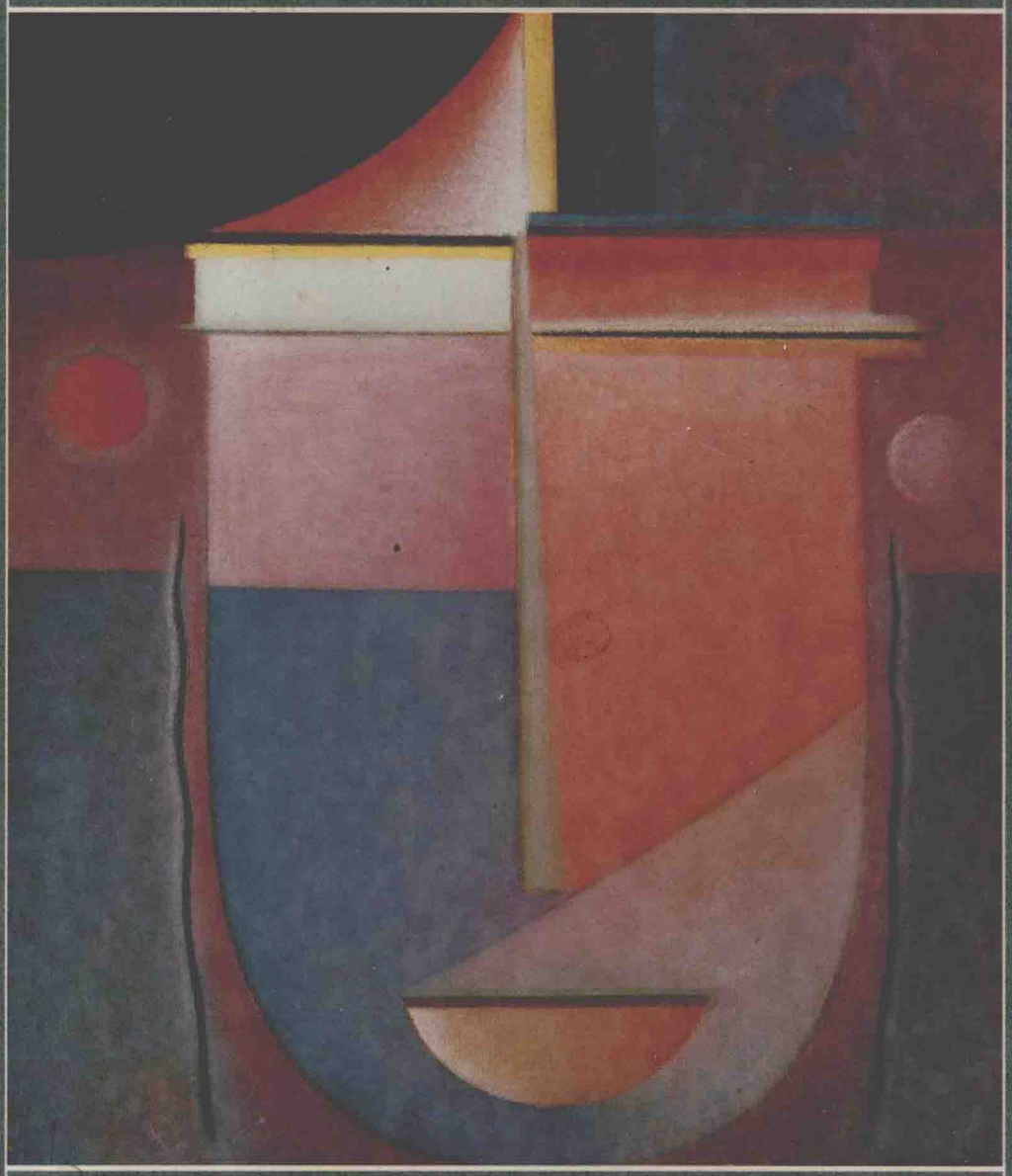
ABNORMAL PSYCHOLOGY

CURRENT PERSPECTIVES

RICHARD R. BOOTZIN ♦ JOAN ROSS ACOCELLA
LAUREN B. ALLOY



SIXTH EDITION

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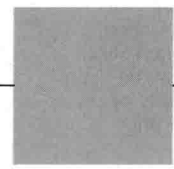

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PREFACE

The sixth edition of *Abnormal Psychology: Current Perspectives* preserves—and improves on—the strengths of the fifth edition. The multiperspective approach, which recognizes all the major viewpoints on psychological disorder, has been strengthened by the addition of the cognitive perspective, which we believe has earned a place now beside older theoretical traditions within abnormal psychology. Our new material on the cognitive perspective has largely been the contribution of Dr. Lauren B. Alloy of Temple University, our new coauthor and a widely respected authority in cognitive approaches to psychopathology. The chapter-by-chapter overview that follows highlights the new topics that the addition of the cognitive perspective has added to this text.

The research orientation of the book has again been strengthened in this edition. Throughout the book, recent research findings have been added—many of them reflecting new discoveries about the causes of particular disorders and hopeful new methods of treatment. As in the last edition, we have sought to strengthen our discussion of the neuroscience perspective, recognizing the continuing importance of discoveries in this area. We hope that our discussion here, whether of genetic studies, biochemical research, or brain imaging, will be exciting and illuminating.

Certain organizational changes have been made in this edition to accommodate the addition of the cognitive perspective and to reflect the body of new research that we wished to discuss. The introductory chapters on the major perspectives have been made more concise, with certain related perspectives treated in a single chapter. Anxiety disorders, the subject of much recent research, now occupy a chapter of their own, as do the somatoform and dissociative disorders. Biological therapy too has been given its own chapter. In the interests of conciseness, we have treated autism and mental retardation in a single chapter, recognizing that although autism is a distinct disorder, most autistic children have severe cognitive deficits.

Another concern in this edition has been updating and adding to our case material. We believe that case studies are valuable teaching tools; accordingly, we have used a case to introduce each of the disorders chapters. It is our hope that by putting case studies up front, we will both capture the students' attention and give them an immediate sense of what these disorders mean.

Finally, we have done a good deal of work to make the book—as its subtitle suggests—truly *current*. From high-risk studies of schizophrenia to an update on "date rape" to the latest thinking on new drugs such as Prozac and Clozapine, we have brought every chapter up to date.

Revision Overview

Chapter 1 (Abnormal Behavior: Yesterday and Today), in addition to giving a more balanced view of the treatment of the disturbed throughout history, introduces the cognitive perspective.

Chapter 2 (The Psychodynamic and Humanistic-Existential Perspectives) recognizes that humanistic-existential psychology was both an outgrowth of and a reaction to psychodynamic thinking. Treatment of both perspectives is more concise and up to date.

Chapter 3 (The Behavioral, Cognitive, and Sociocultural Perspectives) recognizes that these perspectives, which share an empirical emphasis, developed in reaction to earlier schools. An entirely new section introduces the cognitive perspective, describing major cognitive thinkers and cognitive processes.

Chapter 4 (The Neuroscience Perspective) has additional information on important brain structures such as the limbic system and on the differences between brain hemispheres.

Chapter 5 (Research Methods in Abnormal Psychology) has new and updated examples of the major concepts in research. Case-control and behavioral high-risk research designs are introduced and the behavioral high-risk design is contrasted with the genetic high-risk design.

Chapter 6 (Diagnosis and Assessment) has a preview of *DSM-IV*, updates on new psychological tests, and a new section on the cognitive approach to assessment.

Chapter 7 (The Anxiety Disorders) is largely a new chapter. There are updated, revised, and expanded discussions of every major disorder, including panic disorder, agoraphobia, generalized anxiety disorder, phobia, obsessive-compulsive disorder, and posttraumatic stress disorder. Much new case material and research has been included. A new section on the cognitive perspective is presented, and the neuroscience perspective has been substantially updated and revised.

Chapter 8 (The Dissociative and Somatoform Disorders) is also largely a new chapter. There are updated, revised, and expanded discussions of every major disorder, including amnesia, fugue, multiple personality disorder, hypochondriasis, somatization disorder, and conversion disorder, and a completely new section on depersonalization disorder. There is much new case material and research throughout the chapter, and all the perspectives sections have been revised and updated. There is completely new material on the cognitive perspective.

Chapter 9 (Psychological Stress and Physical Disorders) has updates on several disorders, including migraine, and certain other disorders have been more concisely treated. There is new material on cognitive factors in coping with stress and the role of minor life stresses.

Chapter 10 (The Mood Disorders) has been reorganized and thoroughly revised. There is updated material on the prevalence, epidemiology, and symptoms of depression, on the course of depression, risk factors, and predictors of relapse. There is a new discussion of anxiety-depression comorbidity. All perspectives sections have been revised and updated, with special emphasis on the cognitive and neuroscience perspectives. The section on suicide has been substantially updated.

Chapter 11 (The Personality Disorders) has updated coverage of diagnostic issues. It has several new cases, additional information on schizotypal and borderline personalities, and updated coverage of behavioral treatments. There is a whole new section on the cognitive perspective, emphasizing faulty schemas. Intriguing new neuroscience research is covered.

Chapter 12 (The Addictive Disorders) has been heavily revised. The distinction between psychoactive substance dependence and abuse is introduced; there is updated information on the social and personal costs of alcoholism. The behavioral and neuroscience perspectives have been substantially revised, and there is a new section on the cognitive perspective, covering cognitive theory and treatment. There is an expanded discussion of Alcoholics Anonymous. There is an updated treatment of smoking. All the sections on the major psychoactive drugs have been revised, with expanded coverage of cocaine.

Chapter 13 (Abnormality and Variation in Sexual Behavior) has been substantially revised. There is new case material, together with two new sections on the cognitive perspective. There are up-

dates on physical treatment of erectile dysfunction, transsexual "reassignment" surgery, the sexual abuse of children, rape, and the treatment of sex offenders. The discussion of homosexuality has been sharply reduced, in keeping with the *DSM* position that homosexuality is not a mental disorder.

Chapter 14 (Schizophrenia and Paranoia) has been revised and updated. There is new information on the prevalence of schizophrenia in the homeless population, on the rates of delusions among schizophrenics, and on mortality rates. There is a revised and expanded discussion of the positive-negative symptoms dimension, including differences in cognitive functioning, brain structure and neurotransmitters, sex ratio, course, and prognosis, and the implications of these differences for etiology.

Chapter 15 (Perspectives on Schizophrenia) has been revised and expanded. There is discussion of new evidence on expressed emotion in schizophrenic families and an updated discussion of social-skills training for schizophrenics. There is a new section on the cognitive perspective that discusses attentional problems as vulnerability factors. The neuroscience perspective has been updated and expanded. It includes new twin and adoption study data, new genetic high-risk studies, new information on brain structure differences in positive and negative symptom schizophrenia. The material on the dopamine hypothesis has been updated and there is new information on the drug Clozapine.

Chapter 16 (Organic Brain Disorders) has new case material, expanded and updated material on Alzheimer's disease, and new material on delirium and on AIDS dementia.

Chapter 17 (Disorders of Childhood and Adolescence) has been reorganized around the empirical method of classifying disorders, so that disorders involving similar kinds of behavior (such as disruptive, "acting out" behavior) are considered together. There is new case material, updated material on attention-deficit hyperactivity disorder, and a new section on the cognitive perspective.

Chapter 18 (Mental Retardation and Autism) has new case material, new material on the education of autistic children and on cognitive-behavioral therapy, and more concise coverage of mental retardation.

Chapter 19 (Individual Psychotherapy) is an expanded chapter on the various kinds of individual therapy. There is added information on therapy outcomes and factors that influence outcome. A substantial section has been added on the cognitive approach to treatment, and there is new information on how to choose a therapist.

Chapter 20 (Group, Family, and Community Therapy) is an expanded chapter with added information on family and marital therapies and an update on inpatient hospitalization.

Chapter 21 (Biological Therapy) contains an update on all major psychiatric drugs, including Clozapine and Prozac, now in a separate chapter.

Chapter 22 (Legal Issues in Abnormal Psychology) has new case material and an update on legal questions such as the "guilty but mentally ill" verdict.

PEDAGOGY

Each chapter begins with an outline that offers the student a concise overview of the material therein. Within each chapter, important terms are highlighted in boldface so that they can be quickly identified. These terms are defined not only in the text when they first appear but also in the glossary at the end of the book. In addition, key terms are listed at the end of each chapter, following the chapter summary. The summaries are organized around the major headings of each chapter. The references are compiled in an extensive reference section at the end of the text. The majority of photographs are new to this edition and are in color.

SUPPLEMENTS

The following ancillary materials are being offered with this edition of *Abnormal Psychology:*

Casebook in Abnormal Psychology, Second Edition, by John Vitkus, Barnard College

Study Guide by Gary and Susan Bothe, Pensacola Junior College

Instructor's Manual, by Caroline M. Clements, Chicago School of Medicine

Test Bank, by Marie Thomas

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Abnormal psychology is a broad field, and in attempting to cover it, we have benefited from the help of the following specialist consultants and reviewers:

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Betsey A. Benson, Director of the Institute for the Study of Developmental Disabilities Mental Health Program and Professor of Psychology at the University of Illinois at Chicago, is a specialist in mental health aspects of mental retardation. Dr. Benson assisted with the mental retardation and autism chapter.

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Ronald T. Brown, Associate Professor of Psychiatry and Pediatrics at the Emory University School of Medicine, is a specialist in childhood psychopathology and pediatric psychology. Dr. Brown assisted with the childhood disorders chapter.

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George Stricker, Distinguished Research Professor at the Derner Institute at Adelphi University, is a specialist in clinical psychology. Dr. Stricker assisted with the psychodynamic perspective chapter and reviewed the psychodynamic perspective sections throughout.

Howard Ulan, an attorney for the Pennsylvania Department of Public Welfare, who also has a Ph.D. in psychology, is a specialist in mental health law. Dr. Ulan assisted with development of the legal issues chapter in this edition as well as in the third, fourth, and fifth editions.

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We hope that this new edition of *Abnormal Psychology* will make students not only more knowledgeable but also more understanding. For in describing what we know so far about why people act as they do, we have attempted to present this complex subject from a human perspective. "Abnormal" is a relative term, the meaning of which has changed many times over the centuries. We offer a balanced approach to the standards against which abnormality is defined. We also present the causal theories in a balanced fashion. This approach is intended to impress on the student the dynamic character of the field: its openness to dispute, to movement, and to change. We hope that the book will also encourage students to appreciate the interconnection between mind and body, which is perhaps the central theme of this book.

Richard R. Bootzin
Joan Ross Acocella
Lauren B. Alloy

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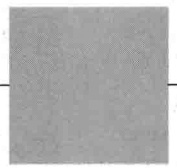

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A MULTIPERSPECTIVE APPROACH

Before we can begin a study of abnormal psychology, we need to think about what kind of behavior deserves to be called "abnormal." Consider the following examples:

A woman becomes seriously depressed after her husband's death. She has difficulty sleeping and loses her appetite.

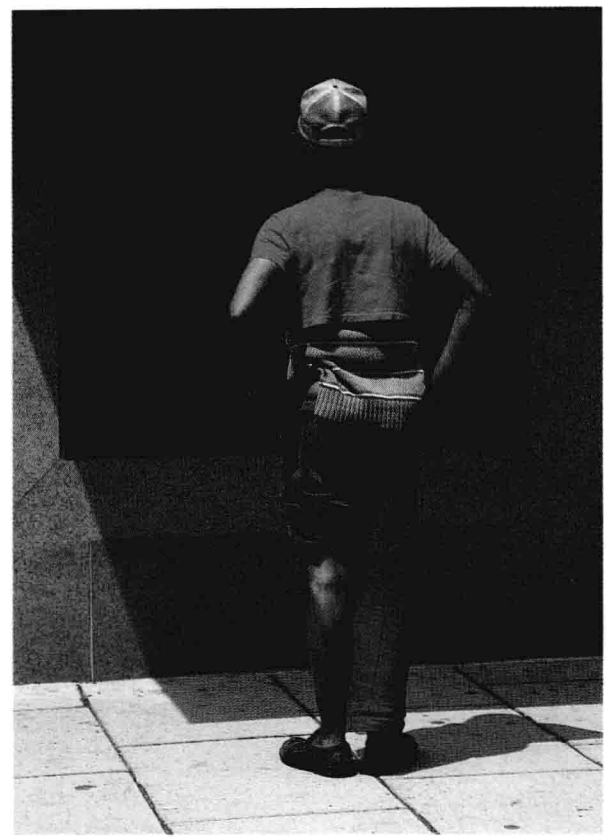
A man tries to force his woman companion to have sexual intercourse even though she says no and resists him physically.

A young man will not travel by airplane and insists on driving or taking buses or trains everywhere, despite considerable inconvenience.

An adolescent girl occasionally indulges in binge eating, after which she forces herself to vomit.

A woman will wear only blue clothing, although her manner of dress is appropriate otherwise.

We begin our exploration of abnormal psychology by considering some ways in which we define the term *abnormal.*



One definition of abnormal behavior has to do with violation of *norms,* or socially imposed standards of acceptable behavior. The vagueness of this definition presents problems, however. Where exactly is the line between mere eccentricity—or even absentmindedness—and truly abnormal behavior?

ABNORMAL BEHAVIOR AND SOCIETY

Defining Abnormal Behavior

When we ask how a society defines psychological abnormality, what we are asking is where that society draws the line between acceptable and unacceptable patterns of thought and behavior. Acceptability is gauged by a variety of measuring sticks, but perhaps the most commonly used is the society's norms.

Norm Violation Every human group lives by a set of **norms**—rules that tell us what it is "right" and "wrong" to do, and when and where and with whom. Such rules circumscribe every aspect of our existence, from our most far-reaching decisions to our most prosaic daily routines.

Consider, for example, the act of eating. Do we eat whatever we want, wherever and whenever we want it? No. Eating is governed by norms as to what is "good for us" to eat, how often we should eat, how much we should eat, and where we should eat. Eating at a rock concert is fine, but eating at a symphony concert is not. Furthermore, there are rules as to when and where certain things can be eaten. Drinking wine with dinner is acceptable; drinking wine with breakfast would be considered odd. Hot dogs at a barbecue are fine; hot dogs at a banquet are not.

Some cultures even have strict rules about whom one can eat with. Certain tribes, for instance, prohibit eating in the presence of blood relatives on the maternal side, since eating makes one vulnerable to being possessed by a devil, and such devils are more likely to appear when one is in the presence of one's maternal relatives.

To outsiders, such norms may seem odd and unnecessarily complicated, but adults who have grown up in the culture and who have assimilated its norms through the process of socialization simply take them for granted. Far from regarding them as folkways, they view them as what is right and proper. And consequently they will tend to label as abnormal anyone who violates these norms. All the examples at the begin-

ning of this chapter, with the exception of the first, involve norm violation to some extent.

In small, highly integrated societies, disagreement over norms is rare. In a large, complex society, on the other hand, there may be little consensus about what is acceptable. For example, the gay liberation movement can be conceptualized as the effort of one group to persuade the society as a whole to adjust its norms so that homosexuality will fall inside rather than outside the limits of acceptability.

Norms are not universal and eternal truths; on the contrary, as we have seen, they vary across time and across cultures. Therefore, they seem a weak basis for the assessment of mental health. Furthermore, whether or not adherence to norms is an appropriate criterion for mental health, it can be called an oppressive criterion. It enthrones conformity as the ideal pattern of behavior and thereby stigmatizes the nonconformist. For norms contain value judgments. People who violate them are not just doing something unusual; they are doing something wrong. Still, despite these objections, norms remain a very important standard for defining abnormality. Though they may be relative to time and place, they are nevertheless so deeply ingrained that they *seem* absolute, and hence anyone who violates them appears abnormal.

Important as norms are, they are not the only standard for defining abnormal behavior. Other criteria are statistical rarity, personal discomfort, maladaptive behavior, and deviation from an ideal state.

Statistical Rarity From a statistical point of view, abnormality is any substantial deviation from a statistically calculated average. Those who fall within the "golden mean"—those, in short, who do what most other people do—are normal, while those whose behavior differs from that of the majority are abnormal.

This criterion is used in some evaluations of psychological abnormality. The diagnosis of mental retardation, for instance, is based in large part on statistical accounting. Those whose tested intelligence falls below an average range for the population (and who also have problems coping with life—which, with intelligence far lower than the average, is likely to be the case) are labeled "retarded" (see Figure 1.1). Careful statistical calculations are not always considered necessary in order to establish deviance, however. In the extreme version of the statistical approach, any behavior that is unusual would be judged abnormal, even if it involves harmless eccentricity—such as wearing only blue clothing, for example.

The statistical-rarity approach makes defining abnormality a simple task. One has only to measure the individual's performance against the average performance. If it falls outside the average range, it is abnormal. There are obvious difficulties with this approach, however. As we saw earlier, the norm-violation approach can be criticized for exalting the shifting values of social groups. Yet the major weakness of the statistical-rarity approach is that it has *no* values; it lacks any system for differentiating between desirable and undesirable behaviors. In the absence of

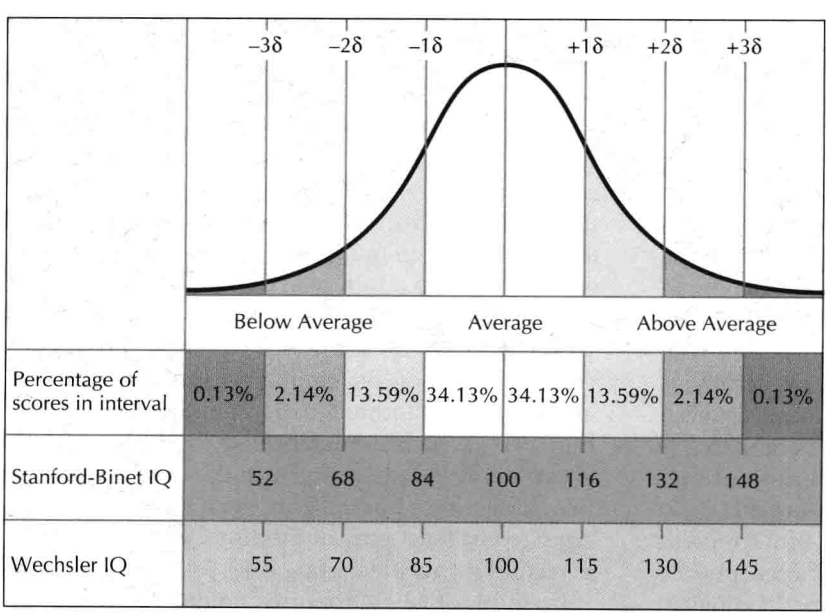


FIGURE 1.1 The distribution of IQ scores in the United States. More than 78 percent of the population scores between 84 and 116 points. Using the statistical approach to abnormality, diagnosticians designate as mentally retarded those falling below approximately 68 points. As the figure indicates, this group is statistically rare, representing only about 2 percent of the population.