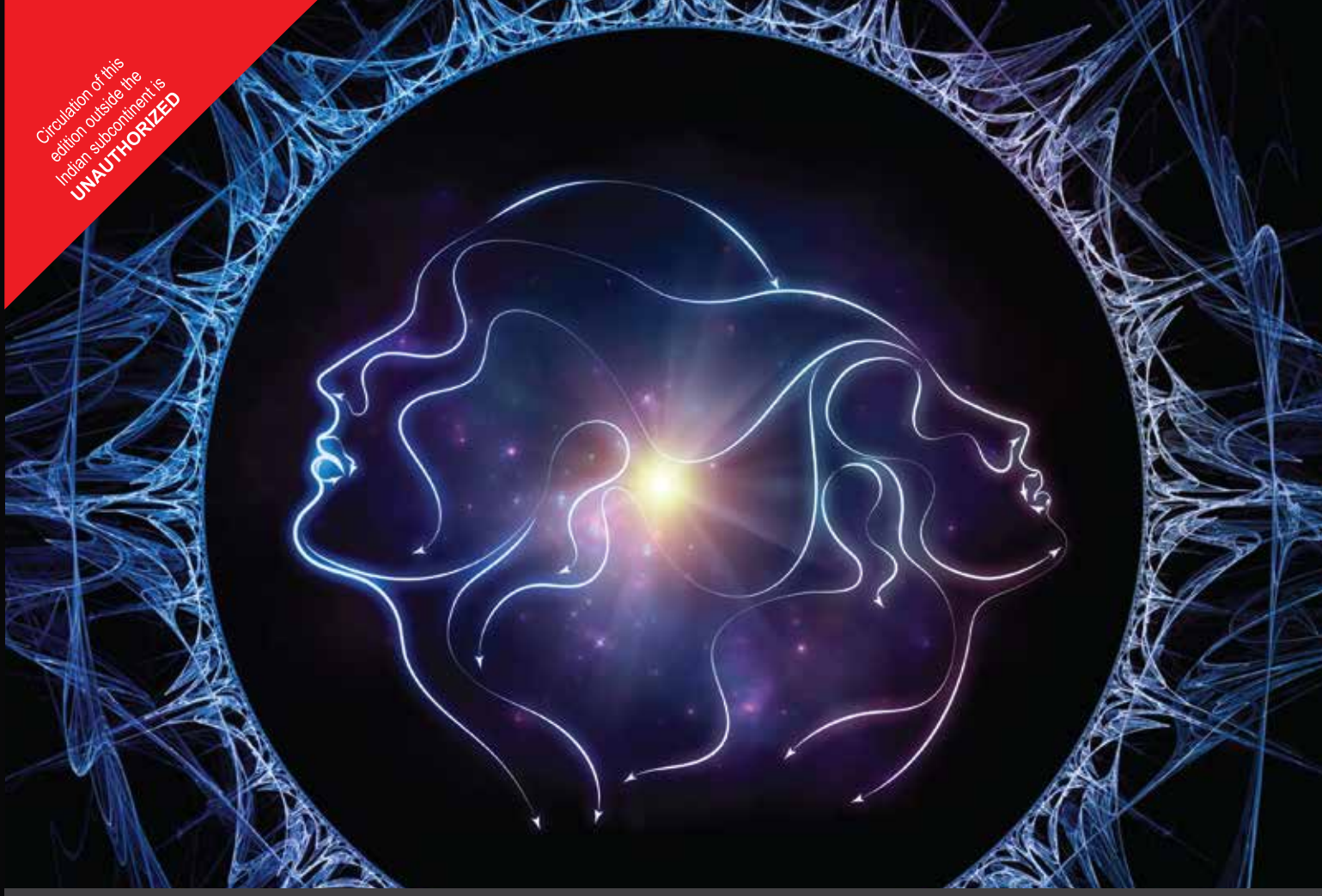

SIXTEENTH EDITION

ABNORMAL PSYCHOLOGY

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Pearson

abnormal psychology

sixteenth edition

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brief contents

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contents

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features

developments in RESEARCH

developments in THINKING

developments in PRACTICE

the WORLD around us

UNRESOLVED issues

DSM-5 Boxes

THINKING CRITICALLY about *DSM-5*

What's New in *DSM-5*? A Quick Guide

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

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

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preface

The guidelines and standards that we follow in our professional activities are not set in stone. Change is a big part of life and new research or novel new theories can impact the way mental health professionals view problems. Although many of the ideas and diagnostic concepts in the field of abnormal psychology have persisted for hundreds of years, changes in thinking do occur. And, at some point there are events that occur that force a rethinking of some issues. Most recently in abnormal psychology, the publication of the *DSM-5*, after years of development and considerable controversy, is one of those momentous changes. Reflecting this, we have revised this new edition of *Abnormal Psychology* to reflect the most up-to-date information about diagnostic categories, classifications, and criteria.

Every time we work on a revision of *Abnormal Psychology* we are reminded of how dynamic and vibrant our field is. Developments in areas such as genetics, brain imaging, behavioral observation, and classification, as well changes in social and government policy and in legal decisions, add to our knowledge base and stimulate new treatments for those whose lives are touched by mental disorders. This is exciting. But the rapid progress of our field also presents its own challenges. One of the most important is how best to provide students with an integrated perspective—one that respects new ideas and discoveries and places them into the existing body of knowledge in a way that emphasizes multiple perspectives, provokes thought, and increases awareness.

We use a biopsychosocial approach to provide a sophisticated appreciation of the total context in which abnormalities of behavior occur. For ease of understanding we also present material on each disorder in a logical and consistent way. More specifically, we focus on three significant aspects: (1) the clinical picture, where we describe the symptoms of the disorder and its associated features; (2) factors involved in the development of the disorder; and (3) treatment approaches. In each case, we examine the evidence for biological, psychosocial (i.e., psychological and interpersonal), and sociocultural (the broader social environment of culture and subculture) influences. Because we wish never to lose sight of the person, we try to integrate as much case material as we can into each chapter. An additional feature of this book is a focus on treatment. Although treatment is discussed in every chapter in the context of specific disorders, we also include a separate chapter that addresses issues in treatment more broadly. This provides students with increased understanding of a wide range of treatment approaches and permits more in-depth coverage than is possible in specific disorder–based chapters.

The Butcher–Hooley–Mineka author team is in a unique position to provide students with an integrated and comprehensive understanding of abnormal psychology. Each author is a noted researcher, an experienced teacher, and a licensed clinician. Each brings different areas of expertise and diverse research interests to the textbook. Importantly, these different perspectives come together in a systematically integrated text that is accessible to a broad audience. The depth and breadth of the author team provides students with learning experiences that can take them to new levels of understanding. Our approach emphasizes the importance of research as well as the need to translate research findings into informed and effective clinical care for all who suffer from mental disorders.

Abnormal Psychology has a long and distinguished tradition as an undergraduate text. Ever since James Coleman wrote the first edition many years ago, this textbook has been considered the most comprehensive in the field. Along the way there have been many changes. However, the commitment to excellence in this now-classic textbook has remained ever constant. In this new edition, we seek to open up the fascinating world of abnormal psychology, providing students with comprehensive and up-to-date knowledge in an accessible and engaging way. We hope that this newest edition conveys some of the passion and enthusiasm for the topic that we still experience every day.

Why Do You Need This New Edition?

If you're wondering why you should buy this new edition of Abnormal Psychology, here are 7 good reasons!

1. The sixteenth edition of Abnormal Psychology includes the most up-to-date and in-depth information about biological influences on the entire spectrum of behavioral abnormalities, while still maintaining its comprehensive and balanced bio-psychosocial approach to understanding abnormal behavior.
2. After years of planning, *DSM-5* was published in May 2013. This major revision of the diagnostic system means that the diagnostic criteria for many disorders have changed. To stay current, you need to know about the changes that have been made in *DSM-5*. Books that do not include coverage of *DSM-5* are books that are out of date.
3. Our new edition provides you with detailed tables showing the current *DSM-5* diagnostic criteria for all the disorders covered in the book.

4. New highlight boxes alert you to some of the most important changes in *DSM-5*. These include changes to the diagnostic criteria for attention-deficit hyperactivity disorder as well as new diagnoses such as binge eating disorder and premenstrual dysphoric disorder.
5. Other feature boxes provide opportunities for critical thinking by illustrating some of the controversies associated with the changes that were (or were not) made. Throughout the book we also provide readers with different perspectives on the likely implications that these changes will have for clinical diagnosis and research in psychopathology.
6. Changes have been made in many chapters to improve the flow of the writing and enhance learning. Reflecting the ever-changing field of abnormal psychology, new references have been added and new research findings highlighted.
7. Finally, at the beginning of each chapter clearly defined Learning Objectives provide the reader with an overview of topics and issues that will be included in the chapter. At the end of each chapter a summary of answers to these Learning Objective questions are provided. In-Review Questions at the end of major sections within chapters also provide additional opportunities for self-assessment and increased learning.

What's New

A major change in the 16th edition of *Abnormal Psychology* is the focus on *DSM-5*. This important revision to the diagnostic system was published in May 2013. To assist both instructors and students, we include specialized feature boxes, highlighting many of the key changes that were made in *DSM-5*. This makes new material immediately accessible. Other important changes in *DSM-5* are also mentioned throughout the text. Providing students with this material as soon as possible after the publication of *DSM-5* reflects our commitment to staying ahead of the curve and to providing students with the most up-to-date information possible.

This new edition of *Abnormal Psychology* has been redesigned to remain visually engaging to the newest generation of students. Chapters begin with learning objective questions. These orient the reader to the material that will be presented in each specific chapter. Learning objective questions are also repeated at the end of each chapter and answers to each are provided. Most chapters also begin with a case study that illustrates the mental health problems to be addressed in the chapter. This serves to capture students' interest and attention right from the outset. Numerous new photographs and illustrations have also been added. In addition, this edition also contains updated case material, new unresolved issues (e.g., why is the study of trauma so contentious?; why are recovery rates in schizophrenia not improving?), and new feature boxes designed to be of high interest to students (e.g., non-suicidal self-injury disorder). Reflecting the ever-changing field of abnormal psychology, numerous new references have been added. Outdated material has been replaced, current findings have been included, and new developments have been identified. The 16th edition also includes the most up-to-date and in-depth information about the role of biological factors in abnormal behavior, while at the same time placing this in the context of a comprehensive biopsychosocial approach. Our coverage of cultural issues and diversity has also been strengthened. We hope readers will be pleased to know that all of this has been accomplished without adding length to the book!

About the Indian Edition

Ever since the dawn of civilization, humanity has been toiling hard, both in the East and the West, to conquer pain and disease. An incessant urge of man to understand the ramifications of anomalous mental behavior so that timely and adequate relief to the afflicted could be provided is a testimony to that effort. The rapid advances seen in the modern era in psychopathology highlight the vast uncharted road that is yet to be treaded, which is indeed a challenge to the scientists and professionals in the field of abnormal psychology.

Although there are many well-written books on abnormal psychology in the market, yet Butcher, Hooley, and Mineka's *Abnormal Psychology,* enjoys an unparalleled uniqueness in terms of its lucidity, style, updated information, and coverage, which is attested by students and researchers in the field. Besides providing the most up-to-date information in terms of the material based on *DSM-5*, the present volume also lets its readers reflect on several issues relating to their future research pursuits.

To contextualize the present edition for the Indian readers, either Indian case studies or Indian adaptation of Western case studies have been included. This edition also covers several culture-specific modifications (e.g., coverage of *Dhat* syndrome, the phenomenon or event of spirit possession as well as faith healing), addition of recent developments (e.g., therapies of neurofeedback for the regulation of dysfunctional cortico-cortical arousal syndromes, such as, depression, relapse prevention strategies for bipolar disorders, and mindfulness and acceptance, and commitment therapy for schizophrenia), inclusion of views about abnormality in ancient Indian texts (e.g., the *Atharva Veda* and *Ayurveda*), and addition of subsections on Yoga, meditation and their role in the management of psychopathology apart from presenting the incidence and prevalence rate in India of almost all major disorders.

Of special importance to the Indian readers is the presentation of policies and legislation of mental health in India including Mental Health Act, 1987, in Chapter 17 that has not found mention in any textbook so far. As far as possible important Indian research studies and research data, wherever available, have been mentioned along with their original sources.

Taken as a whole, this Indian adaptation of *Abnormal Psychology* provides a good blend of global and indigenous materials in bringing out the complex issues related with abnormality. This adaptation hopes to make out a case for undertaking more researches in abnormal psychology based on indigenous models to bring to light hitherto less known aspects in this important area.

Features and Pedagogy

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

Features

FEATURE BOXES

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

CRITICAL THINKING

New to this edition are special highlight boxes about *DSM-5*. Many of the revisions to *DSM-5* were highly contentious and controversial. A new feature box called "Thinking Critically About *DSM-5*" introduces students to the revised *DSM* and encourages them to think critically about the implications of these changes.

UNRESOLVED ISSUES

All chapters include end-of-chapter sections that demonstrate how far we have come and how far we have yet to go in our understanding of psychological disorders. The topics covered here provide insight into the future of the field and expose students to some controversial topics. New to this edition is a discussion of the problems associated with the study of trauma. In another chapter, we raise the contentious issue of whether treatment with antipsychotic medications is helpful or harmful in the very long term.

Pedagogy

LEARNING OBJECTIVES

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

CASE STUDIES

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

IN REVIEW QUESTIONS

Questions appear at the end of each major section within the chapter, providing regular opportunities for self-assessment as students read and further reinforce their learning.

DSM-5 BOXES

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

RESEARCH CLOSE-UP TERMS

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

CHAPTER SUMMARIES

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

KEY TERMS

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

Acknowledgments

It takes each member of the author team more than a year of focused work to produce a new edition of this textbook. During this time, family and friends receive much less attention than they deserve. We are aware that a few lines of acknowledgement in a preface do little to compensate those close to us for all the inconveniences and absences they have endured. Nonetheless, James Butcher would like to thank his wife, Carolyn L. Williams, and his children, Holly Butcher, Sherry Butcher, and Jay Butcher, for their patience and support during this time. Jill Hooley is ever grateful to Kip Schur for his patience, love, support, and ability to retain a sense of humor throughout the revision process. She also thanks Blake T. Haskell for providing valuable information used in Chapter 9. The efforts of graduate student Sara Masland and undergraduates Lauren Fields and Deirdre Gorman are also gratefully acknowledged. Susan Mineka wishes to thank her graduate students, friends, and family for their patience and support for the duration of this project. She also extends special thanks to J. Michael Bailey.

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Many experts, researchers, and users of this book provided us with comments on individual chapters. We are extremely grateful for their input and feedback. Their knowledge and expertise help us keep this text current and accurate. We thank Tia Almpoura and Mohsen Jadidi who provided valuable help. We are also especially grateful to the many reviewers who have given us invaluable feedback on this and previous editions of *Abnormal Psychology*.

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James N. Butcher, Jill M. Hooley, and Susan Mineka

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Chandra Bhal Dwivedi

about the authors

James N. BUTCHER

Professor Emeritus, University of Minnesota

James N. Butcher was born in West Virginia. He enlisted in the army when he was 17 years old and served in the airborne infantry for 3 years, including a 1-year tour in Korea during the Korean War. After military service, he attended Guilford College, graduating in 1960 with a BA in psychology. He received an MA in experimental psychology in 1962 and a PhD in clinical psychology from the University of North Carolina at Chapel Hill. He was awarded Doctor Honoris Causa from the Free University of Brussels, Belgium, in 1990 and an honorary doctorate from the University of Florence, Florence, Italy, in 2005. He is currently professor emeritus in the Department of Psychology at the University of Minnesota. He was associate director and director of the clinical psychology program at the university for 19 years. He was a member of the University of Minnesota Press's MMPI Consultative Committee, which undertook the revision of the MMPI in 1989. He was formerly the editor of *Psychological Assessment*, a journal of the American Psychological Association, and serves as consulting editor or reviewer for numerous other journals in psychology and psychiatry. Dr. Butcher was actively involved in developing and organizing disaster response programs for dealing with human problems following airline disasters during his career. He organized a model crisis intervention disaster response for the Minneapolis-St. Paul Airport and organized and supervised the psychological services offered following two major airline disasters: Northwest Flight 255 in Detroit, Michigan, and Aloha Airlines on Maui. He is a fellow of the Society for Personality Assessment. He has published 60 books and more than 250 articles in the fields of abnormal psychology, cross-cultural psychology, and personality assessment.

Jill M. HOOLEY

Harvard University

Jill M. Hooley is a professor of psychology at Harvard University. She is also the head of the experimental psychopathology and clinical psychology program at Harvard. Dr. Hooley was born in England and received a B.Sc. in psychology from the University of Liverpool. This was followed by research work at Cambridge University. She then attended Magdalen College, Oxford, where she completed her D.Phil. After a move to the United States and additional training in clinical psychology at SUNY Stony Brook, Dr. Hooley took a position at Harvard, where she has been a faculty member since 1985.

Dr. Hooley has a long-standing interest in psychosocial predictors of psychiatric relapse in patients with severe psychopathology such as schizophrenia and depression. Her research has been supported by grants from the National Institute of Mental Health and by the Borderline Personality Disorder Research Foundation. She uses fMRI to study emotion regulation in people who are vulnerable to depression and in people who are suffering from borderline personality disorder. Another area of research interest is nonsuicidal self-harming behaviors such as skin cutting or burning.

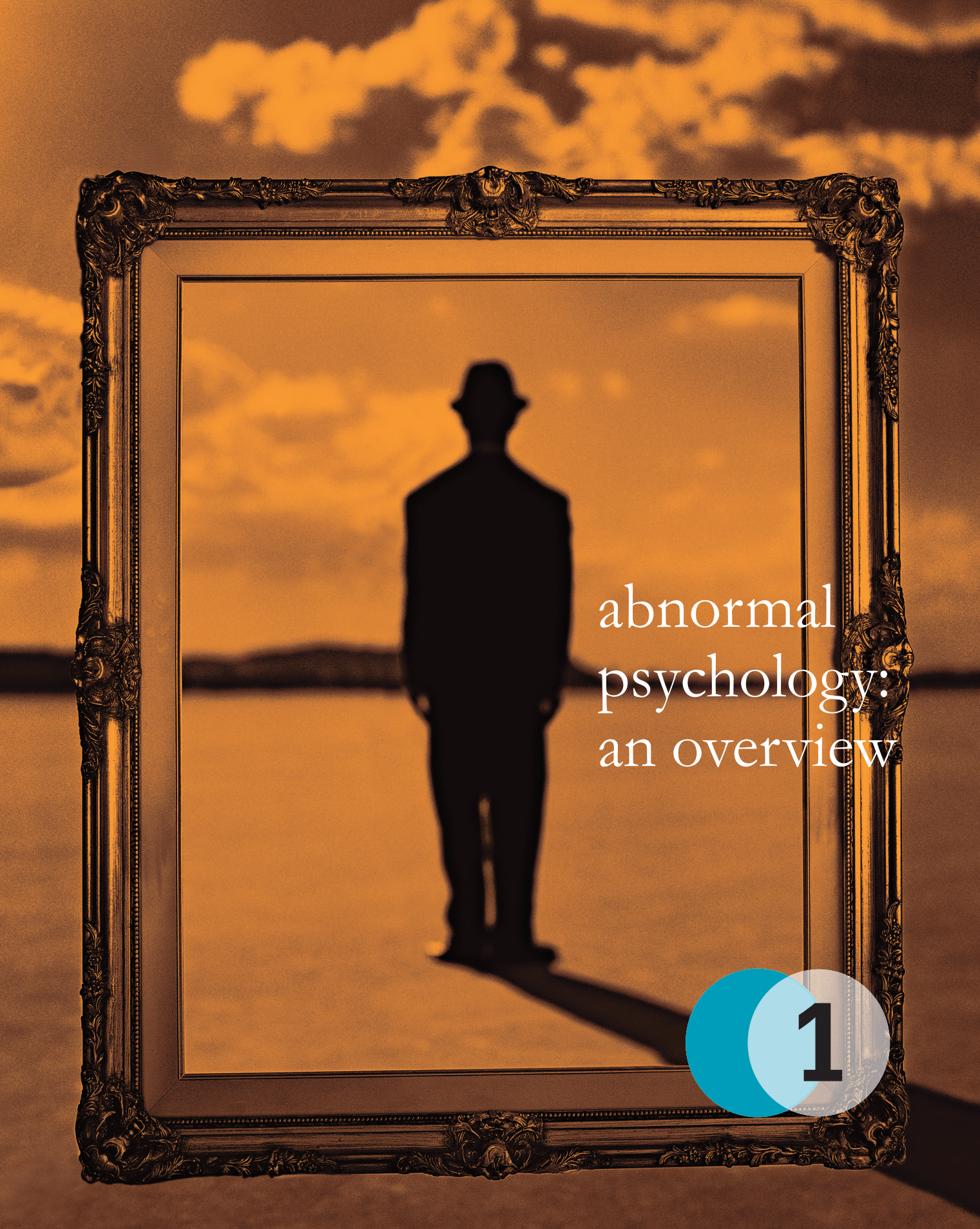
In 2000, Dr. Hooley received the Aaron T. Beck Award for Excellence in Psychopathology Research. She is also a past president of the Society for Research in Psychopathology. The author of many scholarly publications, Dr. Hooley was appointed as Associate Editor for Clinical Psychological Science in 2012. She is also an associate editor for *Applied and Preventive Psychology* and serves on the editorial boards of several journals including the *Journal of Consulting and Clinical Psychology*, the *Journal of Family Psychology*, *Family Process*, and *Personality Disorders: Theory, Research and Treatment*.

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

Susan MINEKA

Northwestern University

Susan Mineka, born and raised in Ithaca, New York, received her undergraduate degree magna cum laude in psychology at Cornell University. She received a PhD in experimental psychology from the University of Pennsylvania and later completed a formal clinical retraining program from 1981 to 1984. She taught at the University of Wisconsin–Madison and at the University of Texas at Austin before moving to Northwestern University in 1987. Since 1987 she has been a professor of psychology at Northwestern, and from 1998 to 2006 she served as director of clinical training there. She has taught a wide range of undergraduate and graduate courses, including introductory psychology, learning, motivation, abnormal psychology, and cognitive-behavior therapy. Her current research interests include cognitive and behavioral approaches to understanding the etiology, maintenance, and treatment of anxiety and mood disorders. She is currently a Fellow of the American Psychological Association, the American Psychological Society, and the Academy of Cognitive Therapy. She has served as editor of the *Journal of Abnormal Psychology* (1990–1994). She also served as associate editor for *Emotion* from 2002 to 2006 and is on the editorial boards of several of the leading journals in the field. She was also president of the Society for the Science of Clinical Psychology (1994–1995) and was president of the Midwestern Psychological Association (1997). She also served on the American Psychological Association's Board of Scientific Affairs (1992–1994, chair 1994), on the Executive Board of the Society for Research in Psychopathology (1992–1994, 2000–2003), and on the Board of Directors of the American Psychological Society (2001–2004). During 1997 and 1998 she was a fellow at the Center for Advanced Study in the Behavioral Sciences at Stanford.



abnormal psychology: an overview

1

learning objectives

1.1
How do we define abnormality and classify mental disorders?

1.2
What are the advantages and disadvantages of classification?

1.3
How common are mental disorders? Which disorders are most prevalent?

1.4
Why do we need a research-based approach in abnormal psychology?

1.5
How do we gather information about mental disorders?

1.6
What kinds of research designs are used to conduct research in abnormal psychology?

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

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

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

Shabana Shabana is 24 years old, attractive, neatly dressed, and educated up to class 9. She was concerned about cleanliness from a young age and she loved being tidy in her appearance. Her health was fine seven years ago. But then she developed an obsession about dirt and contamination. In class, she would frequently check to see if her clothes had become dirty. She would feel guilty for sitting at her desk because she felt that is what led to her clothes getting soiled. These thoughts preoccupied her mind constantly. Gradually, Shabana's self-esteem reduced and her interactions with others decreased. She preferred being on her own and remained in a distressed state of mind. Her interest in studies also waned because of this excessive preoccupation. Her parents persuaded her to get married. After her wedding, she found herself in a new environment with more responsibility that further aggravated her depression, and caused feelings of hopelessness and helplessness.

Jagat Jagat comes from a family with no history of mental illness. He had a normal birth and seemed to develop normally when he was a child. However, when he was 12 years old, Jagat developed abdominal distension with a continuous, dull, aching pain, which lasted for an entire month. About a week following the onset of the pain, the parents noticed changes in his behavior. He became irritable, started to believe that there was a conspiracy against him, and that the others were always talking about him. However, there was no thought disorder. He did not report hearing voices or seeing visions of any kind. There was no history of head injury or drug abuse. He was given antipsychotic drugs that relieved his symptoms.

Perhaps you found yourself asking questions as you read about Shabana and Jagat. For example, because Shabana was always concerned about cleanliness, her fear that her clothes might become dirty in the classroom could be natural. You might have wondered whether she could really have a serious problem. She does. We must ask ourselves: what criteria must be met before someone receives a particular diagnosis? Perhaps you also wondered if other members of Shabana's family had similar problems. They might do. This is a question about what we call family aggregation—that is, whether a disorder runs in families.

You may also have been curious about what was wrong with Jagat and why he believed that people were conspiring against him. Questions about the age of onset of his symptoms and

predisposing factors may also have occurred to you. Jagat has schizophrenia, a disorder that often strikes in late adolescence or early adulthood. As Jagat's case illustrates, it is not unusual for someone who develops schizophrenia to develop at a perfectly normal rate before suddenly becoming ill. You can read more about Jagat's case and his treatment in a 2014 study on this subject by Grover and colleagues.

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

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

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

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

What Do We Mean by Abnormality?

It may come as a surprise to you that there is still no universal agreement about what is meant by *abnormality* or *disorder*. This is not to say we do not have definitions; we do. However, a truly satisfactory definition will probably always remain elusive (Lilienfeld & Landfield, 2008; Stein et al., 2010) even though there is a great deal of general agreement about which conditions are disorders and which are not (Spitzer, 1999).

Why does the definition of a mental disorder present so many challenges? A major problem is that there is no one behavior that makes someone abnormal. However, there are some clear elements or indicators of abnormality (Lilienfeld & Marino, 1999; Stein et al., 2010). No single indicator is sufficient in and of itself to define or determine abnormality. Nonetheless, the more that someone has difficulties in the following areas, the more likely he or she is to have some form of mental disorder.

1. ***Suffering:*** If people suffer or experience psychological pain we are inclined to consider this as indicative of abnormality. Depressed people clearly suffer, as do people with anxiety disorders. But what of the patient who is manic and whose mood is one of elation? He or she may not be suffering. In fact, many such patients dislike taking medications because they do not want to lose their manic "highs." You may have a test tomorrow and be suffering with worry. But we would hardly label your suffering abnormal. Although suffering is an element of abnormality in many cases, it is neither a sufficient condition (all that is needed) nor even a necessary condition (a feature that all cases of abnormality must show) for us to consider something as abnormal.
2. ***Maladaptiveness:*** Maladaptive behavior is often an indicator of abnormality. The person with anorexia may restrict her intake of food to the point where she becomes so emaciated that she needs to be hospitalized. The person with depression may withdraw from friends and family and may be unable to work for weeks or months. Maladaptive behavior interferes with our well-being and with our ability to enjoy our work and our relationships. However, not all disorders involve maladaptive behavior. Consider the con artist and the contract killer, both of whom have antisocial personality disorder. The first may be able glibly to talk people out of their life savings, the second to take someone's life in return for payment. Is this behavior maladaptive? Not for them, because it is the way in which they make their respective livings. We consider them abnormal, however, because their behavior is maladaptive for and toward society.
3. ***Statistical Deviancy:*** The word *abnormal* literally means "away from the normal." But simply considering statistically rare behavior to be abnormal does not provide us with a solution to our problem of defining abnormality. Genius is statistically rare, as is perfect pitch. However, we do not consider

people with such uncommon talents to be abnormal in any way. Also, just because something is statistically common doesn't make it normal. The common cold is certainly very common, but it is regarded as an illness nonetheless.

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

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

   Of course, much depends on the magnitude of the violation and on how commonly the rule is violated by others. As illustrated in the example above, a behavior is most likely to be viewed as abnormal when it violates the standards of society and is statistically deviant or rare. In contrast, most of us have parked illegally at some point. This failure to follow the rules is so statistically common that we tend not to think of it as abnormal. Yet when a mother drowns her children there is instant recognition that this is abnormal behavior.
5. ***Social Discomfort:*** When someone violates a social rule, those around him or her may experience a sense of discomfort or unease. Imagine that you are sitting in an almost empty movie theater. There are rows and rows of unoccupied seats. Then someone comes in and sits down right next to you. How do you feel? In a similar vein, how do you feel when someone you met only 4 minutes ago begins to chat about her suicide attempt? Unless you are a therapist working in a crisis intervention center, you would probably consider this an example of abnormal behavior.
6. ***Irrationality and Unpredictability:*** As we have already noted, we expect people to behave in certain ways. Although a little unconventionality may add some spice to life, there is a point at which we are likely to consider a given unorthodox behavior abnormal. If a person sitting next to you suddenly began to scream and yell obscenities at nothing, you would probably regard that behavior as abnormal. It would be unpredictable, and it would make no sense to you. The disordered speech and the disorganized behavior of patients with schizophrenia are often irrational. Such behaviors are also a hallmark of the manic phases of bipolar disorder. Perhaps the most important factor, however, is our evaluation of whether the person can control his or her behavior. Few of us would consider a roommate who began to recite speeches from King Lear to be abnormal if we knew that he was playing Lear in the next campus Shakespeare production—or even if he was a dramatic person given to extravagant outbursts. On the other hand, if we discovered our roommate lying on the floor, flailing wildly, and reciting Shakespeare, we might consider calling for assistance if this was entirely out of character and we knew of no reason why he should be behaving in such a manner.
7. ***Dangerousness:*** It seems quite reasonable to think that someone who is a danger to him- or herself or to another person must be psychologically abnormal. Indeed, therapists are required to hospitalize suicidal clients or contact the police (as well as the person who is the target of the threat) if they have a client who makes an explicit threat to harm another person. But, as with all of the other elements of abnormality, if we rely only on dangerousness as our sole feature of abnormality, we will run into problems. Is a soldier in combat mentally ill? What about someone who is an extremely bad driver? Both of these people may be a danger to others. Yet we would not consider them to be mentally ill. Why not? And why is someone who engages in extreme sports or who has a dangerous hobby (such as free diving, race car driving, or keeping poisonous snakes as pets) not immediately regarded as mentally ill? Just because we may be a danger to ourselves or to others does not mean we are mentally ill. Conversely, we cannot assume that someone diagnosed with a mental disorder must be dangerous. Although mentally ill people do commit serious crimes, serious crimes are also committed every day by people who have no signs of mental disorder. Indeed, research suggests that in people with mental illness, dangerousness is more the exception than it is the rule (Corrigan & Watson, 2005).

One final point bears repeating. Decisions about abnormal behavior always involve social judgments and are based on the values and expectations of society at large. This means that culture plays a role in determining what is and is not abnormal. For example, in the United States, people do not believe that it is acceptable to murder a woman who has a premarital or an extramarital relationship. However, *karo-kari* (a form of honor killing where a woman is murdered by a male relative because she is considered to have brought disgrace onto her family) is considered justifiable by many people in Pakistan (Patel & Gadit, 2008).

In addition, because society is constantly shifting and becoming more or less tolerant of certain behaviors, what is considered abnormal or deviant in one decade may not be considered abnormal or deviant a decade or two later. At one time, homosexuality was classified as a mental disorder. But this is no longer the case. A generation ago, pierced noses and navels

were regarded as highly deviant and prompted questions about a person's mental health. Now, however, such adornments are commonplace, considered fashionable by many, and attract little attention. What other behaviors can you think of that are now considered normal but were regarded as deviant in the past?

As you think about these issues, consider the person described in The World Around Us box on page 5. Is he a courageous man of profound moral commitment? Or is his behavior abnormal and indicative of a mental disorder? Do others share your view about him?

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

In the United States, the accepted standard for defining various types of mental disorders is the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. This manual, commonly referred to as the *DSM*, is revised and updated from time to time. The current version, called *DSM-5*, was published in 2013. Its revision has been a topic of much debate and controversy. In the box on page 6 we explain more about the *DSM* and discuss why a revision was necessary.

the WORLD around us

Extreme Generosity or Pathological Behavior?

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

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

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

Kravinsky's donations did not end when his financial assets became depleted. He began to be preoccupied with the idea of nondirected organ donations, in which an altruistic person gives an organ to a total stranger. When he learned that he could live quite normally with only one kidney, Kravinsky decided that the personal costs of giving away one of his kidneys were minimal compared to the benefits received by the kidney recipient.

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

His wife, however, did not share his view. Although she had consented to bequeathing substantial sums of money to worthwhile charities, when it came to her husband offering his kidney, she could not support him.

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

(*Continued*)

Three months later, Kravinsky left his home in the early hours of the morning, drove to the hospital, and donated his right kidney. He informed his wife after the surgery was over. In spite of the turmoil that his kidney donation created within his family, Kravinsky's mind turned back to philanthropy almost immediately. "I lay there in the hospital, and I thought about all my other good organs. When I do something good, I feel that I can do more. I burn to do more. It's a heady feeling." By the time he was discharged, he was wondering about giving away his one remaining kidney.

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

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

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

This new *DSM-5* definition of mental illness was based on input from various *DSM-5* workgroups as well as other sources (Broome & Bortolotti, 2010; First & Wakefield, 2010; Stein et al., 2010). Although this definition will still not satisfy everyone, it brings us ever closer to a good working description. Keep in mind that any definition of abnormality or mental disorder must be somewhat arbitrary. Rather than thinking of the *DSM* as a finished product, it should always be regarded as a work in progress and regular updates and modifications are to be expected. Although earlier versions of the *DSM* used Roman numerals to refer to each specific edition (e.g., *DSM-IV*), Arabic numerals are now being used instead of Roman numerals (5 versus V) to facilitate updating (e.g., *DSM*-5.1, *DSM*-5.2) in the future.

THINKING CRITICALLY about *DSM-5*

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

DSM-5

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

Since *DSM-1* was first published in 1952, the *DSM* has been revised from time to time. Revisions are important because they allow new scientific developments to be incorporated into how we think about mental disorders. The revision process for *DSM-5* had the goals of maintaining continuity with the previous edition (*DSM-IV*) as well as being guided by new research findings. But another guiding principle was that no constraints should be placed on the level of change that could be made. If this strikes you as a little contradictory, you are correct. Striking the right balance between change and continuity presented considerable challenges. It also created a great deal of controversy. As part of the revision process, experts in specific disorders were invited to join special *DSM-5* work groups and make specific recommendations for change. In some cases, the debates were so heated that people resigned from their work groups! Now that *DSM-5* is here, not everyone is happy with some of the changes that have been made. On the other hand, many of the revisions that have been made make a lot of sense. In the chapters that follow we highlight key changes in *DSM-5*. We also try to help you think critically about the reasons behind the specific modifications that were proposed and understand why they were accepted.

Why Do We Need to Classify Mental Disorders?

If defining abnormality is so contentious and so difficult, why do we try to do it? One simple reason is that most sciences rely on classification (e.g., the periodic table in chemistry and the classification of living organisms into kingdoms, phyla, classes, and so on in biology). At the most fundamental level, classification systems provide us with a **nomenclature** (a naming system) and enable us to *structure information* in a more helpful manner.

Organizing information within a classification system also allows us to study the different disorders that we classify and therefore to learn more about not only what causes them but also how they might best be treated. For example, thinking back to the cases you read about, Monique has alcohol and drug use disorders, and John has schizophrenia. Knowing what disorder each of them has is clearly very helpful, as John's treatment would likely not work for Monique.

A final effect of classification system usage is somewhat more mundane. As others have pointed out, the classification of mental disorders has social and political implications (see Blashfield & Livesley, 1999; Kirk & Kutchins, 1992). Simply put, defining the domain of what is considered to be pathological establishes the range of problems that the mental health profession can address. As a consequence, on a purely pragmatic level, it furthermore delineates which types of psychological difficulties warrant insurance reimbursement and the extent of such reimbursement.

What Are the Disadvantages of Classification?

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

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

Related to stigma is the problem of **stereotyping**. Stereotypes are automatic beliefs concerning other people that are based on minimal (often trivial) information (e.g., people who wear glasses are more intelligent; New Yorkers are rude; everyone in the South has a gun). Because we may have heard about certain behaviors that can accompany mental disorders, we may automatically and incorrectly infer that these behaviors will also be present in any person we meet who has a psychiatric diagnosis. This is reflected in the comment, "People like you don't go back to work," in the case example of James McNulty.

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

At this point I had my most powerful experience with stigma. I was 38 years old. I had recently been discharged after a psychiatric hospitalization for a suicide attempt, I had no place to live, my savings were exhausted, and my only possession was a 4-year-old car. I contacted the mental health authorities in the state where I then lived and asked for assistance in dealing with my mental illness. I was told that to qualify for assistance I would need to sell my car and spend down the proceeds. I asked how I was supposed to get to work when I recovered enough to find a job. I was told, "Don't worry about going back to work. People like you don't go back to work." (McNulty, 2004)

Take a moment to consider honestly your own attitudes toward people with mental disorders. What assumptions do you tend to make? Do you view people with mental illness as less competent, more irresponsible, more dangerous, and more unpredictable? Research has shown that such attitudes are not uncommon (see A. C. Watson et al., 2004). Can you recall movies, novels, or advertisements that maintain such stereotypes? What are some ways in which you can challenge the false assumptions that are so common in the media? Do you think reality TV shows such as *Hoarders*, *Obsessed*, or *My Strange Addiction* have a helpful or harmful impact on societal attitudes?

Finally, stigma can be perpetuated by the problem of **labeling**. A person's self-concept may be directly affected by being given a diagnosis of schizophrenia, depression, or some other form of mental illness. How might you react if you were told something like this? Furthermore, once a group of

symptoms is given a name and identified by means of a diagnosis, this diagnostic label can be hard to shake even if the person later makes a full recovery.

It is important to keep in mind, however, that diagnostic classification systems do not classify people. Rather, *they classify the disorders that people have*. When we note that someone has an illness, we should take care not to define him or her by that illness. Respectful and appropriate language should instead be used. At one time, it was quite common for mental health professionals to describe a given patient as "a schizophrenic" or "a manic-depressive." Now, however, it is widely acknowledged that it is more accurate (not to mention more considerate) to say, "a person with schizophrenia," or "a person with manic depression." Simply put, the person is not the diagnosis.

How Can We Reduce Prejudicial Attitudes Toward the Mentally Ill?

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

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

How Does Culture Affect What Is Considered Abnormal?

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

The Japanese, in contrast, are not worried about the number 13. Rather, they attempt to avoid the number 4. This is because in Japanese the sound of the word for "four" is similar to the sound of the word for "death" (see Tseng, 2001, pp. 105–6).

There is also considerable variation in the way different cultures describe psychological distress. For example, there is no word for "depressed" in the languages of certain Native Americans, Alaska Natives, and Southeast Asian cultures (Manson, 1995). Of course, this does not mean that members from such cultural groups do not experience clinically significant depression. As the accompanying case illustrates, however, the way some disorders present themselves may depend on culturally sanctioned ways of articulating distress.

Stigma of Abnormality in India: Abnormality is Nothing but Being Haunted by Evil Spirits

In India, if you claim to be haunted by evil spirits, you are necessarily deemed to be possessed by them. Possession is a broad term that refers to "an integration of spirit and matter, force or power and corporeal reality, in a cosmos where the boundaries between an individual and her environment are acknowledged to be permeable, flexibly drawn, or at least negotiable" (Boddy, 1994). Possession, therefore, is a state in which the host's cognitive, affective, and conative faculties are under the control of someone who may not be material. "As an indigenous category in ancient and classical India, possession is not a single, simple, reducible category that describes a single, simple reducible experience or practice but is distinguished by extreme multivocality, involving fundamental issues of emotion, aesthetics, language and personal identity" (Smith, 2006).

In other words, when an evil spirit (or a higher or nobler spirit) takes control over someone's thoughts and action, the behavioral pattern of the "possessed" person changes in comparison to their natural pattern. It merits mention that anthropologists have recorded evidences of varied types of possessions in Asia, Africa, Afro-America, Latin America, Oceania, and Europe. However, in India, such incidences take on a more sinister tone. The possessed individuals are said to be afflicted by the evil spirit of a ghost, who may either have taken possession of the host or the ghost may have been "transported" into the host by a sorcerer through *jadu-tona* (witchcraft). Besides, there is another type of possession where the individual is convinced that a divine force (such as a deity) has blessed them and that they are now a medium for that deity. There is a deep-rooted stigma about abnormality in India, and as Christoph Lauber and Wulf Rossler (2009) have reported in a review of studies from 1996 to 2006, the role of a supernatural or religious belief, or belief in sorcery, as a factor contributing to the onset of abnormality in most parts of India cannot be discounted.

The phenomenon of possession is nothing less than a multilayered reality in India and it would be impossible to delimit it into a definite theoretical structure. Spirituality lies at the root of almost all explanations of such conditions; belief in supernatural phenomena is deeply ingrained in the Indian mindset. Let us examine the idea of a host being possessed by a deity. Here, the host starts behaving as the deity itself. Their voice changes and they start showering blessings or curses on other people. The host is quick to point out any shortcoming in the performance of the rituals during *puja*. The host's consciousness is attributed to the reigning deity (*devi ke sawari*). In another type of possession, a ghost or wandering evil spirit (*preta*) is said to take over the host, whose behavior then resembles that of a mental patient. The patient ignores their appearance and remains in a disheveled state, their voice becomes hoarse, and they may sometimes become violent as well. They scream and shout filthy abuses on all the attendees. They state their point of origin and even their desires, which they say, if left unfulfilled, will bring calamity upon those present. Usually the services of expert sorcerers are sought for assuaging such an evil spirit.

A similar pattern of behavior is also noticed when an evil spirit is said to have transported into the host in order to relieve the host from trouble, cure an illness, or bring disaster upon another individual. In this case, too, a sorcerer is brought in. Women are sometimes accused of being witches and they are socially condemned to death. In an incident reported in 2015 in Jharkhand, five tribal women, including a mother and daughter, were suspected of practicing witchcraft in a village in Ranchi. They were lynched by a mob of over 70 people in Kajaya Maraytoli. They were all beaten to death by the villagers, who battered them with sticks, bricks, and stones. The killers also disfigured the faces of their victims after killing them. What was even more shocking was the tacit involvement of a few undergraduate students from the local college. A report in *The Sunday Express* in August 2014 also revealed that as many as 49 women, who were suspected of practicing witchcraft, were killed in a similar manner. A recent review of 28 studies of the dissociative trance disorder (During et al., 2011) provides some support for the existence dissociative trance and possession disorders. According to this review, such cases need careful study and must be placed in a special category of mental disorders within the sphere of dissociative trance disorder.

→ Depression in a Native American Elder

JGH is a 71-year-old member of a Southwestern tribe who has been brought to a local Indian Health Service hospital by one of his granddaughters and is seen in the general medical outpatient clinic for multiple complaints. Most of Mr. GH's complaints involve nonlocalized pain. When asked to point to where he hurts, Mr. GH indicates his chest, then his abdomen, his knees, and finally moves his hands "all over." Barely whispering, he mentions a phrase in his native language that translates as "whole body sickness." His granddaughter notes that he "has not been himself" recently. Specifically, Mr. GH, during the past 3 or 4 months, has stopped attending or participating in many events previously important to him and central to his role in a large extended family and clan. He is reluctant to discuss this change in behavior as well as his feelings. When questioned more directly, Mr. GH acknowledges that he has had difficulty falling asleep, sleeps intermittently through the night, and almost always awakens at dawn's first light. He admits that he has not felt like eating in recent months but denies weight loss, although his clothes hang loosely in many folds. Trouble concentrating and