MODULE 13.1

What Is Abnormal Behavior?

- What criteria are used to determine whether behavior is abnormal?
- What are the major models of abnormal behavior?
- What are psychological disorders?

Concept 13.1
Psychologists use several criteria in determining whether behavior is abnormal, including unusualness, social deviance, emotional distress, maladaptive behavior, dangerousness, and faulty perceptions of reality.

Determining whether behavior is abnormal is a more complex problem than it may seem at first blush. Most of us get anxious or depressed from time to time, but our behavior is not abnormal. The same behavior may be deemed normal under some circumstances but abnormal in others. For example, anxiety during a job interview is normal, but anxiety experienced whenever you board an elevator is not. Deep feelings of sadness are appropriate when you lose a loved one, but not when things are going well or following a mildly upsetting event that others take in stride.

Charting the Boundaries Between Normal and Abnormal Behavior

Where, then, might we draw the line between normal and abnormal behavior? Psychologists typically identify abnormal behavior based on a combination of the following criteria (Nevid, Rathus, & Greene, 2003):

1. *Unusualness.* Behavior that is unusual, or experienced by only a few, may be abnormal—but not in all cases or situations. Surely it is unusual for people to report "hearing voices" or, like Claire, to walk through town warding off demons. Yet uncommonness, by itself, is not sufficient to be deemed abnormal. Exceptional behavior, such as the ability to hit a three-point jump shot with some regularity or to become a valedictorian, is also unusual; but it is not abnormal.
2. *Social deviance.* All societies establish standards or social norms that define socially acceptable behaviors. Deviation from these norms is often used as a criterion for labeling behavior as abnormal. The same behavior might be considered abnormal in some contexts but perfectly acceptable in others. For example, we might consider it abnormal to shout vulgarities at strangers in the street. Yet shouting vulgarities at an umpire or referee who misses an important call in a ballgame may fall within the range of acceptable social norms, however offensive it might be.
3. *Emotional distress.* States of emotional distress, such as anxiety or depression, are considered abnormal when inappropriate, excessive, or prolonged relative to the person's situation.
4. *Maladaptive behavior.* Behavior is maladaptive when it causes personal distress, is self-defeating, or is associated with significant health, social, or occupational problems. For example, abuse of alcohol or other drugs may threaten an individual's health and ability to function in meeting life's responsibilities.
5. *Dangerousness.* Violent or dangerous behavior is another criterion for which we need to examine the social context. For example, engaging in behavior that is dangerous to oneself or others may be an act of bravery in times of war, but not in peacetime. Hockey players and football players regularly engage in physically aggressive behavior that may be dangerous to themselves or their opponents, but their (controlled) violent behavior is often rewarded with lucrative contracts and endorsement deals. Outside the sanctioned

Is This Man Abnormal? Abnormality must be judged in relation to cultural standards. The behavior and style of dress of this football fan may be in bad taste but would probably not be considered abnormal in a contemporary context.

contexts of warfare and sports, however, violent behavior is likely to be considered abnormal.

6. *Faulty perceptions or interpretations of reality.* **Hallucinations** ("hearing voices" or seeing things that are not there) involve distorted perceptions of reality. Similarly, fixed but unfounded beliefs, called **delusions**, such as believing that FBI agents are listening in on your phone conversations, represent faulty interpretations of reality (unless of course the FBI really is tapping your phone).

As we shall see next, the cultural context in which behavior occurs must also be evaluated when making judgments about whether behavior is abnormal.

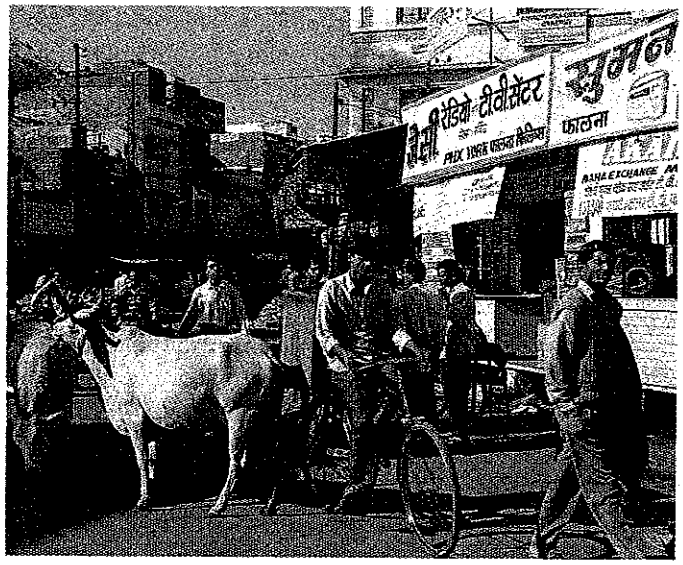
Concept 13.2
Behavior that is deemed to be normal in some cultures may be considered abnormal in others.

Cultural Bases of Abnormal Behavior Psychologists take the cultural context into account when making judgments about abnormal behavior. They realize that the same behavior can be normal in one culture but abnormal in another. For example, in the majority American culture, "hearing voices" is deemed abnormal. Yet among some Native American peoples, it is considered normal for individuals to hear voices of their recently deceased relatives. They believe that the voices of the departed call out as their spirit ascends to the afterworld (Kleinman, 1987). Such behavior, because it falls within the normal spectrum of the culture in which it occurs, is not deemed abnormal—even if it may seem so to people from other cultures.

Abnormal behavior patterns may be expressed differently in different cultures. For example, people in Western cultures may experience anxiety in the form of excessive worries about financial, health, or job-related concerns. Among some native African peoples and Australian aboriginal peoples, anxiety may be expressed in the form of fears of witchcraft or sorcery (Kleinman, 1987). And among the Chinese, depression is often expressed in the form of physical symptoms, such as headaches, fatigue, and weakness, rather than as feelings of sadness (American Psychiatric Association, 2000; Parker, Gladstone, & Chee, 2001).

Concept 13.3
Culture-bound disorders are abnormal behavior patterns found in only one or a few cultures.

Some forms of abnormal behavior in a particular culture may have no direct counterpart in another culture. For example, **culture-bound syndromes** are psychological disorders that occur in only one culture, or perhaps in only a few (American Psychiatric Association, 2000; Osborne, 2001). For example, in cases of **Dhat syndrome**, a disorder found primarily in India, men experience intense fears of losing semen during nocturnal emissions (Akhtar, 1988). Culture-bound



Culture-Bound Syndromes Culture-bound syndromes are found in only one culture, or perhaps a few, and may represent exaggerated forms of commonly held superstitions and belief patterns.

hallucinations Perceptions ("hearing voices" or seeing things) that are experienced in the absence of external stimuli.

delusions Fixed but patently false beliefs, such as believing that one is being hounded by demons.

culture-bound syndromes Psychological disorders found in only one or a few cultures.

Dhat syndrome A culture-bound syndrome found in India in which men develop intense fears about losing semen.

About It

Normal vs. Abnormal?

What criteria do you use to distinguish between normal and abnormal behavior? How do the criteria you use stack up against those described in the text?

syndromes often reflect exaggerated forms of commonly held superstitions and belief patterns of a particular culture. In Indian culture, there is a popular belief that loss of semen is harmful because it depletes the man's body of its vital natural energy (Chadda & Ahuja, 1990).

Alternatively, the same behavior may be judged abnormal at some points in time but not at others. For example, although the American Psychiatric Association once classified homosexuality as a type of mental disorder, it no longer does so. Many professionals today consider homosexuality a variation of sexual behavior rather than an abnormal behavior pattern (Cabaj & Stein, 1996).

Applying the Criteria Reconsider the examples of Claire and Phil described at the start of this chapter. Is their behavior abnormal? Claire's behavior certainly met several of the criteria of abnormal behavior. It was clearly unusual as well as socially deviant, and it represented what most people would take to be a delusion—believing you are protecting the community from demons. It was also clearly maladaptive and dangerous, as it put at risk not only Claire herself but also the drivers who were forced to swerve out of the way to avoid hitting her.

Mental Health: Culture, Race, and Ethnicity/Link

Phil, on the other hand, had good contact with reality. He understood that his fears exceeded the dangers he faced. Yet his phobia was a source of considerable emotional distress and was maladaptive because it impaired his ability to carry out his occupational and family responsibilities. We might also employ a criterion of unusualness here. Relatively few people have such fears of confinement that they avoid flying or taking elevators. Yet, as we have noted, unusualness alone is not a sufficient criterion for abnormality.

The behavior of these individuals could be considered abnormal, although they invoke different criteria. Overall, professionals apply multiple criteria when making judgments about abnormality.

Models of Abnormal Behavior

Concept 13.4
Throughout much of Western history, the prevailing view of abnormal behavior was based on a concept of demonic possession.

Abnormal behavior has existed in all societies, even though the view of what is or is not abnormal varies from culture to culture and has changed over time. In some cases, these explanations have led to humane treatment of people with abnormal behavior, but more frequently, people deemed to be "mad" or mentally ill were treated cruelly or harshly.

Exorcism Exorcism was used in medieval times to expel evil spirits from people believed to be possessed.

Early Beliefs Throughout much of Western history, from ancient times through the Middle Ages, people thought that those displaying abnormal behavior were controlled by supernatural forces or possessed by demonic spirits. Beliefs in supernatural causes of abnormal behavior, especially the doctrine of demonic possession, held sway until the rise of scientific thinking in the seventeenth and eighteenth centuries. The treatment of choice for demonic possession—*exorcism*—was used to ferret out satanic forces or the Devil himself from the afflicted person's body. If that didn't work, there were even more forceful "remedies," such as the torture rack. Not surprisingly, many recipients of these "cures" attempted to the best of their ability to modify their behavior to meet social expectations.

The period spanning the fifteenth through seventeenth centuries was a dangerous time to be unpopular with one's neighbors. This was an era of massive religious persecution of people deemed to be witches or in league with witches. Many people accused of witchcraft were burned at the stake. Though some "witches" may have been people with disturbed behavior, modern scholars believe that accusations of witchcraft were mostly used as a convenient way of disposing of people who were nuisances or political rivals, of seizing property, and of suppressing heresy (Spanos, 1978).

Concept 13.5
ith the rise of scientific thought, ention began to shift from religious gma to scientific or naturalistic planations of human behavior.

The Medical Model The eighteenth and nineteenth centuries were times of rapid advances in medical science. Among the more notable advances were the development of a vaccine against the ancient scourge of smallpox, the discovery of the bacterial causes of diseases such as anthrax and leprosy, and the introduction of antiseptics in surgery to prevent infections. It was against this backdrop of medical discovery and shifts from religious dogma to scientific or naturalistic explanations of human behavior that the first modern model of abnormal behavior was developed, the **medical model**. The medical model is based on the belief that abnormal behavior patterns represent *mental illnesses* that have a biological, not demonic, basis and can be classified by their particular characteristics, or symptoms.

Concept 13.6
ychodynamic, behavioral, humanis-, and cognitive models focus on the ychological roots of abnormal havior.

Psychological Models Even as the medical model was taking shape, theorists were actively developing psychological models of abnormal behavior. The first major psychological model of abnormal behavior was the psychodynamic model developed by Sigmund Freud. Freud believed that abnormal behavior arises from unconscious conflicts during childhood that remain unresolved in the personality. These conflicts result from the need to control primitive sexual and aggressive impulses or to channel them into socially acceptable outlets. Psychological symptoms (a phobia, for example) are merely the outward expressions of inner turmoil. The person may be aware of the symptom (the phobia) but not of the unconscious conflicts that gave rise to it. Contemporary psychodynamic theorists differ from Freud in some respects, but they retain the central belief that unconscious conflicts are at the root of abnormal behavior patterns.

At about the time that Freud was plumbing the depths of the unconscious, behaviorists were exploring the role of learning in the development of abnormal behavior. Pavlov's discovery of the conditioned response gave the early behaviorist movement a model for studying how maladaptive behaviors, such as phobias, could be learned or acquired through experience. The behavioral model is based on the belief that most forms of abnormal behavior are learned in the same ways that normal behavior is learned. Among the early demonstrations of the role of learning in the development of abnormal behavior was the experiment with "Little Albert" (discussed in Chapter 5). In this experiment, John B. Watson and his colleague Rosalie Rayner (1920) induced a fear of white rats in a young boy by presenting a noxious stimulus (loud banging sound) whenever a rat was brought close to the child. The repeated pairing of the conditioned stimulus (rat) and unconditioned stimulus (loud banging) instilled a conditioned response (fear evoked by the rat itself).

The humanistic model offers another psychological perspective on abnormal behavior. Humanistic theorists such as Carl Rogers and Abraham Maslow rejected the belief that human behavior is the product of either unconscious processes or simple conditioning. Human beings, they argued, possess an intrinsic ability to make conscious choices and to strive toward self-actualization. Abnormal behavior develops when people encounter roadblocks on the path toward personal growth or self-actualization. To satisfy the demands of others to think, feel, and act in certain ways, people may become detached from their true selves and develop a distorted self-image that can lead to emotional problems such as anxiety and depression. Humanistic theorists believe that people with psychological problems need to become more aware of their true feelings and come to accept themselves for who they truly are.

nedical model A framework for understanding abnormal behavior patterns as ymptoms of underlying physical disorlers or diseases.

Cognitive theorists, such as Albert Ellis and Aaron Beck, believe that irrational or distorted thinking leads to emotional problems and maladaptive behavior. Examples of faulty styles of thinking include magnifying or exaggerating the consequences of negative events ("making mountains out of molehills") and

interpreting events in an overly negative way, as though one were seeing things through blue-colored glasses.

Concept 13.7
The sociocultural model views abnormal behavior in terms of the social and cultural contexts in which it occurs.

The Sociocultural Model The sociocultural model views the causes of abnormal behavior within the broader social and cultural contexts in which the behavior develops. Theorists in this tradition believe that abnormal behavior may have more to do with social ills or failures of society than with problems within the individual. Accordingly, they examine a range of social and cultural influences on behavior, including social class, poverty, ethnic and cultural background, and racial and gender discrimination. Sociocultural theorists believe that the stress of coping with poverty and social disadvantage can eventually take its toll on mental health. This view is buttressed by evidence that severe forms of abnormal behavior, such as schizophrenia and depression, are found proportionately more often within poor and socially disadvantaged groups (Ostler et al., 2001).

Sociocultural theorists also focus on the effects of labeling people as mentally ill. They recognize that because of social prejudices, people who are labeled mentally ill are often denied job or housing opportunities and become stigmatized or marginalized in society. These theorists join with other professionals in arguing for greater understanding and support for people with mental health problems.

In a powerful demonstration of the effects of psychiatric labeling, psychologist David Rosenhan (1973) had seven friends and colleagues present themselves to the admissions office of a mental hospital. They pretended they were hearing voices that said "empty," "hollow," and "thud." Each of these pseudopatients was admitted, and all but one was diagnosed with schizophrenia. Even though they did not exhibit any other symptoms or report hearing any more voices, staff members interpreted their otherwise normal behavior as symptoms of their illness. For example, when they took notes on what they observed, staff members described their behavior as "paranoid." Rosenhan suggested that a psychiatric diagnosis has a "stickiness" that makes it difficult for people to see beyond the label and treat patients as individuals.

Concept 13.8
Today there is increasing convergence toward a biopsychosocial model of abnormal behavior, which focuses on the contributions and interactions of biological and psychosocial influences.

The Biopsychosocial Model Today we have many different models to explain abnormal behavior. Indeed, because there are different ways of looking at a given phenomenon, we can't conclude that one particular model is necessarily right and all the others wrong. Each of these models—medical, psychological, and sociocultural—has something unique to offer our understanding of abnormal behavior. None offers a complete view.

Abnormal behavior presents us with many puzzles as we attempt to unravel its causes. How is mental functioning affected by biology—by genes, brain structures, and neurotransmitter systems? What psychological factors are involved, such as underlying motives or conflicts, personality traits, cognitions, and learned behaviors? And how is our behavior affected by society and culture? Many psychologists today subscribe to the view that most forms of abnormal behavior are not simply products of biology or environment alone; rather, they result from complex interactions of biological, psychological, and sociocultural factors. The view that multiple factors representing these different domains interact in the development of abnormal behavior is called the **biopsychosocial model** (Kiesler, 1999). We are only beginning to put together the pieces of what has turned out to be a very complicated puzzle—the subtle and often complex patterns of underlying factors that give rise to abnormal behavior patterns.

A prominent example of the biopsychosocial model is the **diathesis-stress model**. According to this model, certain people have a vulnerability or predisposition, called a **diathesis**, that increases their risks of developing a particular disorder. Though usually genetic in nature, the diathesis may include psychological factors such as maladaptive personality traits or dysfunctional thinking patterns (Just, Abramson, & Alloy, 2001; Lewinsohn, Joiner, & Rohde, 2001; Ormel et al.,

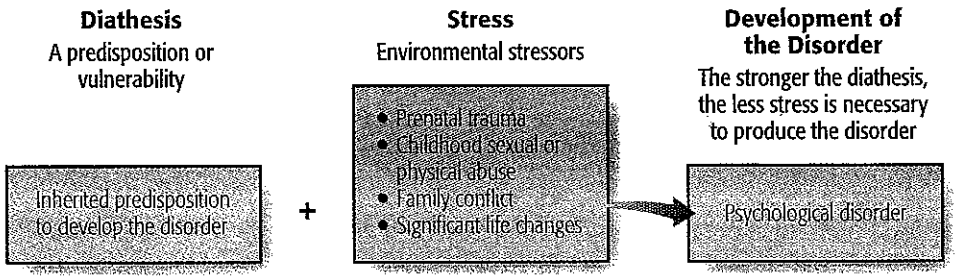


Figure 13.1 The Diathesis-Stress Model
The diathesis-stress model posits that the development of particular disorders involves an interaction of a predisposition (diathesis), usually genetic in nature, and exposure to life stress.

Source: Nevid, Rathus, & Greene, 2003.

2001). Whether the person possessing a diathesis develops the particular disorder depends on the level of stress he or she experiences. Stressors may include family conflict, prolonged unemployment, loss of loved ones, physical or sexual abuse, brain trauma, or infectious illness. If the person encounters a low level of stress, or has effective skills for handling stress, the disorder may never emerge even if a diathesis is present. But the stronger the diathesis, the less stress is typically needed to produce the disorder (see Figure 13.1). In some cases, the diathesis may be so strong that the disorder develops even under the most benign life circumstances.

What Are Psychological Disorders?

Concept 13.9
Psychological disorders are patterns of disturbed behavior, mood, thinking, or perception that cause personal distress or impaired functioning.

Distinctive patterns of abnormal behavior are classified as **psychological disorders**—also known as *mental disorders* or *mental illnesses* within the medical model. Psychological disorders involve disturbances of mood, behavior, thought processes, or perception that result in significant personal distress or impaired functioning. Examples of psychological disorders include schizophrenia, anxiety disorders such as phobias and panic disorder, and mood disorders such as major depression.

How Many Are Affected? Psychological disorders are far more common than many people think. You may not have had contact with people severely impaired by psychological disorders, but chances are that either you or someone you know will be affected by a psychological disorder at one time or another. Investigators find that about one in two adult Americans develops a diagnosable psychological disorder at some point in her or his life (Kessler, 1994; see Figure 13.2). If we also take into account the economic costs of diagnosing and treating these disorders, and the lost productivity and wages that result from them, it is fair to say

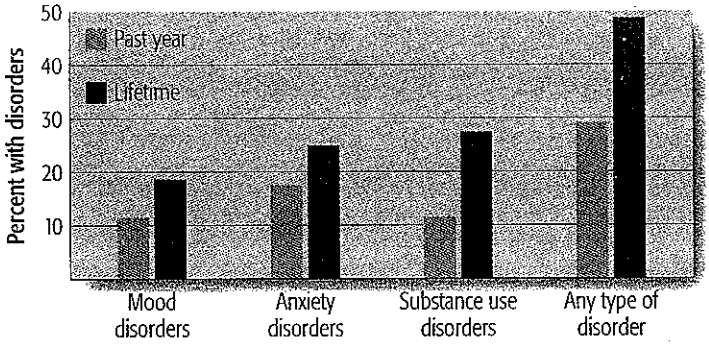


Figure 13.2 Prevalence of Psychological Disorders
These data were drawn from a representative survey of the adult U.S. population in the 15 to 49 age range. Nearly 50 percent suffer from a diagnosable psychological or mental disorder at some point in their lives. About three in ten are suffering from a current disorder.

Source: National Comorbidity Survey; Kessler et al., 1994.

biopsychosocial model An integrative model for explaining abnormal behavior patterns in terms of the interactions of biological, psychological, and sociocultural factors.

diathesis-stress model A type of biopsychosocial model that relates the development of disorders to the combination of a diathesis, or predisposition, usually genetic in origin, and exposure to stressful events or life circumstances.

diathesis A vulnerability or predisposition to developing a disorder.

psychological disorders Abnormal behavior patterns characterized by disturbances in behavior, thinking, perceptions, or emotions that are associated with significant personal distress or impaired functioning. Also called *mental disorders* or *mental illnesses*.

that virtually everyone is affected by psychological disorders (Druss et al., 2000; "Mental Health Problems," 2000).

Concept 13.10
The DSM, the diagnostic system used most widely for classifying psychological or mental disorders, consists of five dimensions or axes of evaluation.

How Are Psychological Disorders Classified? One reference book found on the shelves of virtually all mental health professionals and probably dog-eared from repeated use is the *Diagnostic and Statistical Manual of Mental Disorders,* or DSM—currently in a fourth, text-revised edition, the DSM-IV-TR (American Psychiatric Association, 2000). The manual contains descriptions and diagnostic criteria for every recognized psychological disorder, which in the manual are called *mental disorders.*

The DSM classifies mental disorders on the basis of their distinctive features or symptoms. But the DSM goes beyond merely classifying various disorders. It represents a multiaxial system consisting of multiple axes or dimensions that help the examiner conduct a comprehensive evaluation of a person's mental health (see Table 13.1). Axis I and Axis II comprise the diagnostic classifications. The DSM classifies mental disorders into several major groupings, including *anxiety disorders, mood disorders, eating disorders,* and *personality disorders.*

Axis III lists general medical conditions and diseases, such as cancer and AIDS, that may affect a person's mental health, whereas Axis IV allows the examiner to note any psychosocial and environmental problems that impair the person's ability to function, such as stressful life events, homelessness, and lack of social support. Finally, Axis V allows the examiner to make a global assessment of the person's overall level of functioning in meeting life responsibilities.

Though the DSM is the most widely used diagnostic system, it is not without its critics. Questions remain about the reliability and validity of certain diagnostic classifications (Langenbucher et al., 2000; Widiger & Clark, 2000). Some mental health professionals challenge the system as based too heavily on the

TABLE 13.1 The Multiaxial DSM System

Axis	Type of Information	Brief Description
Axis I	Clinical disorders	Mental disorders that impair functioning or cause distress, including anxiety disorders, mood disorders, dissociative and somatoform disorders, schizophrenia, eating disorders, sleep disorders, and disorders usually first diagnosed in infancy, childhood, or adolescence
	Other conditions that may be a focus of clinical attention	Problems that may warrant attention, but do not represent diagnosable mental disorders, such as academic, vocational, or social problems affecting daily functioning
Axis II	Personality disorders	A class of mental disorders characterized by excessively rigid, enduring, and maladaptive ways of relating to others and adjusting to external demands
	Mental retardation	A generalized delay or impairment in the development of intellectual and adaptive skills or abilities
Axis III	General medical conditions	Illnesses and other medical conditions that may be important to the understanding or treatment of the person's psychological disorder
Axis IV	Psychosocial and environmental problems	Problems in the person's social or physical environment that may affect the diagnosis, treatment, and outcome of mental disorders
Axis V	Global assessment of functioning	Overall judgment of the person's level of functioning in meeting the responsibilities of daily life

Source: Adapted from the DSM-IV-TR (American Psychiatric Association, 2000).

medical model in which abnormal behaviors are assumed to be symptoms of underlying disorders or mental illnesses. Yet many clinicians find the system useful in providing designated criteria to help them formulate diagnostic impressions. Perhaps it is best to think of the DSM as a work in progress rather than as a finished product.

Let us next consider several of the major classes of psychological disorders. Each of the remaining modules in this chapter discusses a major class or type of psychological disorder and describes the prominent symptoms of specific disorders represented within each class, the rates of occurrence of these disorders, and theories about their underlying causes.

See Concept Chart 13.1 for a listing of the major contemporary models of abnormal behavior.

CONCEPT CHART 13.1
Contemporary Models of Abnormal Behavior

	Model	Focus	Key Questions
Medical Model	Medical model	Biological underpinnings of abnormal behavior	What role is played by neurotransmitters in abnormal behavior? By genetics? By brain abnormalities?
Psychological Models	Psychodynamic model	Unconscious conflicts and motives underlying abnormal behavior	How do particular symptoms represent or symbolize unconscious conflicts? What are the childhood roots of a person's problem?
	Behavioral model	Learning experiences that shape the development of abnormal behavior	How are abnormal patterns of behavior learned? What role does the environment play in explaining abnormal behavior?
	Humanistic model	Roadblocks that block self-awareness and self-acceptance	How does a person's emotional problems reflect a distorted self-image? What roadblocks did the person encounter in the path toward self-acceptance and self-realization?
	Cognitive model	Faulty thinking underlying abnormal behavior	What styles of thinking characterize people with particular types of psychological disorders? What role do personal beliefs, thoughts, and ways of interpreting events play in the development of abnormal behavior patterns?
	Sociocultural model	Social ills contributing to the development of abnormal behavior, such as poverty, racism, and prolonged unemployment; relationships between abnormal behavior and ethnicity, gender, culture, and socioeconomic level	What relationships exist between social-class status and risks of psychological disorders? Are there gender or ethnic group differences in various disorders? How are these explained? What are the effects of stigmatization of people who are labeled mentally ill?
	Biopsychosocial model	Interactions of biological, psychological, and sociocultural factors in the development of abnormal behavior	How might genetic or other factors predispose individuals to psychological disorders in the face of life stress? How do biological, psychological, and sociocultural factors interact in the development of complex patterns of abnormal behavior?