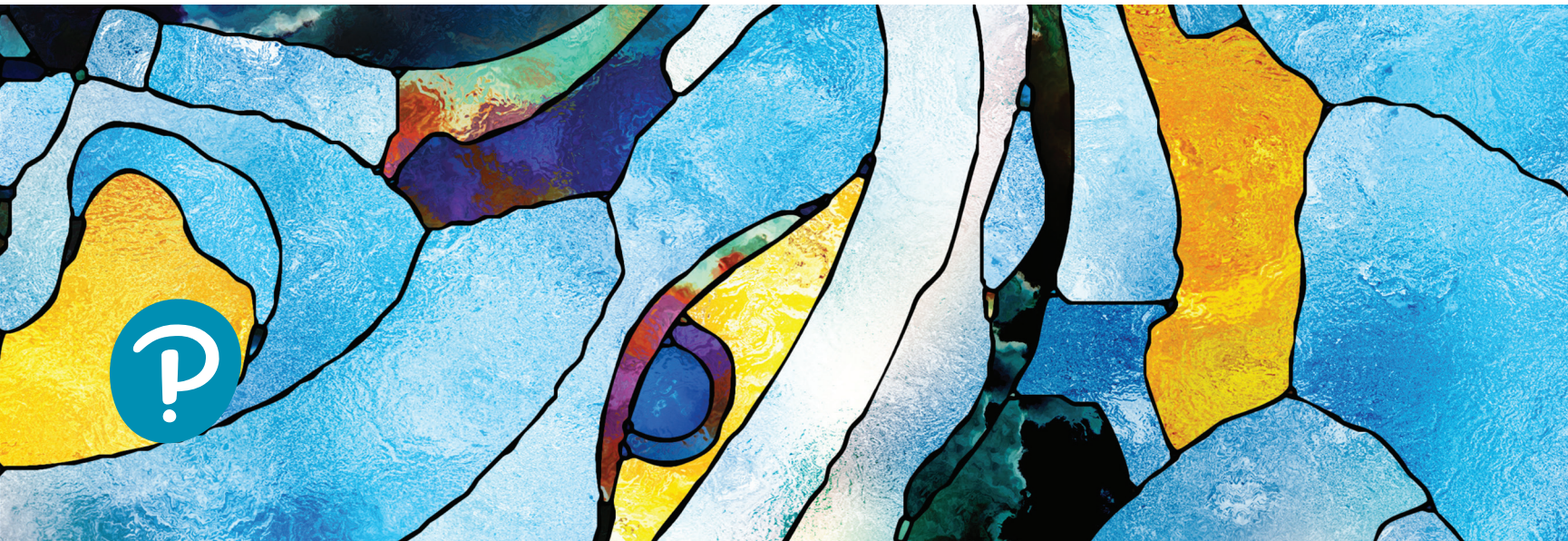
ABNORMAL PSYCHOLOGY

EIGHTEENTH EDITION

JILL M. HOOLEY | MATTHEW K. NOCK | JAMES N. BUTCHER



Abnormal Psychology

Eighteenth Edition

Global Edition

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DSM-5: A Quick Guide

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

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

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

Preface

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

Each author on the Hooley, Nock, and Butcher team is a noted researcher, an experienced teacher, and a licensed clinician. Each brings different areas of expertise and diverse research interests to the text. And please don't hold the fact that two of us teach at Harvard against us! We are passionate about abnormal psychology and we are committed to making our text as accessible as possible to a broad range of students. Our approach emphasizes the importance of research as well as the need to translate research findings into informed and effective clinical care for all who suffer from mental disorders.

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

For ease of understanding we present material on each disorder in a logical and consistent way. More specifically, we focus on three significant aspects: (1) the clinical picture, where we describe the symptoms of the disorder and its associated features; (2) factors involved in the development of the disorder; and (3) treatment approaches. In each case, we examine the evidence for biological, psychosocial (i.e., psychological and interpersonal), and sociocultural (the broader social environment of culture and subculture) influences. We also want students to remember that behind every diagnosis is a *person*. To keep this in the forefront, we try to integrate as much case material as we can into each chapter. Our book also continues to have a heavy focus on treatment. Treatment is discussed in every chapter in the context of specific disorders. Additionally, we include a separate chapter that addresses issues in treatment more broadly. This provides students with increased understanding of a wide range of treatment approaches and permits more in-depth coverage than is possible in specific disorder–based chapters.

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

Why Do You Need This New Edition?

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

reminded of how dynamic and vibrant our field is (not to mention how hard it is to keep up with all the new research!). This edition reflects the newest and most relevant research findings, presented in ways designed to be as engaging as possible to the next generation of students.

So What's New?

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

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

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

Features and Pedagogy

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

Features

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

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

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

Pedagogy

LEARNING OBJECTIVES Each chapter begins with learning objectives. These orient the reader to the material that will be presented in each specific chapter. Learning objectives are also repeated by the section they apply to and summarized at the end of each chapter. This provides students with an excellent tool for study and review. In this edition, sections of many chapters have

also been reorganized and material has been streamlined whenever possible. All the changes that have been made are designed to improve the flow of the writing and enhance pedagogy.

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

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

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

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

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

Supplement Package

Instructor's Manual (9781292364599)

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

Test Bank (9781292364636)

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

Lecture PowerPoint Slides (9781292364629)

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

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

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

Acknowledgments

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

Holly Butcher, Sherry Butcher, and Jay Butcher, for their patience and support during this time.

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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 are also especially grateful to the many reviewers who have given us invaluable feedback on this and previous editions of *Abnormal Psychology*: Joe Davis, CSU/SWC; Dan Fox, University of Houston; Marvin Lee, Tennessee State University; Stevie McKenna, Rutgers University; Loreto Prieto, Iowa State University; Hugh Riley, Baylor University; Edward Selby, Rutgers University; Tasia Smith, University of Florida; Stephanie Stein, Central Washington University; David Topor, Harvard University; Anthony Zoccolillo, Texas A&M; Angela Bragg, Mount Hood Community College; Greg Carey, University of Colorado; Louis Castonguay, Pennsylvania State University; Richard Cavasina, California University of Pennsylvania; Dianne Chambless, University of Pennsylvania; Lee Anna Clark, The University of Iowa; Barbara Cornblatt, Hofstra Northwell School of Medicine; William Paul Deal, University of Mississippi; Raymond L. Eastman, Stephen F. Austin State University; John F. Edens, Sam Houston State University; Colleen Ehrnstrom, University of Colorado at Boulder; William Fals-Stewart, The State University of New York at Buffalo; John P. Forsyth, The State University of New York at Albany; Louis R. Franzini, San Diego State University; David H. Gleaves, Texas A&M University; Michael Green, University of California at Los Angeles; Steven Haynes, University of Hawaii at Manoa; Kathi Heffner, Ohio University; Daniel Holland, University of Arkansas at Little Rock; Steven Hollon, Vanderbilt University; Joanne Hoven Stohs, California State University Fullerton; Robert Howland, University of Pittsburgh, School of Medicine; Jean W. Hunt, Cumberland College; Alexandrea Hye-Young Park, Virginia Tech; William G. Iacono, University of Minnesota; Jessica Jablonski, University of Delaware; Erick Janssen, Indiana University; Sheri Johnson, University of Miami; Ann Kane, Barnstable High; Alan Kazdin, Yale University; Lynne Kemen, Hunter College; Carolin Keutzer, University of Oregon; John F. Kihlstrom, University of California at Berkeley; Gerald Koocher, Simmons College; David Kosson, Chicago Medical School; Marvin Lee, Tennessee State University; Brett Litz, Boston University; Brendan Maher, Harvard University; Richard McNally, Harvard University; Edwin Megargee, Florida State University; William Miller, University of New Mexico; Robin Morgan, Indiana University Southeast; Michael Neboschick, College of Charleston; Chris Patrick, Florida State University; Marcus Patterson, University of Massachusetts; John Daniel Paxton, Lorain County Community College; Walter Penk, Memorial Veterans Hospital, Bedford, MA; Diego Pizzagalli, Harvard University; Lauren Polvere, Concordia University; Andy Pomerantz, Southern Illinois University, Edwardsville; Harvey Richman, Columbus State University; Barry J. Ries, Minnesota State University; Lizabeth Roemer, University of Massachusetts at Boston; Rick Seime, Mayo Clinic; Frances Sessa, Pennsylvania State University, Abington; Brad Schmidt, Ohio State University; Kandy Stahl, Stephen F. Austin State University; Stephanie Stein, Central Washington University; Xuan Stevens, Florida International University; Eric Stice, University of Texas at Austin; Marcus Tye, Dowling College; Beverly Vchulek, Columbia College; Michael E. Walker, Stephen F. Austin State University; Clifton Watkins, University of North Texas; Nathan Weed, Central Michigan University; Kenneth J. Zucker, Centre for Addiction and Mental Health, Ontario, Canada; Katherine Bonafide, SUNY Cortland; Jessamy Comer, Rochester Institute of Technology; Elizabeth Hood, Nash Community College; Theresa Kay, Weber State University; Don Knox, Wayland Baptist University; Teresa Leyro, Rutgers, The State University of New Jersey; Amanda Morrison, California State University, East Bay; Ava Szeli, Arizona State University; and Thomas Valentine, The Ohio State University.

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About the Authors

Jill M. Hooley
Harvard University

Jill M. Hooley is a professor of psychology at Harvard University. She is also the head of the experimental psychopathology and clinical psychology program at Harvard and, in addition, serves as Director of Undergraduate Studies for the Psychology Department. Dr. Hooley was born in England and received a BSc in psychology from the University of Liverpool. This was followed by research work at Cambridge University. She then attended Magdalen College, Oxford, where she completed her D. Phil. After a move to the United States and additional training in clinical psychology at SUNY Stony Brook, Dr. Hooley took a position at Harvard, where she has been a faculty member for longer than she can remember.

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

In 2000, Dr. Hooley received the Aaron T. Beck Award for Excellence in Psychopathology Research. She is also a past president of the Society for Research in Psychopathology. The author of many scholarly publications, Dr. Hooley served as Associate Editor for *Clinical Psychological Science* from 2012 to 2016. She also serves on the editorial boards of journals including *Family Process* and *Personality Disorders: Theory, Research and Treatment*. In 2015 Dr. Hooley received the Zubin Award for Lifetime Achievement in Psychopathology Research from the Society for Research in Psychopathology.

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

Matthew K. Nock
Harvard University

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

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

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

James N. Butcher
Professor Emeritus, University of Minnesota

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

Chapter 1

Abnormal Psychology: Overview and Research Approaches

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Learning Objectives

1.1 Explain how we define abnormality and classify mental disorders.

1.2 Describe the advantages and disadvantages of classification.

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

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

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

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

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

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

1.9 Explain the key features of an experimental design.

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

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

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

Jessica

Jessica is a 25-year-old postgraduate student enrolled in a human resource management course. She is a proactive, hardworking, and enthusiastic researcher and aims to publish her research papers in top journals. If you were to meet her, you would think that she is a rising star with a bright future, not someone who has severe personal problems. However, Jessica has actually been drinking alcohol since she was 14, and smokes at least one full pack of cigarettes every day. Although she does not go out and drink with her friends, her housemate usually finds her drinking spirits alone in the student hostel despite the campus housing policy prohibiting students from drinking in any of the student residences. As a result of frequent hangovers, Jessica has missed a few morning classes. Thanks to the flexible schedule of her postgraduate course, she has the option of not signing up for specific morning classes. She also said that drinking at night helps *calm* her down and provides subsequent inspiration for her academic project, while smoking *wakes* her up and energizes her. While she knows that these bad habits will jeopardize her health and academic development in the long run, Jessica has been unable to effectively stop smoking and drinking.

Bryan

Bryan was born into an affluent family. There were no problems when he was born, and he seemed to develop normally when he was a child. He went to one of the best universities, earned a degree in computer engineering, and found a high-paying job near his home. Initially his career went well, but a few years into his contract he found that he was never happy with his job. Since he was from a prestigious university, his supervisor had very high expectations of him. Bryan was always expected to be better than his coworkers, which was extremely stressful at times. Due to the nature of the male-dominated computer engineer field coupled with the undue expectations, which compelled him to work overtime, his social life was affected. He also began to develop sleep problems. As a result, he became chronically lethargic and showed symptoms of mood disorder. On a few occasions, he was found crying out loud in the office with no obvious triggers. All these issues caused him to become unproductive and eventually being fired by the company. Unable to repay the high mortgage loan, he spent all his savings in a few months and eventually lost his house. His family then took him back home. He began to isolate himself in his room, believing that he could never be happy nor successful again. His appetite diminished significantly, and he was sent to a hospital due to symptoms of malnourishment. He was later diagnosed with depression, mood disorder, and anorexia.

Perhaps you found yourself asking questions as you read about Jessica and Bryan. For example, because Jessica doesn't drink when she is out with her friends, you might have wondered whether she could really have a serious

Pictorial Press Ltd/Alamy Stock Photo

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

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

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

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

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

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

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

What Do We Mean by Abnormality?

1.1 Explain how we define abnormality and classify mental disorders.

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

Indicators of Abnormality

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

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

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

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

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

Paul Cookney/Professional Sport/Topham/The Image Works

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

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

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

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

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

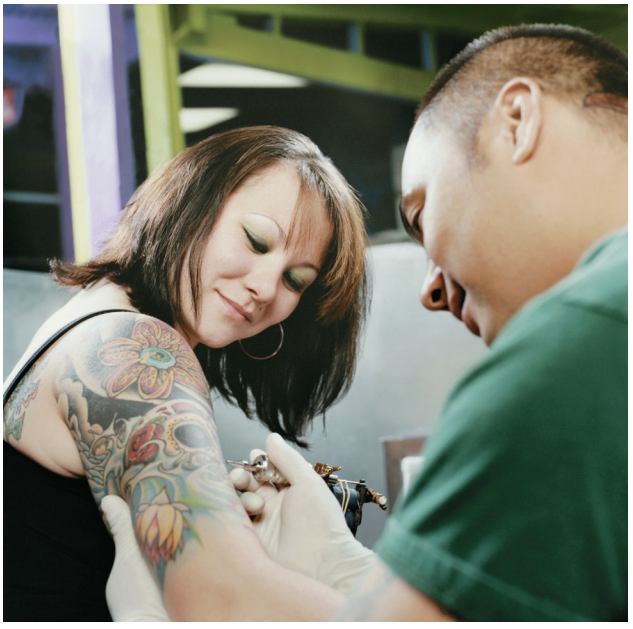
evaluation of whether the person can control his or her behavior. Few of us would consider a roommate who began to recite speeches from *King Lear* to be abnormal if we knew that he was playing Lear in the next campus Shakespeare production—or even if he was a dramatic person given to extravagant outbursts.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

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

Vitalii Nesterchuk/Shutterstock

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

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



Digital Vision/Getty Images

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

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

The World Around Us

Extreme Generosity or Pathological Behavior?

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

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

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

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

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

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

Jon Adams/UPI Photo Service/Newscom

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

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

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

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

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