disorder may break out in clusters of people, like an epidemic (Bartholomew, 1998; Sachdev, 1985). Similar genital-shrinking fears have been reported in India and in West African countries (Dzokoto & Adams, 2005; Mather, 2005).

CASE 1.1 • FROM THE OUTSIDE: Cultural Influence on Symptoms

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

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

(Kar, 2005, p. 34)

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

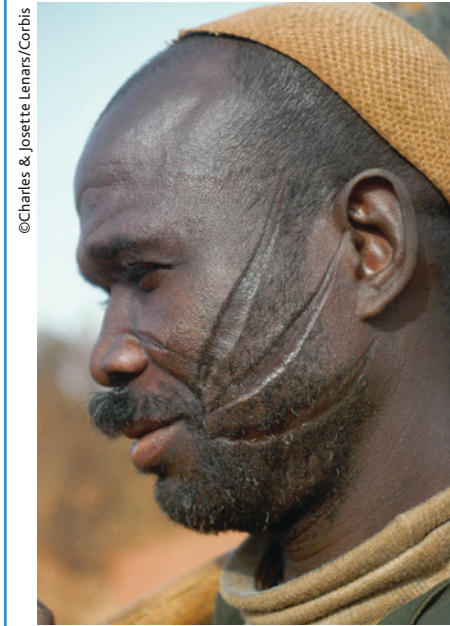
Let's examine the behavior of the Beales within their context and culture. Big Edie's father claimed that his ancestors were prominent French Catholics; she and her siblings grew up financially well off. Big Edie was a singer and a performer, but, as a product of her time, she was expected to marry well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

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

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

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

GETTING THE PICTURE



©Charles & Josette Lenars/Corbis



UpperCut Images/Superstock

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