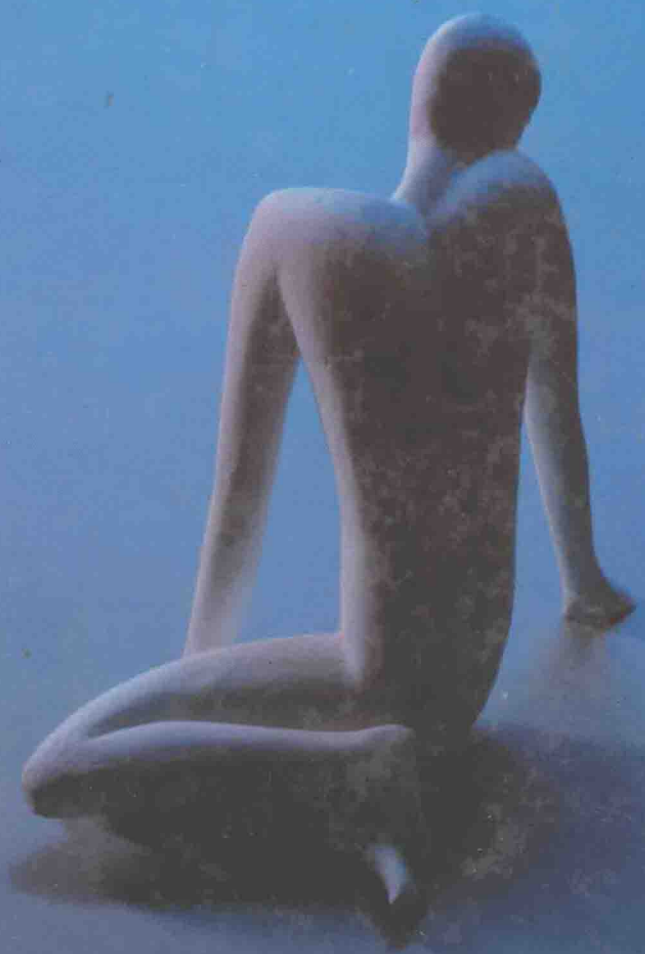
FIFTH EDITION

ABNORMAL PSYCHOLOGY

CURRENT PERSPECTIVES



RICHARD R. BOOTZIN
JOAN ROSS ACOCELLA

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ABNORMAL PSYCHOLOGY

CURRENT PERSPECTIVES

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McGraw-Hill, Inc.
New York St. Louis San Francisco Auckland Bogotá
Caracas Lisbon London Madrid Mexico Milan
Montreal New Delhi Paris San Juan Singapore
Sydney Tokyo Toronto

ABNORMAL PSYCHOLOGY CURRENT PERSPECTIVES
Fifth Edition

987

Library of Congress Cataloging-in-Publication Data

Bootzin, Richard R., 1940–
Abnormal psychology.

Bibliography: p.
Includes indexes.
1. Psychology, Pathological. I. Acocella, Joan Ross, 1945– . II. Title. [DNLM: 1. Psychopathology. WM 100 B7235a]
RC454.B577 1988 616.89 87-12810

ISBN 0-07-555147-0

Cover and Book Design: Glen M. Edelstein

Sculpture by Linda Peer, courtesy of the artist.

Photo by Ken Karp.

PREFACE

The fifth edition of *Abnormal Psychology: Current Perspectives* preserves—and improves on—the strengths of the fourth edition. The multi-perspective approach, which recognizes all the major viewpoints on psychological disorder, has been retained and updated. The newly issued revised edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (usually referred to as *DSM-III-R*) is fully integrated into the text. This brings *Abnormal Psychology: Current Perspectives* up to date with the most influential and widely used diagnostic tool in the field, and it is an important feature of this new edition. The research orientation of this edition has again been strengthened. Throughout the book, recent research findings have been added—many of them reflecting exciting new discoveries about the causes of particular disorders.

One of our major goals in preparing this edition was to augment and strengthen our discussion of the neuroscience perspective. Because of the ever-increasing importance of research into the biological causes of abnormality, we have increased our coverage of the neuroscience perspective to a full chapter (Chapter 5). In this chapter we describe both the broad ideas and methods of the field and some of the specific techniques it has contributed to the study of abnormal behavior. We hope that our discussion here, whether of genetic studies, biochemical research, or of new techniques in brain imaging—including some of the most significant findings of the past few years—will be both illuminating and exciting.

We continue to concern ourselves not only with the scientific aspects of abnormal psychology in this edition, however, but with its human aspects as well. Recognizing the crucial role of social support in preventing and in treating the various disorders, we have expanded our discussion of the role of the family as an aid to the troubled person. And recognizing that this influence works both ways, we have considered the stress that disordered behavior—whether its cause is schizophrenia, alcoholism, or Alzheimer's disease—can place on a family. We have also considered larger social issues: Has "deinstitutionalization" been a success? How has society's treatment of mentally ill defendants changed in the aftermath of the John Hinckley case? And so on.

Finally, we have done a good deal of work to make the book—as its subtitle suggests—truly *current.* From changing patterns of drug abuse to the explosion of cognitive research on depression to increasing concern about child abuse, we have brought every chapter up to date.

REVISION OVERVIEW

The following is an overview of what is new in this edition, in addition to changes brought about by *DSM-III-R:*

Chapter 1 (history) reflects current research in the history of abnormality, which questions the idea that earlier ages routinely treated the disturbed as "possessed" or as witches. The picture is a far more subtle one than most texts acknowledge.

Chapter 2 (psychodynamic perspective) has added discussion of influential trends in post-Freudian psychology. Highlighted are Margaret Mahler and object relations theory and Heinz Kohut's theory of narcissism.

Chapter 3 (behavioral perspective) contains expanded information on the cognitive behavioral perspective and its developing therapies.

Chapter 4 (humanistic-existential and sociocultural perspectives) now contains a discussion of the contributions of Rollo May.

Chapter 5 (neuroscience perspective) is a new chapter devoted to genetic, neurological, and biochemical research, including new brain imaging methods.

Chapter 6 (research methods) is devoted to familiarizing students with research procedures and problems in abnormal psychology.

Chapter 7 (diagnosis and assessment) has an expanded discussion of computer assessment and the issues associated with it.

Chapter 8 (anxiety, somatoform, and dissociative disorders) has new research on panic disorders.

Chapter 9 (psychological stress and physical disorders) has been extensively revised to reflect the dramatic increase in research in this field.

Chapter 10 (mood disorders) covers another area in which there has been a great deal of exciting new research. Our chapter reflects this activity by including new research on cognitive theories of depression and an expanded neuroscience section. It also contains new material on dysthymia, cyclothymia, and seasonal affective disorder.

Chapter 11 (personality disorders) now contains descriptions of all the personality disorders listed in *DSM-III-R*. It also describes the controversy about two newly proposed disorders.

Chapter 12 (addictive disorders) describes the treatment approach known as relapse prevention and adds information on compulsive gambling.

Chapters 14 and 15 (schizophrenia and paranoia) have new research on communication within families and expanded coverage of recent research in neuroscience.

Chapter 16 (organic disorders) contains additional information on Alzheimer's disease and its impact on victims and their families.

Chapter 17 (childhood and adolescent disorders) includes new material on the problem of child abuse and on the prevention of childhood disorders.

Chapter 18 (autism) has been reorganized and rewritten to reflect recent research on autism and severe developmental disabilities.

Chapter 19 (retardation) covers new information in legal decisions relating to institutional care and the new early intervention programs that seek to help retarded babies and young children develop their abilities. It takes up the question of dual diagnosis, recognizing that many retarded children have other disorders as well. It also has expanded coverage of the emotional and social problems of the retarded adult.

Chapter 20 (psychotherapy) has an increased focus on commonalities across therapies and includes recent research on the evaluation of therapies.

Chapter 21 (other forms of treatment), a newly reorganized chapter, includes a comparison of drug treatment with psychotherapy, together with information on the impact of the deinstitutionalization movement and its successes and failures.

Chapter 22 (legal issues) has an update of the recent court decisions affecting commitment and patients' rights.

PEDAGOGY

Each chapter begins with an outline that offers the student a concise overview of the chapter. Important terms within each chapter are 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 full-scale glossary at the end of the book. At the end of each chapter there is a summary section, which allows the reader to review the material already covered. References cited in this edition range from classic citations to the newest research, which is only now making its major impact in the field. The references are compiled in an extensive reference section at the end of the text. For this fifth edition, a complete review was undertaken of the illustrations. More than half of the photographs were changed in order to complement better the text. And many are now in color to make the text more attractive.

SUPPLEMENTS

The ***Study Guide to Accompany Abnormal Psychology, Fifth Edition,*** is intended to help students understand the vocabulary and concepts of abnormal psychology. Each chapter corresponds to a chapter in the text and contains an outline of major concepts, learning objectives, a study outline, exercises testing key terms and concepts, practice multiple-choice questions, and essay questions.

The ***Casebook in Abnormal Psychology*** by John Vitkus, Barnard College, is a compilation of case studies illustrating a wide range of clinical problems and amplifying the concepts presented in the text. Each case study, based on real-life patients, includes a description of the presenting complaint, a detailed personal history, analysis of treatment, and discussion. The case treatments reflect a broad spectrum of approaches including the humanistic, neuroscience, psychodynamic, behavioral, and eclectic perspectives.

A new ***Test Bank,*** with over 1,300 multiple-choice questions that are both factual and applied, and are referenced to the text page on which the correct answer can be found, has been written exclusively for *Abnormal Psychology,* Fifth Edition. A **computerized test bank** is available for the IBM PC/PC-XT (or true compatibles) and Apple IIe/2c computers. The ***Instructor's Manual*** offers instructors chapter outlines, lecture topics, essay questions and answers, and an annotated video/film list and references. The *Instructor's Manual* and *Test Bank* are published as one volume.

ACKNOWLEDGMENTS

We would like to thank those talented people who worked with us on the editorial, design, and production stages: Barry Fetterolf, Mary Falcon, Alison Husting, Judith Kromm, Bob Greiner, Glen Edelstein, Andy Roney, Kathy Bendo, and Leonora Morgan. We wish to thank especially Betty Gatewood for her work in developing this current edition; she has brought skill, dedication, and sensitivity to this project.

The breadth of coverage of abnormal psychology is so great that we asked a number of specialist consultants and reviewers to assist us. We are indebted to the following people for their help:

Specialist Consultants

Amedeo Giorgi, Director of Research, Saybrook Institute in San Francisco, is a specialist in existential psychology. Dr. Giorgi assisted with the presentation of the humanistic-existential perspective.

Joseph LoPiccolo, professor and chairman, department of psychology, University of Missouri, is a specialist in sexual function and dysfunction. Dr. LoPiccolo assisted with the sexual disorders chapter in this edition and in the previous third and fourth editions.

Theodore Millon, professor at the University of Miami, Coral Gables, is a specialist in personality disorders. Dr. Millon assisted with the chapter on personality disorders.

Steven Reiss, professor of psychology at the University of Illinois, Chicago, is a specialist in the treatment of emotional disorders of the retarded. Dr. Reiss assisted with the chapter on mental retardation in this edition and in the fourth edition.

Lawrence Squire, professor of psychology at the Veterans Administration Medical Center, San Diego, and University of California/San Diego, is a specialist in neuropsychology. Dr. Squire reviewed the neuroscience perspective sections throughout.

George Stricker, professor and dean, 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 supervised the preparation of the legal issues chapter for the third, fourth, and fifth editions.

Charles Wenar, professor of psychology at Ohio State University, is a specialist in developmental psychology. Dr. Wenar assisted with the chapter on the disorders of childhood and adolescence.

Steven Zarit, professor at the University of Southern California, Los Angeles, is a specialist in clinical neuropsychology. Dr. Zarit assisted with the organic brain disorders chapter.

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Lorna Wing, Institute of Psychiatry, Maudley Hospital, London, England

We hope that this new edition of *Abnormal Psychology* will make the student 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 upon 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.

R. R. B.

J. R. A.

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CHAPTER 1

Abnormal Behavior: Yesterday and Today

ABNORMAL BEHAVIOR AND SOCIETY

Defining Abnormal Behavior
Explaining Abnormal Behavior
Treating Abnormal Behavior

CONCEPTIONS OF ABNORMAL BEHAVIOR: A SHORT HISTORY

Ancient Societies: Deviance and the Supernatural
The Greeks and the Rise of Science
The Middle Ages and the Renaissance: Natural and Supernatural
The Eighteenth and Nineteenth Centuries: The Supremacy of Science
Foundations of Modern Abnormal Psychology

A MULTIPERSPECTIVE APPROACH

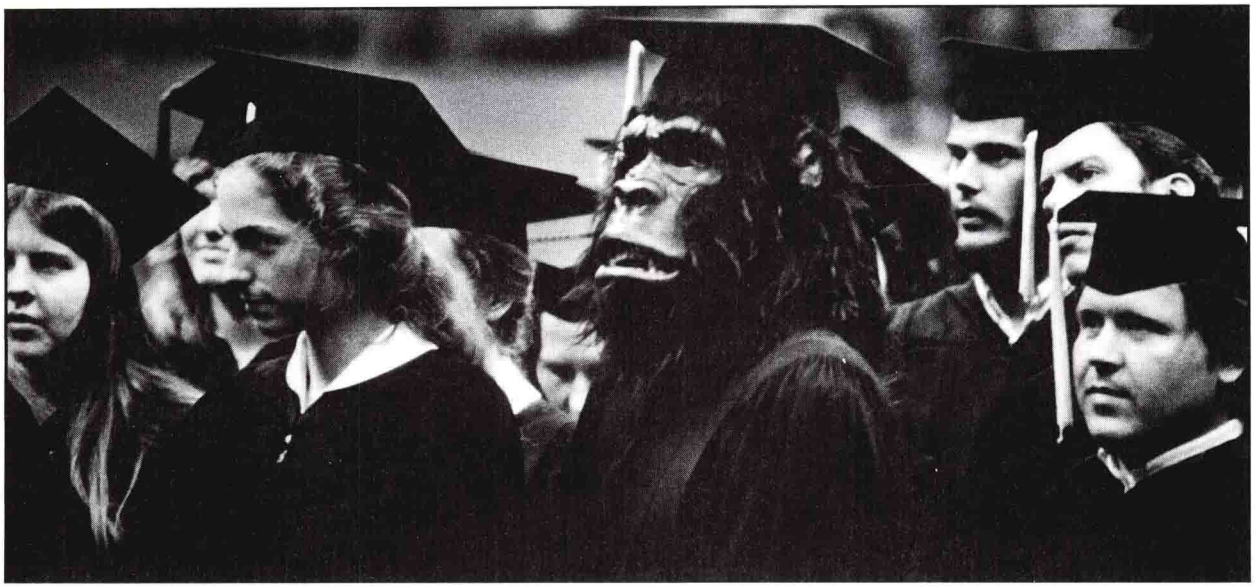
A century ago, if a father "disciplined" his misbehaving son with a vicious beating, most of his neighbors would not have considered this treatment unusual; today we would think the man guilty of child abuse. Likewise, today many people place their aging parents in nursing homes, where they are deprived of their accustomed surroundings, of companionship, and of any useful role to perform—a practice that would have been considered extraordinary a hundred years ago.

Ideas about acceptable behavior change over time, sometimes slowly, sometimes more rapidly. Similarly, ideas about psychological abnormality change from century to century and from society to society. "Abnormality," "madness," "lunacy"—by whatever name—is a relative concept. We begin our exploration of abnormal psychology by considering what "abnormality" has meant and what it means today.

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.



One way we define abnormal behavior is by asking whether it violates a norm—a socially imposed standard of acceptable behavior. The vagueness of this definition presents problems, however: where exactly is the line between mere eccentricity and truly abnormal behavior? (Adolahe/Southern Light)

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 ordinary act of eating. Do we eat whatever we want, wherever and whenever we want it? We do not. 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 rather 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 been raised 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 regard them as what is right and proper. And consequently they will tend to label as abnormal anyone who violates these norms.

In a small, highly integrated society, there will be little disagreement over norms. In a large, complex society, on the other hand, there may be considerable friction among different groups over the question of what is right and proper. For example, the Gay Liberation movement may 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.

In a sense, the use of norms as a standard for judging mental health may seem inappropriate. 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 applying the label "abnormal" to anyone. Furthermore, whether or not adherence to norms is an appropriate criterion for mental health, it may be called an oppressive criterion. It enthones conformity as the ideal pattern of behavior and it stigmatizes the nonconformist. For norms contain value judgments. People who violate them are not just doing something unusual; they

are doing something wrong. Yet 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.

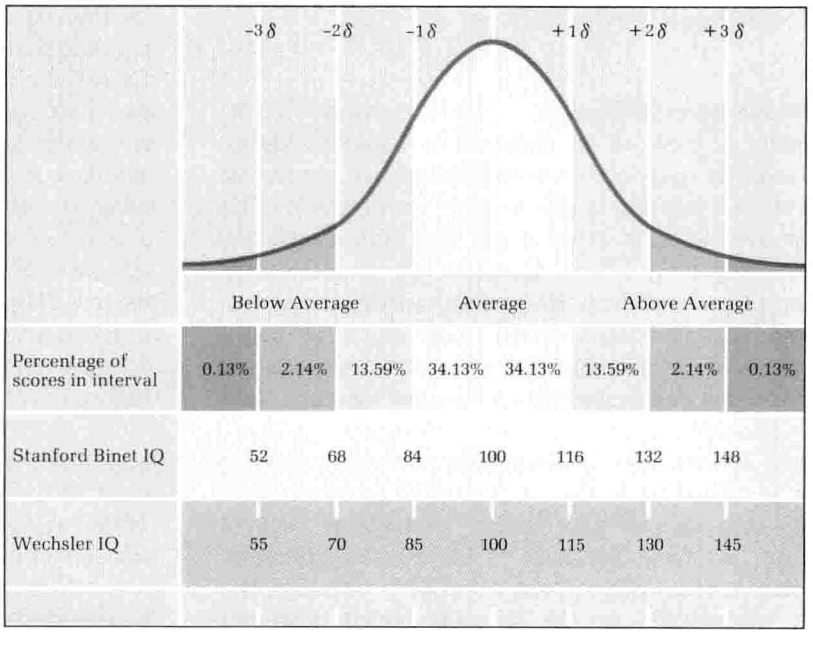
Statistical Rarity From a statistical point of view, abnormality is any substantial deviation from a statistically calculated average. Those who fall within the "golden mean"—those, in short, who do what most other people do—are normal, while those whose behavior differs from that of the majority are 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). However, careful statistical calculations are not always considered necessary in order to establish deviance. In the extreme version of the statistical approach, any behavior that is simply unusual would be judged abnormal.

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. However, there are obvious difficulties with this approach. 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 such a system, it is the average behavior that tends to be considered the ideal. Such a point of view is potentially very dangerous, since it discourages and denigrates even valuable deviations from the norm. For example, not only mentally retarded people but also geniuses—and particularly geniuses with new ideas—may be considered candidates for psychological treatment. Of course, most users of the statistical-rarity approach acknowledge that not all deviations from the average should be identified as abnormal, yet the focus on the norm does have discomforting implications.

Personal Discomfort An alternative criterion for defining abnormality is personal discomfort. If people are content with their lives, then their lives are 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.



no concern to the mental health establishment. If, on the other hand, they are distressed over their thoughts or behavior, then they require treatment.

This is a more "liberal" approach than the two we have just discussed, in that it makes people the judges of their own normality, rather than subjecting them to the judgment of the society or the diagnostician. And this is the approach that is probably the most widely used in the case of the less severe psychological disorders. Most people in psychotherapy are there not because anyone has declared their behavior abnormal but because they themselves are unhappy.

Reasonable as it may be in such cases, the personal-discomfort criterion has obvious weaknesses as a comprehensive standard for defining abnormal behavior. The same behavior pattern may cause very different degrees of dissatisfaction in different people. If we focus on dissatisfaction, we are left with no stable criterion for evaluating the behavior itself. The lack of an objective standard is especially problematic in the case of behaviors that cause serious harm or are socially disruptive. Is teenage drug addiction to be classified as abnormal only if the teenager in question expresses dissatisfaction with this way of life? Furthermore, even if a behavior pattern is not necessarily harmful, it may still merit psychological attention in the absence of personal distress. People who believe that their brains are receiving messages from outer space may inflict no great pain on others and may report no unhappiness with their lives, yet in the eyes of most people they would appear to be in need of psychological treatment.

Maladaptive Behavior A fourth criterion for defining a behavior as abnormal is maladaptiveness. Here the question is whether the person, given that behavior pattern, is able to meet the demands of his or her life—hold down a job, deal with friends and family, pay the bills on time, and the like. If not, the pattern is abnormal. This standard overlaps somewhat with that of norm violation. After all, many norms are rules for adapting our behavior to our own and our society's requirements. (To arrive for work drunk is to violate a norm; it is also maladaptive, in that it may get you fired.) The maladaptiveness standard is also connected to that of personal discomfort, for it is often the consequences of maladaptive behavior (e.g., lost jobs) that cause us discomfort. At the same time, the maladaptiveness standard is unique in that it concentrates on the practical matter of getting through life with some measure of success.

This practical approach makes the maladaptiveness standard a useful one. Those whose behavior makes them unable to cope with the everyday demands of life would seem obvious candidates for psychological help. Furthermore, the maladaptiveness standard is favored by many professionals for its elasticity—because it focuses on behavior *relative to life circumstances,* it can accommodate many different styles of living. But as with the personal-discomfort criterion, this liberalism is purchased at the cost of values, and it raises certain moral questions. Are there not, for example, certain kinds of circumstances to which we should *not* adapt? Can we say that the behavior of Germans who adapted poorly to Hitler's regime—who became depressed or rebellious, losing jobs and friends as a result—was abnormal? This question raises another: Just how liberal is the maladaptiveness standard? Like the norm-violation standard, it does seem to favor conformity, since, in general, those who adapt well are those who "fit in."

Deviation from an Ideal As we shall see in later chapters, several psychological theories describe an ideally well-adjusted personality, any deviation from which is interpreted as abnormal to a greater or lesser degree. Since the ideal is difficult to achieve, most people are seen as being poorly adjusted at least part of the time. One may strive to achieve the ideal, but one seldom makes it.

In light of such theories, many people may judge themselves to be abnormal, or at least in need of psychological treatment, even though they have no particularly troubling behavioral symptoms. For example, a woman may have a number of friends and a reasonably satisfying job and yet consider herself a candidate for psychotherapy because she lacks something—an intimate relationship with another person, a sense of realizing her full potential—that is held up as a criterion for mental health by one or another theory. This standard is obviously related to the personal-discomfort standard; the source of the personal discomfort—and hence of the presumed need for treatment—may be a failure to achieve an ideal.

The shortcomings of the deviation-from-an-ideal approach are again obvious. First, a person who falls short of an ideal does not necessarily merit the label "abnormal" or require treatment. The pursuit of ideal adjustment can add to people's troubles, making them feel seriously inadequate, whereas they may simply be imperfect, like all human beings. Second, psychological theories are as relative to time and place as

social norms, and they change even more quickly. Thus if norms are a weak foundation for the evaluation of mental health, theoretical ideals are even weaker. (And at least social norms ask only for the possible.) Nevertheless, the need to achieve something more than ordinary adjustment has propelled many people into psychotherapy in recent years—and especially into group therapies oriented toward what is called "personal growth."

In sum, behavior may be identified as abnormal in a variety of ways, no one of which is foolproof. In practice, the judgment of abnormality, whether by professional diagnosticians or by family and neighbors, is usually based on a combination of standards. The person's happiness, relation to social norms, and ability to cope—and also the society's ability to cope with him or her—are all taken into account in varying degrees.

Explaining Abnormal Behavior

As we have just seen, defining abnormal behavior is a complex task. The same is true of the problem of explaining abnormal behavior—that is, identifying its causes. Since antiquity, Western society has developed theories of abnormal behavior. Not only do the theories vary with the kinds of abnormality they seek to explain; they often compete with each other to explain the same abnormality—and the entire problem of abnormal behavior. These various explanations have a common base in that they are all naturalistic. That is, in keeping with a secular and scientific age, they seek to account for abnormal behavior in terms of natural events—disturbances in the body or disturbances in human relationships. Beyond this, however, they differ considerably, and since they will figure importantly in the succeeding chapters of this book, it is worth examining them briefly at this point.

The Medical Model According to what is loosely called the **medical model** (or *disease model*), abnormal behavior is like a disease: each kind of abnormal behavior, like each disease, has specific *causes* and a specific *set of symptoms* (a "syndrome"). In its strictest sense, the medical model also implies that the abnormal behavior is **biogenic**—that is, it results from some malfunction within the body. However, even those who do not think that all abnormal behavior is biologically *caused* may still reflect the assumptions of the medical model if they consider "symptoms" the products of underlying causes.

Biogenic theories of abnormal behavior have been with us since ancient times. In the Middle Ages and the Renaissance they coexisted with supernatural theory, the belief that abnormal behavior was caused by God or, more often, the devil. But in the eighteenth and early nineteenth centuries, religious explanations went into decline, and theories of biological causation predominated. Since abnormal behavior was considered an illness, it was thought to be the exclusive province of medicine. It was within the framework of these assumptions that the modern discipline of abnormal psychology developed in the nineteenth century. Most of the major early theoreticians of abnormal psychology, regardless of their specific theories, were medical doctors who saw abnormality as illness.

This newly dominant medical approach was soon rewarded by a series of extremely important breakthroughs. Several previously unexplained behavior patterns were found to result from identifiable brain pathologies—infection, poisoning, and the like. Such discoveries brought immense prestige to the organic theory of abnormal behavior. Medicine, it was assumed, would ultimately conquer madness. And on this assumption, madness was increasingly turned over to the medical profession.

At the same time, there remained many patterns of abnormal behavior—indeed, the majority—for which no medical cause had been discovered. Yet because researchers were confident that such causes would eventually be found (and because abnormal behavior was by now the province of medicine), these patterns were treated *as if* they were organically based. In other words, they were treated according to a medical "model." (In scientific terms, a "model" is an analogy.) This meant not only that abnormal behavior should be handled by physicians, in hospitals, and by means of medical treatments (for instance, drugs); it also meant that the entire problem of deviant behavior should be conceptualized in medical terms. Today, even those who seriously question the medical model still find themselves using such terms as "symptom," "syndrome," "pathology," "mental illness," "mental disorder," "patient," "therapy," "treatment," and "cure," all of which are derived from the medical analogy (Price, 1978). Although this book is not based on the medical model, such terms will occur here repeatedly. They are almost unavoidable.

A number of psychologists and other researchers in abnormal psychology, however, have pointed out that the medical model is merely an analogy. Most