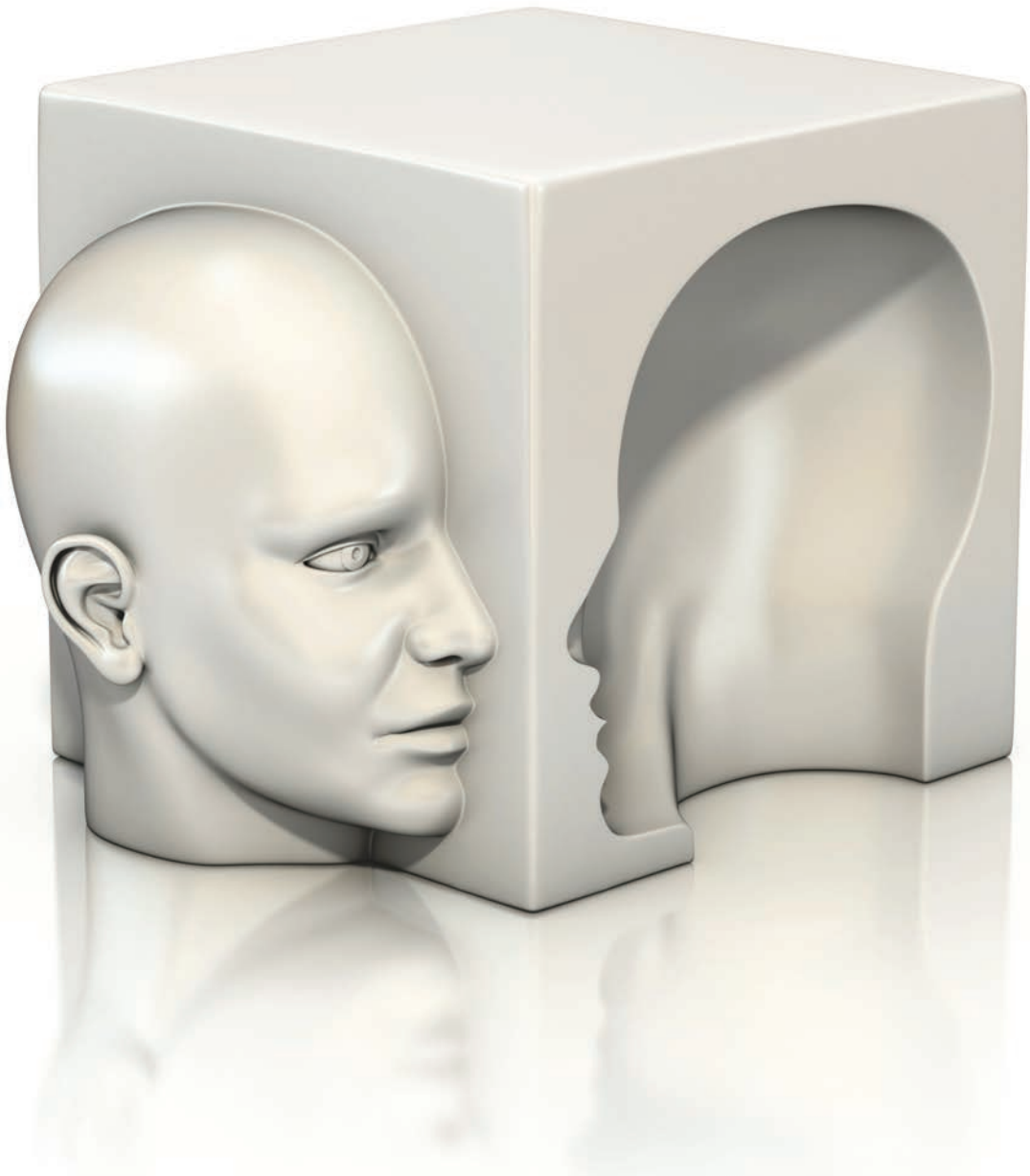
GLOBAL EDITION

Abnormal Psychology

EIGHTH EDITION

Thomas F. Oltmanns
Robert E. Emery



ALWAYS LEARNING

PEARSON

abnormal psychology

eighth edition

Global Edition

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preface

Emotional suffering touches all of our lives at some point in time. Psychological problems affect many of us directly and all of us indirectly—through our loved ones, friends, and the strangers whose troubled behavior we cannot ignore. Abnormal psychology is not about "them." Abnormal psychology is about all of us.

Abnormal psychology is also about scientific inquiry. In this eighth edition of our text, once again, we bring both the science and the personal aspects of abnormal psychology to life. We answer pressing intellectual and human questions as accurately, sensitively, and completely as possible, given the pace of new discoveries. Throughout this book, we offer an engaging yet rigorous treatment of abnormal psychology, highlighting both the latest research and theory and the urgent needs of the people behind the disorders.

Why Do You Need This New Edition?

- *DSM-5*! The eighth edition of *Abnormal Psychology* is completely updated with information from the recently published *DSM-5*. We delayed our revision for a few months, so we could do more than just add tables of *DSM-5* diagnostic criteria. You will find a great many *DSM-5* tables, of course. But you will also see a discussion of the conceptual, practical, and political debates about *DSM-5* integrated throughout the text.
- *Thinking Critically About DSM-5* is a new feature that appears in every chapter. We teach students about *DSM-5*. Then we encourage the students to *think deeply* about the pros and cons of this diagnostic system. How does *DSM-5* deal with dimensions versus categories in defining abnormal behavior? Is autism really best viewed as a spectrum disorder? What arguments lie behind *DSM-5*'s decision to include new diagnoses like binge eating disorder and hoarding disorder? Has *DSM-5* taken the descriptive approach too far, for example, grouping diagnoses like anorexia nervosa and pica together because both involve eating? What does *DSM-5* say about the causes and treatment of mental disorders?
- We include hundreds of new studies about *DSM-5* and dozens of other topics. Psychological science is dynamic, ever-changing, and ever-growing. Our textbook grows with the field, bringing to life both the exciting process of discovery and important new findings about disorders and their causes and effective treatment. This eighth edition is at the cutting edge, because we have culled the best and most important new research from thousands of studies to include hundreds of new ones here.
- How can a student new to abnormal psychology learn to think critically about such a broad, important topic? We guide you in your learning—and in critical thinking—with "The Big Picture" a set of probing questions that open each chapter. "The Big Picture" orients you to key issues and themes covered in the relevant chapter. Each chapter ends with "The Big Picture Revisited," returning to the key issues, briefly summarizing the central point, and directing you to pages where you can find a discussion of the details. You may have been asking yourself these kind of critical questions, but if in case you weren't, we show you how to keep the big picture in mind.
- We focus on the forest *and* the trees. *Abnormal Psychology* is about real people. We bring the human side of psychology problems to life with a series of new *Speaking Out* videos that we edited personally. We promise that these videos will make you think and make you feel, too. We also have included more on the human side of psychological problems with new and updated case studies, as well as updated "Getting Help" features that offer practical advice for you and your loved ones.
- You will find that *Abnormal Psychology* introduces you to new concepts from the frontiers of understanding interactions between genes and the environment. For example, are you a "dandelion" who can survive in most any environment, or instead are you a fragile "orchid" who will wither under harsh conditions but bloom gloriously in the right environment?
- You will find new and updated discussions of treatments that work. Do we at last have an effective treatment for adolescents with anorexia nervosa? Read our discussion of the "Maudsley method" in Chapter 10.
- We do not shy away from controversy, because we all can learn from facing the issues squarely. "Sexual addiction" seems to be epidemic. Is this a mental disorder? We draw you into the latest issues, research, and debates in Chapter 12. Or speaking of epidemics, what about the purported "epidemic of autism"? We not only take you through the misguided (and largely resolved) controversy about vaccines and autism, but also discuss how much current controversy about the autism "epidemic" stems from much broader criteria used to diagnose autism spectrum disorder.

DSM-5 Is Here and Intergrated Everywhere in This Eighth Edition!

Much anticipated and at long last, *DSM-5* was published in May 2013. The new version of the Diagnostic and Statistical Manual includes many changes. A great many of the revisions incorporated into *DSM-5* are a step forward. Others, well, not so much. . . .

We eagerly awaited the final publication of the *DSM-5*, as did other mental health professionals and textbook authors. We were

curious to see what much-discussed and debated changes made it into the final *DSM-5*, and what diagnoses and diagnostic criteria remained the same. Naturally, we wanted our eighth edition of *Abnormal Psychology* to include *DSM-5*, so that students and instructors could have up-to-date information on this very influential diagnostic system. Yet, we made a decision not to rush this revision. Why? We wanted to do more than just include tables with new, *DSM-5* diagnostic criteria. We wanted to integrate and evaluate *DSM-5* into the fabric of every chapter. As a result, we might not be the first textbook published to be able to proclaim that we include *DSM-5*. We think it's better to be able to say that the eighth edition of our text includes, integrates, and evaluates *DSM-5* in a thorough, careful, and critical way.

Of course, you will find a great many tables of *DSM-5* diagnostic criteria in this text. But you will find much more. The most visible addition is our brand-new feature, *Thinking Critically About DSM-5*. Appearing in every chapter, *Thinking Critically About DSM-5* asks and answers questions like these: How does the *DSM-5*'s categorical diagnostic system deal with dimensional variations in abnormal (and normal) behavior? Is autism really best viewed as a spectrum disorder? What arguments—scientific, political, and practical—lie behind *DSM-5*'s decision to include new diagnoses like binge eating disorder and temper dysregulation disorder? Has *DSM-5* taken the descriptive approach too far, too literally grouping diagnoses together based solely on appearance (such as pica and anorexia nervosa)? What does (and doesn't) *DSM-5* say about the causes and treatment of mental disorders—and why?

Our goal in writing the *Thinking Critically About DSM-5* features was, first, to teach students about the *DSM-5*, and, second, to help students *think* about *DSM-5*. We want students to understand the principles behind classification and diagnosis in general. We want them to grapple with the conceptual and empirical uncertainties concerning particular disorders. We also want students to recognize at least some of the practical and political agendas that influence what, in the context of our culture and times, we decide is or isn't a mental disorder.

These ambitious goals require more than *DSM-5* tables and new features. So, we also integrated various diagnostic and conceptual controversies about *DSM-5* throughout every chapter. Of course, we updated the text specifically for *DSM-5*. But in fact, we have highlighted the theoretical issues behind various diagnoses in every edition of our text. We are proud to note that many contemporary controversies surrounding the *DSM-5* have been highlighted in our text for a long time. To offer just one example: Should abnormal behavior be classified along dimensions or into categories? This issue has been a key theme of Oltmanns and Emery, *Abnormal Psychology*, since the first edition. Questions like this are not just about the *DSM-5*. Debates about topics like dimensions versus categories are about critical thinking in general. Consider this question: Where does an instructor set cutoffs, turning the dimension of test score averages into the category of letter grades? Now, *that's* a debate about dimensions and categories that a student can understand!

Critical Thinking

Abnormal Psychology is all about critical thinking. We believe that critical thinking is essential for science, for helping those in need, and for the intellectual and personal development of our students. Today's students are overwhelmed with information from all kinds of media. Critical thinking is indispensible, so students can distinguish between information that is good, bad, or ugly (to borrow a phrase from our favorite Western movie). We want students to think critically about abnormal psychology—and everything else.

We encourage the readers of *Abnormal Psychology* to be *inquiring skeptics*. Students need to be skeptical in evaluating all kinds of claims. We help them to do so by teaching students to *think like psychological scientists*. Yet, we also want students to be inquiring, to be skeptical not cynical. Pressing human needs and fascinating psychological questions make it essential for us to seek answers, not just explode myths.

In this eighth edition of our text, we emphasize critical thinking in several ways. As noted, we include the new feature, *Thinking Critically About DSM-5.* We also refined our chapter opening feature, "The Big Picture," to link even more tightly with our chapter ending, "The Big Picture: Critical Thinking Review." "The Big Picture" draws students into each chapter by posing common yet critical questions about key substantive topics. The questions also orient the student to conceptual themes about the substance and the methods of abnormal psychology. Then, at the end of each chapter, we have a section called "The Big Picture: Critical Thinking Review," which summarizes key, big-picture questions and includes handy page references for review purposes.

We also have continued to revise and expand our "Critical Thinking Matters" discussions, which are found in every chapter. These features address some timely, often controversial, and always critically important topics, for example, the purported link between vaccines and autism (see Chapter 2). Critical thinking matters because psychological problems matter deeply to those who suffer and to their loved ones. Good research tells us—and them—which treatments work, and which ones don't, as well as what might cause mental illness, and what doesn't. Critical thinking matters because students in abnormal psychology surely will not remember all the details they learn in this course. In fact, they shouldn't focus exclusively on facts, because data will change with new scientific developments. But if students can learn to think critically about abnormal psychology, the lesson will last a lifetime and be used repeatedly, not only in understanding psychological problems, but also in every area of their lives.

Our "Critical Thinking Matters" features help students to *think* about science, about pseudo-science, and about themselves. For example, in Chapter 2 we address the mistaken belief, still promoted widely on the Internet and in the popular media, that mercury in widely used measles/mumps/rubella (MMR) vaccinations

in the 1990s caused an epidemic of autism (and perhaps a host of other psychological problems for children). "Critical Thinking Matters" outlines the concerns of the frightened public, but goes on to point out (1) the failure to find support for this fear in numerous, large-scale scientific studies; (2) the scientific stance that the burden of proof lies with the proponents of any hypothesis, including speculations about MMR; (3) the widely ignored fact that 10 of the original 13 authors who raised the theoretical possibility *publicly withdrew their speculation about autism and MMR*; (4) the fact that the findings of legal actions, sadly, do not necessarily reach conclusions consistent with scientific knowledge; and (5) recent discrediting of the scientists, journal article, and legal findings that originally "supported" this false claim. As we discuss in Chapter 15, moreover, the apparent epidemic of autism very likely resulted from increased awareness of the disorder and loosened criteria for diagnosing autism, not from an actual increase in cases.

Real People

We want students to think critically about disorders *and* to be sensitive to the struggles of individuals with psychological problems. As scientist-practitioners, we see these dual goals not only as compatible, but also as essential. One way that we underscore the personal nature of emotional problems is in our "Getting Help" features found in every chapter. In "Getting Help," we directly address the personal side of psychological disorders and try to answer the sorts of questions that students often ask us privately after a lecture or during office hours. The "Getting Help" sections give responsible, empirically sound, and concrete guidance on such personal topics as

- What treatments should I seek out for a particular disorder? (See Chapters 2, 6, 10, and 12)
- What can I do to help someone I know who has a psychological problem? (See Chapters 5, 9, 10, and 16)
- How can I find a good therapist? (See Chapters 3, 5, and 12)
- Where can I get reliable information from books, the Internet, or professionals in my community? (See Chapters 1, 5, 7, and 11)
- What self-help strategies can I try or suggest to friends? (See Chapters 6, 11, and 12)

Students can also find research-based information on the effectiveness and efficacy of various treatments in Chapter 3, "Treatment of Psychological Disorders," and in the "Treatment" headings near the end of every disorder chapter. We cover treatment generally at the beginning of the text but in detail in the context of each disorder, because different treatments are more or less effective for different psychological problems.

"Speaking Out" Videos

One of the best ways to understand the needs of the people behind the disorders is to hear their stories in their own words. We worked in consultation with Pearson and NKP Productions to produce (and expand) a video series called ***Speaking Out: Interviews with People Who Struggle with Psychological Disorders.*** The earlier cases in the *Speaking Out* series were introduced with previous editions of our book. We have added four new cases, addressing the following problem areas: gender dysphoria, nonsuicidal self-injury, dissociative amnesia, and binge eating disorder. These interviews give students a window into the lives of people who in many ways may not be that different from anyone else, but who do struggle with various kinds of mental disorder. As before, the new video cases also include a segment called "A Day in the Life," which features interviews with friends and family members who discuss their relationships, feelings, and perspectives. We introduce students to each of these people in the appropriate chapters of our book, using their photos and a brief description of relevant issues that should be considered when viewing the video cases. The full versions of the interviews are available to instructors either on DVD or on MyPsychLab.com (www.mypsychlab.com).

We are especially proud of the *Speaking Out* videos and view them as a part of our text, not as a supplement, because we were intimately involved with their production. As with the original series, we screened the new video cases, helped to construct and guide the actual interviews, and gave detailed feedback on how to edit the films to make the disorders real for students and fit closely with the organization and themes in our eighth edition.

New Research

The unsolved mysteries of abnormal psychology challenge all of our intellectual and personal resources. In our eighth edition, we include the latest "clues" psychological scientists have unearthed in doing the detective work of research, including references to hundreds of new studies. But the measure of a leading-edge textbook is not merely the number of new references; it is the number of new studies the authors have reviewed and evaluated before deciding which ones to include and which ones to discard. For every new reference in this edition of our text, we have read many additional papers before selecting the one gem to include. Some of the updated research and perspectives in this edition include:

- Updated discussion regarding the general definition of mental disorders, as employed in *DSM-5*, and new estimates regarding the number of mental health professionals delivering services (*Chapter 1*)
- Enhanced coverage of gene–environment interactions (including "orchids" versus "dandelions") and failures to replicate the effects of specific genes (*Chapter 2*)
- New evidence on what makes placebos "work," on disseminating evidenced-based treatments, and "3rd wave" CBT (*Chapter 3*)
- Revised discussion of the reliability of diagnosis, based on new evidence from the *DSM-5* field trials (*Chapter 4*)

- New mention of premenstrual dysphoric disorder (a category added to *DSM-5*), and new discussion of evidence regarding the increase in military suicides, which have received considerable attention in the popular media (*Chapter 5*)
- Addition of material on hoarding disorder (another new diagnostic category added to *DSM-5*) and expanded coverage of the diagnostic features and prevalence of obsessive-compulsive symptoms and spectrum disorders, which are now listed separately from anxiety disorders in *DSM-5* (*Chapter 6*)
- Further consideration of resilience in response to trauma, questions about secondary trauma, and new questions about somatoform and dissociative disorders (*Chapter 7*)
- New research on cultural differences in social support, religion, and coping, and the daily experience of pain (*Chapter 8*)
- Careful explanation of the two approaches to classification of personality disorders that are now included in *DSM-5* as well as the similarities and distinctions between them (*Chapter 9*)
- Questions and new information about binge eating disorder and obesity; latest evidence on redefining, treating (the Maudsley method), and preventing eating disorders; up-to-date consideration of women's portrayal in the media (*Chapter 10*)
- New evidence regarding the frequency of overdose deaths attributed to opioid pain-killers, which has increased dramatically in recent years as well as expanded coverage of gambling disorder, which is now listed with Substance-Related and Addictive Disorders in *DSM-5* (*Chapter 11*)
- Discussion of the revised approach to the definition and classification of paraphilic disorders (*Chapter 12*)
- Careful consideration of the proposed diagnostic construct "Attenuated Psychosis Syndrome," including its potential benefits as well as likely negative consequences (*Chapter 13*)
- Explanation of the change to neurocognitive disorders as the overall diagnostic term for this chapter as well as the deletion of the term amnestic disorder (*Chapter 14*)
- More questions about the autism spectrum, the so-called epidemic of autism, and estimates of the prevalence of autism spectrum disorder (*Chapter 15*)
- Questions about the *DSM-5*'s elimination of childhood disorders; updated discussion of adolescent depression, antidepressants, suicide risk; careful consideration of the new diagnosis and the issues behind it, disruptive mood dysregulation disorder (*Chapter 16*)
- Further consideration of "relational diagnoses," complicated grief, and psychological pain (*Chapter 17*)
- Discussion of how diagnostic thresholds are a matter of life and death in the case of intellectual disabilities; new material on advanced psychiatric directives (*Chapter 18*)

Still the Gold Standard

We see the most exciting and promising future for abnormal psychology in the integration of theoretical approaches, professional specialties, and science and practice, not in the old, fractured competition among "paradigms," a split between psychology and psychiatry, or the division between scientists and practitioners. We view integration as the gold standard of any forward-looking abnormal psychology text, and the gold standard remains unchanged in the eighth edition of our textbook.

Integrating Causes and Treatment

For much of the last century, abnormal psychology was dominated by theoretical paradigms, a circumstance that reminds us of the parable of the seven blind men and the elephant. One blind man grasps a tusk and concludes that an elephant is very much like a spear. Another feels a leg and decides an elephant is like a tree, and so on. Our goal from the first edition of *Abnormal Psychology* has been to show the reader the whole elephant. We do this through our unique *integrative systems approach*, in which we focus on what we know today rather than what we used to think. In every chapter, we consider the latest evidence on the *multiple* risk factors that contribute to psychological disorders, as well as the most effective psychological and biomedical treatments. Even if science cannot yet paint a picture of the whole elephant, we clearly tell the student what we know, what we don't know, and how psychologists think the pieces might fit together.

Pedagogy: Integrated Content and Methods

We also continue to bring cohesion to abnormal psychology—and to the student—with pedagogy. Each disorder chapter unfolds in the same way, providing a *coherent* framework with a *consistent chapter outline*. We open with an Overview followed by one or two extended Case Studies. We then discuss Symptoms, Diagnosis, Frequency, Causes, and, finally, Treatment.

Abnormal psychology is not only about the latest research, but also about the methods psychologists use (and invent) in order to do scientific detective work. Unlike any other text in this field, we cover the scientific method by offering brief "Research Methods" features in every single chapter. Teaching methods in the context of content helps students appreciate the importance of scientific procedures and assumptions, makes learning research methods more manageable, and gives the text flexibility. By the end of the text, our unique approach allows us to cover research methods in *more* detail than we could reasonably cover in a single, detached chapter. Many of our students have told us that the typical research methods chapter seems dry, difficult, and—to our great disappointment—irrelevant. These problems never arise with our integrated, contextualized approach to research methods.

Abnormal psychology also is, of course, about real people with real problems. We bring the human, clinical side of abnormal psychology alive with detailed "Case Studies." The case studies take

the reader along the human journey of pain, triumph, frustration, and fresh starts that is abnormal psychology. The cases help students to think more deeply about psychological disorders, much as our own clinical experience enriches our understanding. (We both have been active clinicians as well as active researchers throughout our careers.) In extended cases near the beginning of each chapter, in briefer cases later, and in first-person accounts throughout, the student sees how ordinary lives are disrupted by psychological problems—and how effective treatment can rebuild shattered lives. The case studies also make the details and complexity of the science concrete, relevant, and essential to the "real world."

Sometimes a study or problem suggests a departure from current thinking or raises side issues that deserve to be examined in detail. We cover these emerging ideas in features identified by the topic at hand. One example of an emerging issue we discuss in this way is whether the female response to stress might be to "tend and befriend" rather than fight or flight (Chapter 8). Other topics include the common elements of suicide (Chapter 5) and a system for classifying different types of rapists (Chapter 12).

Supplements Package

MyPsychLab for Abnormal Psychology

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

VIRTUAL CASE STUDIES

Virtual Case Studies offers you a science-based, interactive simulation where you can learn how a number of risk factors and protective factors could impact disorder development in a virtual person. As you progress through the simulation you will not act as the character or as a clinician, but will be able to independently explore a variety of different behaviors, events, and outcomes that one who suffers from a disorder could potentially encounter. There are no right or wrong selections, as exploring the impact of both risk and protective factors in the life of the character will provide valuable insights into the experience of a disorder along a continuum. The following Virtual Case Studies are available at mypsychlab.com:

Anxiety Disorders
Mood Disorders
Eating Disorders
Substance Use Disorders

SPEAKING OUT: INTERVIEWS WITH PEOPLE WHO STRUGGLE WITH PSYCHOLOGICAL DISORDERS

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

INSTRUCTOR'S MANUAL

A comprehensive tool for class preparation and management, each chapter includes learning objectives, a chapter outline, lecture suggestions, discussion ideas, classroom activities, discussion questions, and video resources. Available for download on the Instructor's Resource Center at http://www.pearsonglobaleditions.com/Oltmanns.

TEST BANK

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

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LECTURE POWERPOINT SLIDES

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 http://www.pearsonglobaleditions.com/Oltmanns.

ENHANCED LECTURE POWERPOINT SLIDES WITH EMBEDDED VIDEOS

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

POWERPOINT SLIDES FOR PHOTOS, FIGURES, AND TABLES

Contain only the photos, figures, and line art from the textbook. Available for download on the Instructor's Resource Center at http://www.pearsonglobaleditions.com/Oltmanns.

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Writing and revising this textbook is a never-ending task that fortunately is also a labor of love. This eighth edition is the culmination of years of effort and is the product of many people's hard work. The first people we wish to thank for their important contributions to making this the text of the future, not of the past, are the following expert reviewers who have unselfishly offered us a great many helpful suggestions, both in this and in previous editions: John Dale Alden, III, Lipscomb University; John Allen, University of Arizona; Hal Arkowitz, University of Arizona; Jo Ann Armstrong, Patrick Henry Community College; Gordon Atlas, Alfred University; Deanna Barch, Washington University; Catherine Barnard, Kalamazoo Community College; Thomas G. Bowers, Pennsylvania State University, Harrisburg; Stephanie Boyd, University of South Carolina; Gail Bruce-Sanford, University of Montana; Ann Calhoun-Seals, Belmont Abbey College; Caryn L. 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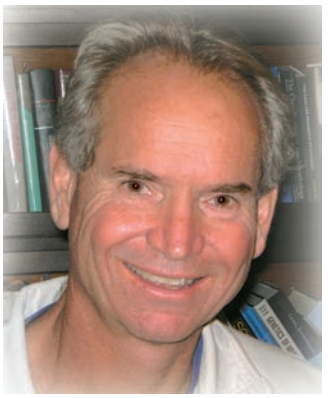

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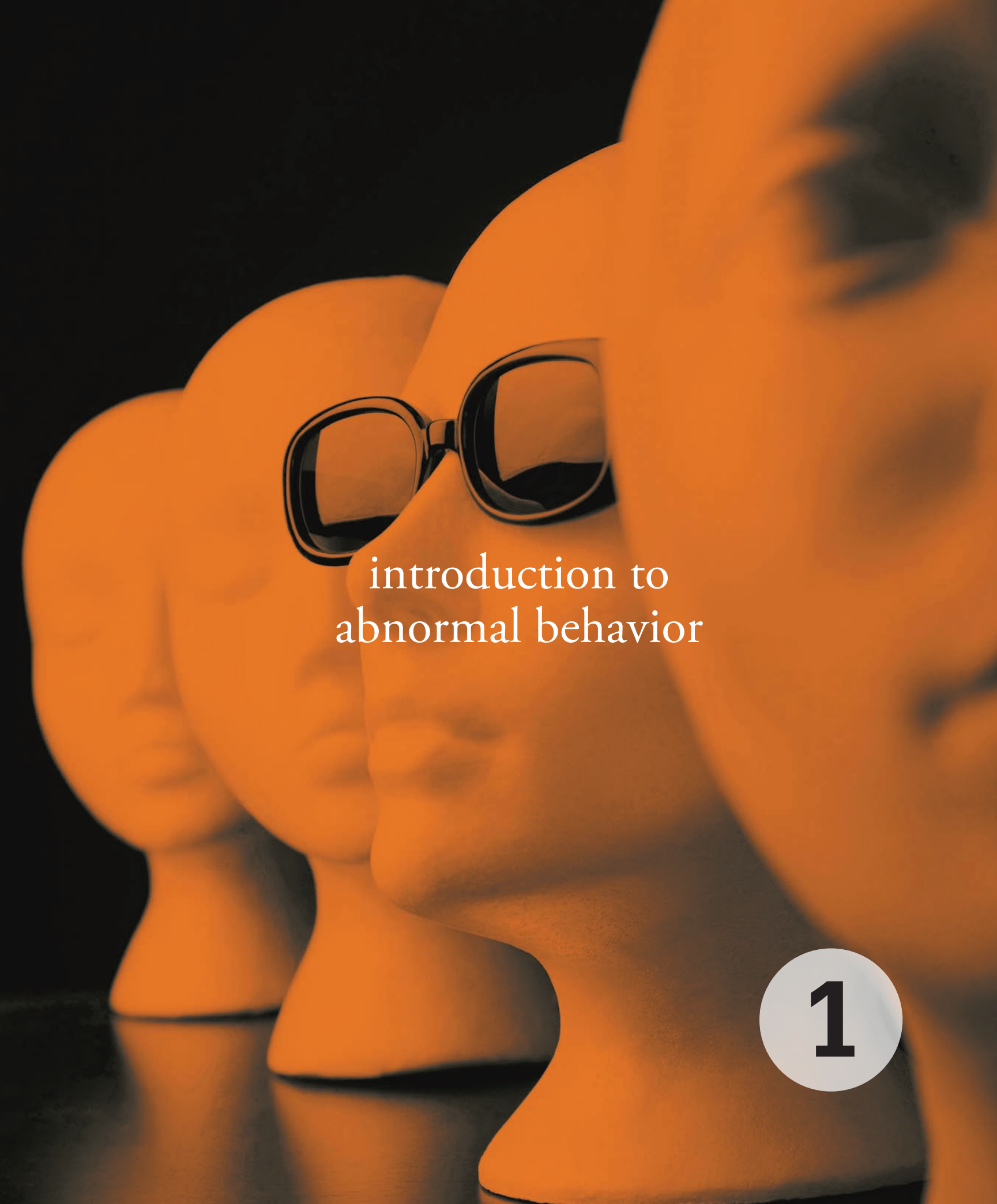


introduction to abnormal behavior

1

The Big Picture

learning objectives

1.1
What is the difference between normal and abnormal behavior?

1.2
How does culture influence the definition of mental disorders?

1.3
How does the impact of mental disorders compare to that of other health problems?

1.4
Who provides help for people with mental disorders?

1.5
Why do scientific methods play such an important role in psychology's approach to the study of mental disorders?

Mental disorders touch every realm of human experience; they are part of the human experience. They can disrupt the way we think, the way we feel, and the way we behave. They also affect relationships with other people. These problems often have a devastating impact on people's lives. In countries such as the United States, mental disorders are the second leading cause of disease-related disability and mortality, ranking slightly behind cardiovascular conditions and slightly ahead of cancer (Lopez et al., 2006). The purpose of this book is to help you become familiar with the nature of these disorders and the various ways in which psychologists and other mental health professionals are advancing knowledge of their causes and treatment.

Many of us grow up thinking that mental disorders happen to a few unfortunate people. We don't expect them to happen to us or to those we love. In fact, mental disorders are very common. At least two out of every four people will experience a serious form of abnormal behavior, such as depression, alcoholism, or schizophrenia, at some point during his or her lifetime. When you add up the numbers of people who experience these problems firsthand as well as through relatives and close friends, you realize that, like other health problems, mental disorders affect all of us. That is why, throughout this book, we will try to help you understand not only the kind of disturbed behaviors and thinking that characterize particular disorders, but also the people to whom they occur and the circumstances that can foster them.

Most importantly, this book is about all of us, not "them"—anonymous people with whom we empathize but do not identify. Just as each of us will be affected by medical problems at some point during our lives, it is also likely that we, or someone we love, will have to cope with that aspect of the human experience known as a disorder of the mind.

Overview

The symptoms and signs of mental disorders, including such phenomena as depressed mood, panic attacks, and bizarre beliefs, are known as **psychopathology.** Literally translated, this term means *pathology of the mind.* **Abnormal psychology** is the application of psychological science to the study of mental disorders.

In the first four chapters of this book, we will look at the field of abnormal psychology in general. We will look at the ways in which abnormal behaviors are broken down into categories of mental disorders that can be more clearly defined for diagnostic purposes, and how those behaviors are assessed. We will also discuss current ideas about the causes of these disorders and ways in which they can be treated.

This chapter will help you begin to understand the qualities that define behaviors and experiences as being abnormal. At what point does the diet that a girl follows in order to perform at her peak as a ballerina or gymnast become an eating disorder? When does grief following the end of a relationship become major depression? The line dividing normal from abnormal is not always clear. You will find that the issue is often one of degree rather than exact form or content of behavior.

The case studies in this chapter describe the experiences of two people whose behavior would be considered abnormal by mental health professionals. Our first case will introduce you to a person who suffered from one of the most obvious and disabling forms of mental disorder, known as schizophrenia. Kevin's life had been relatively unremarkable for many years. He had done well in school, was married, and held a good job. Unfortunately, over a period of several months, the fabric of his normal life began to fall apart. The transition wasn't obvious to either Kevin or his family, but it eventually became clear that he was having serious problems.

→ A Husband's Schizophrenia with Paranoid Delusions

Kevin and Joyce Warner (not their real names*) had been married for eight years when they sought help from a psychologist for their marital problems. Joyce was 34 years old, worked full time as a pediatric nurse, and was six months pregnant with her first child. Kevin, who was 35 years old, was finishing his third year working as a librarian at a local university. Joyce was extremely worried about what would happen if Kevin lost his job, especially in light of the baby's imminent arrival.

Although the Warners had come for couples therapy, the psychologist soon became concerned about certain eccentric

*Throughout this text we use fictitious names to protect the identities of the people involved.

aspects of Kevin's behavior. In the first session, Joyce described one recent event that had precipitated a major argument. One day, after eating lunch at work, Kevin had experienced sharp pains in his chest and had difficulty breathing. Fearful, he rushed to the emergency room at the hospital where Joyce worked. The physician who saw Kevin found nothing wrong with him, even after extensive testing. She gave Kevin a few tranquilizers and sent him home to rest. When Joyce arrived home that evening, Kevin told her that he suspected that he had been poisoned at work by his supervisor. He still held this belief.

Kevin's belief about the alleged poisoning raised serious concern in the psychologist's mind about Kevin's mental health. He decided to interview Joyce alone so that he could ask more extensive questions about Kevin's behavior. Joyce realized that the poisoning idea was "crazy." She was not willing, however, to see it as evidence that Kevin had a mental disorder. Joyce had known Kevin for 15 years. As far as she knew, he had never held any strange beliefs before this time. Joyce said that Kevin had always been "a thoughtful and unusually sensitive guy." She did not attach a great deal of significance to Kevin's unusual belief. She was more preoccupied with the couple's present financial concerns and insisted that it was time for Kevin to "face reality."

Kevin's condition deteriorated noticeably over the next few weeks. He became extremely withdrawn, frequently sitting alone in a darkened room after dinner. On several occasions, he told her that he felt as if he had "lost pieces of his thinking." It wasn't that his memory was failing, but rather he felt as though parts of his brain were shut off.

Kevin's problems at work also grew worse. His supervisor informed Kevin that his contract would definitely not be renewed. Joyce exploded when Kevin indifferently told her the bad news. His apparent lack of concern was especially annoying. She called Kevin's supervisor, who confirmed the news. He told her that Kevin was physically present at the library, but he was only completing a few hours of work each day. Kevin sometimes spent long periods of time just sitting at his desk and staring off into space and was sometimes heard mumbling softly to himself.

Kevin's speech was quite odd during the next therapy session. He would sometimes start to speak, drift off into silence, then reestablish eye contact with a bewildered smile and a shrug of his shoulders. He had apparently lost his train of thought completely. His answers to questions were often off the point, and when he did string together several sentences, their meaning was sometimes obscure. For example, at one point during the session, the psychologist asked Kevin if he planned to appeal his supervisor's decision. Kevin said, "I'm feeling pressured, like I'm lost and can't quite get here. But I need more time to explore the deeper side. Like in art. What you see on the surface is much richer when you look closely. I'm like that. An intuitive person. I can't relate in a linear way, and when people expect that from me, I get confused."

Kevin's strange belief about poisoning continued to expand. The Warners received a letter from Kevin's mother, who lived in another city 200 miles away. She had become ill after going out for dinner one night and mentioned that she must have eaten something that made her sick. After reading the letter, Kevin became convinced that his supervisor had tried to poison his mother, too.

When questioned about this new incident, Kevin launched into a long, rambling story. He said that his supervisor was a Vietnam veteran, but he had refused to talk with Kevin about his years in the service. Kevin suspected that this was because the supervisor had been a member of army intelligence. Perhaps he still was a member of some secret organization. Kevin suggested that an agent from this organization had been sent by his supervisor to poison his mother. Kevin thought that he and Joyce were in danger. Kevin also had some concerns about Asians, but he would not specify these worries in more detail.

Kevin's bizarre beliefs and his disorganized behavior convinced the psychologist that he needed to be hospitalized. Joyce reluctantly agreed that this was the most appropriate course of action. She had run out of alternatives. Arrangements were made to have Kevin admitted to a private psychiatric facility, where the psychiatrist prescribed a type of antipsychotic medication. Kevin seemed to respond positively to the drug, because he soon stopped talking about plots and poisoning—but he remained withdrawn and uncommunicative. After three weeks of treatment, Kevin's psychiatrist thought that he had improved significantly. Kevin was discharged from the hospital in time for the birth of their baby girl. Unfortunately, when the couple returned to consult with the psychologist, Kevin's adjustment was still a major concern. He did not talk with Joyce about the poisonings, but she noticed that he remained withdrawn and showed few emotions, even toward the baby.

When the psychologist questioned Kevin in detail, he admitted reluctantly that he still believed that he had been poisoned. Slowly, he revealed more of the plot. Immediately after admission to the hospital, Kevin had decided that his psychiatrist, who happened to be from Korea, could not be trusted. Kevin was sure that he, too, was working for army intelligence or perhaps for a counterintelligence operation. Kevin believed that he was being interrogated by this clever psychiatrist, so he had "played dumb." He did not discuss the suspected poisonings or the secret organization that had planned them. Whenever he could get away with it, Kevin simply pretended to take his medication. He thought that it was either poison or truth serum.

Kevin was admitted to a different psychiatric hospital soon after it became apparent that his paranoid beliefs had expanded. This time, he was given intramuscular injections of antipsychotic medication in order to be sure that the medicine was actually taken. Kevin improved considerably after several weeks in the hospital. He acknowledged that he had experienced paranoid thoughts. Although he still felt suspicious from time to time, wondering whether the plot had actually been real, he recognized that it could not really have happened, and he spent less and less time thinking about it.

Recognizing the Presence of a Disorder

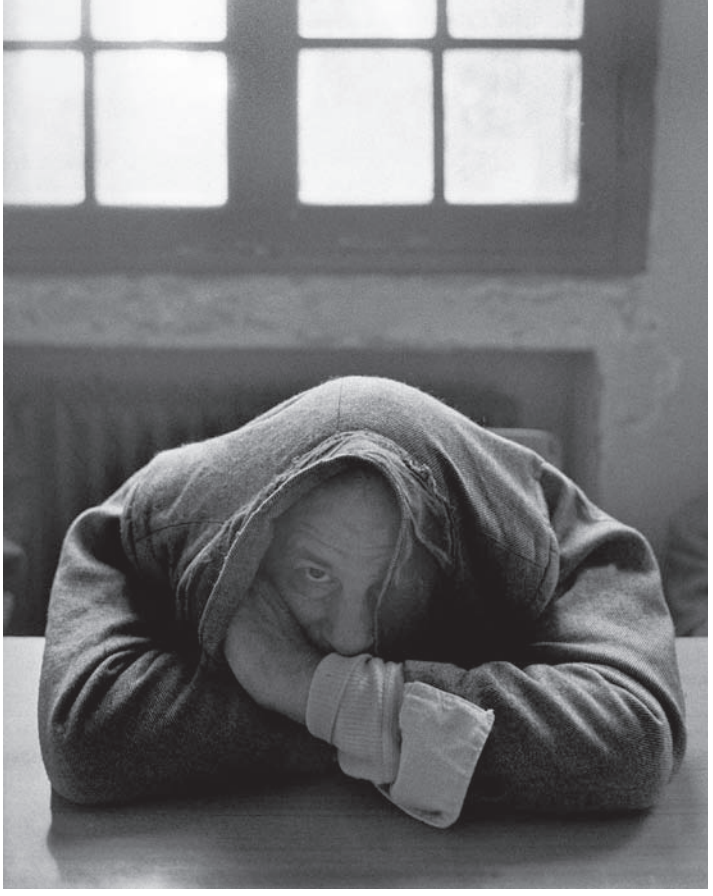
Some mental disorders are so severe that the people who suffer from them are not aware of the implausibility of their beliefs. Schizophrenia is a form of **psychosis,** a general term that refers to several types of severe mental disorders in which the person is considered to be out of contact with reality. Kevin exhibited several psychotic symptoms. For example, Kevin's firm belief that he was being poisoned by his supervisor had no basis in reality. Other disorders, however, are more subtle variations on normal experience. We will shortly consider some of the guidelines that are applied in determining abnormality.

Mental disorders are typically defined by a set of characteristic features; one symptom by itself is seldom sufficient to make a diagnosis. A group of symptoms that appear together and are assumed to represent a specific type of disorder is referred to as a **syndrome.** Kevin's unrealistic and paranoid belief that he was being poisoned, his peculiar and occasionally difficult-to-understand patterns of speech, and his oddly unemotional responses are all symptoms of schizophrenia (see Chapter 13). Each symptom is taken to be a fallible, or imperfect, indicator of the presence of the disorder. The significance of any specific feature depends on whether the person also exhibits additional behaviors that are characteristic of a particular disorder.

The duration of a person's symptoms is also important. Mental disorders are defined in terms of *persistent* maladaptive behaviors. Many unusual behaviors and inexplicable experiences are short lived; if we ignore them, they go away. Unfortunately, some forms of problematic behavior are not transient, and they eventually interfere with the person's social and occupational functioning. In Kevin's case, he had become completely preoccupied with his suspicions about poison. Joyce tried for several weeks to ignore certain aspects of Kevin's behavior, especially his delusional beliefs. She didn't want to think about the possibility that his behavior was abnormal and instead chose to explain his problems in terms of lack of maturity or lack of motivation. But as the problems accumulated, she finally decided to seek professional help. The magnitude of Kevin's problem was measured, in large part, by its persistence.

Impairment in the ability to perform social and occupational roles is another consideration in identifying the presence of a mental disorder. Delusional beliefs and disorganized speech typically lead to a profound disruption of relationships with other people. Like Kevin, people who experience these symptoms will obviously find the world to be a strange, puzzling, and perhaps alarming place. And they often elicit the same reactions in other people. Kevin's odd behavior and his inability to concentrate on his work had eventually cost him his job. His problems also had a negative impact on his relationship with his wife and his ability to help care for their daughter.

Kevin's situation raises several additional questions about abnormal behavior. One of the most difficult issues in the field



People with schizophrenia are sometimes socially withdrawn and find social relationships to be puzzling or threatening.

centers on the processes by which mental disorders are identified. Once Kevin's problems came to the attention of a mental health professional, could he have been tested in some way to confirm the presence or absence of a mental disorder?

Psychologists and other mental health professionals do not at present have laboratory tests that can be used to confirm definitively the presence of psychopathology because the processes that are responsible for mental disorders have not yet been discovered. Unlike specialists in other areas of medicine where many specific disease mechanisms have been discovered by advances in the biological sciences, psychologists and psychiatrists cannot test for the presence of a viral infection or a brain lesion or a genetic defect to confirm a diagnosis of mental disorder. Clinical psychologists must still depend on their observations of the person's behavior and descriptions of personal experience.

Is it possible to move beyond our current dependence on descriptive definitions of psychopathology? Will we someday have valid tests that can be used to establish independently the presence of a mental disorder? If we do, what form might these tests take? The answers to these questions are being sought in many kinds of research studies that will be discussed throughout this book.

Before we leave this section, we must also mention some other terms. You may be familiar with a variety of words that are commonly used in describing abnormal behavior. One term is *insanity,* which years ago referred to mental dysfunction but today is a legal term that refers to judgments about whether a person

Andy Warhol was one of the most influential painters of the 20th century. His colleague, Jean-Michel Basquiat, was also an extremely promising artist. His addiction to heroin, which led to a fatal overdose, provides one example of the destructive impact of mental disorders.

should be held responsible for criminal behavior if he or she is also mentally disturbed (see Chapter 18). If Kevin had murdered his psychiatrist, for example, based on the delusional belief that the psychiatrist was trying to harm him, a court of law might consider whether Kevin should be held to be *not guilty by reason of insanity.*

Another old-fashioned term that you may have heard is *nervous breakdown.* If we said that Kevin had "suffered a nervous breakdown," we would be indicating, in very general terms, that he had developed some sort of incapacitating but otherwise unspecified type of mental disorder. This expression does not convey any specific information about the nature of the person's problems. Some people might also say that Kevin was acting *crazy.* This is an informal, pejorative term that does not convey specific information and carries with it many unfortunate, unfounded, and negative implications. Mental health professionals refer to psychopathological conditions as mental disorders or abnormal behaviors. We will define these terms in the pages that follow.

Defining Abnormal Behavior

Why do we consider Kevin's behavior to be abnormal? By what criteria do we decide whether a particular set of behaviors or emotional reactions should be viewed as a mental disorder? These are important questions because they determine, in many ways, how other people will respond to the person, as well as who will be responsible for providing help (if help is required). Many attempts have been made to define abnormal behavior, but none is entirely satisfactory. No one has been able to provide a consistent definition that easily accounts for all situations in which the concept is invoked (Phillips et al., 2012; Zachar & Kendler, 2007).

One approach to the definition of abnormal behavior places principal emphasis on the individual's experience of personal distress. We might say that abnormal behavior is defined in terms of subjective discomfort that leads the person to seek help from a mental health professional. However, this definition is fraught with problems. Kevin's case illustrates one of the major reasons that this approach does not work. Before his second hospitalization, Kevin was unable or unwilling to appreciate the extent of his problem or the impact his behavior had on other people. A psychologist would say that he did not have *insight* regarding his disorder. The discomfort was primarily experienced by Joyce, and she had attempted for many weeks to deny the nature of the problem. It would be useless to adopt a definition that considered Kevin's behavior to be abnormal only after he had been successfully treated.

Another approach is to define abnormal behavior in terms of statistical norms—how common or rare it is in the general population. By this definition, people with unusually high levels of anxiety or depression would be considered abnormal because their experience deviates from the expected norm. Kevin's paranoid beliefs would be defined as pathological because they are idiosyncratic. Mental disorders are, in fact, defined in terms of experiences that most people do not have.

This approach, however, does not specify *how* unusual the behavior must be before it is considered abnormal. Some conditions that are typically considered to be forms of psychopathology are extremely rare. For example, gender dysphoria, the belief that one is a member of the opposite sex trapped in the wrong body, affects less than 1 person out of every 30,000. In contrast, other mental disorders are much more common. Mood disorders affect 1 out of every 5 people at some point during their lives; alcoholism and other substance use disorders affect approximately 1 out of every 6 people (Kessler et al., 2005; Moffitt et al., 2010).

Another weakness of the statistical approach is that it does not distinguish between deviations that are harmful and those

MyPsychLab VIDEO CASE

Bipolar Disorder

FELIZIANO

"Depression is the worst part. My shoulders feel weighted down, and your blood feels warmer than it is. You sink deeper and deeper."

Watch the **Video** *Feliziano: Bipolar Disorder* on **MyPsychLab**

As you watch the interview and the day-in-the-life segments, ask yourself what impact Feliziano's depression and hypomania seem to have on his ability to function. Are these mood states harmful?

that are not. Many rare behaviors are not pathological. Some "abnormal" qualities have relatively little impact on a person's adjustment. Examples are being extremely pragmatic or unusually talkative. Other abnormal characteristics, such as exceptional intellectual, artistic, or athletic ability, may actually confer an advantage on the individual. For these reasons, the simple fact that a behavior is statistically rare cannot be used to define psychopathology.

Harmful Dysfunction

One useful approach to the definition of mental disorder has been proposed by Jerome Wakefield of Rutgers University (Wakefield, 2010). According to Wakefield, a condition should be considered a mental disorder if, and only if, it meets two criteria:

1. The condition results from the inability of some internal mechanism (mental or physical) to perform its natural function. In other words, something inside the person is not working properly. Examples of such mechanisms include those that regulate levels of emotion, and those that distinguish between real auditory sensations and those that are imagined.
2. The condition causes some harm to the person as judged by the standards of the person's culture. These negative consequences are measured in terms of the person's own subjective distress or difficulty performing expected social or occupational roles.

A mental disorder, therefore, is defined in terms of **harmful dysfunction.** This definition incorporates one element that is based as much as possible on an objective evaluation of performance. The natural function of cognitive and perceptual processes is to allow the person to perceive the world in ways that are shared with other people and to engage in rational thought and problem solving. The dysfunctions in mental disorders are assumed to be the product of disruptions of thought, feeling, communication, perception, and motivation.

In Kevin's case, the most apparent dysfunctions involved failures of mechanisms that are responsible for perception, thinking, and communication. Disruption of these systems was presumably responsible for his delusional beliefs and his disorganized speech. The natural function of cognitive and perceptual processes is to allow the person to perceive the world in ways that are shared with other people and to engage in rational thought and problem solving. The natural function of language abilities is to allow the person to communicate clearly with other people. Therefore, Kevin's abnormal behavior can be viewed as a pervasive dysfunction cutting across several mental mechanisms.

The harmful dysfunction view of mental disorder recognizes that every type of dysfunction does not lead to a disorder. Only dysfunctions that result in significant harm to the person are considered to be disorders. This is the second element of the definition. There are, for example, many types of physical dysfunctions, such as albinism, reversal of heart position, and fused toes, that clearly represent a significant departure from the way that some biological process ordinarily functions. These conditions are not considered to be disorders, however, because they are not necessarily harmful to the person.

Kevin's dysfunctions were, in fact, harmful to his adjustment. They affected both his family relationships—his marriage to Joyce and his ability to function as a parent—and his performance at work. His social and occupational performances were clearly impaired. There are, of course, other types of harm that are also associated with mental disorders. These include subjective distress, such as high levels of anxiety or depression, as well as more tangible outcomes, such as suicide.

The definition of abnormal behavior employed by the official *Diagnostic and Statistical Manual of Mental Disorders,* published by the American Psychiatric Association and currently in its fifth edition—*DSM-5* (APA, 2013)—incorporates many of the factors that we have already discussed. This classification system is discussed in Chapter 4. This definition is summarized in Table 1.1, along with a number of conditions that are specifically excluded from the *DSM-5* definition of mental disorders (Stein et al., 2010).

The *DSM-5* definition places primary emphasis on the consequences of certain behavioral syndromes. Accordingly, mental disorders are defined by clusters of persistent, maladaptive behaviors that are associated with personal distress, such as anxiety or depression, or with impairment in social functioning, such as job performance or personal relationships. The official definition, therefore, recognizes the concept of dysfunction, and it spells out ways in which the harmful consequences of the disorder might be identified.

The *DSM-5* definition excludes voluntary behaviors, as well as beliefs and actions that are shared by religious, political,

TABLE 1.1
Defining Characteristics of Mental Disorders

Features
1. A syndrome (groups of associated features) that is characterized by disturbance of a person's cognition, emotion regulation, or behavior.
2. The consequences of which are clinically significant distress or disability in social, occupational, or other important activities.
3. The syndrome reflects a dysfunction in the psychological, biological, or developmental processes that are associated with mental functioning.
4. Must not be merely an expectable response to common stressors and losses or a culturally sanctioned response to a particular event (e.g., trance states in religious rituals).
5. That is not primarily a result of social deviance or conflicts with society.

Source: Based on Stein, D. J., Phillips, K. A., Bolton, D. D., Fulford, K. M., Sadler, J. Z., & Kendler, K. S. 2010. What is a mental/psychiatric disorder? From DSM-IV to DSM-V. Psychological Medicine, 40, 1759–1765.

or sexual minority groups (e.g., gays and lesbians). In the 1960s, for example, members of the Yippie Party intentionally engaged in disruptive behaviors, such as throwing money off the balcony at a stock exchange. Their purpose was to challenge traditional values. These were, in some ways, maladaptive behaviors that could have resulted in social impairment if those involved had been legally prosecuted. But they were not dysfunctions. They were intentional political gestures. It makes sense to try to distinguish between voluntary behaviors and mental disorders, but the boundaries between these different forms of behavior are difficult to draw. Educated discussions of these issues depend on the consideration of a number of important questions (see Critical Thinking Matters on page 29).

In actual practice, abnormal behavior is defined in terms of an official diagnostic system. Mental health, like medicine, is an applied rather than a theoretical field. It draws on knowledge from research in the psychological and biological sciences in an effort to help people whose behavior is disordered. Mental disorders are, in some respects, those problems with which mental health professionals attempt to deal. As their activities and explanatory concepts expand, so does the list of abnormal behaviors. The practical boundaries of abnormal behavior are defined by the list of disorders that are included in the official *Diagnostic and Statistical Manual of Mental Disorders.* The categories in that manual are listed inside the back cover of this book. The *DSM-5* thus provides another simplistic, although practical, answer to our question as to why Kevin's behavior would be considered abnormal: He would be considered to be exhibiting abnormal behavior because his experiences fit the description of schizophrenia, which is one of the officially recognized forms of mental disorder (see Thinking Critically About *DSM-5*).

Mental Health Versus Absence of Disorder

The process of defining abnormal behavior raises interesting questions about the way we think about the quality of our lives when mental disorders are *not* present. What is mental health? Is optimal mental health more than the absence of mental disorder? The answer is clearly "yes." If you want to know whether one of your friends is physically fit, you would need to determine more than whether he or she is sick. In the realm of psychological functioning, people who function at the highest levels can be described as *flourishing* (Fredrickson & Losada, 2005; Keyes, 2009). They are people who typically experience many positive emotions, are interested in life, and tend to be calm and peaceful. Flourishing people also hold positive attitudes about themselves and other people. They find meaning and direction in their lives and develop trusting relationships with other people. Complete mental health implies the presence of these adaptive characteristics. Therefore, comprehensive approaches to mental health in the community must be concerned both with efforts to diminish the frequency and impact of mental disorders and with activities designed to promote flourishing.

Culture and Diagnostic Practice

The process by which the *Diagnostic and Statistical Manual* is constructed and revised is necessarily influenced by cultural considerations. **Culture** is defined in terms of the values, beliefs, and practices that are shared by a specific community or group of people. These values and beliefs have a profound influence on opinions regarding the difference between normal and abnormal behavior (Bass et al., 2012).

The impact of particular behaviors and experiences on a person's adjustment depends on the culture in which the person

THINKING CRITICALLY about DSM-5

Revising an Imperfect Manual

The official diagnostic manual for mental disorders is revised by the *American Psychiatric Association* on a regular basis, about once every 15 to 20 years. You might be surprised that the classification system changes so often, but these updates reflect the evolution of our understanding regarding these complex problems. Even more well-established and widely accepted classification systems change. You may remember when Pluto was removed from the list of planets, or recall that new elements have been added to the Periodic Table as a result of nuclear science. Classification systems change as knowledge expands.

The fifth and latest version, *DSM-5*[1], was published in 2013, an event surrounded by excitement as well as heated controversy. More than a dozen workgroups concerned with specific disorders (e.g., mood disorders, psychotic disorders) were composed of expert researchers and clinicians who had been appointed to represent current knowledge in their respective areas. Each group produced a series of proposals that were subjected to public comments as well as field trials that were intended to generate data regarding the reliability of the new definitions. In the end, some experts considered the final product to be a major step forward while others viewed it as a serious step back (Kupfer & Regier, 2011; Frances & Widiger, 2012).

We have added a new feature, *Thinking Critically About DSM-5*, to each chapter in this text. These features are designed to

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help you understand ways in which this diagnostic manual has evolved, criteria that are used to judge its progress, and issues that are most controversial following publication of its latest edition. We don't want you to accept the *DSM-5* definitions simply because they were published on the authority of the American Psychiatric Association. On the other hand, we also don't want you to reject the manual because everything in it isn't perfect. Above all else, remember that *DSM-5* is a handbook, not the Bible (Frances, 2012). There are no absolute truths to be found in the classification of mental disorders.

The debates about *DSM-5* generate considerable emotion from people on both sides because changes in the manual affect so many people's lives. Crucial economic resources are clearly at stake. Adding a diagnostic category can create or expand a market for specific treatments (e.g., medications to treat a new disorder may reap enormous profits) while also raising challenging issues about whether insurance companies must pay for those treatments, whether schools will be expected to provide special services, and whether the government must pay disability claims. There are also pressures on the other side. Deleting an existing category, or narrowing the criteria that are used to define it, can create serious hardships for individuals and families who are then unable to find or afford suitable services upon which they depend. Mental health professionals, research scientists, and patient advocacy groups all play a crucial role in these debates.

Everyone agrees that the classification system must evolve, but what principles should guide this process of change? When *DSM-IV* (APA, 1994) was being produced, the process was designed to be conservative. Changes were presumably allowed only when there was substantial evidence to support a shift in the diagnostic criteria for a particular disorder. A few years later, when discussions about *DSM-5* began, the process was designed to be more open. Workgroups were encouraged to make changes that would bring the system in line with contemporary thinking, even if hard evidence was not available to indicate that the change was empirically justified. Reasonable arguments can be made for both approaches to the revision process. Ultimately, the value of these changing definitions will be judged by the outcomes. Are the new definitions meaningful? Can they be used to improve people's lives?

In the midst of public debates about the *DSM-5* process, another issue has taken center stage. What group is best positioned to manage this system? The American Psychiatric Association clearly owns *DSM,* having launched its original version in 1952. Given the fact that other mental health professions also play important roles in treating and studying mental disorders, does it make sense for this one organization to be the sole owner and manager of the classification system that governs so many aspects of our lives? Should decisions to change the system be guided, even in part, by the enormous economic benefits that have fallen to one professional organization? Some critics have argued that the classification system for mental disorders should be governed by some type of government organization, such as the National Institutes of Health, rather than a profit-making professional association. This issue will undoubtedly be debated and explored in coming years.

[1]Previous editions of the manual have been identified using roman numerals, e.g., DSM-III, DSM-IV. The current edition uses Arabic numerals in the hope that more frequent revisions of the text (e.g., DSM-5.1 and so on) can be produced easily and labeled clearly, much like updates to computer software packages.

lives. To use Jerome Wakefield's (1992) terms, "only dysfunctions that are socially disvalued are disorders" (p. 384). Consider, for example, the *DSM-5* concept of female orgasmic disorder, which is defined in terms of the absence of orgasm accompanied by subjective distress or interpersonal difficulties that result from this disturbance (see Chapter 12). A woman who grew up in a society that discouraged female sexuality might not be distressed or impaired by the absence of orgasmic responses. According to *DSM-5,* she would not be considered to have a sexual problem. Therefore, this definition of abnormal behavior is not culturally universal and might lead us to consider a particular pattern of behavior to be abnormal in one society and not in another.

There have been many instances in which groups representing particular social values have brought pressure to bear on decisions shaping the diagnostic manual. The influence of cultural changes on psychiatric classification is perhaps nowhere better illustrated than in the case of homosexuality. In the first and second editions of the *DSM,* homosexuality was, by definition, a form of mental disorder, in spite of arguments expressed by scientists, who argued that homosexual behavior was not abnormal (see Chapter 12). Toward the end of the 1960s, as the gay and lesbian rights movement became more forceful and outspoken, its leaders challenged the assumption that homosexuality was pathological. They opposed the inclusion of homosexuality in the official diagnostic manual. After extended and sometimes heated discussions, the board of trustees of the American Psychiatric Association agreed to remove homosexuality as a form of mental illness. They were impressed by numerous indications, in personal appeals as well as the research literature, that homosexuality, per se, was not invariably associated with impaired functioning. They decided that, in order to

CRITICAL THINKING matters

Is Sexual Addiction a Meaningful Concept?

Stories about mental disorders appear frequently in the popular media. One topic that once again attracted a frenzy of media attention in 2010 was a concept that has been called "sexual addiction." Tiger Woods, the top-ranked golfer in the world and wealthiest professional athlete in history, confessed to having a series of illicit sexual affairs and announced that he would take an indefinite break from the professional tour. At the time, Woods was married to former Swedish model Elin Nordegren, who had given birth to their second child earlier that same year. More than a dozen women came forward to claim publicly that they had sexual relationships with Woods, and several large companies soon cancelled lucrative endorsement deals that paid him millions of dollars to endorse their products. Newspapers, magazines, and television programs sought interviews with professional psychologists who offered their opinions regarding Woods' behavior. Why would this fabulously successful, universally admired, iconic figure risk his marriage, family, and career for a seemingly endless series of casual sexual relationships?

Many experts responded by invoking the concept of mental disorder, specifically "sexual addiction" (some called it "sexual compulsion," and one called it the "Clinton syndrome" in reference to similar problems that had been discussed in the midst of President Clinton's sex scandal in 1998). The symptoms of this disorder presumably include low self-esteem, insecurity, need for reassurance, and sensation seeking, to name only a few. One expert claimed that 20 percent of highly successful men suffer from sexual addiction.

Most of the stories failed to mention that sexual addiction does not appear as an officially recognized mental disorder in *DSM-5*. That, by itself, is not an insurmountable problem. Disorders have come and gone over the years, and it's possible that this one—or some version of it—might eventually turn out to be useful. In fact, the work group that revised the list of sexual disorders for *DSM-5* did consider but ultimately rejected adding a new category called "hypersexual disorder" (Reid et al., 2012) (see Thinking Critically About DSM-5 in Chapter 12). We shouldn't ignore a new concept simply because it hasn't become part of the official classification system (or accept one on faith, simply because it has). The most important thing is that we *think critically* about the issues that are raised by invoking a concept like sexual addiction.

At the broadest possible level, we must ask ourselves "What is a mental disorder?" Is there another explanation for such thoughtless and damaging behavior? Tiger Woods received several weeks of treatment for sexual addiction at a residential mental health facility. Has that treatment been shown to be effective for this kind of behavioral problem? Is it necessary? Does the diagnosis simply provide him with a convenient excuse that might encourage the public to forgive his immoral behavior?

Another important question is whether sexual addiction is more useful than other similar concepts (Moser, 2011). For example, narcissistic personality disorder includes many of the same features (such as lack of empathy, feelings of entitlement, and a history of exploiting others). What evidence supports the value of one concept over another? In posing such questions, we are not arguing for or against a decision to include sexual addiction or hypersexual disorder as a type of mental disorder. Rather, we are encouraging you to think critically.

Students who ask these kinds of questions are engaged in a process in which judgments and decisions are based on a careful analysis of the best available evidence. In order to consider these issues, you need to put aside your own subjective feelings and impressions, such as whether you find a particular kind of behavior disgusting, confusing, or frightening. It may also be necessary to disregard opinions expressed by authorities whom you respect (politicians, journalists, and talk-show hosts). Be skeptical. Ask questions. Consider the evidence from different points of view, and remember that some kinds of evidence are better than others.

be considered a form of mental disorder, a condition ought to be associated with subjective distress or seriously impaired social or occupational functioning. The stage was set for these events by gradual shifts in society's attitudes toward sexual behavior (Bullough, 1976; Minton, 2002). As more and more people came to believe that reproduction was not the main purpose of sexual behavior, tolerance for greater variety in human sexuality grew. The revision of the *DSM*'s system for describing sexual disorders was, therefore, the product of several forces, cultural as well as political. These deliberations are a reflection of the practical nature of the manual and of the health-related professions. Value judgments are an inherent part of any attempt to define "disorder" (Sedgwick, 1981).

Many people think about culture primarily in terms of exotic patterns of behavior in distant lands. The decision regarding homosexuality reminds us that the values of our own culture play an intimate role in our definition of abnormal behavior. These issues also highlight the importance of cultural change. Culture is a dynamic process; it changes continuously as a result of the actions of individuals. To the extent that our definition of abnormal behavior is determined by cultural values and beliefs, we should expect that it will continue to evolve over time.

Who Experiences Abnormal Behavior?

Having introduced many of the issues that are involved in the definition of abnormal behavior, we now turn to another clinical example. The woman in our second case study, Mary Childress, suffered from a serious eating disorder known as *bulimia nervosa.* Her problems raise additional questions about the definition of abnormal behavior.

As you are reading the case, ask yourself about the impact of Mary's eating disorder on her subjective experience and social adjustment. In what ways are these consequences similar to those seen in Kevin Warner's case? How are they different? This case also introduces another important concept associated with the way that we think about abnormal behavior: How can we identify the boundary between normal and abnormal behavior? Is there an obvious distinction between eating patterns that are considered to be part of a mental disorder and those that are not? Or is there a gradual progression from one end of a continuum to the other, with each step fading gradually into the next?

→ A College Student's Eating Disorder

Mary Childress was, in most respects, a typical 19-year-old sophomore at a large state university. She was a good student, in spite of the fact that she spent little time studying, and was popular with other students. Everything about Mary's life was relatively normal—except for her bingeing and purging.

Mary's eating patterns were wildly erratic. She preferred to skip breakfast entirely and often missed lunch as well. By the middle of the afternoon, she could no longer ignore the hunger pangs. At that point, on two or three days out of the week, Mary would drive her car to the drive-in window of a fast-food restaurant. Her typical order included three or four double cheeseburgers, several orders of french fries, and a large milkshake (or maybe two). Then she binged, devouring all the food as she drove around town by herself. Later she would go to a private bathroom, where she wouldn't be seen by anyone, and purge the food from her stomach by vomiting. Afterward, she returned to her room, feeling angry, frustrated, and ashamed.

Mary was tall and weighed 110 pounds. She believed that her body was unattractive, especially her thighs and hips. She was extremely critical of herself and had worried about her weight for many years. Her weight fluctuated quite a bit, from a low of 97 pounds when she was a senior in high school to a high of 125 during her first year at the university. Her mother was a "full-figured" woman. Mary swore to herself at an early age that she would never let herself gain as much weight as her mother had.

Purging had originally seemed like an ideal solution to the problem of weight control. You could eat whatever you wanted and quickly get rid of it so you wouldn't get fat. Unfortunately, the vomiting became a vicious trap. Disgusted by her own behavior, Mary often promised herself that she would never binge and purge again, but she couldn't stop the cycle.

For the past year, Mary had been vomiting at least once almost every day and occasionally as many as three or four times a day. The impulse to purge was very strong. Mary felt bloated after having only a bowl of cereal and a glass of orange juice. If she ate a sandwich and drank a diet soda, she began to ruminate about what she had eaten, thinking, "I've got to get rid of that!" Usually, before long, she found a bathroom and threw up. Her excessive binges were less frequent than the vomiting. Four or five times a week she experienced an overwhelming urge to eat forbidden foods, especially fast food. Her initial reaction was usually a short-lived attempt to resist the impulse. Then she would space out or "go into a zone," becoming only vaguely aware of what she was doing and feeling. In the midst of a serious binge, Mary felt completely helpless and unable to control herself.

There weren't any obvious physical signs that would alert someone to Mary's eating problems, but the vomiting had begun to wreak havoc with her body, especially her digestive system. She had suffered severe throat infections and frequent, intense stomach pains. Her dentist had noticed problems beginning to develop with her teeth and gums, undoubtedly a consequence of constant exposure to strong stomach acids.

Mary's eating problem started to develop when she was 15 years old. She had been seriously involved in gymnastics for several years, but eventually developed a knee condition that forced her to give up the sport. She gained a few pounds in the next month or two and decided to lose weight by dieting. Buoyed by unrealistic expectations about the immediate, positive benefits of a diet that she had seen advertised on television, Mary initially adhered rigidly to its recommended regimen. Six months later, after three of these fad diets had failed, she started throwing up as a way to control her intake of food.

Mary's problems persisted after she graduated from high school and began her college education. She felt guilty and ashamed about her eating problems. She was much too embarrassed to let anyone know what she was doing and would never eat more than a few mouthfuls of food in a public place, such as the dorm cafeteria. Her roommate, Julie, was from a small town on the other side of the state. They got along reasonably well, but Mary managed to conceal her bingeing and purging, thanks in large part to the fact that she was able to bring her own car to campus. The car allowed her to drive away from campus several times a week so that she could binge.

Mary's case illustrates many of the characteristic features of bulimia nervosa. As in Kevin's case, her behavior could be considered abnormal not only because it fits the criteria for one of the categories in *DSM-5* but also because she suffered from a dysfunction (in this case, of the mechanisms that regulate appetite) that was obviously harmful. The impact of the disorder was greatest in terms of her physical health: Eating disorders can be fatal if they are not properly treated because they affect so many vital organs of the body, including the heart and kidneys. Mary's social