Nolen-Hoeksema's

NINTH EDITION

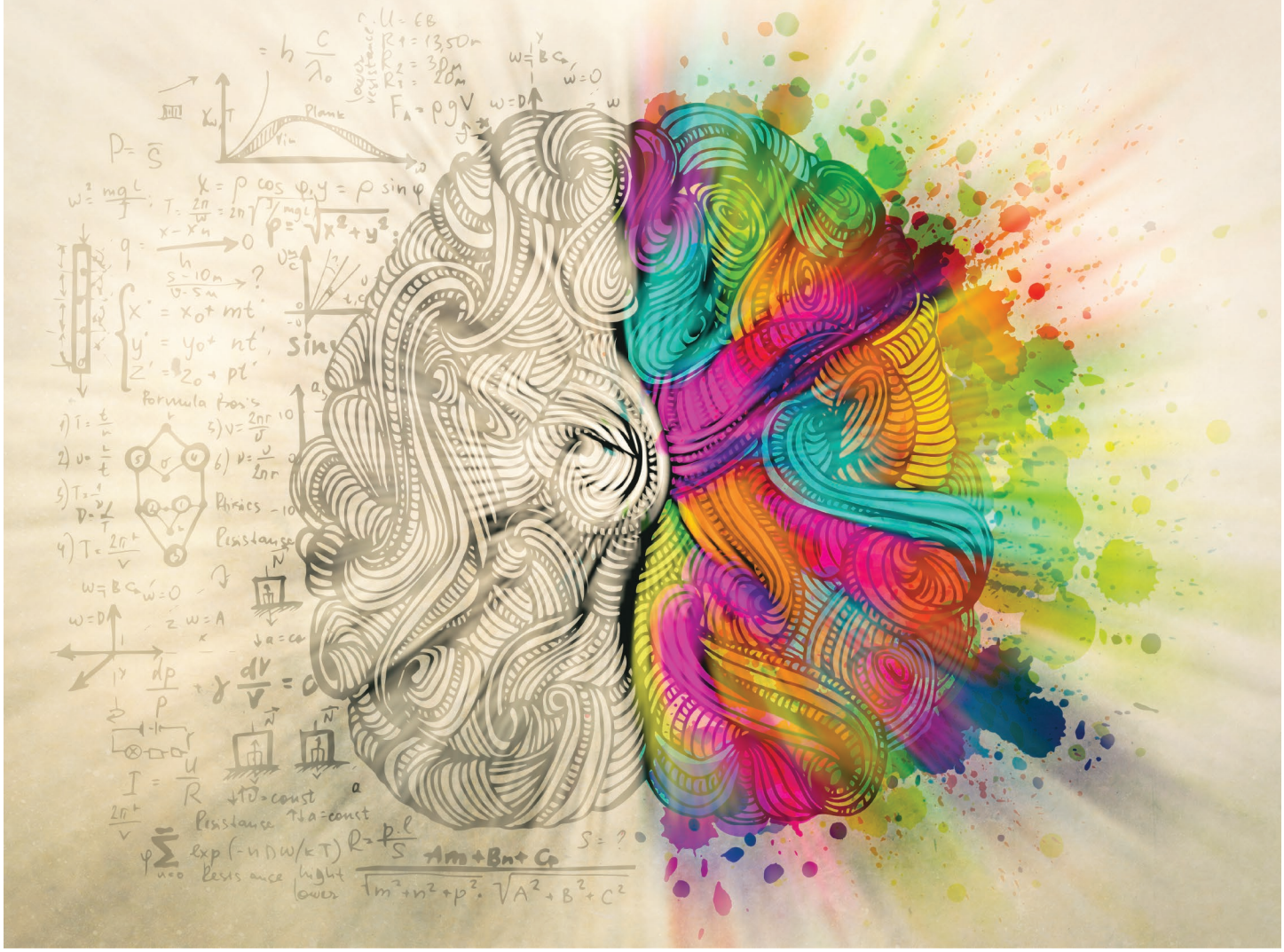
ABNORMAL PSYCHOLOGY

Heather Jennings

Mc Graw Hill

Nolen-Hoeksema's

Abnormal Psychology



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ABOUT THE AUTHOR

Courtesy of Morgan Avery Jennings

Heather Jennings is a professor of psychology at Mercer County Community College in West Windsor, New Jersey, where her teaching career spans almost 20 years. Dr. Jennings is passionate about teaching, student success, and engaging students in thinking critically about psychological concepts. As a community college graduate, Dr. Jennings embraces this valuable system that provides educational access to many first-generation, under-represented, and underserved college students.

Dr. Jennings completed her Masters of Arts degree in Clinical Psychology from Columbia University, Teachers College and spent several years working in psychiatric emergency screening services as well as home-based, shelter-based, and school-based therapy programs before earning her PhD in Educational Psychology from Temple University. Dr. Jennings' research interests include the psychological variables that impact academic success among community college students.

Dr. Jennings is also an animal advocate and has run a non-profit dog rescue for more than 10 years that provides rescue, rehabilitation, and re-homing for dogs in need. A native of the Jersey Shore, Dr. Jennings loves the beach and spending time on her farm with family, friends, dogs, and chickens. In her spare time, she enjoys refinishing furniture and is usually covered in paint.

BRIEF CONTENTS

CONTENTS

GUIDE TO DIVERSITY, EQUITY, AND INCLUSION

Global changes included specifying mini-cases in terms of gender identity, preferred pronouns, and sexual orientation as appropriate to the case. Additionally, sources were cited from researchers publishing in such journals as

- *Journal of Gay & Lesbian Mental Health*
- *World Journal of Psychiatry*
- *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*
- *Journal of Cross-Cultural Psychology*
- *Culture and Psychology*
- *International Journal of Emergency Mental Health*
- *International Journal of Women's Dermatology*
- *Journal of Interpersonal Violence*
- *Psychology of Popular Media Culture*
- *Journal of Black Studies*
- *Journal of College Student Development*
- *Archives of Sexual Behavior*
- *Body image*
- *Social Media + Society*
- *International Journal of Advanced Studies in Sexology*
- *International Journal for Equity in Health*
- *AIDS Care*
- *Global Social Sciences Review*

Citations of studies and researchers representing diverse and international samples and issues appear throughout the book.

Chapter 1: Looking at Abnormality

- Expanded coverage of how cultural norms help define abnormality.
- Revised coverage of how cultural relativism relates to definitions of abnormality.
- Expanded coverage of how women throughout history were subject to "diagnoses" of disorder and through them had their behavior controlled, cited in Kapsalis (2017). Coverage of "hysteria" and the wandering womb is expanded.
- Coverage provided on culture and its effect on therapeutic treatment.
- Ancient theories of abnormality across cultures and over time are presented.
- Prehistoric views and treatments of abnormality are given.
- Coverage on ancient Chinese treatment of abnormality: balancing yin and yang.
- Theories and treatments of abnormality from ancient Egypt, Greece, and Rome are provided.
- Updated coverage on contemporary treatment regarding racial disparities and solutions.
- Shades of Gray box shows how sociocultural gender biases affect diagnosis of disorders in women versus men.

Chapter 2: Theories and Treatment of Abnormality

- Coverage provided on socioeconomic disadvantages as transdiagnostic risk factors.
- Significantly expanded coverage of the stigmatization and mental health risks experienced by LGBTQI+ people, citing research by Casey, Wootton, & McAloon (2020).
- New coverage of social media and its impact on bias and the development of echo-chambers that separate social groups often in term of misinformation, citing Wang, Sirianni, Tang, Zheng, & Fu, 2020 and Chou, Oh, & Klein (2018).
- Analysis of cross-cultural issues in treatment: individualistic versus collectivistic cultures.
- New coverage given on multiculturalism and the clinician's need to integrate and embrace cultural difference citing Jones-Smith (2019).
- Added content on innovative mental health interventions, such as synchronous telehealth treatments, because of COVID-19, which highlight the disparities among underserved populations, ethnic minorities and people of color, citing Reay, Looi, & Keightly (2020).
- Coverage of the influence of perceived social group membership on how society views socio-demographic groups, citing D. W. Sue, D. Sue, Neville, & Smith (2019).
- Coverage provided on culturally responsive treatment.
- Revised case study of a Hong Kong immigrant to the United States.
- Coverage on cross-cultural competencies.
- Cultural differences in treating children.
- Culturally specific therapies: Native American and Hispanic examples.
- Prevention programs: focus on social determinants of mental health issues.
- Added content on laws and social policies that affect mental health outcomes for sexually marginalized groups.

Chapter 3: Assessing and Diagnosing Abnormality

- Coverage of the cultural factors in assessing children and adolescents.
- Evaluating individuals across cultures, drawing on research by Soto, et al. (2018); Dominguez (2017), Alegria, Nakash, & Johnson (2018), and others.

- New coverage of the cultural factors in parental assessment of their children, highlighting Asian parenting and citing Nguyen & McAloon (2018).
- Disparities in quality of mental health care across cultures.
- Impact on treatment of cultural differences between therapist and client
- Coverage of *DSM-5* and cultural issues

Chapter 4: The Research Endeavor

- Cross-cultural research on problems in generalizing results of research conducted on White middle-class college students to all social and cultural groups.
- Investigating similarities and differences among cultural groups.
- Different manifestations of disorders across cultures and their impact on research.
- New coverage of the impact of high global migration rates and language differences on conducting research, citing Squires, Sadarangani, & Jones (2020).

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

- Coverage of the sociocultural factors related to separation anxiety.
- Changed Case Study participants to Navaho family members.
- Coverage of cross-national similarities and differences regarding generalized anxiety disorder
- Cultural and global differences regarding social anxiety disorders, citing Yli-Länttä (2020).
- Coverage of gender differences as they relate to social anxiety disorders.
- Transnational comparisons of phobias.
- World prevalence rates regarding obsessive compulsive disorder.
- Gender differences associated with body dysmorphic disorder, citing Ryding & Kuss (2020).
- World-wide research on trauma and PTSD.
- Coverage of social factors relating to PTSD.
- Hate crimes against Latinx and LGBTQ people and other acts of terror resulting in PTSD, citing Yu-Ru & Wen-Ting (2020) and Mclaughlin & Kar (2019).
- Keira's Story, a box about Keira and her friend Justine at the gay nightclub, Pulse, the night of a mass shooting. The box describes Keira's subsequent PTSD.
- Gender and cross-cultural differences regarding PTSD.
- Racial differences and PTSD.
- Ethnic identity and PTSD, citing Nikulina, Bautista, & Brown (2019).
- Coverage of ethnic identity as a protective factor regarding the possible development of certain psychological disorders.

Chapter 6: Somatic Symptom and Dissociative Disorders

- Clinical use of cultural traditions to treat somatic symptom disorder.
- Global research on diagnosis of dissociative identity disorder (DID).
- Cultural oppression and DID prevalence.
- Revision of the *DSM* to make diagnosis of DID more applicable to diverse cultural groups.
- Latinx population and DID versus *ataque de nervios*.

Chapter 7: Mood Disorders and Suicide

- New Extraordinary People box featuring Dwayne "The Rock" Johnson and his experience with depression.
- International research on unipolar mania.
- US and global prevalence rates of bipolar disorder.
- Cohort effects (age difference) and depression.
- Gender and depression: gender difference, socialization, biological and sociocultural factors.
- Ethnicity, race and depression: focus on Latinx, African American, and Asian American experiences.
- New coverage of major depressive disorder rates among Black, indigenous, and people of color (BIPOC), citing Coman and Wu (2018).
- New coverage of resilience, lower rates of depression, gender, and minority racial groups, citing Laird, et al, 2019.
- New Profiles box on Kanye West and bipolar disorder, citing Lane (2020).
- New coverage on cross-national prevalence rates of unipolar mania, citing Jules, Ajdacic-Gross, & Rossler (2020).
- US and international suicide prevalence rates of bipolar disorder.
- US regional suicide prevalence rates: higher rural rates.
- Gender differences and suicide.
- Ethnic and cross-cultural differences regarding suicidality prevalence rates (Non-Hispanic Whites, American Indian/Alaska Native, African American, Latinx).
- Racial and ethnic factors in suicidality.
- Global comparisons of suicide rates.
- Ethnic and racial factors of suicide and children.
- Substantial new coverage of suicide and LGBTQI+ people: adolescent, young adult, and adult populations, citing the National LGBT Health Education Center (2018) and Hayes (2019).
- Suicide and older adults.
- Global comparisons of suicide and stress.
- Expanded coverage of social media, gender, and suicide, citing Poland, Lieberman, & Niznik (2019) and Yildiz, Orak, Walker, & Solakogluidiz (2019).

Chapter 8: Schizophrenia Spectrum and Other Psychotic Disorders

- Global prevalence rates of schizophrenia: developed versus less-developed countries.
- Gender differences, citing Häfner (2019).
- Cultural influences on epidemiology, phenomenology, outcome, and treatment.
- Psychosocial perspectives on socioeconomic factors, deprived urban settings, social drift.

- US and international findings on Immigration, stress and schizophrenia:.
- Cross-cultural perspectives: traditional beliefs and practices: Case of a Javanese woman
- Culturally appropriate tools to improve the effectiveness of family interventions in multicultural settings, citing Driscoll, Sener, Angmark, & Shaikh (2019).
- Schizophrenia and stigma, citing Mannarini & Rossi (2019) and Fox, Earnshaw, Taverna, & Vogt (2018).

Chapter 9: Personality Disorders

- Global comparisons of paranoid personality disorder.
- African American experience and social and environmental risk factors regarding paranoid personality disorder.
- Comparative global prevalence rates on schizotypal personality disorder.
- Coverage on race and gender on paranoid personality disorder:
- Racial difference and borderline personality disorder (Hispanic, White, African American, East Asian prevalence rates and sociocultural factors), citing Haliczer et al. (2019).
- Gender and borderline personality disorder.
- Gender differences and narcissistic personality disorder.
- Racial differences and narcissistic personality disorder.
- Gender differences and avoidant personality disorder.
- Gender differences and dependent personality disorder.
- Changed Case Study on dependent disorder to feature a gay couple.
- Gender differences and obsessive-compulsive personality disorder.
- Racial and ethnic differences and obsessive-compulsive personality disorder.

Chapter 10: Attention-Deficit/Hyperactivity Disorder

- Sex and gender differences and Attention-Deficit/hyperactivity disorder (ADHD), citing Mowlem, Agnew-Blais, Taylor, & Asherson (2019).
- Global comparisons of fetal alcohol syndrome prevalence rates.
- The impact diverse socioeconomic backgrounds on intellectual disability.
- The impact of gender, culture, and education on neurocognitive disorder.
- African American and Caribbean Hispanics: experience with neurocognitive disorder.
- Institutionalization versus family care: European American, Asian American, Hispanic examples.

Chapter 11: Disruptive, Impulse-Control and Conduct Disorders

- Gender differences and conduct disorders.
- Racial differences and conduct disorders, citing Patel, et al. (2018).
- Racial and socioeconomic differences regarding conduct disorders and hospitalization.
- Gender differences and antisocial personality disorder, citing Azevedo, Vieira-Coehlo, Castelo-Branco, Coehlo, & Figueiredo-Braga (2020).

Chapter 12: Eating Disorders

- Updated coverage of gender and eating disorders (ED), citing Allen, Robson, & Laborde, 2020.
- Updated coverage of gender differences and anorexia nervosa, citing Murray, Quintana, Loeb, Griffiths, & Le Grange (2019).
- Provided coverage ethnic differences and anorexia nervosa.
- Case study of a Chinese woman with anorexia nervosa.
- Presented coverage of gender differences and bulimia nervosa.
- Included coverage of cultural, ethnic and racial differences regarding bulimia nervosa.
- Presented coverage of gender differences and binge-eating disorder.
- Updated coverage of ethnic and racial differences in obesity, Centers for Disease Control and Prevention (2018).
- Updated coverage of global comparisons of obesity, citing Centers for Disease Control and Prevention (2018) and the World Health Organization (2018).
- Provided coverage of gender differences and obesity.
- Social pressure and cultural norms impacting eating disorders.
- Changed Case Study on anorexia from cis-girl to trans-girl.
- Updated coverage "Western" and "non-Western" eating disorders, citing Ioannou, et al. (2020).

Chapter 13: Sexual Disorders and Gender Diversity

- Extraordinary People: *David Reimer, The Boy Who Was Raised as a Girl*.
- Presented extended coverage of female sexual interest/arousal disorder.
- Updated coverage of male erectile disorder, citing Retzler, 2019 and Kessler, Sollie, Challacombe, Briggs, & Van Hemelrijck (2019).
- Updated global cultural factors related to sexual disfunction, citing Santana, et al. (2019) and Vaishnav, Saha, Mukherji, & Vaishnav (2020).
- Updated considerations for LGBTQ people: stress from prejudice on sexual function, citing Kerckhof et al (2019).
- Transgender: specified stressors (such as violence and transphobia), citing Cocchetti et al. (2021) and Flores, Mallory, & Conron (2020).
- Treating LGBTQ people: therapist training and sensitivity.
- Coverage of the professional disavowal of "conversion" therapy, citing, American Psychological Association, 2019 and Flores, Mallory, & Cannon (2020).

- Included diversity of sexual expression versus paraphilic disorders, citing Thibaut (2020).
- Updated coverage of controversies regarding gender dysphoria and gender diversity.
- Updated coverage of treatments for gender dysphoria, citing Bizic (2018).
- Coverage of gender dysphoria versus transgender experience.

Chapter 14: Substance Use and Gambling Disorder

- Updated coverage of gender differences and alcohol use disorder, citing Krieger, Young, Anthenien, & Neighbors (2018).
- Updated coverage of racial differences and alcohol use disorder, citing Tucker, Chandler, & Witkiewitz (2020).
- Updated coverage of age differences and alcohol use disorder, citing Tucker, et al. (2020).
- Included information on cultural differences and alcohol use.
- New coverage of transnational comparisons of use of Ecstasy (MDMA), citing van Amsterdam, Pennings, & van den Brink (2020).
- Included coverage of sociocultural factors relating to substance abuse, citing Moustafa et al. (2020).
- Updated coverage of gender and substance abuse, citing White, 2020 and Guinle & Sinha (2020).
- Included coverage of older adults and substance abuse.

Chapter 15: Health Psychology

- Updated coverage of gender and stress, citing Robert, Virpi, & John (2019).
- Presented coverage on the impact of minority status, socioeconomic status and culture on stress.
- Highlighted coverage of African American experience and stress.
- Presented gender differences and coping strategies.
- Highlighted coverage of cultural differences in coping.
- Updated and expanded coverage of working with people with AIDS and HIV, citing Spann, van Luenen, Garnefski, & Kraaij (2020) and Bhochhibh (2020).
- Presented coverage of gender differences and coronary heart disease.
- Highlighted coverage on racial differences and hypertension (highlighting African American experience).

Chapter 16: Mental Health and the Law

- Updated coverage on racial stereotypes and assumptions about mental illness, citing Kunsst, Myhren, & Onyeador (2018).
- Coverage of racial status and rates of acquittal in cases with insanity defenses.
- Coverage presented on socioeconomic status and incarceration rates.
- Updated coverage on gender, mental illness, and incarceration rates, citing Al-Rousan, (2017).

PREFACE

Welcome to the ninth edition of Nolen-Hoeksema's *Abnormal Psychology!* The foundation of this book is based on the outstanding scholarship of the late, Dr. Susan Nolen-Hoeksema who was an innovative educator and researcher in the field of psychology. I am honored to continue her vision in this new edition and provide students and faculty with a comprehensive survey of psychological disorders that emphasizes the human perspective. As an educator, I approached this new edition with diversity, inclusion, compassion, and student comprehension as my focus. In terms of best teaching practices, I believe that students are the centerpiece of our shared table. With this philosophy in mind, I created content in this edition to enhance student comprehension and engagement by making information about psychological disorders relatable and contemporary. Although psychological disorders are inherently fascinating to discuss, that does not mean students will always understand the complexities and best clinical practices for treatment. Continuing the practices of Susan Nolen-Hoeksema, *Abnormal Psychology* is designed to promote awareness and empathy about mental health issues, best practices for treatments, and cutting-edge psychological research to better understand how to identify, treat and prevent psychological dysfunction.

At the same time, *Abnormal Psychology* connects proven scholarship with student performance. Through Connect for Abnormal Psychology, a digital assignment and assessment platform, students gain the insight they need to study smarter and improve performance. Connect for *Abnormal Psychology* includes assignable and assessable videos, quizzes, exercises, and interactivities, all associated with learning objectives.

connect® A PERSONALIZED EXPERIENCE THAT LEADS TO IMPROVED LEARNING AND RESULTS

How many students think they know everything about abnormal psychology but struggle on the first exam? Students study more effectively with Connect and SmartBook.

- Connect's assignments help students contextualize what they've learned through application, so they can better understand the material and think critically.
- Connect reports deliver information regarding performance, study behavior, and effort so instructors can quickly identify students who are having issues or focus on material that the class hasn't mastered.
- SmartBook helps students study more efficiently by highlighting what to focus on in the chapter, asking review questions, and directing them to resources until they understand.
- SmartBook creates a personalized study path customized to individual student needs.

SmartBook is now optimized for mobile phone and tablet and is accessible for students with disabilities. Content-wise, it has been enhanced with improved learning objectives that are measurable and observable to improve student outcomes. SmartBook personalizes learning to individual student needs, continually adapting to pinpoint knowledge gaps and focus learning on topics that need the most attention. Study time is more productive and, as a result, students are better prepared for class and coursework. For instructors, SmartBook tracks student progress and provides insights that can help guide teaching strategies.

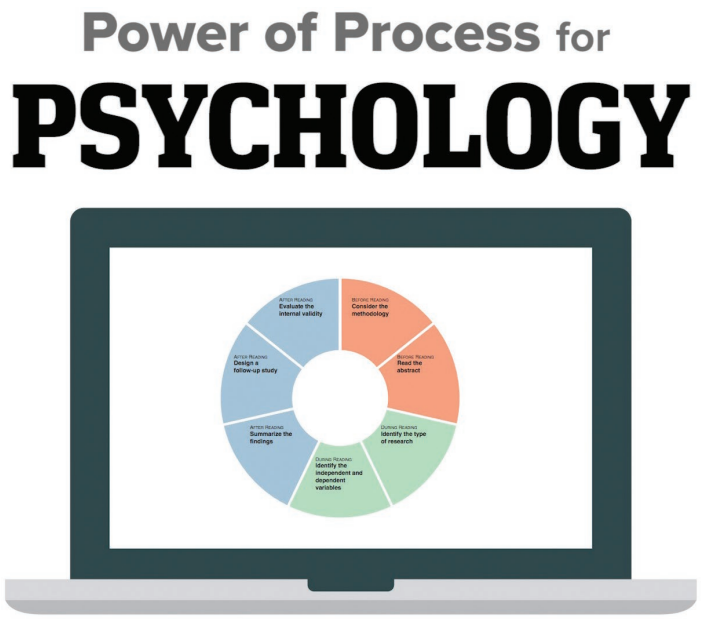
SMARTBOOK® POWERFUL REPORTING

Whether a class is face-to-face, hybrid, or entirely online, McGraw Hill Connect provides the tools needed to reduce the amount of time and energy instructors spend administering their courses. Easy-to-use course management tools allow instructors to spend less time administering and more time teaching, while reports allow students to monitor their progress and optimize their study time.

- The **At-Risk Student Report** provides instructors with one-click access to a dashboard that identifies students who are at risk of dropping out of the course due to low engagement levels.
- The **Category Analysis Report** details student performance relative to specific learning objectives and goals, including APA learning goals and outcomes and levels of Bloom's taxonomy.
- The **SmartBook Reports** allow instructors and students to easily monitor progress and pinpoint areas of weakness, giving each student a personalized study plan to achieve success.

PREPARING STUDENTS FOR HIGHER-LEVEL THINKING

At the higher-end of Bloom's taxonomy, **Power of Process** guides students through the process of critical reading and analysis. Faculty can select or upload content, such as journal articles, and assign guiding questions to move students toward higher-level thinking and analysis.



New to this edition and found in Connect, **Writing Assignments** offer faculty the ability to assign a full range of writing assignments to students) with just-in-time feedback.

You may set up manually scored assignments in a way that students can

- automatically receive grammar and high-level feedback to improve their writing before they submit a project to you;
- run originality checks and receive feedback on "exact matches" and "possibly altered text" that includes guidance about how to properly paraphrase, quote, and cite sources to improve the academic integrity of their writing before they submit their work to you.

The new writing assignments will also have features that allow you to assign milestone drafts (optional), easily re-use your text and audio comments, build/score with your rubric, and view your own originality report of student's final submission.

Available in Connect, **Faces of Abnormal Psychology** connects students to real people living with psychological disorders. Through its unique video program, Faces of Abnormal Psychology helps students gain a deeper understanding of psychological disorders and provides an opportunity for critical thinking.

Interactive Case Studies help students understand the complexities of psychological disorders. Co-developed with psychologists and students, these immersive cases bring the intricacies of clinical psychology to life in an accessible, gamelike format. Each case is presented from the point of view of a licensed psychologist, a social worker, or a psychiatrist. Students observe sessions with clients and are asked to identify major differentiating characteristics associated with each of the psychological disorders presented. Interactive Case Studies are assignable and assessable through McGraw Hill Education's Connect.

Inform and Engage on Psychological Concepts

At the lower end of Bloom's taxonomy and located in Connect, **NewsFlash** is a multimedia assignment tool that ties current news stories, TedTalks, blogs, and podcasts to key psychological principles and learning objectives. Students interact with relevant news stories and are assessed on their ability to connect the content to the research findings and course material. NewsFlash is updated twice a year and uses expert sources to cover a wide range of topics including: emotion, personality, stress, drugs, COVID-19, disability, social justice, stigma, bias, inclusion, gender, LGBTQA+, and many more.

SUPPORTING INSTRUCTORS WITH TECHNOLOGY

With McGraw Hill Education, you can develop and tailor the course you want to teach.

McGraw Hill Campus (www.mhcampus.com) provides faculty with true single-sign-on access to all of McGraw Hill's course content, digital tools, and other high-quality learning resources from any learning management system. McGraw Hill Campus includes access to McGraw Hill's entire content library, including eBooks, assessment tools, presentation slides, and multimedia content, among other resources, providing faculty open, unlimited access to prepare for class, create tests/quizzes, develop lecture material, integrate interactive content, and more.

With **Tegrity,** you can capture lessons and lectures in a searchable format and use them in traditional, hybrid, "flipped classes," and online courses. With Tegrity's personalized learning features, you can make study time efficient. Its ability to affordably scale brings this benefit to every student on campus. Patented search technology and real-time learning management system (LMS) integrations make Tegrity the market-leading solution and service.

With McGraw Hill Education's **Create,** faculty can easily rearrange chapters, combine material from other content sources, and quickly upload content you have written, such as your course syllabus or teaching notes, using McGraw Hill Education's Create. Find the content you need by searching through thousands of leading McGraw Hill Education textbooks. Arrange your book to fit your teaching style. Create even allows you to personalize your book's appearance by selecting the cover and adding your name, school, and course information. Order a Create book, and you will receive a complimentary print review copy in 3 to 5 business days or a complimentary electronic review copy via email in about an hour. Experience how McGraw Hill Education empowers you to teach your students your way. **http://create.mheducation.com**

TRUSTED SERVICE AND SUPPORT

McGraw Hill Education's Connect offers comprehensive service, support, and training throughout every phase of your implementation. If you're looking for some guidance on how to use Connect, or want to learn tips and tricks from super-users, you can find tutorials as you work. Our Digital Faculty Consultants and Student Ambassadors offer insight into how to achieve the results you want with Connect.

INTEGRATION WITH YOUR LEARNING MANAGEMENT SYSTEM

McGraw Hill integrates your digital products from McGraw Hill Education with your school's learning management system (LMS) for quick and easy access to best-in-class content and learning tools. Build an effective digital course, enroll students with ease, and discover how powerful digital teaching can be.

Available with Connect, integration is a pairing between an institution's LMS and Connect at the assignment level. It shares assignment information, grades, and calendar items from Connect into the LMS automatically, creating an easy-to-manage course for instructors and simple navigation for students. Our assignment-level integration is available with **Blackboard Learn, Canvas by Instructure,** and **Brightspace by D2L,** giving you access to registration, attendance, assignments, grades, and course resources in real time, in one location.

Instructor Supplements

Instructor's Manual. The instructor's manual provides a wide variety of tools and resources for presenting the course, including learning objectives and ideas for lectures and discussions.

Test Bank and **Test Builder.** Organized by chapter, the questions are designed to test factual, conceptual, and applied understanding; all test questions are available within Test Builder.

Available within Connect, Test Builder is a cloud-based tool that enables instructors to format tests that can be printed, administered within a Learning Management System, or exported as a Word document of the test bank. Test Builder offers a modern, streamlined interface for easy content configuration that matches course needs, without requiring a download.

Test Builder allows you to:

- access all test bank content from a particular title
- easily pinpoint the most relevant content through robust filtering options
- manipulate the order of questions or scramble questions and/or answers
- pin questions to a specific location within a test
- determine your preferred treatment of algorithmic questions
- choose the layout and spacing
- add instructions and configure default settings

Test Builder provides a secure interface for better protection of content and allows for just-in-time updates to flow directly into assessments.

PowerPoint Presentations. The PowerPoint presentations, available in both dynamic lecture-ready and accessible WCAG-compliant versions, highlight the key points of the chapter and include supporting visuals. All of the slides can be modified to meet individual needs.

Remote Proctoring and Browser-Locking Capabilities. Remote proctoring and browser-locking capabilities, hosted by Proctorio within Connect, provide control of the assessment environment by enabling security options and verifying the identity of the student.

- Seamlessly integrated within Connect, these services allow instructors to control students' assessment experience by restricting browser activity, recording students' activity, and verifying students are doing their own work.
- Instant and detailed reporting gives instructors an at-a-glance view of potential academic integrity concerns, thereby avoiding personal bias and supporting evidence-based claims.

CHAPTER-BY-CHAPTER CHANGES

Chapter 1: Looking at Abnormality

- Updated and expanded content in Abnormality along the Continuum.
- Revised content on the 4Ds of abnormality.
- Added COVID-19-related content.
- Revised coverage of "hysteria" and the "wandering uterus."
- Revised content on deinstitutionalization and the Mental Retardation Facilities and Community Mental Health Center Construction Act (1963).
- Updated case study on Khloe, a person with extensive long-term hospitalizations.
- Updated and expanded content on the managed health care system and mentally ill individuals and those with substance abuse.
- Added content regarding subpopulations at risk for not receiving mental health treatment, such as minorities, people of color, and underserved populations.
- Updated professional degrees for psychology and counseling professions.

Chapter 2: Theories and Treatment of Abnormality

- Revised content on Phineas Gage.
- Updated and expanded content on frontal lobe function.
- Expanded Down Syndrome content.
- Added content on environmental and genetic factors associated with disease.
- Updated content on medication to treat psychological disorders.
- Updated content on electroconvulsive therapy (ECT).
- Updated content on repetitive transcranial magnetic stimulation (rTMS) and vagus nerve stimulation.

- Removed content on Freud's psychosexual stages of development, fixations, penis envy, Oedipal/Electra complex, etc.
- Expanded content on psychodynamic therapies, including relational psychoanalysis, the relationship between therapist and client, transference, and countertransference.
- Revised content on acceptance and commitment intervention and mindfulness techniques.
- Added content on innovative mental health interventions, such as synchronous telehealth treatments, because of COVID-19, highlighting the disparities among underserved populations, ethnic minorities, and people of color.
- Expanded content related to disasters, social norms, and stigma that impact marginalized groups such as people of color and LGBTQI+.
- Added content on laws and social policies that affect mental health outcomes for sexually marginalized groups.
- Revised content on cross-cultural issues in treatment, including cultural sensitivity, multiculturalism in practice, culturally relevant therapy, and treatment outcomes.
- Revised content and graphic on primary, secondary, and tertiary prevention programs.
- Added content on developing positive therapeutic relationships and related treatment outcomes.

Chapter 3: Assessing and Diagnosing Abnormality

- Updated introduction.
- Added new section, "How are psychological disorders evaluated?"
- Expanded content on the assessment and diagnostic process.
- Revised content on validity, reliability, and standardization, including new graphic.
- Revised clinical interview content including five (5) categories of the mental status exam, types of clinical interviews (structured, unstructured, and semi-structured) and symptom questionnaires (i.e., MMPI-2).
- New content on the modes of self-report assessment and outcomes via smartphone technology.
- Updated and expanded content on intelligence testing.
- Updated information on Rorschach testing to include current research on validity issues.
- Updated and expanded information on the influence of culture, parental self-reports, parental attitudes about mental health services, perceptions about psychological symptoms displayed by their children, and parental history of psychological disorders on treatment access.
- Revised content on barriers to treatment that focus on cultural factors that affect ethnic minorities and people of color.
- Revised information on the evolution of the *DSM* system.
- Updated and expanded content on the *DSM-5* and *ICD 11* classification systems.
- Removed *DSM-IV* description of Axes 1–5.
- Added section entitled, "What Happens after a Diagnosis is Made?" about creating treatment plans and working with mental health professionals.

Chapter 4: The Research Endeavor

- Expanded the introduction on research across the continuum to highlight categorical versus continuum models.
- Added new Extraordinary People section on social media and echo-chambers.
- Updated content on independent and dependent variables.
- Expanded and updated content on case studies to include neurological biomarkers and brain imaging research on DID.
- Expanded and updated content on correlational research.

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

- Chapter entirely reorganized.
- Revised continuum to reflect feelings of anxiety rather than fear.
- Added new introduction section and clarified typical versus atypical anxiety.
- Updated prevalence rates for anxiety with emphasis on culture and ethnicity related to diagnostic differences among groups.
- Added new section on the impact of COVID-19 on anxiety and mental health.
- Revised introduction to panic disorder and the biological and psychological factors associated with panic disorder.
- Revised content on separation anxiety disorder for children and adults.
- Updated information on genetics and separation anxiety disorder.
- Expanded and updated information on environmental and parenting factors on anxiety disorders.
- Expanded and revised content on treating separation anxiety disorder.
- Added new section on selective mutism.
- Updated content on generalized anxiety disorder (GAD).
- Updated coverage of social anxiety disorder.
- Updated and expanded coverage of specific phobias.
- Added new introduction section on organization of obsessive-compulsive and related disorders based on *DSM-5* standards.
- Added new profile on celebrity soccer player David Beckham and his battle with OCD.
- Added new Case Study (Carl's compulsions) to highlight compulsive behaviors of OCD.
- Revised discussion of OCD symptomatology.
- Updated prevalence rates and course for OCD with emphasis on sex differences across the lifespan.
- Updated prevalence rates for OCD with emphasis on age groups, sex, culture, and ethnicity related to diagnostic differences among groups.

- Added and updated content on Hoarding Disorder.
- Expanded and updated content on Trichotillomania.
- Expanded and updated content on Excoriation.
- Updated and expanded content on Body Dysmorphic Disorder (BDD), including a new section on the influence of social media platforms on body dissatisfaction.
- Added content on BDD specifier "With absent insight/delusional beliefs."
- Revised content on Muscle dysmorphia (MD).
- Updated information on biological contributions to OCD and related disorders.
- Added section on the link between the hypothalamic-pituitary-adrenal (HPA) axis and obsessive-compulsive type disorders.
- Updated section on the role of inflammation and infection in the development of OCD and related disorders.
- Updated content on cognitive behavioral theories related to OCD development.
- Updated and expanded introduction section on trauma.
- Added new PTSD case study: "Keira's story."
- Updated and expanded discussion of PTSD and traumatic experiences highlighting differences between men and women.
- Updated section on symptoms of PTSD and Acute Stress Disorder (ASD).
- Added section on Reactive Attachment Disorder (RAD).
- Added section on Disinhibited Social Engagement Disorder.
- Updated and expanded section on types of traumas.
- Added section about the mass shooting at Pulse nightclub (2016) and research on resiliency through community support and support networks.
- Added research on increased psychological vulnerability for PTSD following exposure to multiple traumatic events.
- Revised coverage of secondary and vicarious trauma, as well as repeated exposure via social media and frequent access to news updates.
- Revised coverage on risk factors and coping mechanisms for PTSD.
- Updated and expanded coverage of ethnic and cultural differences related to trauma exposure and PTSD.
- Added section on ethnic identity as a protective factor vis-a-vis certain psychological disorders.

Chapter 6: Somatic Symptom and Dissociative Disorders

- Revised discussion of the mind-body connection with regard to physical illness symptoms.
- Updated coverage of diagnostic information, comorbidities, and prevalence rates for Somatic Symptom Disorder and Illness Anxiety Disorder.
- Added a section on the influence of COVID-19 on mental health conditions and preoccupations.
- Expanded content on the impact of trauma on somatic symptoms.
- Revised information on the treatment of somatic symptom and illness anxiety disorder.
- Updated somatic symptom disorder case study.
- Revised content on conversion disorder (Functional Neurological Symptom Disorder).
- Revised content on factitious disorder imposed on self; factitious disorder imposed on another; and malingering.
- Added new introduction on dissociative disorders.
- Revised content on consciousness and the impact of trauma on dissociation, brain function, cognitive unconscious, and dissociation.
- Substantially revised coverage of Dissociative Identity Disorder (DID).
- New content on Dissociative Amnesia including prevalence rates and memory failure.
- Updated content on retrograde amnesia.
- Added content on the impact of recovering traumatic memories.
- Revised content on neurological model of repression.
- Updated and expanded content on state-dependent memory retrieval.
- Updated and expanded discussion on the controversies surrounding DID diagnosis.

Chapter 7: Mood Disorders and Suicide

- Updated Mood Disorders along the Continuum.
- Added new Extraordinary People on Dwayne "the Rock" Johnson.
- Revised and expanded section on symptoms of depression.
- Added content on Major Depressive Disorder (MDD), including updated references on course and specifiers for MDD.
- Updated and expanded content on Complex Bereavement Disorder.
- Added new content of Persistent Depressive Disorder.
- Revised significantly content on Premenstrual Dysphoric Disorder (PMDD).
- Revised content on Disruptive Mood Dysregulation Disorder (DMDD).
- Added new coverage of mental health resiliency among Black, indigenous, and people of color (BIPOC) and depressive disorders.
- Added section on MDD in children and adolescents.
- Added new content on the impact of COVID-19 on children and adolescent mental health.
- Added content on suicidality among children and adolescents.
- Expanded and revised introduction on Bipolar Disorders.
- Added new section on mania.

- Added new profile on Kanye West and mania.
- Updated and expanded content on unipolar mania to include impact of culture on diagnosis.
- Revised content on Bipolar I Disorder.
- Updated content on Rapid Cycling Bipolar Disorder.
- Expanded content on bipolar disorders in children and adolescents.
- Expanded content on prevalence rates and course of bipolar disorder (I and II) across the world.
- Expanded and updated genetic factors associated with biological pathways to depressive disorders.
- Added updated content on neural and synaptic plasticity associated with depressive disorders.
- Expanded content on hypothalamic-pituitary-adrenal axis (HPA) activation, chronic stress, and depressive disorders.
- Added content on adverse childhood experiences (ACEs) on depression.
- Added significant coverage on the gut microbiome and the impact of altered gut microbiota composition on stress, anxiety, depressive symptoms, and social behavior.
- Added content on the influence of microorganisms, central nervous system inflammation, immune function, and stress on neurotransmitter function.
- Added content on the association between neuroinflammation and the development of major depressive disorder (MDD).
- Updated content on behavioral theories and learned helplessness theories of depression.
- Updated an expanded content on psychological flexibility as it relates to COVID-19 adaptation.
- Added section on the possible influence of social media and smartphone use on depression.
- Updated and expanded content on generational differences in disclosing depressive disorders.
- Expanded coverage of genetic factors, brain structure, and psychosocial factors associated with bipolar disorder.
- Expanded section on dysregulation of the circadian rhythms on bipolar disorder.
- Revised content on anti-depressant (SSRI) and Norepinephrine-Dopamine Reuptake Inhibitor, and lithium medication.
- Updated content on Electroconvulsive Therapy (ECT).
- Revised content on Vagus Nerve Stimulation (VNS) *and* repetitive transcranial magnetic stimulation (rTMS).
- Updated suicide statistics with data on sex, race/ethnicity, geographic location, and age group.
- Updated content on gender differences in suicidality.
- Added content on racial/ethnic minorities and the influence of culture on suicide.
- Revised section on suicide in children and adolescents.
- Added new section on LGBTQI+ individuals and the associated risk factors for depression and suicide.
- Updated content on college student risk of suicide.
- Added content on the influence of social media, access to streaming media services, and suicide contagion and self-harm among adolescent populations.
- Updated content on gun access and suicidality.

Chapter 8: Schizophrenia Spectrum and Other Psychotic Disorders

- Updated and expanded the introduction.
- Re-ordered presentation of content to symptoms, diagnosis, course, and prognosis of schizophrenia.
- Updated and clarified section on positive symptoms and negative symptoms of schizophrenia.
- Expanded content on delusions.
- Updated research on the impact of worry and rumination on paranoid thinking.
- Added new profile on delusional behavior.
- Updated research on grandiose delusions.
- Updated content on audio-visual hallucinations.
- Updated content on cognitive deficits.
- Updated content on diagnostic content.
- Updated and expanded content on prevalence and course of schizophrenia.
- Added content on early-onset schizophrenia.
- Updated research on gender differences in schizophrenia.
- Added international prevalence data for schizophrenia.
- Revised content on outcomes for individuals with schizophrenia, including rates of relapse, remission, and treatment.
- Revised content on differences between men and women with schizophrenia.
- Updated content on the prevalence, treatment, and prognosis of Delusional Disorder.
- Updated prevalence data and genetic heritability for schizotypal personality disorder.
- Revised content on multifactorial contributions to schizophrenia to include genetic vulnerability and environmental risk factors.
- Revised content on the prevalence of schizophrenia and heredity among biological relatives.
- Updated research on twin studies and adoption studies examining heritability of schizophrenia.
- Added new section titled “Birth Complications” on the perinatal risk factors associated with the development of schizophrenia.
- Added research and figure on the two-hit model of neurodevelopmental disturbance.
- Added research on the role of maternal infection during pregnancy and the development of psychotic disorders.
- Added research on maternal and fetal inflammatory responses to infection and the impact on neurodevelopment.
- Added content on the association between maternal immune activation (MIA) and the development of psychiatric disorders such as autism spectrum disorder (ASD) and schizophrenia in offspring.

- Added content on viral pandemics and increased incidences of schizophrenia, which includes recent data on coronaviruses and COVID-19.
- Added content on the association of psychotic disorders with altered gut microbiota composition and microbiota-gut-brain axis.
- Updated content on dopamine theory, the diathesis-stress model, HPA axis, and neural circuit dysfunction.
- Updated research on social drift theory.
- Added section on trauma, childhood adversity, social inequality, and urban living as risk factors for schizophrenia.
- Added content on stressful life events and relapse rates among individuals with psychotic disorders.
- Added section about exposure to household pets as a protective factor associated with reduced risk of developing schizophrenia.
- Updated and expanded content on the family influence, expressed emotion, and relapse rates for those with schizophrenia.
- Added content on cultural differences in the level and presentation of emotional expression and subsequent rates of relapse for those with schizophrenia.
- Added content on the development of culturally appropriate tools to improve the effectiveness of family interventions in multicultural settings.
- Updated content on second generation antipsychotic medications and response rates.
- Updated and expanded research on the use of clozapine which includes efficacy rates, side effects, and treatment outcomes.
- Updated and expanded content on family-oriented interventions, the use of psychoeducation programs, and outcomes in the treatment of schizophrenia.
- Updated and expanded content on Assertive Community Treatment (ACT) programs.
- Added new research on differences in cultural perception of mental illness, stigmatizing attitudes and behaviors, negative stereotypes, adverse treatment in interactions, impact on treatment seeking behaviors, and discrimination.

Chapter 9: Personality Disorders

- Updated Personality along the Continuum personality traits.
- Revised comprehensively the coverage of Paranoid Personality Disorder (PPD).
- Revised descriptive content, international research, comorbidities, and references for Schizoid Personality Disorder.
- Significantly revised coverage of Schizotypal Personality Disorder relating to descriptive traits, family history, adoption, twin studies, comorbidity, course, and international prevalence rates (highlighting ethnic and sex differences), and the impact of childhood adversity and trauma.
- Clarified and expanded descriptive traits of cluster B personality disorders.
- Revised coverage of Borderline Personality Disorder (BPD), including content on increased association of self-harm and suicide attempt; prevalence rates, including research on men, women, and people of color; comorbidity; course for BPD; the impact of BPD caregiving on family members; and treatments.
- Updated and expanded descriptive traits of Histrionic Personality Disorder (HPD).
- Updated and expanded content Narcissistic Personality Disorder (NPD), including clinical traits, comorbidity, course, and prevalence rates (accenting research on minorities and people of color).
- Revised coverage of Avoidant Personality Disorder (AVPD), including prevalence and comorbidity rates and research on the relationship between neglect and emotional abuse by early caregivers.
- Revised content on Dependent Personality Disorder (DPD), including content on comorbidity and symptom overlap between personality disorders by cluster; behavioral and cognitive models of DPD, attachment theory and treatment.
- Revised coverage of Obsessive-Compulsive Personality Disorder (OCPD), including overlap with OCD; comorbidity; ethnic, gender, and racial differences; family, genetic, and neurological studies on OCPD; and treatment outcomes.

Chapter 10: Neurodevelopmental and Neurocognitive Disorders

- Revised introduction on ADHD.
- Updated prevalence estimates and clinical traits of ADHD, including research on gut-brain axis.
- Revised content on Autism Spectrum Disorder (ASD).
- Removed *DSM-IV* content on Pervasive Developmental Disorders (PDDs).
- Added content on the influence of maternal gut microbiome.
- Added content on the impact of maternal immune activation (MIA) and inflammation on neurodevelopmental disorders.
- Added content on the role of immune dysregulation/inflammation and the microbiota-gut-brain axis in the development of ASD behaviors.
- Added content on the role of childhood adversity, stress, and neglect on systemic inflammation.
- Expanded content on ASD treatments.
- Updated content on Down Syndrome.
- Updated content and prevalence data for Fetal Alcohol Syndrome (FAS).
- Updated and expanded content on behavioral strategies and early intervention programs used to help individuals with intellectual disability (ID).
- Revised content on mainstreaming education practices and outcomes for students with ID.
- Revised content on Tourette's disorder and persistent motor or vocal tic disorder (PMVTD).
- Updated content on habit reversal therapy for motor disorders.

- Updated prevalence estimates for major and mild neurocognitive disorders.
- Expanded content on neurocognitive disorder due to Lewy body disease.
- Updated content on HIV-Associated Neurocognitive Disorder (HAND).
- Updated content on traumatic brain injury (TBI).

Chapter 11: Disruptive, Impulse-Control, and Conduct Disorders

- Updated and expanded clinical discussion of conduct disorder which includes prevalence rates for ethnic minorities, as well as diagnostic and treatment disparities for people of color.
- Updated case study on child with opposition defiant disorder (ODD).
- Updated and expanded discussion for ODD, which includes updated references which includes research on impaired emotional and facial recognition as it is related to self-regulation.
- Updated and expanded content on the influence of neurotransmitters on symptoms of ODD.
- Updated and expanded content on childhood risk factors for the development of ODD.
- Updated discussion of antisocial personality disorder (ASPD).
- Updated ASPD prevalence estimates, comorbidity rates, and heritability rates.
- Updated content on adverse childhood experiences and the development of ASPD.
- Updated content on treatment efficacy for ASPD.
- Updated content for the neurological basis of intermittent explosive disorder (IED).

Chapter 12: Eating Disorders

- Added content to the introduction on eating disorders.
- Added and updated content on clinical symptoms and physical consequences of anorexia nervosa.
- Added case study for anorexia nervosa which includes a sexually marginalized individual.
- Clarified distinction between restrictive and purging type of anorexia nervosa (AN).
- Updated prevalence estimates for AN to include new data on mortality rates and men affected with AN and/or disordered eating practices.
- Updated prevalence estimates on bulimia nervosa, including suicidality rates.
- Updated coverage of binge-eating disorder (BED).
- Updated and revised content on the course of BED, as well as gender differences.
- Removed *DSM-IV* content on eating disorder not otherwise specified (EDNOS).
- Updated and expanded content on other specified feeding or eating disorders.
- Updated and expanded content on the influence of neurotransmitters and neurocognitive deficits on the development of eating disorders.
- Added content on the role of gut microbiota and bacteria on the development of eating disorders.
- Added content on social media and the development of body dissatisfaction and the eating disorders.
- Expanded content on the impact of family dynamics and parenting styles on eating disorders.
- Updated content on effective treatments for eating disorder.

Chapter 13: Sexual Disorders and Gender Diversity

- Revised the Sexuality and Gender along the Continuum feature.
- Updated coverage of erectile dysfunction (ED).
- Revised content on sexual dysfunction to include new global research focused on women and psychosocial factors associated with sexual dysfunction.
- Updated and expanded content for sexual dysfunctions among LGBTQ individuals.
- Clarified content on paraphilic disorders regarding typical versus atypical sexual arousal.
- Updated the table, The Kinds of Sexual Practices People Find Appealing.
- Updated and expanded content on paraphilic disorders.
- Revised and updated content on fetishistic and transvestic disorders.
- Revised and updated content for Sexual Sadism and Sexual Masochism.
- Updated coverage of voyeuristic disorder and *exhibitionistic disorder.*
- Updated content on frotteurism, including gender and cultural differences.
- Updated coverage of pedophilic disorder, including material on gender differences.
- Revised case study on pedophilia.
- Updated and expanded on treatments for pedophilia.
- Revised and updated content on treatments for gender dysphoria included new research on gender affirmation surgery (GAS).

Chapter 14: Substance Use and Gambling Disorders

- Revised content on tolerance and substance withdrawal.
- Updated content on the combination of substance abuse and dependence into one disorder called substance use disorder.
- Updated content on alcohol use and alcohol use disorder.
- Update prevalence data for each substance discussed throughout chapter.
- Updated and expanded content on nicotine use to include vaping prevalence and medical consequences.
- Updated content on hallucinogens and PCP.

- Updated and expanded content on cannabis use, prevalence estimates, and the use of medical marijuana.
- Updated content on the use of inhalants.
- Updated and expanded content on the use of Ecstasy (MDMA) and expanded content on the psychological factors that influence substance abuse disorders.
- Updated content on gender differences among men and women with alcohol use disorder (AUD) which includes global data and cultural implications.
- Revised, updated, and expanded content on the use of methadone maintenance programs and treatment outcomes.
- Updated content on cognitive behavioral therapy (CBT) and motivational interviewing (MI) for substance use disorders.
- Added contact on the impact of COVID-19 on access to substance use services and the increased use of telemedicine in response to COVID-19 distancing requirements.
- Added content on the influence of smart phone and gaming apps on gambling disorder.
- Added content on the influence of COVID-19 on gambling behaviors.

Chapter 15: Health Psychology

- Added content on the influence of social media platforms and online health communities that enhance social support.
- Updated content on chronic arousal of the fight-or-flight system for individuals with psychological disorders.
- Expanded coverage of neuroimmunological research and psychological stress, which includes HPA axis and activation of the sympathetic nervous system.
- Added content on guy microbiota, neuroinflammation, and immune response on psychiatric and neurogenerative diseases.
- Updated and expanded content on stress reduction, psychosocial interventions, and improved health for those with cancer.
- Updated content on psychosocial interventions for individuals living with HIV/AIDS which includes program outcomes that increase the use of active antiretroviral therapy (ART), and the impact of stigma on this population.
- Updated and expanded research on gender differences and psychological factors found among those with cardiovascular disease.
- Updated, revised, and expanded content on the influence of personality type (Type A, Type B, Type C, and Type D) on physical health.
- Added content on the influence of COVID-19 pandemic on insomnia.
- Update and expanded content on sleep terror disorder.

Chapter 16: Mental Health and the Law

- Updated content on competence to stand trials and the ability to make medical decisions.
- Expanded content on the rates of incarceration among those with serious mental illness.

Nolen-Hoeksema's
Abnormal Psychology

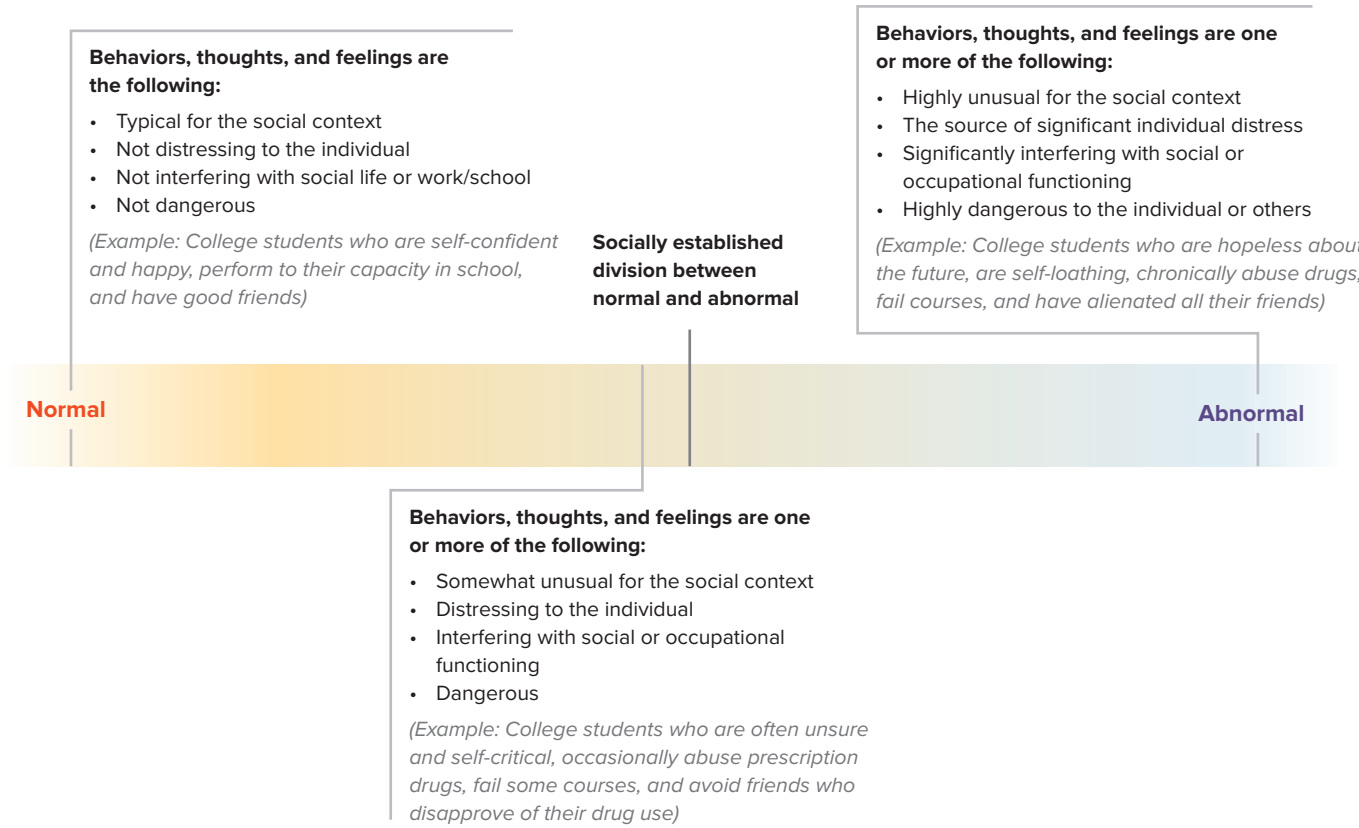
Chapter 1

Zeyu Wang/Getty Images

Looking at Abnormality

CHAPTER OUTLINE

Abnormality Along the Continuum



What is normal, anyway? As humans, we often search for a dividing point where normal ends and abnormal behavior suddenly begins. It would make life much easier if this threshold existed; but unfortunately, there is no definitive way to know exactly where *normal* behavior lives within the human experience. Everyday, we are motivated by various thoughts and feelings to behave in ways that others may deem normal or abnormal. However, it's important to recognize that the label we place upon these behaviors (normal vs. abnormal) is related directly to the context in which these behaviors occur, the factors that surround these behaviors, and the culture in which we live. Behaviors considered to be normal in one culture may be considered abnormal in other cultures, and vice versa.

We are each experts in identifying abnormal behavior since we have been socialized in a culture that dictates and defines the behaviors considered acceptable or typical. For example, it would not be unusual to see large groups of people walking around your neighborhood dressed like zombies or killer clowns on Halloween, but if you saw this same group on a random day in the spring, you may quickly turn and run in the other direction. And, you would be wise to run! Prior to the COVID-19 crisis, it may have been unusual to wear a face mask in public. Now, it's become a standard of behavior in a relatively short period of time. You may even remark to another person that you like their face mask!

As human beings, we are all subject to violating these socially defined boundaries of normal behavior. This can lead us to think, feel, or behave in ways that are considered abnormal by others, cause distress to the individual or those around them, or lead to problematic behaviors. For example, it's not uncommon for people to feel hurt or rejected after a relationship ends and it takes time for those feelings to fade. Is it "normal" to keep checking Instagram to see what your ex is doing without you? When does the typical act of checking Instagram or the social media account(s) of your ex-boyfriend or girlfriend become abnormal?

Since there is no way to determine where normal ends and abnormal begins, the *normal-abnormal continuum* is used to illustrate these transitions in behavior. You will see that this **continuum model of abnormality** applies to all the disorders we discuss in this book. In this chapter, we discuss some of the factors that influence how thoughts, emotions, and behaviors are labeled abnormal.

Extraordinary People

My illness began slowly, gradually, when I was between the ages of 15 and 17. I began having visual hallucinations in which people changed into different characters, the change indicating to me their moral value. For example, the mother of a good friend always changed into a witch, and I believed this to be indicative of her evil nature. At the time I didn't know what to make of these changes in my perceptions. On the one hand, I thought they came as a gift from God, but on the other hand, I feared that something was dreadfully wrong. However, I didn't tell anyone what was happening; I was afraid of being called insane.

Source: Anonymous, "First Person Account: Portrait of a Schizophrenic," Schizophrenic Bulletin, 18, 1992. pp. 333–334.

Given the range of human behaviors from common or expectable to strange and even bizarre, abnormal psychology is a very popular subject, how could it not be? This field of study is devoted to understanding, treating, and preventing psychological dysfunction. Abnormal psychology, also known as **psychopathology,** focuses on behaviors that are atypical or unexpected. With this fascinating nature of abnormal psychology, it can be easy for people to become so wrapped up in the terminology, the clusters of symptoms and clinical jargon associated with various psychological disorders that they forget about the people behind the disorder. It is critical to remember that while this topic is very interesting, we must never lose sight of the human perspective. Like any other area of human behavior, psychological disorders are part of the human experience and, as a result, impact us all directly or indirectly. You will learn the symptoms that characterize different psychological disorders, but most importantly, how these symptoms affect the lives of people everyday. It is equally important to realize that while many of the disorders presented in this book seriously influence day-to-day life, they are all treatable, and many are preventable.

The purpose of this book is not only to provide you with information, facts and figures, theories, and research but also to help you understand the experience of people with psychological disorders. The good news is that, thanks to an explosion of research in the past few decades, effective biological and psychological treatments are available for many of the mental health problems we discuss.

DEFINING ABNORMALITY

Once we have determined that a behavior or a person is abnormal we often insert a word to describe this abnormality, sometimes unkindly. Words like crazy or nuts are common in popular culture and easy to use without realizing the unintended consequences. Just like any disparaging label, these words are used to dismiss and dehumanize people who we consider different. What these words also do is reinforce **stigma** among those with mental health issues, which has an impact on how we view those with psychological disorders and how they can see themselves. While difficult to fully define abnormality in all contexts, professionals can use a variety of criteria to assess abnormal function in an individual.

The Four Ds of Abnormality

There is no singular way to define abnormal behavior among professionals. However, modern judgments of abnormality are influenced by the interplay of four dimensions, often called "the four Ds": dysfunction, distress, deviance, and dangerousness. Behaviors, thoughts, and feelings are dysfunctional when they interfere with the person's ability to function in daily life, to hold a job, or to form close relationships. The more dysfunctional behaviors and feelings are, the more likely they are to be considered abnormal by mental health professionals. For example, thinking that is out of touch with reality (such as believing you are Satan and should be punished) makes it difficult to function in everyday life and so is considered dysfunctional.

Behaviors and feelings that cause distress to the individual or those around them are also likely to be considered abnormal. Many of the problems we discuss in this book cause individuals tremendous emotional distress, but how a person's behavior affects those around them is also an important consideration. Imagine in the middle of a lecture a man enters the room wearing nothing but a small bikini bottom, sits down next to you and begins eating a sandwich. This man is engaged in the lecture, he asks questions, and is showing no signs of distress. How do you feel sitting next to this person? Our social norms would dictate very different attire in a classroom setting, particularly in regions where the weather is cold. This violation of our typical classroom practice could cause feelings of distress or discomfort in you, but not to the man wearing only bikini bottoms. In other cases, the person displaying

SHADES OF GRAY **DISCUSSION**

Consider the following descriptions of two students. In the year between her eighteenth and nineteenth birthdays, Jennifer, who is 5′6″, dropped from a weight of 125 pounds to 105 pounds. The weight loss began when Jennifer had an extended case of the flu and lost 10 pounds. Friends complimented her on being thinner, and Jennifer decided to lose more weight. She cut her intake of food to about 1,200 calories, avoiding carbs as much as possible, and began running a few miles every day. Sometimes she is so hungry she has trouble concentrating on her schoolwork. Jennifer values her new lean look so much, however, that she is terrified of gaining the weight back. Indeed, she'd like to lose a few more pounds so she could fit into a size 2.

Mark is what you might call a "heavy drinker." Although he is only 18, he has ready access to alcohol, and most nights he typically drinks at least five or six beers. He rarely feels drunk after that much alcohol, though, so he might also throw back a few shots, especially when he is out partying on Saturday nights. He's been caught a few times and received tickets for underage drinking, but he proudly displays them on his dorm wall as badges of honor. Mark's grades are not what they could be, but he finds his classes boring and has a hard time doing the work. Do you find Jennifer's or Mark's behaviors abnormal? How would you rate their level of dysfunction, distress, deviance, and danger? (Discussion appears at the end of this chapter.)

abnormal behavior is not in distress but causes others distress through chronic lying, stealing, or violence.

Behavior that deviates from the social norm is another way to assess abnormality since behaviors are influenced by cultural norms and practices within our community. Behaviors that defy our social expectations are easy to spot, but they vary in terms of the culture. It is common to see a person wearing shorts at the gym, but walking outside when it is snowing deviates from the norm. No one criterion defines abnormality, so while wearing shorts in very cold weather is behavior that deviates from the norm, this behavior does not make someone abnormal. Finally, some behaviors and feelings, such as suicidal gestures, are of potential harm to the individual, whereas other behaviors and feelings, such as excessive aggression, could potentially harm others. Such dangerous behaviors and feelings are often seen as abnormal. Once an individual's behaviors or feelings cross that line, we might be justified in suggesting that there is something "wrong" with that person or thinking that a psychological disorder may be present. However, it is important to note that abnormal behavior, even when agreed upon, is not the same as a psychological disorder. The diagnosis of a psychological disorder requires that specific criteria be met after a psychological evaluation is complete. Meaning, displaying abnormal behavior is not necessarily enough to be assigned a psychological diagnosis. We will discuss this topic in depth in Assessing and Diagnosis Abnormality.

The Disease Model of Mental Illness

A common belief is that behaviors, thoughts, or feelings can be viewed as pathological or abnormal if they are symptoms of a *mental illness.* This implies that a disease process, much like hypertension or diabetes, is present. For example, when many people say that an individual "has schizophrenia" (which is characterized by distorted perceptions and a loss of contact with reality), they imply that he or she has a disease that should show up on some sort of biological test, just as hypertension shows up when a person's blood pressure is taken.

To date, however, no biological test is available to diagnose any of the types of psychological disorder we discuss in this book (Hyman, 2010). This is not just because we do not yet have the right biological tests. In modern conceptualizations, mental disorders are not viewed as singular diseases with a common pathology that can be identified in all people with the disorder. Instead, mental health experts view mental disorders as collections of problems in thinking or cognition, in emotional responding or regulation, and in social behavior (Cuthbert & Insel, 2013; Hyman, 2010). Thus, for example, a person diagnosed with schizophrenia has a collection of problems in behavior, rational thinking, and emotional response in everyday life. It is this collection of problems that we label schizophrenia. It is still possible, and in the case of schizophrenia likely, that biological factors are associated with these problems in thinking, feeling, and behaving. But it is unlikely that a singular disease process underlies the symptoms we call schizophrenia.

Cultural Norms

Consider these behaviors:

1. A man driving a nail through his hand
2. A woman refusing to eat for several days
3. A man barking like a dog and crawling on the floor on his hands and knees

4. A woman building a shrine to her dead husband in her living room and leaving food and gifts for him at the altar

Do you think these behaviors are abnormal? You might reply, "It depends." Several of these behaviors are accepted in certain circumstances. In many religious traditions, for example, refusing to eat for a period of time, or fasting, is a common ritual of cleansing and penitence. You might expect that some of the other behaviors listed, such as driving a nail through one's hand or barking like a dog, are abnormal in all circumstances, yet even these behaviors are accepted in certain situations. In Mexico, some Christians have themselves nailed to crosses on Good Friday to commemorate the crucifixion of Jesus. Among the Yoruba of Africa, traditional healers act like dogs during healing rituals (Murphy, 1976). Thus, the context, or circumstances surrounding a behavior, influences whether the behavior is viewed as abnormal.

Cultural norms play a large role in defining abnormality. A good example is the behaviors people are expected to display when someone they love dies (Rosenblatt, 2008). In cultures dominated by Shinto and Buddhist religions, it is customary to build altars to honor dead loved ones, to offer them food and gifts, and to speak with them as if they were in the room. In cultures dominated by Christian and Jewish religions, such practices would potentially be considered quite abnormal.

Cultures have strong norms for what is considered acceptable behavior for men versus women, and these gender-role expectations also influence the labeling of behaviors as normal or abnormal (Addis, 2008). In many cultures, men who display sadness or anxiety or who choose to stay home to raise their children while their wives work are at risk of being labeled abnormal, while women who are assertive, career-focused, or who don't want to have children are at risk of being labeled abnormal.

Cultural relativism is the view that there are no universal standards or rules for labeling a behavior abnormal; instead, behaviors can be labeled abnormal only relative to cultural norms (Bassett & Baker, 2015; Snowden & Yamada, 2005). The advantage of this perspective is that it honors the norms and traditions of different cultures, rather than imposing the standards of one culture on judgments of abnormality. Yet opponents of cultural relativism argue that dangers arise when cultural norms are allowed to dictate what is normal or abnormal. In particular, psychiatrist Thomas Szasz (1961, 2011) noted that throughout history, societies have labeled individuals and groups abnormal in order to justify controlling or silencing them. Hitler branded Jews abnormal and used this label as one justification for the Holocaust. The former Soviet Union sometimes branded political dissidents mentally ill and confined them in mental hospitals. When the slave trade was active in the United States, slaves who tried to escape their masters could be diagnosed with a mental disease that was said to cause them to desire freedom; the prescribed treatment for this disease was whipping and hard labor.

Most mental health professionals do not hold an extreme relativist view on abnormality, recognizing the dangers of basing definitions of abnormality solely on cultural norms. Yet even those who reject an extreme cultural-relativist position recognize that culture and gender have a number of influences on the expression of abnormal behaviors and on the way those behaviors are treated. First, culture and gender can influence the ways people express symptoms. People who lose touch with reality may believe that they have divine powers, but whether they believe they are Jesus or Mohammed depends on their religious background.

Second, culture and gender can influence people's willingness to admit to certain types of behaviors or feelings (Snowden & Yamada, 2005). People in Eskimo and Tahitian cultures may be reluctant to admit to feeling anger because of strong cultural norms against the expression of anger. The Kaluli of New Guinea and the Yanomamo of Brazil, however, value the expression of anger and have elaborate and

In Mexico, some Christians have themselves nailed to a cross to commemorate the crucifixion of Jesus. *cdrin/Shutterstock*

complex rituals for expressing it (Jenkins, Kleinman, & Good, 1991).

Third, culture and gender can influence the types of treatments deemed acceptable or helpful for people exhibiting abnormal behaviors. Some cultures may view drug therapies for psychopathology as most appropriate, while others may be more willing to accept psychotherapy (Snowden & Yamada, 2005). Throughout this book, we will explore these influences of culture and gender on behaviors labeled abnormal.

HISTORICAL PERSPECTIVES ON ABNORMALITY

Across history, three types of theories have been used to explain abnormal behavior. The **biological theories** have viewed abnormal behavior as similar to physical diseases, caused by the breakdown of systems in the body. The appropriate cure is the restoration of bodily health. The **supernatural theories** have viewed abnormal behavior as a result of divine intervention, curses, demonic possession, and personal sin. To rid the person of the perceived affliction, religious rituals, exorcisms, confessions, and atonement have been prescribed. The **psychological theories** have viewed abnormal behavior as a result of psychological processes, such as beliefs, coping styles, and life events such as trauma, bereavement, or chronic stress. There are a variety of methods to treat abnormal behavior with these theories such as rest, relaxation, or change of environment to improve psychological health. These three types of theories have influenced how people acting abnormally have been regarded in society. A person thought to be abnormal because he or she was a sinner, for example, would be regarded differently from a person thought to be abnormal because of a disease.

Ancient Theories

Our understanding of prehistoric people's conceptions of abnormality is based on inferences from archaeological artifacts—fragments of bones, tools, artwork, and so on—as well as from ancient writings about abnormal behavior. It seems that humans have always viewed abnormality as something needing special explanation.

Driving Away Evil Spirits

Historians speculate that even prehistoric people had a concept of insanity, probably one rooted in supernatural beliefs (Selling, 1940). A person who acted oddly was suspected of being possessed by evil spirits. The typical treatment for abnormality, according to supernatural theories, was exorcism—driving the evil spirits from the body of the suffering person. Shamans, or healers, would recite prayers or incantations, try to talk the spirits out of the body, or make the body an uncomfortable place for the spirits to reside—often through extreme measures such as starving or beating the person. At other times, the person thought to be possessed by evil spirits would simply be killed.

When the slave trade was active, slaves who tried to escape were sometimes labeled as having mental illness and were beaten to "cure" them. *Jean Baptiste Debret/Getty Images*

One treatment for abnormality during the Stone Age and well into the Middle Ages may have been to drill holes in the skull of a person displaying abnormal behavior to allow the spirits to depart (Tatagiba, Ugarte, & Acioly, 2015). Archaeologists have found skulls dating back to a half-million years ago in which sections of the skull have been drilled or cut away. The tool used for this drilling is called a trephine, and the operation is called **trephination.** Some historians believe that people who were seeing or hearing things that were not real and people who were chronically sad were subjected to this form of brain surgery (Feldman & Goodrich, 2001). Presumably, if the person survived this surgery, the evil spirits would have been released and the person's abnormal behavior would decline. However, we cannot know with certainty that trephination was used to drive away evil spirits. Other historians suggest that it was used primarily for the removal of blood clots caused by stone weapons during warfare and for other medical purposes (W. Maher & B. Maher, 1985).

Some scholars believe that holes found in ancient skulls are from trephination, a crude form of surgery possibly performed on people acting abnormally. *Prisma/UIG via Getty Images*

Ancient China: Balancing Yin and Yang

Some of the earliest written sources on abnormality are ancient Chinese medical texts (Tseng, 1973). The *Nei Ching* (Classic of Internal Medicine) was probably written around 2674 BCE by Huang Ti, the legendary third emperor of China.

Ancient Chinese medicine was based on the concept of yin and yang. The human body was said to contain a positive force (yang) and a negative force (yin), which confronted and complemented each other. If the two forces were in balance, the individual was healthy. If not, illness, including insanity, could result. For example, excited insanity was considered the result of an excessive positive force:

> The person suffering from excited insanity initially feels sad, eating and sleeping less; he then becomes grandiose, feeling that he is very smart and noble, talking and scolding day and night, singing, behaving strangely, seeing strange things, hearing strange voices, believing that he can see the devil or gods, etc. As treatment for such an excited condition, withholding food was suggested, because food was considered to be the source of positive force and the patient was thought to be in need of a decrease in such force (Tseng, 1973, p. 570).

Chinese medical philosophy also held that human emotions were controlled by internal organs. When the "vital air" was flowing on one of these organs, an individual experienced a particular emotion. For example, when air flowed on the heart, a person felt joy; when on the lungs, sorrow; when on the liver, anger; when on the spleen, worry; and when on the kidney, fear. This theory encouraged people to live in an orderly and harmonious way so as to maintain the proper movement of vital air.

Although the perspective on psychological symptoms represented by ancient texts was largely a biological one, the rise of Taoism and Buddhism during the Chin and T'ang dynasties (420–618 CE) led to some religious interpretations of abnormal behavior. Evil winds and ghosts were blamed for bewitching people and for inciting people's erratic emotional displays and uncontrolled behavior. Religious theories of abnormality declined in China after this period (Tseng, 1973).

Ancient Egypt, Greece, and Rome: Biological Theories Dominate

Other ancient writings on abnormal behavior are found in the papyri of Egypt and Mesopotamia (Veith, 1965). The oldest of these, a document known as the Kahun Papyrus after the ancient Egyptian city in which it was found, dates from about 1900 BCE. This document lists a number of disorders, each followed by a physician's judgment of the cause of the disorder and the appropriate treatment.

Some of the earliest writings on mental disorders are from ancient Chinese texts. This illustration shows a healer at work. *Chronicle/Alamy Stock Photo*

Several disorders apparently left people with unexplainable aches and pains, sadness or distress, and apathy about life. These disorders were said to occur only in women and were attributed to a "wandering uterus." The uterus was believed to wander around the body like an animal, hungry for semen. It could wander around the body creating various physical ailments, for example, if it wandered the wrong direction and made its way to the throat there would be choking, coughing, or loss of voice, if it got stuck in the the rib cage, there would be chest pain or shortness of breath (Kapsalis, 2017).

Most any symptom that belonged to a female body could be attributed to the wandering uterus. The diagnosis was a catch-all explanation for behavior that afflicted women throughout history and was not only prevalent in the West among mainly White women but it had its prehistory in Ancient Egypt, Greece, Italy, the Far East and Middle East as well. Later, the Greeks named this disorder *hysteria* (from the Greek word *hystera,* which means "uterus"). Various treatments existed within these different cultures for this phenomenon which included vaginal fumigations, bitter potions, balms, fragrances, and vaginal inserts

made of wool, that were used to bring the uterus back to its proper place. The triad of marriage, sexual intercourse, and pregnancy was the ultimate treatment for the troublesome womb (Kapsalis, 2017).

These days, the term "hysteria" is outdated and no longer used in reference to physiological symptoms that are the likely result of psychological processes. Hysteria is undoubtedly the first psychological disorder associated with women with over 4,000 years of history. The phenomenon of the wandering uterus is an excellent example of how psychological disorders can be often misunderstood, misinterpreted, and generate pseudo-scientific prejudice and bias (Tasca, Rapetti, Carta, & Fadda, 2012).

Beginning with Homer, the Greeks wrote frequently of people acting abnormally (Wallace & Gach, 2008). The physician Hippocrates (460–377 BCE) described a case of a common phobia: A man could not walk alongside a cliff, pass over a bridge, or jump over even a shallow ditch without feeling unable to control his limbs or his vision becoming impaired.

Most average Greeks and Romans saw abnormal behavior as an affliction from the gods. Those afflicted retreated to temples honoring the god Aesculapius, where priests held healing ceremonies. Plato (423–347 BCE) and Socrates (469–399 BCE) argued that some forms of abnormal behavior were divine and could be the source of great literary and prophetic gifts.

For the most part, however, Greek physicians rejected supernatural explanations of abnormal behavior (Wallace & Gach, 2008). Hippocrates, often regarded as the father of medicine, argued that abnormal behavior was like other diseases of the body. According to Hippocrates, the body was composed of four basic humors: blood, phlegm, yellow bile, and black bile. All diseases, including abnormal behavior, were caused by imbalances in the body's essential humors. Based on careful observation of his many patients, which included listening to their dreams, Hippocrates classified abnormal behavior into four categories: epilepsy, mania, melancholia, and brain fever.

The treatments prescribed by the Greek physicians were intended to restore the balance of the four humors. Sometimes these treatments were physiological and intrusive, such as bleeding a patient to treat disorders that were thought to result from an excess of blood. Other treatments consisted of rest, relaxation, a change of climate or scenery, a change of diet, or living a temperate life. Some nonmedical treatments prescribed by these physicians sound remarkably like those prescribed by modern psychotherapists. Hippocrates, for example, believed that removing a patient from a difficult family could help restore mental health. Plato argued that insanity arose when the rational mind was overcome by impulse, passion, or appetite. Sanity could be regained through a discussion with the individual that was designed to restore rational control over emotions (W. Maher & B. Maher, 1985).

Among the Greeks of Hippocrates' and Plato's time, the relatives of people considered insane were encouraged to confine their afflicted family members to the home. The state claimed no responsibility for insane people; it provided no asylums or institutions, other than the religious temples, to house and care for them. The state could, however, take rights away from people declared insane. Relatives could bring suit against those they considered insane, and the state could award the property of insane people to their relatives. People declared insane could not marry or acquire or dispose of their own property. Poor people who were considered insane were simply left to roam the streets if they were not violent. If they were violent, they were locked away. The general public greatly feared insanity of any form, and many people thought to be insane were shunned or even stoned (W. Maher & B. Maher, 1985).

Medieval Views

The Middle Ages (around 400–1400 CE) are often described as a time of backward thinking dominated by an obsession with supernatural forces, yet even within Europe supernatural theories of abnormal behavior did not dominate until the late Middle Ages, between the eleventh and fifteenth centuries (Neugebauer, 1979). Prior to the eleventh century, witches and witchcraft were accepted as real but were considered mere nuisances, overrated by superstitious people. Severe emotional shock and physical illness or injury most often were seen as the causes of bizarre behaviors. For example, English court records attributed mental health problems to factors such as a "blow received on the head," explained that symptoms were "induced by fear of his father," and noted that "he has lost his reason owing to a long and incurable infirmity" (Neugebauer, 1979, p. 481). While laypeople probably did believe in demons and curses as causes of abnormal behavior, there is strong evidence that physicians and government officials in the early Middle Ages attributed abnormal behavior to physical causes or traumas.

Witchcraft

Beginning in the eleventh century, the power of the Catholic Church in Europe was threatened by the breakdown of feudalism and rebellions. The Church interpreted these threats in terms of heresy and Satanism. The Inquisition was established originally to rid the Earth of religious heretics, but eventually those

practicing witchcraft or Satanism also became the focus of hunts. The witch hunts continued long after the Reformation, perhaps reaching their height during the fifteenth to seventeenth centuries—the period known as the Renaissance (Mora, 2008).

Some psychiatric historians have argued that persons accused of witchcraft must have been mentally ill (Veith, 1965; Zilboorg & Henry, 1941). Accused witches sometimes confessed to speaking with the devil, flying on the backs of animals, or engaging in other unusual behaviors. Such people may have been experiencing delusions (false beliefs) or hallucinations (unreal perceptual experiences), which are signs of some psychological disorders. However, confessions of such experiences may have been extracted through torture or in exchange for a stay of execution (Spanos, 1978).

In 1563, Johann Weyer published *The Deception of Dreams,* in which he argued that those accused of being witches were suffering from melancholy (depression) and senility. The Church banned Weyer's writings. Twenty years later, Reginald Scot, in his *Discovery of Witchcraft* (1584), supported Weyer's beliefs: "These women are but diseased wretches suffering from melancholy, and their words, actions, reasoning, and gestures show that sickness has affected their brains and impaired their powers of judgment" (Castiglioni, 1946, p. 253). Again, the Church—joined this time by the state—refuted the arguments and banned Scot's writings.

As is often the case, change came from within. In the sixteenth century, Teresa of Avila, a Spanish nun who was later canonized, explained that the mass hysteria that had broken out among a group of nuns was not the work of the devil but was the result of infirmities or sickness. She argued that these nuns were *comas enfermas,* or "as if sick." She sought out natural causes for the nuns' strange behaviors and concluded that they were due to melancholy, a weak imagination, or drowsiness and sleepiness (Sarbin & Juhasz, 1967).

The culture so completely accepted the existence of witches and witchcraft that some perfectly sane people may have self-identified as witches. In addition, most writings of medieval and Renaissance times, as well as writings from the witch hunt period in Salem, Massachusetts, clearly distinguish between people who were mad and people who were witches. The distinction between madness and witchcraft continues to this day in cultures that believe in witchcraft.

Some people burned at the stake as witches may have had mental disorders that caused them to act abnormally. *Bettmann/Getty Images*

Psychic Epidemics

Psychic epidemics are defined as a phenomenon in which large numbers of people engage in unusual behaviors that appear to have a psychological origin. During the Middle Ages, reports of dance frenzies or manias were frequent. A monk, Peter of Herental, described a rash of dance frenzies that broke out over a 4-month period in 1374 in Germany:

> Both men and women were abused by the devil to such a degree that they danced in their homes, in the churches and in the streets, holding each other's hands and leaping in the air. While they danced they called out the names of demons, such as Friskes and others, but they were unaware of this nor did they pay attention to modesty even though people watched them. At the end of the dance, they felt such pains in the chest, that if their friends did not tie linen clothes tightly around their waists, they cried out like madmen that they were dying (Cited in Rosen, 1968, pp. 196–197).

Other instances of dance frenzy were reported in 1428 during the feast of Saint Vitus, at Schaffhausen, at which a monk danced himself to death. In 1518 a large epidemic of uncontrolled dance frenzy occurred at the chapel of Saint Vitus at Hohlenstein, near Zabern. According to one account, more than 400 people danced during the 4 weeks the frenzy lasted. Some writers of the time began to call the frenzied dancing Saint Vitus' dance.

A similar phenomenon, *tarantism,* was noted in Italy as early as the fourteenth century and became prominent in the seventeenth century. People suddenly developed an acute pain, which they attributed to the bite of a tarantula. They jumped around and danced wildly in the streets, tearing at their clothes and beating each other with whips. Some people dug holes in the earth and rolled on the ground; others howled and made obscene gestures. At the time, many

people interpreted dance frenzies and tarantism as the results of possession by the devil. The behaviors may have been the remnants of ancient rituals performed by people worshiping the Greek god Dionysus.

We see episodes of psychic epidemics in modern times. On February 8, 1991, a number of students and teachers in a high school in Rhode Island thought they smelled noxious fumes coming from the ventilation system. The first person to detect these fumes, a 14-year-old girl, fell to the floor, crying and saying that her stomach hurt and her eyes stung. Other students and the teacher in that room then began to experience symptoms. They were moved into the hallway with a great deal of commotion. Soon students and teachers from adjacent rooms, who could see clearly into the hallway, began to experience symptoms. Eventually, 21 people (17 students and 4 teachers) were admitted to the local hospital emergency room. All were hyperventilating, and most complained of dizziness, headache, and nausea. Although some initially showed symptoms of mild carbon monoxide intoxication in blood tests, no evidence of toxic gas in the school could be found. The physicians treating the children and teachers concluded that the outbreak was a case of mass hysteria prompted by the fear of chemical warfare during the Persian Gulf War (Rockney & Lemke, 1992).

Psychic epidemics are no longer viewed as the result of spirit possession or the bite of a tarantula. Rather, psychologists attempt to understand them through research from social psychology on the influence of others on individuals' self-perceptions. The social context can affect even our perceptions of our own bodies, as we will see when we discuss people's differing reactions to psychoactive substances such as marijuana (see the chapter "Substance Use and Gambling Disorders") and people's interpretations of their physical sensations (see the chapter "Somatic Symptom and Dissociative Disorders").

The Spread of Asylums

As early as the twelfth century, many towns in Europe took some responsibility for housing and caring for people considered mentally ill (Kroll, 1973). Remarkable among these towns was Gheel, Belgium, where townspeople regularly took into their homes the mentally ill who were visiting the shrine of Saint Dymphna for cures.

In about the eleventh or twelfth century, general hospitals began to include special rooms or facilities for people exhibiting abnormal behavior. The mentally ill were little more than inmates in these early hospitals, housed against their will, often in extremely harsh conditions. One of the most famous of these hospitals was the Hospital of Saint Mary of Bethlehem, in London, which officially became a mental hospital in 1547. This hospital, nicknamed Bedlam, was famous for its deplorable conditions. At Bedlam and other mental hospitals established in Europe in the sixteenth, seventeenth, and eighteenth centuries, patients were exhibited to the public for a fee. They lived in filth and confinement, often chained to the wall or locked inside small boxes. The following description of the treatment of patients in La Bicêtre Hospital, an asylum for male patients in Paris, provides an example of typical care:

Bedlam—the Hospital of Saint Mary of Bethlehem in London—was famous for the chaotic and deplorable conditions in which people with mental disorders were kept. *SOTK2011/Alamy Stock Photo*

> The patients were ordinarily shackled to the walls of their dark, unlighted cells by iron collars which held them flat against the wall and permitted little movement. Often there were also iron hoops around the waists of the patients and both their hands and feet were chained. Although these chains usually permitted enough movement that the patients could feed themselves out of bowls, they often kept them from being able to lie down at night. Since little was known about dietetics, and the patients were presumed to be animals anyway, little attention was paid to whether they were adequately fed or whether the food was good or bad. The cells were furnished only with straw and were never swept or cleaned; the patient remained in the midst of all the accumulated ordure. No one visited the cells except at feeding time, no provision was made for warmth, and even the most elementary gestures of humanity were lacking. (Adapted from Selling, 1940, pp. 54–55)

The laws regarding the confinement of the mentally ill in Europe and the United States were concerned with the protection of the public and the ill person's relatives (Busfield, 1986; Scull, 1993). For example, Dalton's 1618 edition of *Common Law* states that "it is lawful for the parents, kinsmen or other friends of a man that is mad, or frantic . . . to take him and put him into a house, to bind or chain him, and to beat him with rods, and to do any other forcible act to reclaim him, or to keep him so he shall do no hurt" (Allderidge, 1979).

The first Act for Regulating Madhouses in England was passed in 1774, with the intention of cleaning up the deplorable conditions in hospitals and madhouses and protecting people from being unjustly jailed for insanity. This act provided for the licensing and inspection of madhouses and required that a physician, a surgeon, or an apothecary sign a certificate before a patient could be admitted. The act's provisions applied only to paying patients in private madhouses, however, and not to the poor people confined to workhouses.

These asylums typically were established and run by people who thought that abnormal behaviors were medical illnesses. For example, Benjamin Rush (1745–1813), one of the founders of American psychiatry, believed that abnormal behavior was caused by excessive blood in the brain and prescribed bleeding the patient, or drawing huge amounts of blood from the body. Thus, although the supernatural theories of the Middle Ages have often been decried as leading to brutal treatment of people with mental illnesses, the medical theories of those times and of the next couple of centuries did not always lead to better treatment.

In the medieval and early modern periods, doctors used bleeding to treat people with mental disorders and many other ailments.
Photo Researchers/Science History Images/Alamy Stock Photo

Moral Treatment in the Eighteenth and Nineteenth Centuries

The eighteenth and nineteenth centuries saw the growth of a more humane treatment of people with mental health problems, a period known as the **mental hygiene movement.** This new treatment was based on the psychological view that people developed problems because they had become separated from nature and had succumbed to the stresses imposed by the rapid social changes of the period (Rosen, 1968). The prescribed treatment, including prayers and incantations, was rest and relaxation in a serene and physically appealing place.

A leader of the movement for **moral treatment** of people with abnormality was Philippe Pinel (1745–1826), a French physician who took charge of La Bicêtre in Paris in 1793. Pinel argued, "To detain maniacs in constant seclusion and to load them with chains; to leave them defenceless, to the brutality of underlings . . . in a word, to rule them with a rod of iron . . . is a system of superintendence, more distinguished for its convenience than for its humanity or success" (Grob, 1994, p. 27). Pinel believed that many forms of abnormality could be cured by restoring patients' dignity and tranquility.

Pinel ordered that patients be allowed to walk freely around the asylum. They were provided with clean and sunny rooms, comfortable sleeping quarters, and good food. Nurses and professional therapists were trained to work with the patients to help them regain their sense of tranquility and engage in planned social activities. Although many physicians thought Pinel himself was mad for releasing the patients from confinement, his approach was remarkably successful. Many people who had been locked away in darkness for decades became able to control their behavior and reengage in life. Some improved so much that they could be released from the asylum. Pinel later successfully reformed La Salpêtrière Hospital, a mental hospital for female patients in Paris (Grob, 1994).

In 1796 the Quaker William Tuke (1732–1822) opened an asylum in England, called The Retreat, in direct response to the brutal treatment he saw being delivered at other facilities to people with abnormal behavior. Tuke's treatment was designed to restore patients' self-restraint by treating them with respect and dignity and encouraging them to exercise self-control (Grob, 1994).

One of the most militant crusaders for moral treatment of the insane was Dorothea Dix (1802–1887). A retired schoolteacher living in Boston, Dix visited a jail on a cold Sunday morning in 1841 to teach a Sunday school class to women inmates. There she discovered the negligence and brutality that characterized the treatment of poor people exhibiting abnormal behavior, many of whom were simply warehoused in jails.

That encounter began Dix's tireless quest to improve the treatment of people with mental health problems. Dix's lobbying efforts led to the passage of laws and appropriations to fund the cleanup of mental hospitals and the training of mental health professionals dedicated to the moral treatment of patients. Between 1841 and 1881, Dix personally helped establish more than 30 mental institutions in the United States, Canada, Newfoundland, and Scotland. Hundreds more public hospitals for the insane established during this period by others were run according to humanitarian perspectives.

Unfortunately, the moral treatment movement grew too fast. As more asylums were built and more people went into them, the capacity of the asylums to recruit mental health professionals and to maintain a humane, individual approach to each patient declined (Grob, 1994; Scull, 1993). The physicians, nurses, and other caretakers simply did not have enough time to give each patient the calm and dedicated attention needed. The fantastic successes of the early moral treatment movement gave way to more modest successes, and to many outright failures, as patients remained impaired or their condition worsened. Even some patients who received the best moral treatment could not benefit from it because their problems were not due to a loss of dignity or tranquility. With so many patients receiving moral treatment, the number of patients who failed to benefit from it increased, and questions about its effectiveness grew louder (Grob, 1994).

At the same time, the rapid pace of immigration into the United States in the late nineteenth century meant that an increasing percentage of its asylum patients were from different cultures and often from the lower socioeconomic classes. Prejudice against these "foreigners," combined with increasing attention to the failures of moral treatment, led to declines in public support for funding such institutions. Reduced funding led to even greater declines in the quality of care. At the turn of the twentieth century, many public hospitals were no better than warehouses (Grob, 1994; McGovern, 1985; Scull, 1993).

Effective treatments for most major mental health problems were not developed until well into the twentieth century. Until then, patients who could not afford private care were warehoused in large, overcrowded, physically isolated state institutions that did not offer treatment (Deutsch, 1937).

Philippe Pinel, a leader in the moral movement in France, helped free mental patients from the horrible conditions of the hospitals. *GL Archive/Alamy Stock Photo*

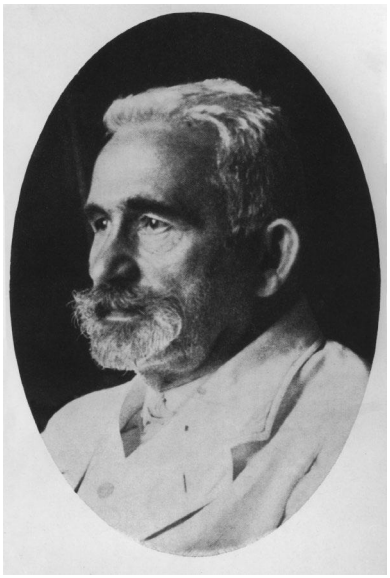
THE EMERGENCE OF MODERN PERSPECTIVES

Although the treatment of people who exhibited abnormal behavior unfortunately deteriorated at the turn of the twentieth century, this period of time also saw tremendous advances in the scientific study of disorders. These advances laid the groundwork for the biological, psychological, and social theories of abnormality that now dominate psychology and psychiatry.

Dorothea Dix fought for the moral treatment of mental patients in the United States. *Library of Congress Prints and Photographs Division [LC-USZ62-9797]*

The Beginnings of Modern Biological Perspectives

Basic knowledge of the anatomy, physiology, neurology, and chemistry of the body increased rapidly in the late nineteenth century. With the advancement of this basic knowledge came an increasing focus on biological causes of abnormality. In 1845, German psychiatrist Wilhelm Griesinger (1817–1868) published *The Pathology and Therapy of Psychic Disorders,* presenting a systematic argument that all psychological disorders can be



Emil Kraepelin (1856–1926) developed a classification system for mental disorders that remains influential today.
Hulton Archives/Getty Images

explained in terms of brain pathology. In 1883 one of Griesinger's followers, Emil Kraepelin (1856–1926), also published a text emphasizing the importance of brain pathology in psychological disorders. More important, Kraepelin developed a scheme for classifying symptoms into discrete disorders that is the basis for our modern classification systems (Kendler & Engstrom, 2016), as we will discuss in the chapter "Assessing and Diagnosing Abnormality." Having a good classification system gives investigators a common set of terms for various disorders, as well as, a set of criteria for distinguishing between them, contributing immensely to the advancement of the scientific study of the disorders.

One of the most important discoveries underpinning modern biological theories of abnormality was the discovery of the cause of **general paresis,** a disease that leads to paralysis, insanity, and eventually death (Duffy, 1995). In the mid-1800s, reports that patients with paresis also had a history of syphilis led to the suspicion that syphilis might be a cause of paresis. In 1897, Viennese psychiatrist Richard Krafft-Ebing injected paretic patients with matter from syphilitic sores. None of the patients developed syphilis, and Krafft-Ebing concluded that they must already have been infected with it. The discovery that syphilis is the cause of one form of insanity lent great weight to the idea that biological factors can cause abnormal behaviors (Duffy, 1995).

As we will discuss in more detail in the chapter "Theories and Treatment of Abnormality," modern biological theories of the psychological disorders have focused on the role of genetics, structural and functional abnormalities in the brain, and biochemical imbalances. The advances in our understanding of the biological aspects of psychological disorders have contributed to the development of therapeutic medications.

The Psychoanalytic Perspective

The development of psychoanalytic theory begins with the odd story of Franz Anton Mesmer (1734–1815), an Austrian physician who believed that people have a magnetic fluid in the body that must be distributed in a particular pattern in order to maintain health. The distribution of magnetic fluid in one person could be influenced by the magnetic forces of other people, as well as by the alignments of the planets. In 1778 Mesmer opened a clinic in Paris to treat all sorts of diseases by applying animal magnetism.

The psychological disorders that were the focus of much of Mesmer's treatment were the hysterical disorders, in which people lose functioning or feeling in some part of the body for no apparent physiological reason. His patients sat in darkness around a tub containing various chemicals, and the affected areas of their bodies were prodded by iron rods emerging from the tub. With music playing, Mesmer emerged wearing an elaborate robe, touching each patient as he passed by, supposedly realigning people's magnetic fluids through his own powerful magnetic force. This process, Mesmer said, cured illness, including psychological disorders.

Mesmer eventually was labeled a charlatan by a scientific review committee that included Benjamin Franklin. Yet his methods, known as **mesmerism,** continued to fuel debate long after he had faded into obscurity. The "cures" Mesmer effected in his psychiatric patients were attributed to the trancelike state that Mesmer seemed to induce in his patients. Later this state was labeled hypnosis. Under hypnosis, Mesmer's patients appeared very suggestible, and the mere suggestion that their ailments would disappear seemed enough to make them actually disappear.

The connection between hypnosis and hysteria fascinated several leading scientists of the time, although not all scientists accepted this connection. In particular, Jean Charcot (1825–1893), head of La Salpêtrière Hospital in Paris and the leading neurologist of his time, argued that hysteria (now known as *functional neurological symptom disorder*) was caused by degeneration in the brain. The work of two physicians practicing in the French town of Nancy, Hippolyte-Marie Bernheim (1840–1919) and Ambroise-Auguste Liebault (1823–1904), eventually won over Charcot, however. Bernheim and Liebault showed that they could induce the symptoms of hysteria, such as paralysis in an arm or the loss of feeling in a leg, by suggesting these symptoms to patients who were hypnotized. Fortunately, they could also remove these symptoms under hypnosis. Charcot was so impressed by the evidence that hysteria has psychological roots that he became a leading researcher of the psychological causes of abnormal behavior. The experiments of Bernheim and Liebault, along with the leadership of Charcot, did a great deal to advance psychological perspectives on abnormality.

One of Charcot's students was Sigmund Freud (1856–1939), a Viennese neurologist who went to study with Charcot in 1885. In the course of this work, Freud became convinced that much of the mental life of an individual remains hidden from consciousness. This view was further supported by

Freud's interactions with Pierre Janet (1859–1947) in Paris. Janet was investigating multiple personality disorder, in which people appear to have multiple, distinct personalities, each of which operates independently of the others, often not knowing the others exist (Matarazzo, 1985).

When he returned to Vienna, Freud worked with Josef Breuer (1842–1925), another physician interested in hypnosis and in the unconscious processes behind psychological problems. Breuer had discovered that encouraging patients to talk about their problems while under hypnosis led to a great upwelling and release of emotion, which eventually was called catharsis. The patient's discussion of his or her problems under hypnosis was less censored than conscious discussion, allowing the therapist to elicit important psychological material more easily.

Breuer and Freud collaborated on a paper published in 1893 as *On the Psychical Mechanisms of Hysterical Phenomena,* which laid out their discoveries about hypnosis, the unconscious, and the therapeutic value of catharsis. This paper proved to be a foundation stone in the development of **psychoanalysis,** the study of the unconscious. Freud introduced his ideas to America in 1909 in a series of lectures at Clark University in Worcester, Massachusetts, at the invitation of G. Stanley Hall, one of the founders of American psychology.

Freud wrote dozens of papers and books on his theory of psychoanalysis (discussed in detail in the chapter "Theories and Treatment of Abnormality"), and he became one of the best-known figures in psychiatry and psychology. The impact of Freud's theories on the development of psychology over the next century cannot be overstated. Freudian ideas not only influenced the professional literature on psychopathology but also are used heavily in literary theory, anthropology, and other humanities. They pervade popular notions of psychological processes to this day.

The Roots of Behaviorism

In what now seems like a parallel universe, while psychoanalytic theory was being born, the roots of behaviorism were being planted first in Europe and then in the United States. Ivan Pavlov (1849–1936), a Russian physiologist, developed methods and theories for understanding behavior in terms of stimuli and responses rather than in terms of the internal workings of the unconscious mind. He discovered that dogs could be conditioned to salivate when presented with stimuli other than food if the food was paired with these other stimuli—a process later called **classical conditioning.** Pavlov's discoveries inspired American John Watson (1878–1958) to study important human behaviors, such as phobias, in terms of classical conditioning (see the chapter "Obsessive-Compulsive, Trauma and Stressor-Related Disorders"). Watson rejected psychoanalytic and biological theories of abnormal behaviors such as phobias and explained them entirely on the basis of the individual's history of conditioning. Watson (1930) went so far as to boast that he could train any healthy child to become any kind of adult he wished:

> Give me a dozen healthy infants, well-formed, and my own specified world to bring them up in, and I'll guarantee to take any one at random and train him to be any type of specialist I might select—doctor, lawyer, artist, merchant-chief, and yes, even beggar-man and thief, regardless of his talents, penchants, tendencies, abilities, vocations, and the race of his ancestors (p. 104).

At the same time, two other psychologists, E. L. Thorndike (1874–1949) and B. F. Skinner (1904–1990), were studying how the consequences of behaviors shape their likelihood of recurrence. They argued that behaviors followed by positive consequences are more likely to be repeated than are behaviors followed by negative consequences. This process came to be known as operant, or instrumental, conditioning. This idea may seem simple to us now (one sign of how much it has influenced thinking over the past century), but at the time it was considered radical to argue that even complex behaviors, such as violence against others, can be explained by the reinforcement or punishment these behaviors have received in the past.

Behaviorism—the study of the impact of reinforcements and punishments on behavior—has had as profound an impact on psychology and on our common knowledge of psychology, as has psychoanalytic theory. Behavioral theories have led to many of the effective psychological treatments for disorders that we will discuss in this book.

The Cognitive Revolution

In the 1950s, some psychologists argued that behaviorism was limited in its explanatory power by its refusal to look at internal thought processes that mediate the relationship between stimulus and response. It wasn't until the 1970s that psychology shifted its focus substantially to the study of **cognitions.** Cognitions are thought processes—like attention, interpretation of events, and beliefs—that influence behavior and emotion. The cognitive revolution shifted perspectives toward such internal processes. An important pioneer in this cognitive revolution was Albert Bandura, a clinical psychologist trained in behaviorism who had contributed a

great deal to the application of behaviorism to psychopathology (see the chapters "Theories and Treatment of Abnormality" and "Obsessive-Compulsive, Trauma and Stressor-Related Disorders"). Bandura argued that people's beliefs about their ability to execute the behaviors necessary to control important events—which he called **self-efficacy beliefs**—are crucial in determining people's well-being. Again, this idea seems obvious to us now, but only because it took hold in both professional psychology and lay notions of psychology.

Another key figure in cognitive perspectives was Albert Ellis, who argued that people prone to psychological disorders are plagued by irrational negative assumptions about themselves and the world. Ellis developed a therapy for emotional problems based on his theory called rational-emotive therapy. This therapy was controversial because it required therapists to challenge, sometimes harshly, their patients' irrational belief systems. It became very popular, however, and moved psychology into the study of the thought processes behind serious emotional problems. Another therapy, developed by Aaron Beck, focused on the irrational thoughts of people with psychological problems. Beck's cognitive therapy has become one of the most widely used therapies for many disorders (see the chapter "Theories and Treatment of Abnormality"). Since the 1970s, theorists have continued to emphasize cognitive factors in psychopathology, although behavioral theories have remained strong as interpersonal theories, which we examine in the chapter "Theories and Treatment of Abnormality," have become more prominent.

MODERN MENTAL HEALTH CARE

Halfway through the twentieth century, major breakthroughs were made in drug treatments for some of the major forms of abnormality. In particular, the discovery of a class of drugs that can reduce hallucinations and delusions, known as the phenothiazines (see the chapter "Theories and Treatment of Abnormality"), made it possible for many people who had been institutionalized for years to be released from asylums and hospitals. Since then, there has been an explosion of new drug therapies for psychopathology. The biomedical approach has revolutionized the way we understand and treat mental disorders as biological phenomena. In addition, as we will discuss in the chapter "Theories and Treatment of Abnormality," several types of psychotherapy have been developed that have proven effective in treating a wide range of psychological problems. However, there are still significant problems in the delivery of mental health care, some of which began with the deinstitutionalization movement of the mid-twentieth century.

Deinstitutionalization

By 1960 a large and vocal movement known as the **patients' rights movement** had emerged. Patients' rights advocates argued that mental patients can recover more fully or live more satisfying lives if they are integrated into the community, with the support of community-based treatment facilities—a process known as **deinstitutionalization.** While many of these patients would continue to need around-the-clock care, it could be given in treatment centers based within the community rather than in large institutions where conditions were often poor. In the United States, the **community mental health movement** was officially launched in 1963 by President John Kennedy as a "bold new approach" to mental health care. *The Mental Retardation Facilities and Community Mental Health Center Construction Act* (1963) promoted the release of psychiatric patients from long-term care facilities to short-term and community mental health centers. A direct result of this legislation resulted in the mass closures of psychiatric institutions and long-term care facilities across the United States. The goal of this movement was to offer less restrictive, more humane treatment options and provide coordinated mental health services to people in **community mental health centers,** a move that had both positive and negative consequences.

The deinstitutionalization movement had a massive effect on the lives of people with serious psychological problems. Between 1955 and 2016, the number of patients in state psychiatric hospitals in the United States declined from a high of 559,000 to about 38,000 despite overall population growth, resulting in a rate lower than that before the moral treatment movement (Allison et al., 2018; Fuller, Sinclair, Geller, Quanbeck, & Snook, 2016; Lamb & Weinberger, 2016). Parallel trends were also seen in Europe. Many former psychiatric patients who lived for years in cold, sterile facilities, receiving little useful care, experienced improvements in their quality of life upon their release. Most importantly, these clients were now able to integrate back into the community with support services in place. Rather than living in highly restrictive conditions, deinstitutionalization promoted community-based interventions and better quality of life for those with mental illness.

Several types of community-based treatment facilities were created as part of deinstitutionalization and continue to serve people with mental health problems today. Community mental health centers often include teams of social workers, therapists, and physicians

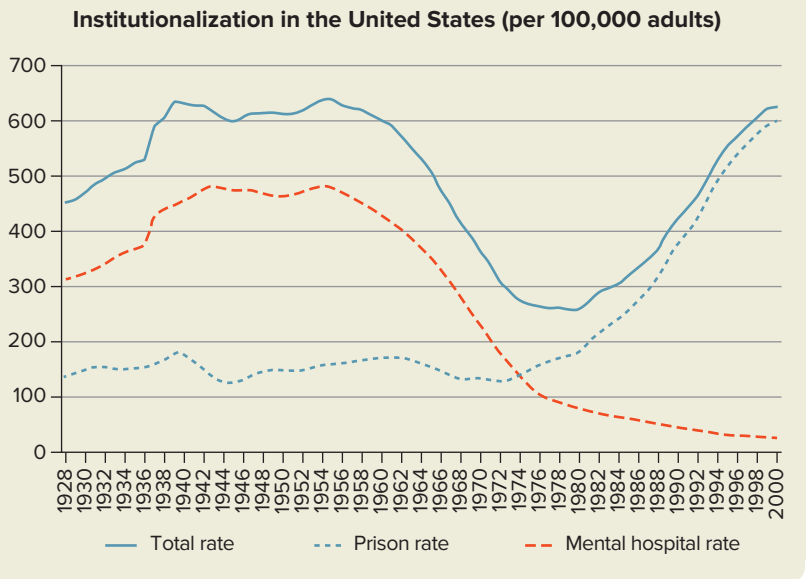
who coordinate care for services within the community, rather than long-term inpatient hospitals. **Halfway houses** offer people with long-term mental health problems the opportunity to live in a structured, supportive environment as they try to reestablish working relationships with family and friends. **Day treatment centers,** which are also known as partial hospitalization programs (PHP), provide more intensive therapy to those in need. Clients in these programs receive approximately 25 hours of psychiatric, occupational, and rehabilitative therapies during the day while residing at home during recovery. These programs are less intensive than inpatient or residential programs, in which participants live at the treatment facility. There are a variety of treatment sites which offer varying levels of care for people in need (Khawaja & Westermeyer, 2010; Ruffalo, 2018).

While the goal is to provide the least restrictive methods of care to those with mental illness, there are times in which hospitalization is necessary. People who experience acute psychiatric symptoms that require hospitalization may go to inpatient units of general hospitals or specialized psychiatric hospitals for treatment. Unlike institutionalization, inpatient hospitalizations are considerably shorter. The average length of stay for an inpatient psychiatric admission is approximately 3 to 10 days. Once their acute problems have subsided, however, they often are released back to a community-based treatment center to continue their care, rather than remaining in a psychiatric hospital. Brief hospitalizations, referred to as *micro-admissions,* and the practice of short-term care reflects one goal of deinstitutionalization, but it has also led to a less effective treatment with poor outcomes for many clients. In reality, the effective treatment of serious mental health issues require time. These brief hospitalizations are often not long enough for treatment to begin working before the client is released. Many of the chronically ill are hospitalized and rehospitalized every few weeks which has created a revolving door within acute crisis and inpatient units (Ruffalo, 2019; Allison et al., 2018).

The results of community mental health movement have significantly impacted the treatment methods for those with psychological disorders in both positive and negative ways. Deinstitutionalization was designed to enhance the quality of life for people in public psychiatric hospitals, but in reality many people left institutions only to find a life of poverty and neglect on the outside due, in part, to underfunding of community mental health programs. Although deinstitutionalization was well intended, it has been criticized for failing to live up to its expectations. Unfortunately, the resources to care for all the psychiatric patients released from institutions have never been adequate. There were not enough halfway houses built or community mental health centers funded to serve the thousands of men and women who formerly were institutionalized or would have been institutionalized if the movement had not taken place (Figure 1). Meanwhile, the state psychiatric hospitals to which former patients would have retreated were closed down by the hundreds. The community mental health movement spread to Europe, with similar consequences. Twenty-eight percent of European countries have few or no community-based services for people with serious mental health problems (Semrau, Barley, Law, & Thornicroft, 2011; WHO World Mental Health Survey Consortium, 2004).

Men and women released from psychiatric institutions began living in nursing homes and other types of group homes, where they received little mental health treatment, or with their families, many of whom were unprepared to handle the challenges of serious mental illness (Lamb & Weinberger, 2016). An unforeseen consequence of deinstitutionalization, was the significant increase in homelessness among discharged psychiatric patients. Certainly not all homeless people are mentally ill, but according to the White House Council of Economic Advisors (2019), 20 percent (111,122 people) of the homeless in the United States had a severe mental illness (SMI) and 86,647 homeless people (16 percent) suffered from chronic substance abuse.

FIGURE 1 **As Deinstitutionalization Led to Fewer People in Mental Hospitals, Incarceration Rates in Prisons Increased Dramatically.** Many observers believe that prisons serve as de facto institutionalization of individuals with mental illness who would previously have been served by mental health facilities.



Although estimates of the prevalence of mental illness vary, studies examining mental illness in the homeless population have generally found a high prevalence of psychological disorders. Various research studies suggest that approximately 20 to 50 percent of the homeless population suffer from SMI and the most common disorders may be alcohol and drug dependence (Balasuriya, Buelt, & Tsai, 2020; Center for Substance Abuse Treatment, 2013; Tinland et al., 2020). Some researchers estimate that up to four-fifths of all long-term homeless adults in the United States and Europe have a major mental disorder, a severe substance use disorder (such as alcohol use disorder), or both (WHO World Mental Health Survey Consortium, 2004). Homelessness and mental illness are intricately connected, and each contributes to the existence of the other. This reciprocal phenomenon forces victims to live in a vicious cycle from which an escape is difficult. People with SMI across the world may become homeless as a direct result of the symptoms of their illness, or as the consequence of eroded social and economic networks, or both. In turn, the experience of homelessness can both precipitate and exacerbate symptoms of mental illness (Moorkath, Vranda, & Naveenkumar, 2018; Smartt et al., 2019).

Deinstitutionalization resulted in the closures of most US public psychiatric hospitals and the reduction in acute general psychiatric beds over recent decades which directly impacts the amount of services available today. These closures have led to a crisis in mental health treatment, as the overall inpatient capacity has not kept pace with the needs of patients with psychiatric disorders (Bastiampillai, Sharfstein, & Allison, 2016). Due to the lack of accessible treatment, many people with SMI may end up in hospitals for short periods of time which operate at a reduced capacity and may not be able to provide adequate treatment. Alternatively, people with mental illness often become part of the criminal justice system.

Unprecedented numbers of people with mental illness are now housed in jails and prisons throughout the United States and around the world in lieu of more humane and appropriate facilities in which to treat them (Bastiampillai et al., 2016; Haney, 2017; Lamb & Weinberger, 2017). Across the United States, correctional facilities are struggling with the reality that they have become the nation's de facto mental health care providers, even though these facilities are ill equipped for the job. The prison system has replaced psychiatric hospitals as the largest institutions housing people with SMI. The criminal justice system now contends with tens of thousands of people with mental illness who, by some counts, make up as much as half of their inmate populations (Roth, 2018). Despite the good intentions of deinstitutionalization, people with SMI are being transinstitutionalized to the criminal justice system. This limited access to inpatient treatment is also associated with higher suicide risk, premature mortality, homelessness, violent crime, and incarceration. People with mental illness are among the most disadvantaged members of our society, and when they end up in the criminal justice system, they tend to fare worse than others (Allison et al., 2018).

Studies of prison inmates suggest that two-thirds had experienced some form of diagnosable mental disorder in their lifetime. Serious mental illness affects men and women in jail at rates four to six times higher than in the general population and 60 percent of jail inmates reported having had symptoms of a mental health disorder in the 12 months prior to incarceration. Despite these high rates of psychological disorders among inmates, 83 percent did not receive mental health care after admission, according to recent studies (Heis, Swavola, & Kang-Brown, 2015; Trestman, Ford, Zhang, & Wiesbrock, 2007).

Thus, although deinstitutionalization began with commendable goals designed to enhance the lives of people with psychological disorders, many of these goals were never fully reached. As a result, deinstitutionalization impacted the mental health care system in profound ways that have not adequately served a majority of people with mental illness. In recent years, the financial strains on local, state, and federal governments have led to the closing of many community

Deinstitutionalization led to a rise in homelessness among people with mental illnesses, who often go untreated.
mikeledray/Shutterstock

mental health centers which has led to less effective and humane care for those in need of mental health services. The overarching goal for those reading this book, who hope to become part of this system, must be to help create a new and better mental health care system that provides comprehensive and appropriate levels of care for people with psychological disorders.

Managed Care

The entire system of private insurance for health care in the United States underwent a revolution in the second half of the twentieth century, when managed care emerged as the dominant means for organizing health care. **Managed care** is a collection of methods for coordinating care that ranges from simple monitoring to total control over what care can be provided and paid for. The goals are to coordinate services for an existing medical problem and to prevent future medical problems. Often, health care providers are given a set amount of money per member (patient) per month and then must determine how best to serve each patient.

Managed care can address some of the problems created by deinstitutionalization. For example, instead of leaving it up to people with a serious psychological problem, or their families, to find appropriate care, the primary provider might find this care and ensure that patients have access to it. Suppose an individual patient reported to his physician that he was hearing voices when no one was around. The physician might refer the patient to a psychiatrist for an evaluation to determine if the patient might be suffering from schizophrenia. In some cases, the primary care physician might coordinate care offered by other providers, such as drug treatments, psychotherapy, and rehabilitation services. The primary provider also might ensure continuity of care so that patients do not "fall through the cracks." Thus, theoretically, managed care can have tremendous benefits for people with long-term, serious mental health problems. For people with less severe psychological problems, the availability of mental health care through managed care systems and other private insurance systems has led to a large increase in the number of people seeking psychotherapy and other types of mental health care.

In the past, there was a significant disparity for those who needed mental health care as compared to those in need to traditional medical care. Even now, depending upon one's insurance coverage, mental health services many not be fully covered by insurance plans, and many people do not have health insurance in the United States. Laws have been passed in recent years that are intended to increase the availability of coverage for mental health services, but these laws are currently being contested. The Affordable Care Act (ACA), passed in 2010, requires insurance plans to cover mental health and substance abuse treatment, and acknowledges the increasing role of primary care providers in psychiatric treatment. The ACA expanded mental health care access in the United States for those already insured, and it is estimated that millions of severely mentally ill people will newly acquire coverage. Prior to the ACA, most behavioral health insurance benefits were separate and unequal compared with benefits for treatment of general medical and surgical conditions. Lack of equity raised the risk of bankruptcy or financial hardship due to mental health expenditures (Druss & Goldman, 2018; Mechanic & Olfson, 2016). However, the current mental health system has yet to fully adjust to sweeping changes, and health care policy remains a complex, controversial, and shifting political territory with clear implications for people with mental disorders. Mental health services are expensive. Because mental health problems are sometimes chronic, mental health treatment can take a long time.

CASE STUDY

Khloe needs long-term care

Fifty-four-year-old, Khloe has a long history psychological dysfunction that has resulted in multiple hospitalizations throughout her adult life. Since her early twenties, Khloe has battled severe symptoms of major depressive disorder that have significantly disrupted her ability to function. Khloe would often engage in self-injury and suicide attempts during depressive episodes, which routinely put her life in danger. As a young adolescent who lacked appropriate coping skills, Khloe would often engage in self-harm, such as cutting her thighs and upper arms, when she felt emotionally unstable. Upon her recent admission to the psychiatric crisis unit of the local hospital, Khloe had attempted suicide by drinking small amounts of a household cleaning product and cut both wrists. This attempt was serious enough to require sutures on her wrists and the contents of her stomach to be pumped out to save her life.

When assessed by the psychiatric crisis team, Khloe reported that she had intended to end her life due to the depressive feelings she was experiencing and if given the opportunity to leave the hospital she would "finish the job" and attempt suicide again. Due to the severity of her symptoms and concern about her safety, the psychiatric crisis team recommended that Khloe be admitted for inpatient treatment. During her assessment in the crisis unit, Khloe expressed

(*continued*)

the desire to improve, despite her suicidal ideation, and agreed to go into the hospital for help. During the process to admit her for inpatient services, the screener was unable to get insurance authorization for her care since she had already been hospitalized that year. Khloe's insurance provider suggested that she be placed in an outpatient program, rather than the intensive inpatient treatment she needed. Despite the insurance company's request, Khloe received inpatient treatment for major depression and suicidal ideation.

After 8 days of treatment, Khloe was released from the hospital and referred to an intensive outpatient clinic to continue her therapy and manage her medication. While Khloe did improve during her inpatient stay, she was not fully stabilized before she left the program and shortly after her discharge, she stopped taking her medication and slipped further into a depressive episode. Within only a few weeks of her last visit to the psychiatric crisis unit, Khloe returned after another suicide attempt. However, during this attempt, Khloe ingested large amounts of household cleaning products which caused extensive internal damage resulting in multi-system organ failure. Despite best interventions, the injury inflicted was too serious for her recover.

Since deinstitutionalization was passed, there are many people in need of long-term mental health care. In an effort to reduce restrictive care for many, a system of short-term care was created that does not always adequately address the needs of people living with serious mental illness, like Khloe.

The Medicaid program, which covers one-quarter of all mental health care spending in the United States, has been a target for reductions in recent years, even as the number of people seeking mental health care has risen. Many states have reduced or restricted eligibility and benefits for mental health care, increased co-payments, controlled drug costs, and reduced or frozen payments to providers (Shirk, 2008). At the same time, reductions in state and city welfare programs and other community services targeted at the poor have made daily life more difficult for poor people in general, and in particular for people with serious mental disorders, who often have exhausted their financial resources. In the Medicaid managed care context, states have employed various tools to promote equal access to treatment for mental illness including benefit mandates, risk adjustment, insurance coverage appeals, reporting requirements, and behavioral health carve-outs. Careful assessment, development, and implementation of such tools is essential in addressing undertreatment for behavioral health issues, including mental illness and substance use disorder (Lawrence, 2020).

Mental illnesses, including substance use disorder, routinely go untreated or undertreated, with tragic results. Research suggests that a substantial number of adults with psychological disorders do not receive treatment for their condition, despite overall increases in the rates of treatment in the past 20 years. The National Comorbidity Survey Replication (2015), reported that only 33 percent of adults with any mental illness and 41 percent of adults with serious mental illness reported receiving mental health treatment in the previous year. People who are less likely to receive treatment tend to be male, Black or Hispanic, younger, uninsured, and of low socioeconomic status (Walker et al., 2015). Other studies suggest that only 50 to 60 percent of people in the United States with serious psychological problems receive stable mental health treatment, with much lower percentages receiving care in less-developed and poorer countries (Kessler et al., 2001; Lawrence, 2020; Wang et al., 2007). For example, in wealthier countries in Europe, such as Finland and Belgium, have more than 20 mental health experts per 100,000 people, whereas poorer countries such as Turkey and Tajikistan have fewer than 2 mental health experts per 100,000 people (Semrau et al., 2011).

Low rates of treatment and unmet needs are persistent among adults with mental illness. Sometimes, people refuse care that might help them, but other times they fall through holes in the health care safety net because of bureaucratic rules designed to shift the burden of mental health care costs from one agency to another, as in the case of Khloe. Recent research suggests that there are many barriers to mental health treatment which include structural barriers, such as cost, lack of insurance or insufficient coverage for services, and not knowing where to go for help or not being able to get an appointment, and attitudinal barriers, such as perceived stigma and perceiving treatments to be ineffective (Walker et al., 2015).

It is also important to consider subpopulations at risk for not receiving mental health treatment. Studies suggest that Black and Hispanic respondents were less likely than non-Hispanic Whites to receive treatment. Regardless of insurance status, there are differences among racial groups in terms of seeking out treatment. Distrust of health care providers, low perceived efficacy of treatment, internalized stigma of mental disorders, and loss of income due to taking time off from work for appointments are key reasons among minorities for not seeking mental health treatment. Culturally tailored interventions may be helpful in overcoming barriers to mental health services. In order to improve access to mental health services, additional strategies to reduce both structural barriers,

such as cost and insurance coverage, and attitudinal barriers are needed (Walker et al., 2015).

As we discuss the research showing the effectiveness of various treatments for specific disorders throughout the remainder of the book, it is important to keep in mind that those treatments can work only if people have access to them.

Professions Within Abnormal Psychology

There are a number of professional opportunities for those interested in working to improve the quality of life for people with psychological disorders. *Psychiatrists* have an MD degree and have received specialized training in the treatment of psychological disorders. This medical doctor could have become a cardiologist, for example, but selected psychiatric medicine as a specialty. Psychiatrists can prescribe medications for the treatment of these problems and have been trained to conduct psychotherapies as well.

Clinical psychologists typically have a PhD in psychology, with a specialization in treating and researching psychopathology. Another option is a PsyD degree which is a doctoral degree from a graduate program that emphasizes clinical training more than research training. Clinical psychologists conduct various forms of psychotherapy, but in most states they do not currently prescribe medications. (They do have limited prescription privileges in some states, and psychologists are lobbying for prescription privileges in many others.)

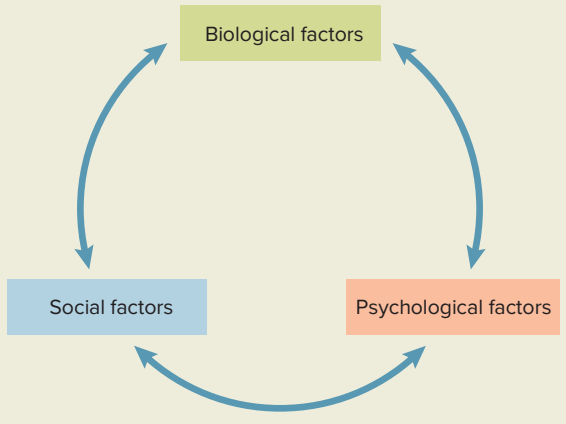
There are many master's-level career options which include *marriage and family therapists (MFT)* who specialize in helping families, couples, and children overcome problems that are interfering with their well-being. *Clinical social workers* have a master's degree in social work (MSW) and often focus on helping people with psychological problems overcome social conditions that are contributing to their problems, such as joblessness or homelessness. Some states have *licensed mental health counselors,* individuals who have graduate training in counseling beyond the bachelor's degree in counseling but have not obtained a PhD. These professionals have completed required course work and passed a licensing exam. *Psychiatric nurses* have a degree in nursing, with a specialization in the treatment of people with severe psychological problems. They often work on inpatient psychiatric wards in hospitals, delivering medical care and certain forms of psychotherapy, such as group therapy to increase patients' contacts with one another. In some states, they have privileges to write prescriptions for psychotherapeutic drugs.

Each of these professions has its rewards and limitations. Students who are interested in one or more of these professions often find it helpful to volunteer as a research assistant in studies of psychological problems or for work in a psychiatric clinic or hospital. Some students find tremendous gratification working with people with psychological problems, whereas others find it more gratifying to conduct research that might answer important questions about these problems. Many mental health professionals of all types combine clinical practice and research in their careers.

CHAPTER INTEGRATION

Although the biological, psychological, and social theories of abnormality have traditionally been viewed as competing with one another to explain psychological disorders, many clinicians and researchers now believe that theories that integrate biological, psychological, and social perspectives on abnormality will prove most useful (Figure 2). For example, in the chapter "Obsessive-Compulsive, Trauma and Stressor-Related Disorders," we discuss theories of anxiety disorders that take into account individuals' genetic and biochemical vulnerabilities, the impact of stressful events, and the role of cognition in explaining why some people suffer debilitating anxiety. Throughout this book, we will emphasize how biological, psychological, and social factors interact with and influence one another to produce and maintain mental health problems. In other words, we will present an integrationist approach to psychological problems.

FIGURE 2 **The Integrationist Approach to Understanding Mental Health.** Many mental health theories today strive to integrate biological, psychological, and social factors in understanding mental health issues. This integrationist approach will be emphasized in this book.



SHADES OF GRAY DISCUSSION

Our society highly values extreme thinness in women, and Jennifer has received substantial reinforcement for her weight loss. Thus, we see her behaviors as not very deviant. Her dieting causes her some dysfunction and distress: She is having trouble concentrating in school and is terrified of gaining weight. But her weight loss is also bringing her social benefits. Are her behaviors dangerous? Extremely thin women risk medical complications such as reduced bone density and heart arrhythmias (see the chapter "Eating Disorders"). So Jennifer's behaviors are somewhat dysfunctional, distressing, and dangerous, but they are so typical of women her age that people will differ in whether they believe her behaviors qualify as abnormal.

Mark's behaviors also seem familiar, because drinking is considered a "rite of passage" by some students. Mark drinks considerably more than most young men (see the chapter "Substance Use and Gambling Disorders"), so his level of drinking is deviant. He also has experienced some dysfunction as a result of his drinking: He has gotten in legal trouble and his grades are low. Mark certainly doesn't seem distressed about his drinking. Mark's behaviors are dangerous: He is more likely to be involved in accidents while drunk and risks alcohol poisoning from the volume he consumes. So Mark's behaviors might be considered more abnormal than Jennifer's behaviors, but people will differ on the degree of abnormality.

Would your judgments of the abnormality of these behaviors change if it were Jennifer who was drinking heavily and Mark who was dieting excessively to lose weight? Cultural norms for thinness and for drinking alcohol differ significantly for women and men. Gender strongly influences our views of normality and abnormality.

CHAPTER SUMMARY

- Cultural relativists argue that the norms of a society must be used to determine the normality of a behavior. Others have suggested that unusual behaviors, or behaviors that cause subjective distress in a person, should be labeled abnormal. Still others have suggested that only behaviors resulting from mental illness or disease are abnormal. All these criteria have serious limitations, however.
- The current consensus among professionals is that behaviors that cause a person to suffer distress, prevent him or her from functioning in daily life, are unusual or deviant, and pose a threat to the person or others are abnormal. These criteria can be remembered as the four Ds: dysfunction, distress, deviance, and dangerousness. Abnormal behaviors fall along a continuum from adaptive to maladaptive, and the location of the line designating behaviors as disordered is based on a subjective decision.
- Historically, theories of abnormality have fallen into one of three categories. Biological theories saw psychological disorders as similar to physical diseases, caused by the breakdown of a system of the body. Supernatural theories saw abnormal behavior as a result of divine intervention, curses, demonic possession, and personal sin. Psychological theories saw abnormal behavior as being a result of stress.
- In prehistoric times, people probably had largely supernatural theories of abnormal behavior, attributing it to demons or ghosts. In the Stone Age, drilling holes in the skull to allow demons to depart, a procedure known as trephination, might have been a treatment for abnormality.
- Ancient Chinese, Egyptian, and Greek texts suggest that these cultures took a biological view of abnormal behavior, although references to supernatural and psychological theories also can be found.
- During the Middle Ages, abnormal behavior may have been interpreted as being due to witchcraft.
- In psychic epidemics and mass hysterias, groups of people show similar psychological and behavioral symptoms. Usually, these have been attributed to common stresses or beliefs.
- Even well into the nineteenth and twentieth centuries, many people who acted abnormally were shut away in prisonlike conditions, tortured, starved, or ignored.
- As part of the mental hygiene movement, the moral management of mental hospitals became more widespread. Patients in these hospitals were treated with kindness and given the best biological treatments available. However, effective biological treatments for most psychological problems were not available until the mid-twentieth century.
- Modern biological perspectives on psychological disorders were advanced by Kraepelin's development of a classification system and the discovery that general paresis is caused by a syphilis infection.

- The psychoanalytic perspective began with the work of Anton Mesmer. It grew as Jean Charcot, and eventually Sigmund Freud, became interested in the role of the unconscious in producing abnormality.
- Behaviorist views on abnormal behavior began with John Watson and B. F. Skinner, who used principles of classical and operant conditioning to explain normal and abnormal behavior.
- Cognitive theorists such as Albert Ellis, Albert Bandura, and Aaron Beck focused on the role of thinking processes in abnormality.
- The deinstitutionalization movement attempted to move mental patients from mental health facilities to community-based mental health centers. Unfortunately, community-based mental health centers have never been fully funded or supported, leaving many former mental patients with few resources in the community.
- Managed care systems are meant to provide coordinated, comprehensive medical care to patients. They can be a great asset to people with long-term, serious psychological disorders.
- The professions within abnormal psychology include psychiatrists, psychologists, marriage and family therapists, clinical social workers, licensed mental health counselors, and psychiatric nurses.

KEY TERMS

continuum model of abnormality
psychopathology
stigma
cultural relativism
biological theories
supernatural theories
psychological theories
trephination
psychic epidemics
mental hygiene movement
moral treatment
general paresis
mesmerism
psychoanalysis
classical conditioning
behaviorism
cognitions
self-efficacy beliefs
patients' rights movement
deinstitutionalization
community mental health movement
community mental health centers
halfway houses
day treatment centers
managed care

Chapter 2

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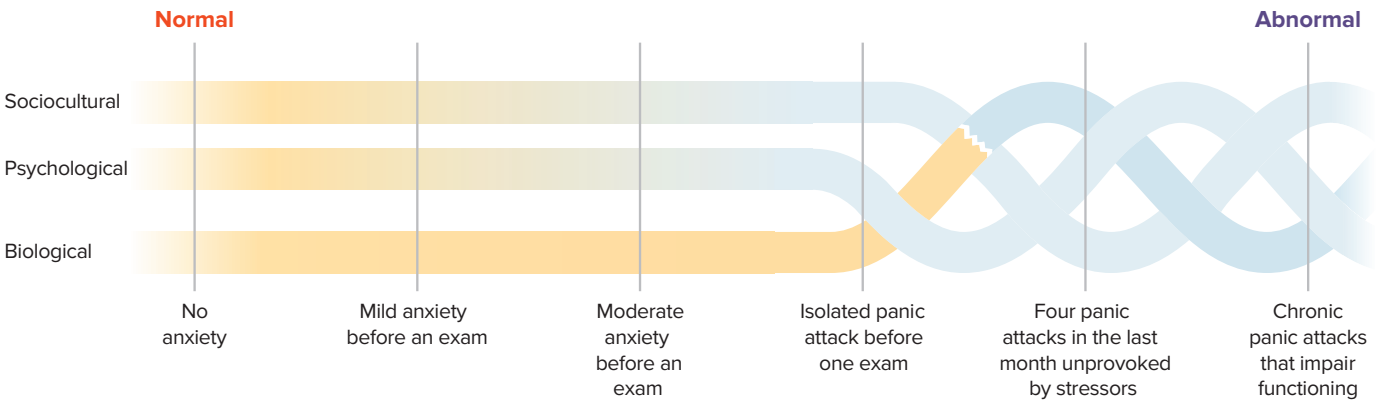
Theories and Treatment of Abnormality

CHAPTER OUTLINE

Approaches Along the Continuum



In this chapter, we discuss three general approaches to understanding psychological disorders. The **sociocultural approach** views these disorders as the result of environmental conditions and cultural norms. The **biological approach** views disorders as the result of abnormal genes or neurobiological dysfunction. The **psychological approach** views disorders as the result of thinking processes, personality styles, emotions, and conditioning.

People who favor a sociocultural approach generally view psychological disorders as falling along a continuum because they do not view these disorders as vastly different from normal functioning. Instead, they think of psychological disorders as labels that society puts on people whose behaviors and feelings differ from social and cultural norms (Chu & Leino, 2017). While they agree that these behaviors may be dysfunctional, distressing, deviant, and dangerous, they see them as understandable consequences of social stress in the individuals' lives.

A decade ago, proponents of the biological approach generally did not accept a continuum model of abnormality. Instead, they viewed psychological disorders as either present or absent—much the way they viewed medical or physical disorders (such as cancer). In recent years, however, proponents of biological approaches have embraced a continuum perspective on abnormality, seeing disorders as collections of deficits in fundamental neurobiological processes (Beauchaine & Constantino, 2017; Cuthbert & Insel, 2013; Hyman, 2010). For example, the symptoms of schizophrenia are increasingly viewed as problems in cognition and emotional processing that are due to deficits in specific areas of the brain. These problems in cognition and emotional processing can range from very mild to very severe, causing symptoms that also vary along a continuum from mild to severe. In other words, a person can have "a little bit of schizophrenia" or can exhibit significantly more symptoms, to the point of qualifying for a diagnosis of schizophrenia.

Psychological approaches to disorders have also been moving toward a continuum model of psychopathology in recent years (Clark, Cuthbert, Lewis-Fernández, Narrow, & Reed, 2017). According to these approaches, psychological processes such as cognition, learning, and emotional control also fall along a continuum that ranges from very typical to highly dysfunctional. Minor learning difficulties, for example, would be placed on the more "typical" end of the continuum, and severe intellectual disabilities on the "dysfunctional" end. Likewise, problems in emotional control might range from feeling blue (typical) to feeling severely depressed with suicidal intentions (dysfunctional). A continuum perspective would suggest that people on the less severe end of the spectrum (who do not meet the criteria for the disorder) give us insight into the behavior of those on the more severe end (those who do meet the criteria).

As we discuss in this chapter, the sociocultural, biological, and psychological approaches are increasingly being integrated into a biopsychosocial approach to mental disorders. This integrative approach suggests that factors along the continua of biological dysfunction, psychological dysfunction, and sociocultural risks interweave to create the problems we call mental disorders.

Extraordinary People

Steven Hayes

Photo by Drew Altizer, Courtesy of Steven C. Hayes

Sitting in a faculty meeting in the Psychology Department at the University of North Carolina at Greensboro, assistant professor Steven Hayes opened his mouth to make a point and found himself unable to utter a sound. His heart began racing, and he thought he might be having a heart attack. He was only 29. The episode passed, but a week later he had a similar experience in another meeting. Over the next 2 years, his attacks of absolute panic became more frequent and began dominating his life. He had great difficulty lecturing and couldn't be in an enclosed place, such as a movie theater or an elevator, without being engulfed with anxiety. He thought his career and his life were over.

Now, nearly 30 years later, Hayes is a full professor at the University of Nevada and one of the most accomplished psychologists in the field, with over 300 published articles. Hayes says that he didn't overcome his debilitating anxiety with medications or with any of the psychotherapies prominent in the 1980s, when he was suffering the most. Instead, he learned to accept that he would have anxiety attacks and to stop fighting them. Out of his experiences, he developed a new form of psychological therapy, called *acceptance and commitment therapy* or *ACT.* This therapy teaches individuals with psychological problems to be more accepting and compassionate toward themselves, to commit to their values, and to use meditation practices that help them live more in the present moment. ACT is one of the hottest of the *third-wave approaches* to psychotherapy, which we discuss later in this chapter.

Steven Hayes was able to integrate his personal experiences with his training in psychology to develop a new theory and therapy of his own. A **theory** is a set of ideas that provides a framework for asking questions about a phenomenon and for gathering and interpreting information about that phenomenon. A *therapy* is a treatment, usually based on a theory of a phenomenon, that addresses those factors the theory says cause the phenomenon.

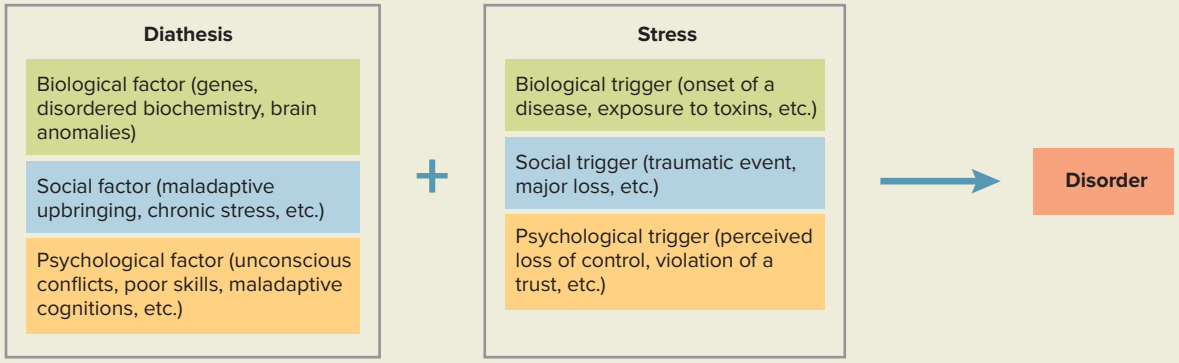
Hayes believed that his anxiety attacks were due to the inability to accept his symptoms, but other theories suggest alternative causes. If you took a biological approach to abnormality, you would suspect that Hayes' symptoms were caused by a biological factor, such as a genetic vulnerability to anxiety, inherited from his parents. The psychological approach, like Hayes' approach, looks for the causes of abnormality in people's beliefs, life experiences, and relationships. Finally, if you took a sociocultural approach, you would consider the ways Hayes' cultural values or social environment might affect his anxiety.

Traditionally, these different approaches have been seen as incompatible. People frequently ask, "Is the cause of these symptoms biological *or* psychological *or* environmental?" This question is often called the nature-nurture question: Is the cause of psychological problems something in the nature or biology of the person, or is it in the person's nurturing or history of events to which the person was exposed? This question implies that such problems must have a single cause, rather than multiple causes. Indeed, most theories of psychological problems over history have searched for the one factor—the one gene, the one traumatic experience, the one personality trait—that causes people to develop a particular set of symptoms.

Many contemporary theorists, however, take a **biopsychosocial approach,** recognizing that the development of psychological symptoms often results from a combination of biological, psychological, and sociocultural factors. These factors are often referred to as *risk factors,* because they increase the risk of psychological problems. Risk factors can be biological, such as a genetic predisposition. They may also be psychological, such as difficulty remaining calm in stressful situations. Or they may be sociocultural, such as growing up with the stress of discrimination based on ethnicity or race.

Certain risk factors may lead to specific types of symptoms; for example, a specific gene, known as DISC1, appears to substantially increase the risk of developing schizophrenia, bipolar disorder, and depression. However, there is some debate among researchers about its significance as a proven etiological

FIGURE 1 **The Diathesis-Stress Model of the Development of Disorders.** According to the diathesis-stress model, the creation of a disorder requires both an existing diathesis to a disorder and a trigger, or stress.



factor (Cannon et al., 2005; Sullivan, 2013; Thompson et al., 2013). More commonly, however, risk factors create increased risk for a number of different problems. For instance, severe stress, such as being the victim of childhood abuse, is associated with increased risk of developing a wide range of psychopathologies (Keyes et al., 2012). Factors that increase risk for multiple types of psychological problems are referred to as *transdiagnostic risk factors* (Krueger, & Eaton, 2015; Nolen-Hoeksema & Watkins, 2011). We will discuss several biological, psychological, and sociocultural transdiagnostic risk factors in this book.

In many cases, a risk factor may not be enough to lead a person to develop severe psychological symptoms. It may take some other experience or trigger for psychopathology to develop. Again, this trigger can be biological, such as an illness that changes a person's hormone levels. Or the trigger can be psychological or social, such as a traumatic event. Only when the risk factor and the trigger or stress come together in the same individual does the full-blown disorder emerge. This situation is often referred to as a **diathesis-stress model** (*diathesis* is another term for risk factor) (Figure 1). Although Hayes may indeed have had a genetic or personality vulnerability to anxiety (his diathesis), it may have been only when he experienced particular stressors that he developed significant anxiety.

Each of the different approaches to abnormality has led to treatments meant to relieve the symptoms people suffer. Proponents of biological theories of mental disorders most often prescribe medication, although several other types of biological treatments are discussed in this book. Proponents of psychological and some sociocultural approaches to abnormality most often prescribe psychotherapy. There are many forms of psychotherapy, but most involve a therapist (psychiatrist, psychologist, clinical social worker, or counselor) talking with the person suffering from psychological problems (typically called a patient or client) about their symptoms and what is contributing to these symptoms. The specific topic of these conversations depends on the therapist's theoretical approach. Both medications and psychotherapy have proven effective in the treatment of many types of psychological symptoms. Medications and psychotherapy are often used together in an integrated approach, although use of medications alone has increased in recent years (Weissman & Cuijpers, 2017). Proponents of sociocultural approaches also may work to change social policies or the social conditions of vulnerable individuals so as to improve their mental health.

In this chapter, we introduce the major theories of abnormality that have dominated the field in its modern history, along with the treatments that derive from these theories. We present the theories and treatments one at a time to make them easier to understand. Keep in mind, however, that most mental health professionals now take an integrated biopsychosocial approach to understanding mental health problems, viewing them as the result of a combination of biological, psychological, and social risk factors and stresses that come together and feed off one another. We will discuss these integrated biopsychosocial approaches throughout this book.

BIOLOGICAL APPROACHES

Consider the story of Phineas Gage, one of the most dramatic examples of the effect of biological factors on psychological functioning.

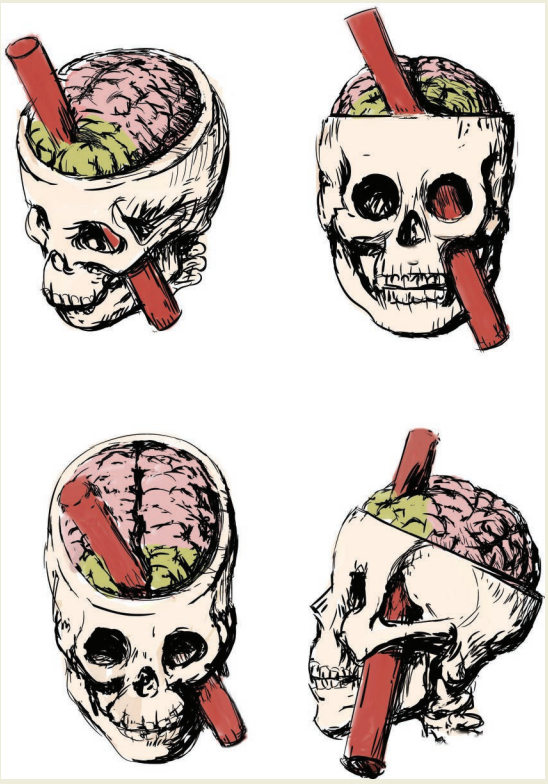
CASE STUDY

On September 13, 1848, Phineas P. Gage, a 25-year-old construction foreman for the Rutland and Burlington Railroad in New England, became the victim of a bizarre accident. On the fateful day, an accident led to a powerful explosion that sent a fine-pointed tamping iron which was 3½ feet long, 1.25 inches in diameter, and weighing 13 lbs, hurling, rocketlike, through Gage's face, skull, and brain. The force of the explosion caused the tamping iron to rocket out of the top of Phineas' skull landing about 80 feet away. Gage was momentarily stunned but regained full consciousness immediately after. He was able to talk and even walk with the help of his men.

Phineas Gage not only survived the momentous injury, in itself enough to earn him a place in the annals of medicine, but he survived as a different man. Gage had been a responsible, intelligent, and socially well-adapted individual, a favorite with peers and elders. He had made progress and showed promise. The signs of a profound change in personality were already evident during his convalescence under the care of his physician, John Harlow. But as the months passed, it became apparent that the transformation was not only radical but difficult to comprehend. In some respects Gage was fully recovered. He remained as able-bodied and appeared to be as intelligent as before the accident, he had no impairment of movement or speech, new learning was intact, and neither memory nor intelligence in the conventional sense had been affected. However, he had become irreverent and capricious. His respect for the social conventions by which he once abided had vanished. His abundant use of profanity offended those around him. Perhaps most troubling, he had taken leave of his sense of responsibility. He could not be trusted to honor his commitments. His employers had deemed him "the most efficient and capable" man in their employ but now they had to dismiss him. In the words of his physician, "the equilibrium or balance, so to speak, between his intellectual faculty and animal propensities" had been destroyed. In the words of his friends and acquaintances, "Gage was no longer Gage." (Adapted from Damasio, Grabowski, Frank, Galaburda, & Damasio, 1994, p. 1102)

This accident destroyed much of Gage's left frontal lobe of the cerebral cortex and basic elements of his personality were noted to have changed. Gage was transformed from a responsible, well-liked, and socially competent man into an impulsive, emotional, and socially inappropriate man after the brain injury.

FIGURE 2 **Phineas Gage's Brain Injury.** Modern neuroimaging techniques have helped identify the precise location of damage to Phineas Gage's brain.



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It has been suggested that many of these symptoms were temporary and his function improved with time which supports the idea that Gage's brain recovered, to some degree.

Recent research suggests that the basis of recovery stems from neuroplasticity, which is the ability of neuronal circuits to adapt and modify connections on both a structural and functional level, ranging from molecular, synaptic, and cellular changes to more global network changes (García-Molina, 2012; Sophie Su, Veeravagu, & Grant, 2018; Turolla, Venneri, Farina, Cagnin, & Cheung, 2018). Almost 150 years later, researchers using modern neuroimaging techniques on Gage's preserved skull and a computer simulation of the tamping-iron accident determined the precise location of the damage to Gage's brain (Figure 2).

Injury to the frontal lobe can result in disruptions to the brain's executive functions which represent higher level cognitive abilities. Attention, inhibition, social cognition and interpersonal behavior,