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ABNORMAL PSYCHOLOGY and LIFE

A DIMENSIONAL APPROACH

CHRISTOPHER A. KEARNEY • TIMOTHY J. TRULL

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Second Edition

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A DIMENSIONAL APPROACH

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To my wife, Kimberlie, and my children, Derek and Claire,
for their great patience and support.

—Christopher A. Kearney

To my wife, Meg, for her love and support.
To Molly, Janey, and Neko for their smiles and laughter.

—Timothy J. Trull

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Christopher A. Kearney, Ph.D., is Distinguished Professor of Psychology, Director of Clinical Training, and Director of the UNLV Child School Refusal and Anxiety Disorders Clinic at the University of Nevada, Las Vegas. He is a Fellow of the American Psychological Association, a licensed clinical psychologist, and the author of numerous journal articles, book chapters, and books related to school refusal behavior, social anxiety, shyness, and selective mutism in youth. He has also published a work on general child psychopathology, *Casebook in Child Behavior Disorders* (Wadsworth), and is or has been on the editorial boards of *Journal of Consulting and Clinical Psychology, Behavior Therapy, Journal of Clinical Child and Adolescent Psychology, Journal of Abnormal Child Psychology, Journal of Psychopathology and Behavioral Assessment, Journal of Anxiety Disorders,* and *Journal of Gambling Studies.* Dr. Kearney has received several awards for his research, teaching, and mentoring, including the Harry Reid Silver State Research Award among others. In addition to his clinical and research endeavors, Dr. Kearney works closely with school districts and mental health agencies to improve strategies for helping children attend school with less distress.

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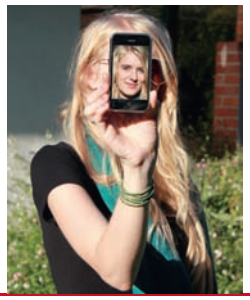

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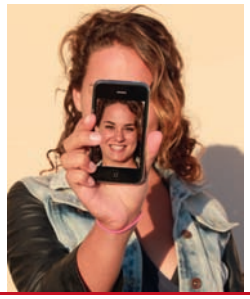

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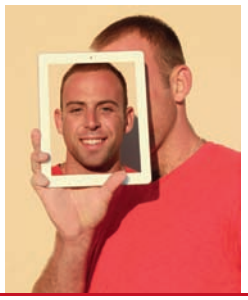

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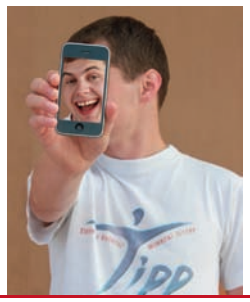

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SPECIAL FEATURES

Preface

When we, the authors, decided to write this textbook, we wanted to create something different for our students. We wanted to create a book that appealed to students by helping them understand that symptoms of psychological problems occur in many people in different ways. We wanted to avoid characterizing mental disorders from a "yes–no" or "us–them" perspective and focus instead on how such problems affect many people to varying degrees in their everyday lives. In essence, we wanted to illustrate how abnormal psychology was really about the struggles that all of us face in our lives to some extent. We represent this approach in our title: *Abnormal Psychology and Life*.

Abnormal psychology is one of the most popular courses on college campuses. Students are eager to learn about unusual behavior and how such behavior can be explained. Many students who take an abnormal psychology course crave a scientific perspective that can help prepare them well for graduate school and beyond. Other students take an abnormal psychology course because they are curious about themselves or people they know and thus seek application and relevance of the course information to their daily lives. Our book is designed to appeal to both types of students. The material in the book reflects state-of-the-art thinking and research regarding mental disorders but also emphasizes several key themes that increase personal relevance. These themes include a dimensional and integrative perspective, a consumer-oriented perspective, and emphases on prevention and cultural diversity. Personal relevance is also achieved by providing information to reduce the stigma of mental disorder; by illustrating comprehensive models of mental disorder that include biological, psychological, and other risk factors; and by employing various pedagogical aids, visually appealing material, and technological utilities.

A Dimensional and Integrative Perspective

A focus on how abnormal psychology is a key part of life comes about in this book in different ways. One main way is our focus on a *dimensional perspective toward mental disorder*. We believe that thoughts, feelings, and behaviors associated with mental disorders are present, to some degree, in all of us. Everyone experiences some level of anxiety, sadness, odd physical symptoms, worry about sexual behavior, and memory problems from time to time, for example. Throughout our chapters we vividly illustrate how different mental disorders can be seen along a continuum of normal, mild, moderate, severe, and very severe emotions, thoughts, and behaviors. We also provide examples along this continuum that parallel common scenarios people face, such as interactions with others and job interviews.

Our dimensional perspective is discussed within the context of an integrative perspective that includes an extensive discussion of risk and protective factors for various mental disorders. Such factors include biological (e.g., genetic, neurochemical, brain changes), personality, psychological (e.g., cognitive, learning, trauma), interpersonal, family, cultural, evolutionary, and other domains. We emphasize a diathesis-stress model and provide sections that integrate risk factors to present comprehensive models of various mental disorders. We also provide an appendix of medical conditions with contributing psychological factors that includes a biopsychosocial perspective to explain the interplay of physical symptoms with stress and other key contributing variables.

A Consumer-Oriented Perspective

Our book is also designed to recognize the fact that today's student is very *consumer-oriented*. Students expect textbooks to be relevant to their own lives and to deliver information about diagnostic criteria, epidemiological data, brain changes, and assessment instruments in visually appealing and technologically sophisticated ways. This textbook adopts a consumer approach in several ways. The chapters in this book contain suggestions for those who are concerned that they or someone they know may have symptoms of a specific mental disorder. These suggestions also come with key questions one could ask to determine whether a problem may be evident. In addition, much of our material is geared toward a consumer approach. In our discussion of neurocognitive disorders such as Alzheimer's disease, for example, we outline questions one could ask when considering placing a parent in a nursing home.

The consumer orientation of this book is also prominent in the last chapter when we discuss topics such as becoming a mental health professional, becoming a client in therapy, treatments available at the community level such as self-help groups, and how to judge a research article, among other topics. Throughout our chapters, we also focus special attention on issues of gender, ethnicity, law and ethics, and violence in separate boxes. We offer visually appealing examples of a dimensional model for each major mental disorder, brain figures, and engaging tables and charts to more easily convey important information. The book is also linked to many technological resources and contains 15 chapters, which fits nicely into a typical 15-week semester.

We also include several pedagogical aids to assist students during their learning process. The chapters are organized in a similar fashion throughout, beginning with initial sections on normal and unusual behavior and followed by discussions of features and epidemiology, stigma, causes and prevention, assessment, treatment, and prognosis. The chapters contain interim summaries and review questions at periodic intervals to help students check their understanding of what they just learned. Bold key terms are placed throughout the chapters and corresponding definitions are placed in the margin. *What Do You Think?* questions appear after the chapter-opening case study, which help students focus on important aspects of the case. Boxes that direct readers to related videos from the Continuum Video Project are featured in the disorder chapters (Chapters 5-14). More information on the Continuum Video Project is on page xxxi. Final comments are also provided at the end of each chapter to link material to previous and future chapters. Broad-based thought questions are also at the end of each chapter to challenge students to apply what they have learned to their daily lives. The writing style of the book is designed to be easy to follow and to succinctly convey key information.

Prevention

Another important theme of this book is *prevention*. Most college students function well in their environment, but everyone has some level of risk for psychological dysfunction or distress. We thus emphasize research-based ways to prevent the onset of psychological problems throughout this textbook. We offer specific sections on prevention and provide a detailed discussion of risk factors for mental disorder and how these risk factors could be minimized. We also provide a discussion of protective factors and strategies that could be nurtured during one's life to prevent psychological problems. Examples include anxiety and stress management, emotional regulation, appropriate coping, healthy diet, and adaptive parenting.

Much of our discussion in this area focuses on primary and secondary prevention, which has great appeal for students. Many prevention programs target those who have not developed a mental disorder or who may be at risk due to individual or environmental factors. A focus on prevention helps students understand what they could do to avert problematic symptoms or to seek help before such symptoms become more severe. Prevention material in the book also focuses on tertiary prevention and relapse prevention, so students can understand what steps people can take to continue healthy functioning even after the occurrence of a potentially devastating mental disorder. The prevention material in this book thus has broad appeal, relevance, and utility for students.

Cultural Diversity

Mental health professionals have made a more concerted effort to achieve greater cultural diversity in their research, to apply findings in laboratory settings to greater numbers of people, and to shine a spotlight on those who are traditionally underserved. We emphasize these greater efforts in this textbook. In addition to the special boxes on diversity, we provide detailed information about cultural syndromes; how symptoms and epidemiology may differ across cultural groups; how certain cultural factors may serve as risk and protective factors for various disorders; how diagnostic, assessment, and treatment strategies may need to be modified for different cultural groups; and how cultural groups may seek treatment or cope differently with symptoms of mental disorder.

Our discussion of cultural diversity applies to various ethnic and racial groups, but diversity across individuals is represented in many other ways as well. We focus heavily on gender differences, sexual orientation, sociocultural factors, migrant populations, and changes in symptoms as people age from childhood to adolescence to adulthood to late adulthood. Our emphasis on cultural and other types of diversity is consistent with our life-based approach for the book: Symptoms of mental disorder can occur in many people in many different ways in many life stages.

Stigma

A focus on a dimensional approach to mental disorder helps us advance another key theme of this book, which is to *reduce stigma*. Stigma refers to socially discrediting people because of certain behaviors or attributes that may lead to them being seen as undesirable in some way. People with schizophrenia, for example, are often stigmatized as people who cannot function or who may even be dangerous. Adopting a dimensional perspective to mental disorder helps reduce inaccurate stereotypes and the stigma associated with many of these problems. You will also see throughout this book that we emphasize people first and a mental disorder second to reduce stigma. You will not see us use words or phrases such as *schizophrenics* or *bulimics* or *the learning disabled.* Instead, you will see phrases such as *people with schizophrenia, those with bulimia,* or *children with learning disorder.* We also provide special sections on stigma throughout the chapters as well as boxes that contain information to dispel common myths about people with mental disorders that likely lead to negative stereotyping.

Clinical Cases and Narratives

Our dimensional perspective and our drive to reduce stigma is enhanced as well by extensive use of clinical cases and personal narratives throughout the book. Clinical cases are presented in chapters that describe a particular mental disorder and are often geared toward cases to which most college students can relate. These cases then reappear throughout that chapter as we discuss features of that disorder as well as assessment and treatment strategies. We also include personal narratives from people who have an actual mental disorder and who can discuss its symptoms and other features from direct experience. All of these cases reinforce the idea that symptoms of mental disorder are present to some degree in many people, perhaps including those easily recognized by a student as someone in his or her life.

New to the Second Edition

The second edition contains many new and exciting changes. Readers will see that the most obvious change is an adaptation to the new edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the *DSM-5*. The chapters remain aligned as they were previously to enhance teaching in a typical semester and to reflect empirical work that has been done for each set of disorders. *DSM-5* criteria are presented to help illuminate symptoms of mental disorders better for students and to convey the dimensional aspects introduced more in the new manual. Examples include continua based on severity, number of symptoms or behavioral episodes, and body mass index, among many others. We also emphasize other aspects of the *DSM-5* that are dimensional in nature, such as the alternative model of personality disorders (Chapter 10). We also make clear how the *DSM-5* has changed with respect to various disorders and how that affects the terminology in the chapters. We hope this helps provide a seamless transition for students and instructors alike.

The second edition also contains more boxes devoted to gender, diversity, violence, and law and ethics. For example, new material has been added regarding concepts related to insanity and to mentoring in graduate school. The second edition also contains new, separate sections regarding stigma for each chapter that covers a set of mental disorders (i.e., Chapters 5–14). These new sections illustrate our commitment to this important topic and present fascinating research with respect to others' views of someone with a mental disorder and treatment and other strategies that have been developed to reduce stigma toward those with mental disorder.

An important process as well has been a thorough review of the material to ensure that students continue to be presented with state-of-the-art research and most current thinking regarding mental disorders, including epidemiology. Several sections of the book have thus been redone or reworked to reflect new data, and hundreds of new citations have been added, most of which are very current. Other sections are new, such as an expansion of research designs in Chapter 4 and a discussion of sleep disorders in the appendix. One thing that has not changed, however, is our deep devotion and commitment to this work and to our students and their instructors.

A brief summary of key changes and additions for each chapter in the second edition is provided here. This is not an exhaustive list but provides some general guidance for those familiar with the first edition.

Chapter 1: Abnormal Psychology and Life

- New case, Travis, at beginning of chapter to match other chapters and give students a specific example to help illustrate concepts in the chapter.
- Diversity material added, including multicultural psychology.
- Information regarding college students and stigma.

Chapter 2: Perspectives on Abnormal Psychology

- Update of heritability information.
- New boxes on violence, law and ethics, and gender, including material on dangerousness and commitment.
- Changes in culture section to match *DSM-5*, such as cultural syndromes.

Chapter 3: Risk and Prevention of Mental Disorders

- New law and ethics box on constructs related to insanity.
- Updated information on treatment cost and other figures regarding college student suicide.

Chapter 4: Diagnosis, Assessment, and Study of Mental Disorders

- New section on classifying abnormal behavior and mental disorder to reflect *DSM-5* changes and to emphasize dimensional assessments, especially with respect to Professor Smith's case.
- Substantial revision of culture and development of mental disorders section to reflect new changes.
- Substantial revision of culture and clinical assessment section to reflect *DSM-5* cultural formulation (and related interview).
- New material in research design sections, including double- and triple-blind designs and natural, analogue, and single-subject experiments.

Chapter 5: Anxiety, Obsessive-Compulsive, and Trauma-Related Disorders

- *DSM-5* clarification regarding these disorders as well as description of new obsessive-compulsive-related disorders such as hoarding and trichotillomania.
- New stigma material regarding anxiety, obsessive-compulsive, and trauma-related disorders.
- Updated heritability and other etiology information.
- Updated assessment and treatment information, such as biological challenges.

Chapter 6: Somatic Symptom and Dissociative Disorders

- *DSM-5* clarification regarding new somatic symptom disorders.
- New stigma material regarding somatic symptom and dissociative disorders.
- Revamped genetics and long-term outcome sections for somatic symptom disorders.

Chapter 7: Depressive and Bipolar Disorders and Suicide

- *DSM-5* clarification regarding new disorders such as disruptive mood dysregulation disorder.
- New stigma material regarding depressive and bipolar disorders.
- Reorganization of manic and hypomanic episode descriptions.

Chapter 8: Eating Disorders

- *DSM-5* clarification regarding eating disorders.
- Revamped epidemiology, genetics, brain changes, and prognosis sections.

Chapter 9: Substance-Related Disorders

- *DSM-5* clarification regarding substance-related disorders and revamping of early section on features.
- New stigma material regarding substance-related disorders.
- New material on college student expectancies regarding alcohol use and treatment of college students with substance use problems.
- New material regarding impulsivity and substance use.
- Revamped section on prevention to reflect changes in the field.

Chapter 10: Personality Disorders

- *DSM-5* clarification regarding personality disorders as well as description of *DSM-5* alternative dimensional model of personality disorders.
- Updated heritability estimates for the personality disorder clusters and brain change.
- New stigma material regarding personality disorders.
- Revamped prognosis section for personality disorders.
- New law and ethics box on personality and insanity, including the concepts of guilty but mentally ill and diminished capacity.

Chapter 11: Sexual Dysfunctions, Paraphilic Disorders, and Gender Dysphoria

- *DSM-5* clarification regarding sexual dysfunctions, paraphilic disorders, and gender dysphoria.
- New stigma material regarding sexual dysfunctions.
- Updated prognosis and other information.

Chapter 12: Schizophrenia and Other Psychotic Disorders

- *DSM-5* clarification regarding psychotic disorders as well as revamping of dimensions of schizophrenia.
- New stigma material regarding psychotic disorders.

Chapter 13: Developmental and Disruptive Behavior Disorders

- *DSM-5* clarification regarding psychotic disorders as well as revamping of dimensions of schizophrenia.
- New stigma material regarding psychotic disorders.

Chapter 14: Neurocognitive Disorders

- *DSM-5* clarification regarding neurocognitive disorders as well as dimensions of neurocognitive functioning.
- New stigma material regarding neurocognitive disorders.

Chapter 15: Consumer Guide to Abnormal Psychology

- Editing throughout to enhance clarity as well as reference updating.
- New gender box on graduate school and mentoring.

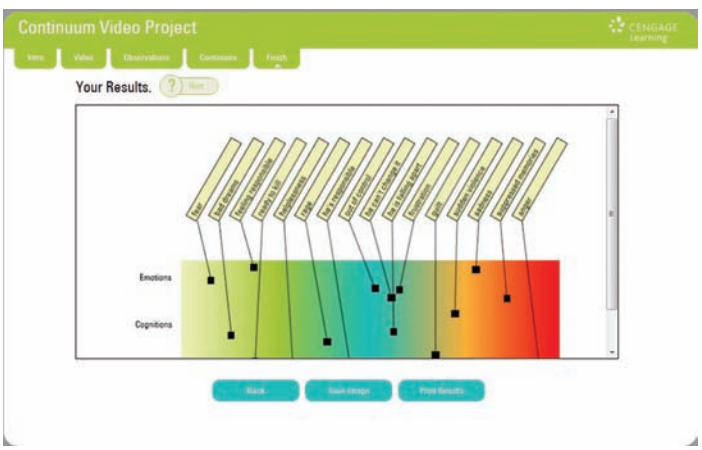
Appendix: Stress-Related Problems

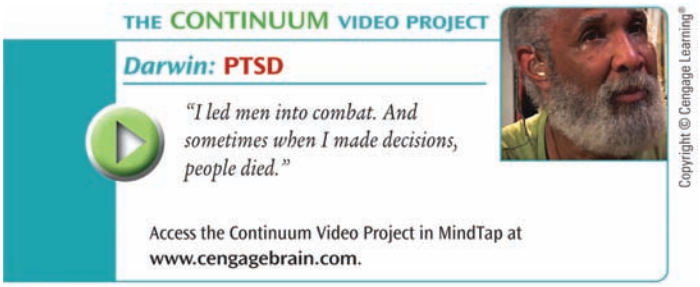
- New prevalence information.
- New section on sleep disorders.
- Key updates regarding Type A and D personalities.

SUPPLEMENTS

Continuum Video Project

The Continuum Video Project provides holistic, three-dimensional portraits of individuals dealing with psychopathologies. Videos show clients living their daily lives, interacting with family and friends, and displaying—rather than just describing—their symptoms. Before each video segment, students are asked to make observations about the individual's symptoms, emotions, and behaviors and then rate them on the spectrum from normal to severe. The Continuum Video Project allows students to "see" the disorder and the person as a human; and helps viewers understand abnormal behavior can be viewed along a continuum.





MindTap

MindTap for Kearney and Trull's *Abnormal Psychology and Life: A Dimensional Approach* is a highly personalized fully online learning platform of authoritative content, assignments, and services offering you a tailored presentation of course curriculum created by your instructor. MindTap guides you through the course curriculum via an innovative learning path where you will complete reading assignments, annotate your readings, complete homework, and engage with quizzes and assessments. MindTap includes the Continuum Video Project.

Go to **cengagebrain.com** to access MindTap.

Online Test Bank

Available online for instructors, the Test bank is an extensive collection of multiple-choice questions for objective tests, all closely tied to the text chapters. We're confident that you will find this to be a dependable and usable test bank.

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Also available online for instructors, the Instructor's Resource Manual is available as a convenient aid for your educational endeavors. It provides a thorough overview of each chapter and includes a wealth of suggestions organized around the content of each chapter in the text.

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These vibrant, Microsoft PowerPoint lecture slides for each chapter assist you with your lecture, by providing concept coverage using images, figures, and tables directly from the textbook!

All of these instructor supplements are available online for download.

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Acknowledgments

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1 Abnormal Psychology and Life

SPECIAL FEATURES

CASE: Travis

Travis is a 21-year-old college junior who has been struggling recently. He and his longtime girlfriend broke up 2 months ago, and he took this very hard. Travis and his girlfriend had been together for 17 months, and she was his first serious romantic relationship. However, the couple eventually became emotionally distant from one another and mutually decided to split following several arguments. Travis initially seemed fine after the breakup but then became a bit sullen and withdrawn about a week later. He began to miss a few classes and spent more time in his dorm room and on his computer.

Since the breakup several weeks ago, Travis seems to be getting worse each day. He rarely eats, has trouble sleeping, and stays in bed much of the day. He "zones out" by playing video games, watching television, or staring out the window for hours per day. Travis has lost about 10 pounds in recent weeks and looks tired and pale. He has also been drinking alcohol more in recent days. In addition, his classroom attendance has declined significantly, and he is in danger of failing his courses this semester.

Travis says little about the breakup or his feelings. His friends have tried everything they can think of to help him feel better, with no success. Travis generally declines their offers to go out, attend parties, or meet other women. He is not mean-spirited in his refusals to go out but rather just shakes his head. Travis's friends have become worried that Travis might hurt himself, but they cannot be with him all the time. They have decided that Travis should speak with someone at the psychological services center on campus and plan on escorting him there today.

Peter Banos/Alamy

What Do You Think?

1. Which of Travis's emotional or behavioral problems concern you the most? Why?
2. What do you think Travis should do?
3. What would you do if you had a friend who was experiencing difficulties like Travis?
4. What emotional or behavioral problems have you encountered in yourself or in others over the past year?
5. Are you surprised when people you know experience emotional or behavioral problems? Why or why not?

Introduction to Abnormal Psychology

You and your classmates chose to take this course for many reasons. The course might be required, or perhaps you thought learning about abnormal, deviant, or unusual behavior was intriguing. Or you might be interested in becoming a mental health professional and thought this course could help prepare you for such a career. Whatever the reason, you have likely known or will eventually know someone with a **mental disorder**. A mental disorder is a group of emotional (feelings), cognitive (thinking), or behavioral symptoms that cause distress or significant problems. About one of four American adults has a mental disorder over the course of a year (Kessler, Chiu, Demler, & Walters, 2005). A survey of students taking classes like this one indicated that almost 97 percent knew at least one person with a mental disorder (Connor-Greene, 2001). Almost 63 percent said they or an immediate family member—such as a parent, sibling, or child—had the disorder. The most commonly reported disorder was depression, a problem that Travis seemed to be experiencing.

Abnormal psychology is the scientific study of problematic feelings, thoughts, and behaviors associated with mental disorders. This area of science is designed to evaluate, understand, predict, and prevent mental disorders and help those who are in distress. Abnormal psychology has implications for all of us. Everyone has feelings, thoughts, and behaviors, and occasionally these become a problem for us or for someone we know. Travis's situation at the beginning of the chapter represents some daily experiences people have with mental disorders. Some of us may also be asked to help a friend or sibling struggling with symptoms of a mental disorder. In addition, all of us are interested in knowing how to improve our mental health and how to prevent mental disorders so we can help family members and friends.

In this book, we provide information to help you recognize mental problems and understand how they develop. We also explore methods used by professionals to prevent and treat mental distress and disorder. Knowing this material will not make you an expert, but it could make you a valuable resource. Indeed, we will present information you can use to make informed decisions and direct yourself and others to appropriate sources of support and help. Based on information in Chapters 5 and 7, for example, you will become knowledgeable about how anxiety and depression affect health and behavior in yourself and others as well as ways of dealing with these common problems.

What Is a Mental Disorder?

As we mentioned, a mental disorder is a group of emotional (feelings), cognitive (thinking), or behavioral symptoms that cause distress or significant problems. Abnormal psychology is the scientific study of problematic feelings, thoughts, and behaviors associated with mental disorders. At first glance, defining problematic or abnormal behavior seems fairly straightforward—isn't abnormal behavior simply behavior that is not normal? In a way, yes, but then we first must know what *normal* behavior is. We often refer to normal behavior as that which characterizes most people. One normal behavior for most people is to leave home in the morning to go to school or work and to interact with others. If a person was so afraid of leaving home that he stayed inside for many weeks or months, this might be considered abnormal—the behavior differs from what most people do.

But what do we mean by *most* people? How many people must engage in a certain behavior for the behavior to be considered normal? And, which group of people should we use to decide what is normal—women, men, people of a certain ethnicity, everyone? You can see that defining normal and abnormal behavior is more complicated than it might appear. Consider the following case:

CASE: Treva Throneberry

Treva Throneberry was born in Texas. Her sisters describe their family as a peaceful and loving one, but Treva paints a different picture. At age 15 years, Treva accused her father of sexual molestation. She later recanted her accusation but was removed from her parents' home and placed in foster care. At age 17 years, Treva ran away from her foster home and was found wandering alone by a roadside before spending time in a mental hospital. A year later, Treva moved into an apartment but soon vanished from town. In 2000, she was charged by Vancouver police with fraud and forgery. Her fingerprints matched those of Treva Throneberry, who was born in 1970, but Treva said she was an 18-year-old named Brianna Stewart. She had been attending Evergreen High School in Vancouver for the past two years, where she was known by everyone as Brianna Stewart. This was the basis for the fraud and forgery charges.

Since her disappearance from Texas, Treva was known by many other names in places across the country. In each town, she initially presented herself as a runaway 15- or 16-year-old in need of shelter who then left suddenly before her new identity turned age 18 years. She would then move to another town and start again as a 15- or 16-year-old. Her foster care mother said Treva could not envision living beyond age 18 years.

Treva was examined by a psychiatrist and found competent to stand trial. At her trial, Treva represented herself. She would not plea-bargain because she insisted she was Brianna Stewart and not Treva Throneberry. She argued in court that she was not insane and did not have a mental disorder that caused her to distort reality or her identity. Despite her claims, however, Treva was convicted of fraud and sentenced to a 3-year jail term. She continues to insist she is Brianna Stewart (White, 2002).

You may think Treva's behavior is abnormal, but why? To address this question, we may consider one of three criteria commonly used to determine whether an emotion, thought, or behavior is abnormal: (1) *deviance from the norm,* (2) *difficulties adapting to life's demands* or difficulties functioning effectively (including dangerous behavior), and (3) *experience of personal distress*.

Deviance from the Norm

Treva's actions are certainly not typical of most teenagers or young adults. Because Treva's behavior is so different from others—*so different from the norm*—her behavior would be considered abnormal. Defining abnormal behavior based on its difference or deviance from the norm is common and has some mass appeal—most people would agree Treva's behaviors are abnormal. Do you? Mental health professionals also rely on deviance from the norm to define abnormal behavior, but they often do so *statistically* by measuring how frequently a behavior occurs among people. Less frequent or less probable behaviors are considered to be abnormal or statistically deviant. Suddenly disappearing from home and assuming a new identity, as Treva did, is a very infrequent behavior that is statistically far from normal behavior.

An objective, statistical method of defining abnormality involves determining the probability of a behavior for a population. Note the bell curve in **Figure 1.1**. This curve shows how likely a behavior is based on its frequency in large groups of people. In this case, a 0 to 100 rating scale indicates level of physical activity among 10-year-olds during a 30-minute recess period. In this graph, 0 = no physical activity and 100 = continuous physical activity. The left axis of the scale shows how many children received a certain activity score: you can see that almost all children received scores in the 20 to 80 range. Based on this distribution of scores, we might statistically define and label the physical activity of children scoring 0 to 19 or 81 to 100 as "abnormal." Note that extremely low *and* extremely high scores are considered abnormal. Some physical activity is the norm, but too little or too much is not. A mental health professional might thus focus on underactive and overactive children in her scientific studies.

Statistical deviance from the norm is attractive to researchers because it offers clear guidelines for identifying emotions, thoughts, or behaviors as normal or abnormal.

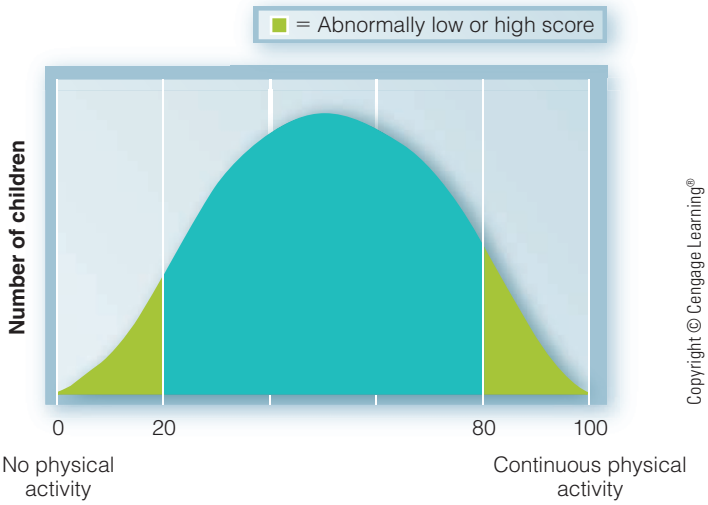
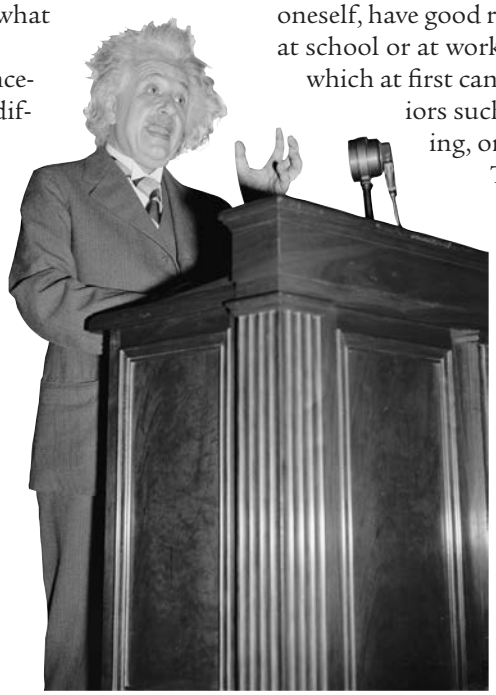


FIGURE 1.1 A STATISTICAL METHOD OF DEFINING ABNORMALITY Extremely low *and* extremely high levels of activity are considered abnormal from a statistical perspective.

However, this approach has some disadvantages. One major disadvantage is that people who differ significantly from an average score are technically "abnormal" or "disordered." But does this make sense for all behaviors or characteristics? Think about intelligence. Using a deviance-from-the-norm criterion, people who score extremely high on an intelligence test would be considered abnormal! But high intelligence is certainly not a disorder. In fact, high intelligence is valued in our society and often associated with success instead of failure. A deviance approach to defining abnormality is thus easy to apply but may fall short for determining what is abnormal.

Another disadvantage of the deviance-from-the-norm criterion is that cultures differ in how they define what is normal. One culture might consider an extended rest period during the workday to be normal, and another culture might not. Likewise, symptoms of mental disorders differ from culture to culture. We often consider self-critical comments and expressions of sadness as indicators of depression, but such behaviors are not always viewed the same way in East Asia (see **Box 1.1**). This is important for mental health professionals to consider when treating someone. Mental health professionals must recognize their own cultural biases and refrain from applying these views inappropriately to someone from another culture. Mental health professionals must also understand that deviance within a culture can change over time—what was deviant 50 years ago may be acceptable today.



Harris & Ewing Collection/Library of Congress Prints and Photographs Division [LC-DIG-hec-28667]

Using a statistical definition of deviance, Albert Einstein would be considered "abnormal" because of his high intelligence.

A final problem with the deviance-from-the-norm criterion is that deciding the statistical point at which a behavior is abnormal can be arbitrary and subject to criticism. The method does not tell us what the correct cutoff should be. Refer again to Figure 1.1. If a child has an activity score of 81, she might be considered abnormal. Realistically, however, is a score of 80 (normal) much different from a score of 81 (abnormal)? Where should the cutoff be, and how do we know if that cutoff point is meaningful?

Difficulties Adapting to Life Demands

Because several problems exist with the deviance-from-the-norm criterion, other judgments are sometimes made to define abnormal behavior. One key judgment often made by mental health professionals is whether a behavior interferes with a person's ability to function effectively. One could argue that Treva's behaviors greatly interfered with her ability to function effectively. She continued to behave in ways that prevented her from adopting an adult role and that eventually landed her in jail. In the case of Travis presented at the beginning of the chapter, you can see his depression kept him from interacting with others and could even lead to self-harm. Indeed, *dangerous behavior* toward oneself or others clearly interferes with an ability to function effectively.

Everyone occasionally has feelings of sadness and discouragement, especially after a tough event such as a breakup. Most people, however, are eventually able to focus better on school, work, or home regardless of these feelings. For other people like Travis, however, feelings of sadness or discouragement become maladaptive. A **maladaptive behavior** is one that interferes with a person's life, including ability to care for oneself, have good relationships with others, and function well at school or at work. Feelings of sadness and discouragement, which at first can be normal, can lead to maladaptive behaviors such as trouble getting out of bed, concentrating, or thinking.

Think about Sasha, who has been very worried since her mother was diagnosed with breast cancer last year. Her mother is currently doing well, and the cancer seems to be in remission, but Sasha cannot stop worrying that her mother's cancer will return. These worries cause Sasha to be so anxious and upset that she cannot concentrate on her schoolwork, and she finds herself irritable and unable to spend much time with her friends. Sasha's worries and behavior, which were understandable at first, have become maladaptive. According to the difficulties-adapting-to-life-demands criterion, Sasha's behaviors might be considered abnormal. Her continual thoughts about her mother's health, coupled with irritability and trouble concentrating,

BOX 1.1 Focus on Diversity

Emotion and Culture

Emotional experience and expression are clearly influenced by culture (Mesquita & Walker, 2003). Pride is promoted in the United States, an individualist culture, through praise, encouragement, and awards for personal accomplishments. As a result, Americans may be more self-focused and individual-achievement oriented. In contrast, non-Western collectivist cultures, as in East Asia, prioritize modesty, social obligations, and interpersonal harmony. People are expected to fit in with others and avoid behaviors that bring individual attention or that create group conflict. An American student asked to present a top-notch paper to her class may quickly accept this invitation and invite friends to her presentation. A Japanese student, however, may be less receptive to such a prospect. The American student came from a culture that promotes individual achievement and recognition, whereas the Japanese student came from a culture that promotes group belongingness and not individual recognition.

Consider another example. Expression of self-criticism is more typical of East Asian culture and does not necessarily indicate a mental disorder. In addition, expressions of depression are more likely labeled abnormal by Americans, but anger is more likely labeled abnormal by East Asians. Expressions of anxiety—especially over fitting in with a group—may be more common or normal in East Asians, but expressions of anger—especially when asserting one's individual rights—may be more common or normal in Americans. If deviance from the norm is used to define abnormal behavior, then cultural identity must be considered. An American psychologist should not, for example, apply her norms regarding emotional expression to someone from East Asia.


PETER PARKS/AFP/Getty Images

Public expressions of anger are less common, and more likely to be seen as deviant, in certain cultures.

prevent her from functioning well as a family member, student, and friend. In fact, Sasha may benefit from some professional intervention at this point. In this case, the focus is not on deviance or norms but on the extent to which a behavior or characteristic interferes with daily functioning.

One advantage of this approach is that problems in daily living—as in school, work, or relationships—often prompt people to seek treatment. Unfortunately, the difference between good functioning and maladaptive behavior is not always easy to measure. In addition, the difference between good functioning and maladaptive behavior differs from person to person. Another problem with this criterion is that different people may view a certain behavior differently. Sasha's family members might see her behaviors as caring and thoughtful, but one of her professors might see her behavior as laziness. Mental health professionals often struggle with how to determine whether a person's behavior is maladaptive or truly interferes with a person's daily functioning.

Another problem with the difficulties-adapting-to-life-demands criterion is that people may engage in very odd behaviors but experience little interference in daily functioning. Consider Henry, a telemarketer living alone in Seattle. He never leaves home because of fear of contamination by airborne radioactivity and bacterial spores released by the Central Intelligence Agency. Henry does not consider himself dysfunctional because he works at home, gets things delivered to him, and communicates to friends or family via telephone and e-mail. Most would agree Henry limits his options by not leaving home and that his thinking is quite peculiar and unrealistic. But is Henry experiencing interference in daily functioning if he is happy the way things are for him? Hasn't he adapted well to his environment? Does he truly need treatment?

Experience of Personal Distress

Maladaptive behavior is not always a source of concern for people like Henry, so they may not seek treatment. Therefore, another criterion used by mental health professionals to define abnormal behavior is experience of personal distress. Consider Margarette, who has irrational fears of entering tunnels or bridges while traveling by car or bus. She is extremely distressed by this and recognizes that these fears are baseless. Unfortunately, Margarette must travel through tunnels or bridges given her residence in Manhattan. She is desperate for treatment of these irrational fears because they cause her so much distress. In Margarette's case, extreme levels of distress created by a behavior such as fear may be

important for defining her behavior as abnormal. In other cases, a behavior could cause great distress for others, which may prompt them to initiate treatment for a person. A child with highly disruptive behavior in school may not be particularly distressed about his actions but may be referred to treatment by his parents.

A personal-distress definition of abnormality has strengths and weaknesses. Personal distress is a hallmark feature of many mental disorders and often prompts people to seek treatment. In addition, most people can accurately assess whether they experience significant emotional and behavioral problems and can share this information when asked. However, some people (like Henry, mentioned earlier) do not report much personal distress even when exhibiting unusual behavior. And, even if a person *is* distressed, no clear guidelines exist for establishing a cutoff point that indicates an abnormal behavior. How much personal distress is too much personal distress?

Defining Abnormality

As you can see, these three approaches to defining abnormality have several strengths and weaknesses. A successful approach to defining abnormality has thus been to combine the perspectives to merge their strengths and avoid their weaknesses (see **Table 1.1**). At least one of three characteristics must be present for abnormality to be defined as such. We refer to emotions, thoughts, or behaviors as abnormal when they

- violate social norms or are statistically deviant (like Treva's unusual behavior, insisting she was another person)
- interfere with functioning (like Sasha's worries that kept her from performing well at school)
- cause great personal distress (like Margarette's fears of tunnels and bridges)

Agreeing on a definition of *mental disorder* is important to **psychopathologists,** who study mental problems to see how disorders develop and continue and how they can be prevented or treated. A lack of consensus on a definition of abnormal behavior can have adverse consequences. Consider partner abuse, a significant problem in the United States. Much research has been conducted by psychologists and other mental health professionals to identify causes of partner abuse so effective treatments can be designed. Some researchers, however, define partner abuse as physical violence, whereas others work from a broader definition that includes physical, emotional, or sexual violence against an intimate partner. A standard or consistent definition of partner abuse is important because individuals who are physically violent against a partner may differ from those who are emotionally or sexually violent. Likewise, individuals using one form of violence may differ from those using multiple forms of violence against intimate partners. If so, treatments that are effective for one type of abuser may not be effective for other types of abusers. Varying definitions of a problem can thus impede our understanding of abnormal psychology.

Michael Blann/Digital Vision/Jupiter Images

This man has not left his home in two years, but he functions fairly normally and is not distressed. Is his behavior abnormal?

Dimensions Underlying Mental Disorders Are Relevant to Everyone

Our discussion to this point might suggest a person's behavior is either abnormal or not, but this is not really so. Along with many experts in abnormal psychology, we view the abnormality of emotions, thoughts, or behaviors as a matter of degree, not of kind. In other words, *emotions, thoughts, and behaviors associated with mental disorders are present, to some degree, in all of us*. This statement may seem strange or even shocking to you at first, but let's explore it a little more. Abnormal behaviors are not simply present or absent but exist along a *continuum* in everyone to some degree. Think about sex drive, motor coordination, anxiety, or sadness. Each characteristic is present to some degree in everyone at different times. We all have some sex drive and coordination, and we all become anxious or sad at times. These characteristics may also change over time—it's likely you are more coordinated now than you were at age 5! Different people also show different levels of these characteristics—you may know people who tend to be more anxious or sad than others.

Deciding whether a behavior is different or deviant from the norm is a matter of degree. Earlier we discussed children's

Table 1.1

Definitions of Abnormal Psychology

Definition	Advantages	Limitations
Deviance from the norm	▶ We use our own judgment or gut feeling. ▶ Once statistical or objective cutoff scores are established, they are easy to apply.	▶ Different cultures have different ideas about what normal behavior is. ▶ "Statistically deviant" behaviors may be valued (e.g., high intelligence). ▶ Arbitrary cutoffs (e.g., is a score of 80 much different from a score of 81?).
Difficulties adapting to life's demands	▶ Typically easy to observe if someone is having difficulty. ▶ Often prompts people to seek psychological treatment.	▶ Unclear who determines impairment or whether a consensus about impairment is required. ▶ Thresholds for impairment not always clear.
Experience of personal distress	▶ Hallmark of many forms of mental disorder. ▶ Individuals may be able to accurately report this.	▶ Some psychological problems are not associated with distress. ▶ Thresholds or cutoffs for distress are not always clear.

activity level—children may be underactive, overactive, and even hyperactive. Deciding whether a behavior is maladaptive also is a matter of degree. Some students concerned about their parents' health cope better than others. Even personal distress is displayed in different degrees. Some people are much more distressed about driving through tunnels than others. All these differences make us unique in some way, which is a good thing. The important thing to remember is that anxiety, sadness, anger, and other emotions and behaviors can be best described along a dimension or continuum from extremely low to extremely high levels. Sometimes we do make pronouncements about people who are "anxious" or "depressed," but this is just a convention of language. These features—like all emotions, thoughts, and behaviors—exist on a continuum. **Figure 1.2** is an example of the full range of emotions, thoughts, and behaviors that might follow from problems in college. Think about where Travis might be on this continuum.

The idea that emotions, thoughts, and behaviors exist in varying degrees on a continuum in people has important implications. When a mental health professional evaluates an individual for symptoms of mental disorder, these three dimensions—emotion, thought, and behavior—figure prominently. Various forms of mental disorder comprise emotions such as anxious or depressed mood, thoughts such as excessive worry, and behaviors such as avoidance of others or hyperactivity.

To explore this continuum idea more deeply, consider **Figure 1.3**. Ricardo started a job as a financial analyst 6 months ago and has been feeling anxious, worried, and overwhelmed for the past 3 weeks. His overall mood, or *emotional state,* has been highly anxious—he has great difficulty eating, sleeping, and interacting with friends. His *cognitive style* can be characterized by intense worry—almost all his thoughts involve what he is doing wrong at his new job and fear that his coworkers and friends will discover the difficult time he is having at work. Because of his anxiety and worry, Ricardo has started to avoid coworkers and friends. This avoidance *behavior* is causing problems for Ricardo, however, because he must meet with clients almost every day.

Consider Yoko as well. Yoko is a young adult with many symptoms related to anxiety. After college, she was hired as a manual writer for a large software company. Yoko has dealt with bouts of anxious mood for most of her life—she almost always feels "on edge" and sometimes has physical symptoms that suggest her body is "on high alert," such as rapid heartbeat, muscle tension, and sweating. These anxiety symptoms worry Yoko, and she often wonders if something is physically wrong with her. Because of her job, however, Yoko can work at home and spends most days without much human contact. This suits Yoko fine because she has never felt completely comfortable around other people and prefers to be alone. Her job requires her to meet with her boss only at the beginning and end of each project. Yoko can tolerate this relatively infrequent contact without much difficulty. So her preference and choice to be alone most of the time does not cause major problems for her.

The combination of psychological symptoms exhibited by Ricardo characterizes social anxiety disorder, which we discuss in Chapter 5. As you can see, though, the emotions, thoughts, and behaviors associated with this disorder exist on a continuum. As this example illustrates, mental disorders include characteristics found among most, if not all, people. Only when levels of these characteristics cross a threshold—when they are

CONTINUUM FIGURE 1.2 Continuum of Emotions, Cognitions, and Behaviors

	Normal	Mild
Emotions	Good alertness and positive emotional state.	Feeling sad or down temporarily, but not for long.
Cognitions	"I'm not getting the grades I want this semester, but I'll keep trying to do my best."	"I'm struggling at school this semester. I wish I could study better, or I'll fail."
Behaviors	Going to classes and studying for the next round of tests. Talking to professors.	Going to classes with some trouble studying. Less contact with others.

Mimi Mollica/In Pictures/Corbis

If people cannot overcome fears they experience when performing an everyday activity such as taking the subway, the fear may be abnormal.

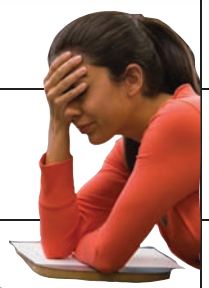
statistically deviant, associated with maladaptiveness, or cause great distress—are they considered abnormal. At one time or another, you have certainly felt anxious, had worrisome thoughts, or had the desire to be alone—similar emotions and thoughts, and their accompanying behaviors, are present to some degree in all of us. In Ricardo's case, however, the degree to which these features are present over the past 3 weeks hinders his daily life.

Figure 1.3 visually depicts this perspective and focuses on several important features of abnormal psychology. Each dimension of abnormality is shown along a continuum, be it *emotional* (e.g., anxious mood), *cognitive* (e.g., worry intensity), or *behavioral* (e.g., avoidance of others) features. Other factors associated with abnormality can be understood from a dimensional perspective as well. The degree to which one is distressed or experiences interference in daily functioning, for example, can be represented on a continuum. As Figure 1.3 shows, Ricardo and Yoko show similar levels of anxious mood, worry intensity, and avoidance behavior. On a scale of 0 (none) to 100 (extremely high), their anxious mood can be rated 85 (very high), their worry intensity can be rated 50 (moderate), and their avoidance can be rated 70 (high). In Yoko's case, however, these symptoms are associated with *lower levels of distress* (rating = 45) and *impairment* (rating = 50). As we noted, Ricardo's level of dysfunction is severe enough to warrant a diagnosis of *social anxiety disorder,* a mental disorder that is characterized by avoidance of social situations, intense anxiety, and clinically significant impairment in functioning. Yoko, however, does not warrant this or any other anxiety diagnosis because her symptoms are not associated with significant impairment in daily functioning. Indeed, she copes with her symptoms so they do not cause her great personal distress.

You might be wondering if the literature and research on anxiety disorders is relevant to Ricardo, Yoko, and even people with much lower levels of anxious symptoms. The answer is yes, absolutely! Features of mental disorder, personal distress, and impairment are all dimensional or continuous in nature. In fact, research suggests that the same causal factors are responsible for these anxiety-related symptoms whether the symptoms are mild, moderate, or severe. Because everyone will experience some of the symptoms discussed in this textbook or know someone who has or will experience these symptoms, abnormal psychology is relevant to all of us. Abnormal psychology is a part of life.

As you read this textbook and understand more that abnormal psychology is a part of life, you will identify with some of the symptoms and disorders we discuss. This does *not* mean, however, that you or someone you know has a mental disorder. Some people, for example, are extremely neat and tidy and do

Moderate	Mental Disorder — less severe	Mental Disorder — more severe
Feeling sad, but a strong positive experience such as a good grade could lift mood.	Intense sadness most of the day with some trouble concentrating and some loss of appetite.	Extreme sadness all the time with great trouble concentrating and complete loss of appetite.
"These bad grades really hurt. This may set me back for a while. I'm really worried."	"I'm so worried about these grades that my stomach hurts. I don't know what to do."	"These bad grades just show what a failure I am at everything. There's no hope; I'm not doing anything today."
Skipping a few classes and feeling somewhat unmotivated to study. Avoiding contact with professors and classmates.	Skipping most classes and unable to maintain eye contact with others. Strong lack of motivation.	Unable to get out of bed, eat, or leave the house. Lack of energy and frequent crying.



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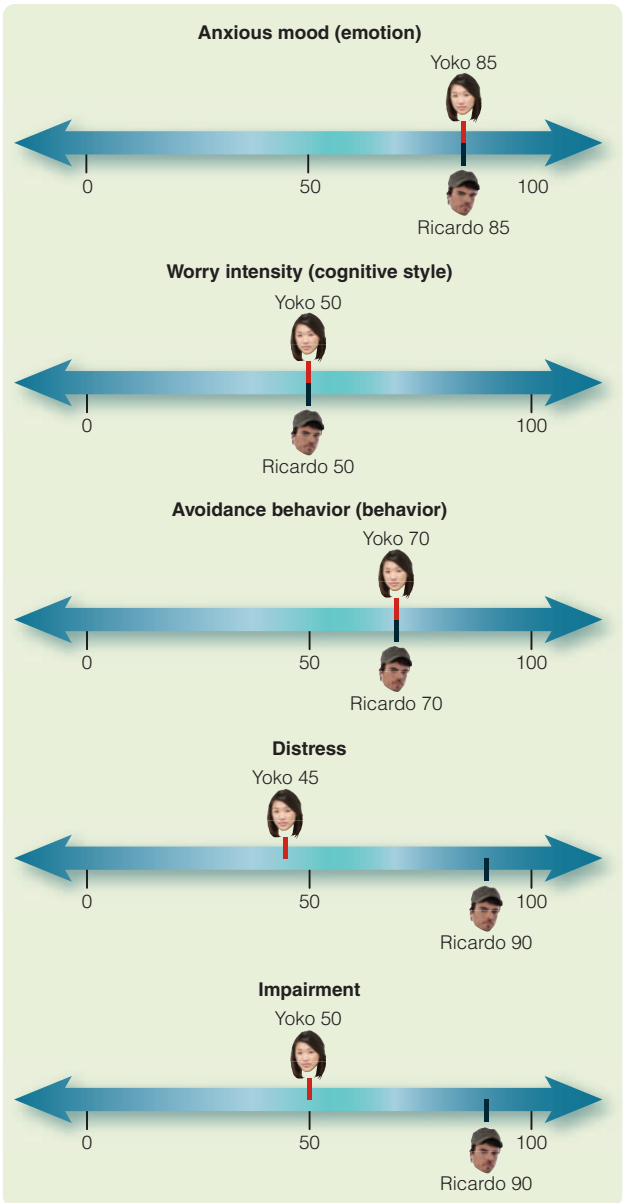

not like things to be disorderly. In fact, they may feel uncomfortable when things are not lined up and organized. If this applies to you or someone you know, you may be tempted to believe you or the person has obsessive-compulsive disorder (Chapter 5). You might share an interest in neatness with someone who has obsessive-compulsive disorder, but you are probably able to tolerate this need for neatness and order and can function even if you were prevented from keeping everything organized. People with very high levels of a characteristic, like a need for neatness, are indeed at risk for developing a condition such as obsessive-compulsive disorder, especially under conditions of high stress. We hope to make you more aware of who is vulnerable for a mental disorder and what can be done to maximize mental health. In doing so, we also emphasize *prevention* of mental disorder, or how people can lower the probability of developing mental disorders.

INTERIM SUMMARY

- A mental disorder is a group of emotional (feelings), cognitive (thinking), or behavioral symptoms that cause distress or significant problems.
- About one of four American adults has a mental disorder each year.
- Abnormal psychology is the scientific study of troublesome emotions, thoughts, and behaviors associated with mental disorders.
- Emotions, thoughts, and behaviors are considered abnormal when they deviate greatly from the norm, interfere with daily functioning, or cause substantial personal distress.

FIGURE 1.3 RICARDO AND YOKO Ricardo and Yoko have similar levels of anxious mood, worry intensity, and avoidance behavior. However, they differ on amount of distress experienced and levels of impairment created by their symptoms. *(Photos courtesy of © 2010 Design Pics/Jupiterimages Corporation [Yoko]; ©Istockphoto.com/Carole Gomez [Ricardo].)*