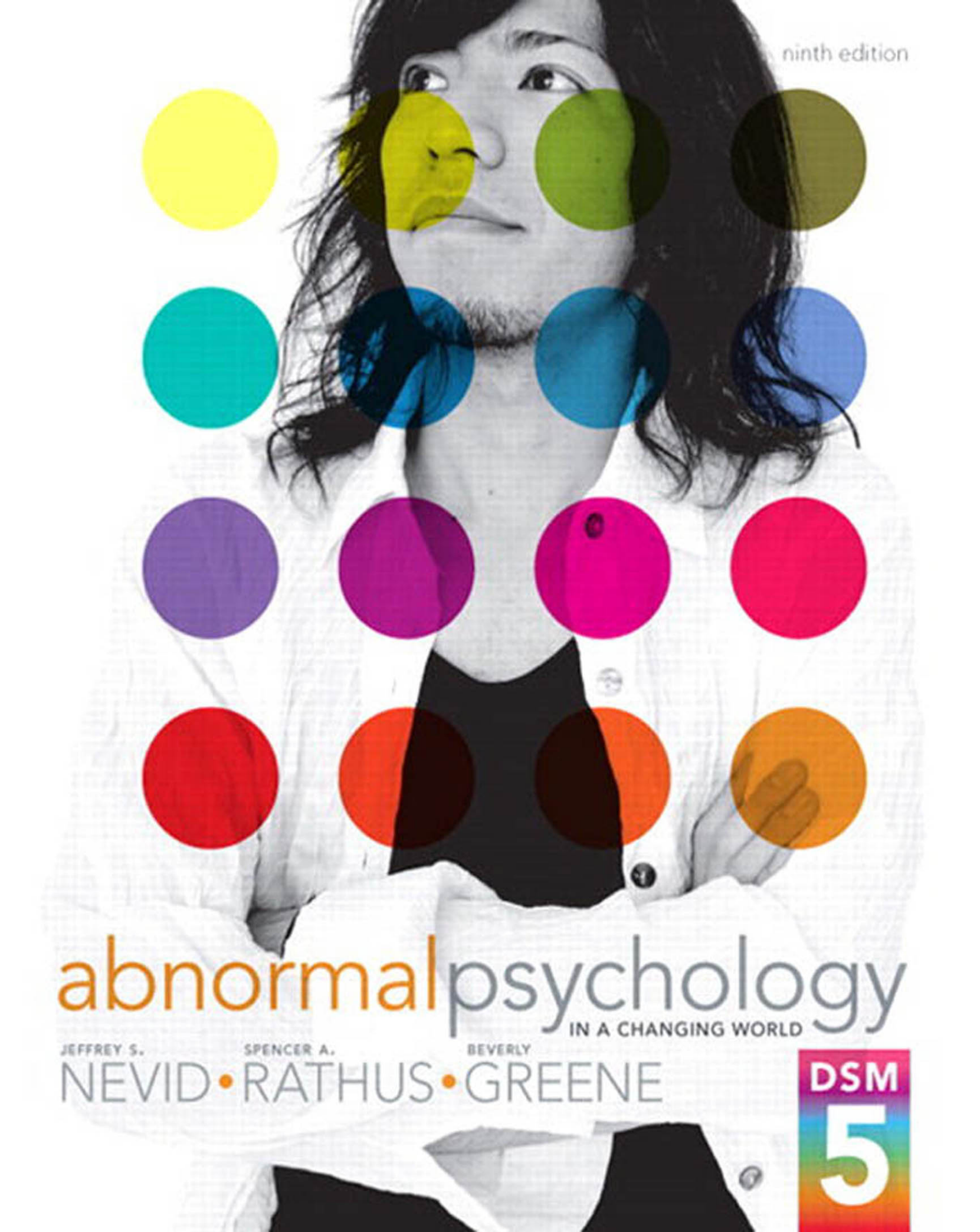
ninth edition



abnormal psychology

IN A CHANGING WORLD

JEFFREY S. NEVID • SPENCER A. RATHUS • BEVERLY GREENE

DSM 5

abnormal psychology

Ninth Edition

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preface

What's New in the Ninth Edition?

Welcome to the ninth edition of *Abnormal Psychology in a Changing World.* We continue to bring readers the latest research developments that inform contemporary understandings of abnormal behavior in a way that both stimulates student interest and makes complex material understandable. Highlights of this new edition include the following**:**

- **Full integration of *DSM-5*—**The *DSM-5* is integrated throughout the text, including reorganization of some chapters to parallel *DSM-5* classification
- **Inclusion of *DSM-5* Criteria Tables—**Updated diagnostic tables highlight *DSM-5* changes for selected disorders
- **Integration of Latest Scientific Developments**—Full updating of latest scientific research, including more than 1,000 new references since the last edition
- **Expanded Coverage of Disorders**—Expansion of coverage of disorders to include Hoarding Disorder, Premenstrual Dysphoric Disorder, Disruptive Mood Dysregulation Disorder, Major and Mild Neurocognitive Disorders, Somatic Symptom Disorder, Illness Anxiety Disorder, Intermittent Explosive Disorder, Pyromania, REM Sleep Behavior Disorder, and Social (Pragmatic) Communication Disorder, among others
- ***@Issue* Critical Thinking features**—This critical thinking boxed feature highlights current controversies in the field and poses critical thinking questions students can answer
- **Learning Objectives**—Learning objectives are now integrated throughout the chapters and tied to levels in Bloom's taxonomy using the unique IDEA model of course assessment
- **Introduction of QR Codes**—Use of QR codes students enables students to directly access sample video case vignettes on their smartphones or computers
- **Chapter Consolidation**—Now organized in 15 chapters to match up with a typical semester, the new edition combines previous chapters on theories and methods of treatment into one chapter (Chapter 2)

Putting a Human Face on the Study of Abnormal Psychology

We approach the teaching of abnormal psychology with five fundamental goals in mind:

- To help students distinguish abnormal from normal behavior and acquire a better understanding of abnormal behavior patterns
- To put a human face on the study of abnormal psychology and increase student sensitivity to the struggles of people suffering from these types of problems
- To help students understand the conceptual bases of abnormal behavior patterns
- To help students understand how our knowledge of abnormal behavior is informed by research developments in the field
- To help students understand how psychological disorders are classified and treated

We recognize there is a basic human dimension to the study of abnormal psychology. We invite students to enter the world of people struggling with psychological disorders by including many illustrative case examples and video case interviews of real people diagnosed with different disorders, and by including a unique pedagogical feature that takes this approach an important step further—the **"I"** feature.

The **"I"** feature brings students directly into the world of people affected by psychological disorders. The "**I"** feature consists of first-person narratives of people with psychological disorders as they tell their own stories in their own words. Incorporating first-person narratives helps break down barriers between "us" and "them," encouraging students to recognize that mental health problems are a concern to us all. At the beginning of every chapter and then integrated in the text, students will discover these poignant personal stories. Examples include the following:

- "Jerry Has a Panic Attack on the Interstate" (Panic Disorder)
- "Jessica's Little Secret" (Bulimia Nervosa)
- "I Hear Something You Can't Hear" (Schizophrenia)
- "Now Is the Last Best Time" (Alzheimer's Disease)

NEW! "@Issue" Critical Thinking Feature Puts a Spotlight on Controversies in the Field

Students may begin the course with an expectation that our knowledge of abnormal psychology is complete and incontrovertible. They soon learn that while we have learned much about the underpinnings of psychological disorders, much more remains to be learned. They also learn that there are many current controversies in the field. By spotlighting these controversies, we encourage students to think critically about these important issues and examine different points of view.

In this edition, we consolidate critical thinking about controversial issues in a boxed feature entitled ***@Issue*.** Here students learn about major controversies and are challenged with critical thinking questions. Instructors may encourage their students to answer the critical thinking questions as

required or elective writing assignments. Examples include the following:

- Should Therapists Treat Clients Online?
- What Accounts for the Gender Gap in Depression?
- Should We Use Drugs to Treat Drug Abuse?
- Is Mental Illness a Myth?

Two of the **@Issue** features in this edition are written by outside contributors who are leading authorities in the field: Dr. Thomas Widiger of the University of Kentucky ("The *DSM* : The Bible of Psychiatry"); and Dr. Jerry Deffenbacher of Colorado State University ("Anger Disorders and the *DSM:* Where Has All the Anger Gone?").

NEW! Interactive Concept Maps in Abnormal Psychology: A Unique Visual Learning Tool

Concept Maps in Abnormal Psychology are unique visual learning diagrams crafted to help students visualize linkages between specific disorders, underlying causal factors, and treatment approaches. Students learn best when they are actively engaged in the learning process. To engage students in active learning, we converted the Concept Maps in this edition to an interactive, online format hosted on *MyPsychLab*. The maps are presented in a fill-in-the-blanks format in which key words and terms are omitted so that students can fill in the missing pieces to complete these knowledge structures. The completed maps may be used as an active study tool or submitted to instructors as required course assignments or extra credit assignments.

Keeping Pace with an Ever-Changing Field

The text integrates the latest research findings and scientific developments in the field that inform our understanding of abnormal psychology. We present these research findings in a way that makes complex material engaging and accessible to the student.

Focus on Neuroscience

As part of our continuing efforts to integrate important advances in neuroscience that inform our understanding of abnormal behavior patterns, we have built upon the very solid foundations in previous editions to include new material from neuroscience research throughout the text. Students will read about the search for endophenotypes in schizophrenia, the emerging field of epigenetics, use of brain scans to diagnose psychological disorders, efforts to probe the workings of the meditative brain, potential use of drugs to enhance effectiveness of exposure therapy, and emerging research exploring whether disturbing memories linked to PTSD might be erased.

The Fully Integrated Textbook

Integrating the *DSM-5*

After years of development and debate, the *DSM-5* is finally here. **The ninth edition of the text is fully integrated with the *DSM-5*.** Instructors are challenged to revise their instructional materials in light of the many changes introduced in the *DSM-5*. We integrated the *DSM-5* throughout the text to allow a seamless transition in teaching abnormal psychology. We apply *DSM-5* criteria in the body of the text and in the many accompanying overview charts throughout the text. Although we recognize the importance of the *DSM* system in the classification of psychological or mental disorders, we believe a course in abnormal psychology should not be taught as a training course in the *DSM* or as a psychodiagnostic seminar. We also recognize the many limitations of the *DSM* system, even in its latest version.

Integrating Diversity

We examine abnormal behavior patterns in relation to factors of diversity such as ethnicity, culture, gender, sexual orientation, and socioeconomic status. We believe students need to understand how issues of diversity affect the conceptualization of abnormal behavior as well as the diagnosis and treatment of psychological disorders. We also believe that coverage of diversity should be integrated directly in the text, not separated off in boxed features.

Integrating Theoretical Perspectives

Students often feel as though one theoretical perspective must ultimately be right and all the others wrong. We examine the many different theoretical perspectives that inform contemporary understanding of abnormal psychology and help students integrate these diverse viewpoints in the ***Tying It Together*** feature. We also explore potential causal pathways involving interactions of psychological, sociocultural, and biological factors. We hope to impress upon students the importance of taking a broader view of the complex problems we address by considering the influences of multiple factors and their interactions.

NEW! Integrating Video Case Examples with Student-Enabled QR Codes

Video case examples provide students with opportunities to see and hear individuals who are diagnosed with different types of psychological disorders. Students can read about the clinical features of specific disorders and, with a few clicks of a computer mouse, see a video case example that illustrates concepts discussed in the text. The video case examples are highlighted in the margins of the text with an icon and can be accessed through *MyPsychLab* at www.mypsychlab.com. We also introduce student-enabled fast response or QR codes that allow students to directly access the first video case in a chapter for display on their smartphones or personal computers.

The video case examples supplement the many illustrative case examples included in the text itself. Putting a human face on the subject matter helps make complex material more accessible. Many of these case examples are drawn from our own clinical files and those of leading mental health professionals.

Integrating Critical Thinking

We encourage students to think more deeply about key concepts in abnormal psychology by including two sets of critical thinking items in each chapter. First, the *@Issue* feature highlights current controversies in the field and includes critical thinking questions that challenge students to think further about the issues discussed in the text. Second, the critical thinking questions at the end of each chapter challenge students to think carefully and critically about concepts discussed in the chapter and to reflect on how these concepts relate to their own experiences or experiences of people they know. To integrate writing-across-the-curriculum (WAC) objectives, instructors may wish to assign the critical thinking questions in the *@Issue* features and the critical thinking questions at the end of each chapter as required or extra-credit writing assignments.

NEW! Integrating Learning Objectives with Bloom's Taxonomy

This edition introduces learning objectives at the start of each chapter. The learning objectives in this text are integrated with the IDEA model of course assessment, which comprise four key acquired skills in the study of abnormal psychology that spell out the convenient acronym, IDEA:

1. **Identify** … criteria used to determine whether behavior is abnormal, categories of psychotropic or psychiatric drugs, specific types of disorders within diagnostic categories, risk factors for suicide among adolescents, etc.
2. **Define** or **Describe** … key features of different psychological disorders and theoretical understandings, etc.
3. **Explain** or **Evaluate** … major perspectives on abnormal psychology, effectiveness of psychotherapy, how cocaine affects the brain, etc.
4. **Apply** … key features of critical thinking, knowledge of healthy sleeping habits, the diathesis-stress model to the development of schizophrenia, etc.

The IDEA model is integrated with the widely used taxonomy of educational objectives developed by the renowned educational researcher Benjamin Bloom. Bloom's taxonomy is arranged in increasing levels of cognitive complexity. The lowest levels comprise basic knowledge and understanding. The middle level involves application of knowledge and the upper levels involve higher level skills of analysis, synthesis, and evaluation.

The learning objectives identified in the IDEA model represent three basic levels of cognitive skills in Bloom's taxonomy. *Identify*, *Describe*, and *Define* learning objectives represent basic levels of cognitive skills (i.e., knowledge and comprehension in the original Bloom taxonomy, or remembering and understanding in the revised Bloom taxonomy). The *Apply* learning objective reflects an intermediate level of cognitive skills involved in application of psychological concepts. *Evaluate* and *Explain* learning objectives assess more complex, higher-order skills in the hierarchy involving analysis, synthesis, and evaluation of psychological knowledge (or analyzing and evaluating domains as represented in the revised taxonomy). By building exams around these learning objectives, instructors can assess not only overall student knowledge, but also acquisition of skills at different levels of cognitive complexity in Bloom's taxonomy.

Maintaining Our Focus

Abnormal Psychology in a Changing World is a complete learning and teaching package that brings into focus four major objectives: (1) integrating an interactionist or biopsychosocial model of abnormal behavior, (2) underscoring the importance of issues of diversity to the understanding and treatment of psychological disorders, (3) maintaining currency, and (4) adopting a student-centric pedagogy.

Focus on the Interactionist Approach

We approached our writing with the belief that a better understanding of abnormal psychology is gained by adopting a biopsychosocial orientation that takes into account the roles of psychological, biological, and sociocultural factors and their interactions in the development of abnormal behavior patterns. We emphasize the value of taking an interactionist approach as a running theme throughout the text. We highlight a prominent interactionist model, the diathesis–stress model, to help students better understand the factors contributing to different forms of abnormal behavior.

Focus on Exploring Key Issues in Our Changing World

The ***A Closer Look*** feature provides opportunities for further exploration of selected topics that reflect cutting-edge issues in the field. A number of the ***A Closer Look*** features focus on advances in neuroscience research.

Focus on Student-Centric Pedagogy

We continually examine our pedagogical approach to find even better ways of helping students succeed in this course. To foster deeper understanding, we include many pedagogical aids, such as ***Truth or Fiction*** chapter openers to capture student attention and interest, ***self-scoring questionnaires*** to encourage active learning through self-examination, and ***overview charts,*** which are capsulized summaries of disorders that students can use as study charts.

"TRUTH OR FICTION" CHAPTER OPENERS

Each chapter begins with a set of ***Truth or Fiction*** questions to whet the student's appetite for the subject matter within the chapter. Some items challenge preconceived ideas and common folklore and debunk myths and misconceptions, whereas others highlight new research developments in the field. Instructors and students have repeatedly reported to us that they find this feature stimulating and challenging.

The ***Truth or Fiction*** questions are revisited and answered in the sections of the chapter where the topics are discussed. Students are thus given feedback concerning the accuracy of their preconceptions in light of the material being addressed.

SELF-SCORING QUESTIONNAIRES

These questionnaires on various topics involve students in the discussion at hand and encourage them to evaluate their own attitudes and behavior patterns. In some cases, students may become more aware of troubling concerns, such as states of depression or problems with drug or alcohol use, which they may want to bring to the attention of a helping professional. We have carefully developed and screened the questionnaires to ensure they will provide students with useful information to reflect on as well as serve as a springboard for class discussion.

OVERVIEW CHARTS

These visually appealing overview charts provide summaries of various disorders. We are gratified by the many comments from students and professors regarding the value of these "at-a-glance" study charts.

"SUMMING UP" CHAPTER SUMMARIES

Summing Up chapter summaries provide brief answers to the learning objectives posed at the beginning of the chapter. These summaries provide students with feedback they can use to compare their own answers to those provided in the text.

Ancillaries

No matter how comprehensive a textbook is, today's instructors and students require a complete teaching package to advance teaching and comprehension. *Abnormal Psychology in a Changing World* is accompanied by the following ancillaries:

MyPsychLab for Abnormal Psychology

MyPsychLab is an online homework, tutorial, and assessment program that truly engages students in learning. It helps students better prepare for class, quizzes, and exams—resulting in better performance in the course. It provides educators a dynamic set of tools for gauging individual and class performance. To order the ninth edition with MyPsychLab, use ISBN 0205965016.

Speaking Out: Interviews with People Who Struggle with Psychological Disorders

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

Volume 1: ISBN 0-13-193332-9
Volume 2: ISBN 0-13-600303-6
Volume 3: ISBN 0-13-230891-6

Instructor's Manual (020597189X)

A comprehensive tool for class preparation and management, each chapter includes learning objectives, a chapter outline, lecture and discussion suggestions, "think about it" discussion questions, activities and demonstrations, suggested video resources, and a sample syllabus. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

Test Bank (0205971881)

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

MyTest (020597838X)

A powerful assessment-generation program that helps instructors easily create and print quizzes and exams. Questions and tests can be authored online, allowing instructors ultimate flexibility and the ability to efficiently manage assessments anytime, anywhere. Instructors can easily access existing questions and edit, create, and store questions using a simple drag-and-drop technique and word-like controls. Data on each question provide information on difficulty level and the page number of corresponding text discussion. For more information, go to www.PearsonMyTest.com.

Lecture PowerPoint Slides (ISBN 0205979610)

The PowerPoint slides provide an active format for presenting concepts from each chapter and feature relevant figures and tables from the text. Available for download on the Instructor's Resource Center at www.pearsonhighered.com.

Enhanced Lecture PowerPoint Slides with Embedded Videos (ISBN 0205997430)

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

PowerPoint Slides for Photos, Figures, and Tables (ISBN 0205979629)

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

CourseSmart (ISBN 0205968368)

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Acknowledgments

With each new edition, we try to capture a moving target, as the literature base that informs our understanding continues to expand. We are deeply indebted to the thousands of talented scholars and investigators whose work has enriched our understanding of abnormal psychology. Thanks to our colleagues who reviewed our manuscript through earlier editions and continue to help us refine and strengthen our presentation of this material:

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received his Ph.D. from the University at Albany. He is on the faculty of the College of New Jersey. His areas of interest include psychological assessment, cognitive behavior therapy, and deviant behavior. He is the originator of the Rathus Assertiveness Schedule, which has become a Citation Classic. He has authored several books, including *Psychology in the New Millennium*, *Essentials of Psychology*, and *The World of Children*. He coauthored *Making the Most of College* with Lois Fichner-Rathus; *AIDS: What Every Student Needs to Know* with Susan Boughn; *Behavior Therapy, Psychology and the Challenges of Life*, *Your Health*, *Health in the New Millennium*, and *HLTH* with Jeffrey S. Nevid; and *Human Sexuality in a World of Diversity* with Jeffrey S. Nevid and Lois Fichner-Rathus. His professional activities include service on the American Psychological Association Task Force on Diversity Issues at the Precollege and Undergraduate Levels of Education in Psychology, and on the Advisory Panel, American Psychological Association, Board of Educational Affairs (BEA) Task Force on Undergraduate Psychology Major Competencies.

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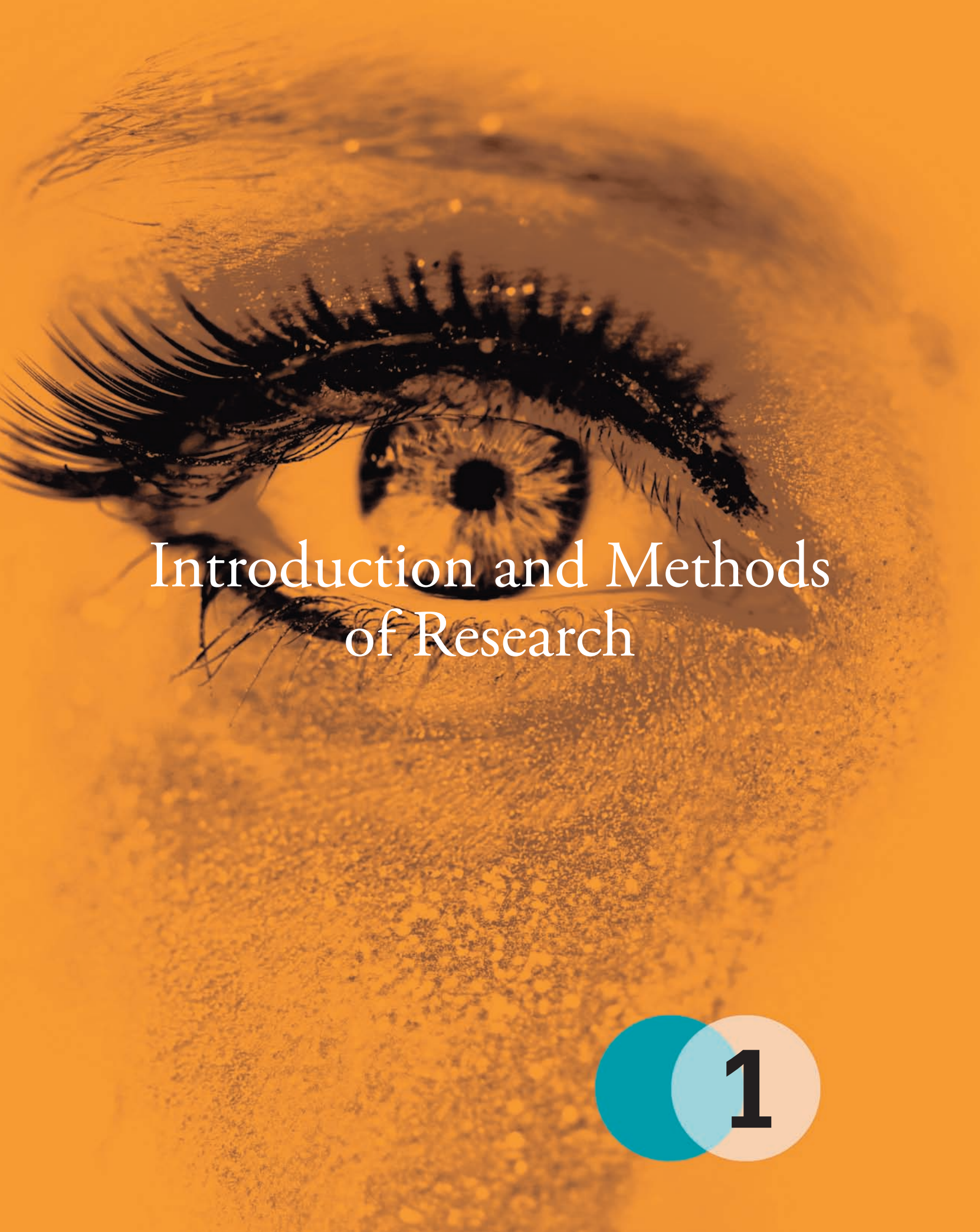


Introduction and Methods of Research

1

learning objectives

1.1
Define the term psychological disorder.

1.2
Identify criteria professionals use to determine whether behavior is abnormal.

1.3
Apply these criteria to case examples discussed in the text.

1.4
Describe the cultural bases of abnormal behavior.

1.5
Describe the historical changes that have occurred in conceptualizations and treatment of abnormal behavior through the course of Western culture.

1.6
Describe the major contemporary perspectives on abnormal behavior.

1.7
Identify the objectives of science and the steps in the scientific method.

1.8
Identify the ethical principles that guide research in psychology.

1.9
Describe the major types of research methods scientists use to study abnormal behavior and evaluate the strengths and weaknesses of these methods.

1.10
Apply key features of critical thinking to the study of abnormal behavior.

truth OR fiction

T☐ F☐ About one in ten American adults suffer from a diagnosable mental or psychological disorder in any given year. (p. 4)

T☐ F☐ Although effective treatments exist for some psychological disorders, we still lack the means of effectively treating most types of psychological disorders. (p. 5)

T☐ F☐ Unusual behavior is abnormal. (p. 5)

T☐ F☐ Psychological problems like depression may be experienced differently by people in different cultures. (p. 9)

T☐ F☐ A night's entertainment in London a few hundred years ago might have included gaping at the inmates at the local asylum. (p. 12)

T☐ F☐ Despite changing attitudes in society toward homosexuality, the psychiatric profession continues to classify homosexuality as a mental disorder. (p. 18)

T☐ F☐ Recent evidence shows there are literally millions of genes in the nucleus of every cell in the body. (p. 28)

T☐ F☐ Case studies have been conducted on dead people. (p. 29)

"I" "Pretty Grisly Stuff"

I never thought I'd ever see a psychologist or someone like that, you know. I'm a police photographer and I've shot some pretty grisly stuff, corpses and all. Crime scenes are not like what you see on TV. They're more grisly. I guess you kind of get used to it. It never bothered me, just maybe at first. Before I did this job, I worked on a TV news chopper. We would take shots of fires and rescues, you know. Now I get uptight sitting in the back seat of a car or riding an elevator. I'll avoid taking an elevator unless I really have no other choice. Forget flying anymore. It's not just helicopters. I just won't go in a plane, any kind of plane.

I guess I was younger then and more daring when I was younger. Sometimes I would hang out of the helicopter to shoot pictures with no fear at all. Now, just thinking about flying makes my heart race. It's not that I'm afraid the plane will crash. That's the funny thing. Not ha-ha funny, but peculiar, you know. I just start trembling when I think of them closing that door, trapping us inside. I can't tell you why.

Source: From the Author's Files

Phil, 42, a police photographer

"I" Cowering Under the Covers

When I start going into a high, I no longer feel like an ordinary housewife. Instead I feel organized and accomplished and I begin to feel I am my most creative self. I can write poetry easily. I can compose melodies without effort. I can paint. My mind feels facile and absorbs everything. I have countless ideas about improving the conditions of mentally retarded children, of how a hospital for these children should be run, what they should have around them to keep them happy and calm and unafraid. I see myself as being able to accomplish a great deal for the good of people. I have countless ideas about how the environment problem could inspire a crusade for the health and betterment of everyone. I feel able to accomplish a great deal for the good of my family and others. I feel pleasure, a sense of euphoria or elation. I want it to last forever. I don't seem to need much sleep. I've lost weight and feel healthy and I like myself. I've just bought six new dresses, in fact, and they look quite good on me.

I feel sexy and men stare at me. Maybe I'll have an affair, or perhaps several. I feel capable of speaking and doing good in politics. I would like to help people with problems similar to mine so they won't feel hopeless.

It's wonderful when you feel like this. . . . The feeling of exhilaration—the high mood—makes me feel light and full of the joy of living. However, when I go beyond this stage, I become manic, and the creativeness becomes so magnified I begin to see things in my mind that aren't real. For instance, one night I created an entire movie, complete with cast, that I still think would be terrific. I saw the people as clearly as if watching them in real life. I also experienced complete terror, as if it were actually happening, when I knew that an assassination scene was about to take place. I cowered under the covers and became a complete shaking wreck. . . . My screams awakened my husband, who tried to reassure me that we were in our bedroom and everything was the same. There was nothing to be afraid of. Nevertheless, I was admitted to the hospital the next day.

Source: Fieve, 1975, pp. 27–28

A firsthand account of a 45-year-old woman with bipolar disorder

"I" **Thomas Hears Voices**

I've been diagnosed as having paranoid schizophrenia. I also suffer from clinical depression. Before I found the correct medications, I was sleeping on the floor, afraid to sleep in my own bed. I was hearing voices that, lately, had turned from being sometimes helpful to being terrorizing. The depression had been responsible for my being irritable and full of dread, especially in the mornings, becoming angry over frustrations at work, and seemingly internalizing other people's problems. . . .

The voices, human sounding, and sounding from a short distance outside my apartment, were slowly turning nearly all bad. I could hear them jeering me, plotting against me, singing songs sometimes that would only make sense later in the day when I would do something wrong at work or at home. I began sleeping on the floor of my living room because I was afraid a presence in the bedroom was torturing good forces around me. If I slept in the bedroom, the nightly torture would cause me to make mistakes during the day. A voice, calling himself Fatty Acid, stopped me from drinking soda. Another voice allowed me only one piece of bread with my meals.

Source: Campbell, 2000, reprinted with permission of the National Institute of Mental Health

Thomas, a young man diagnosed with schizophrenia and major depression

1.1 **Define** the term psychological disorder.

These three people—like many you will meet in this text—struggle with problems that mental health professionals classify as psychological or mental disorders. A **psychological disorder** is a pattern of abnormal behavior that is associated with states of significant emotional distress, such as anxiety or depression, or with impaired behavior or ability to function, such as difficulty holding a job or even distinguishing reality from fantasy. **Abnormal psychology** is the branch of psychology that studies abnormal behavior and ways of helping people who are affected by psychological disorders.

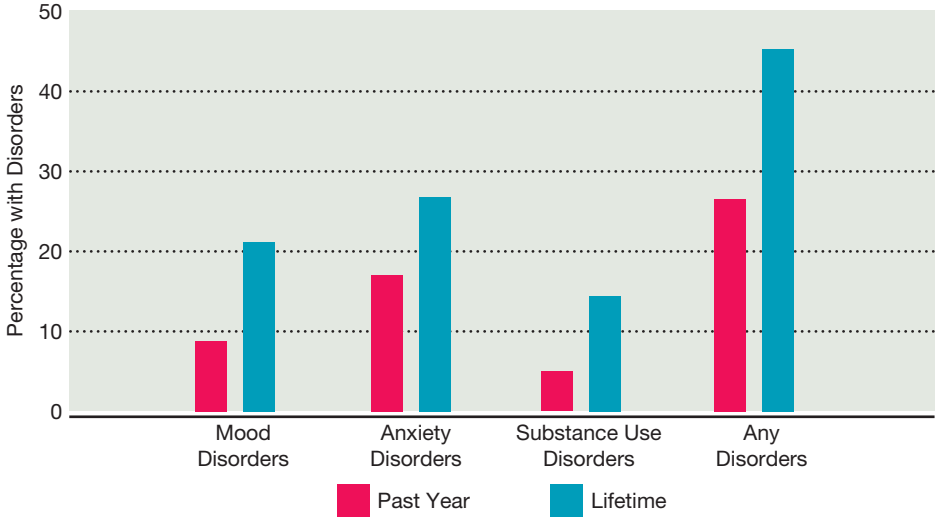
The problem of abnormal behavior might seem the concern of only a few. After all, relatively few people are ever admitted to a psychiatric hospital. Most people never seek the help of a mental health professional, such as a psychologist or psychiatrist. Fewer still ever plead not guilty to crimes on grounds of insanity. Most of us probably have at least one relative we consider "eccentric," but how many of us have relatives we consider "crazy"? And yet, the truth is that abnormal behavior affects all of us in one way or another. Let's break down the numbers.

If we limit the discussion to diagnosable mental disorders, nearly one in two of all Americans (46%) are directly affected at some point in their lives (Kessler, Berglund, Demler, Jin, & Walters, 2005; see Figure 1.1). About one in four adult Americans (26%)

FIGURE 1.1

Lifetime and past-year prevalences of psychological disorders. This graph is based on a nationally representative sample of 9,282 English-speaking U.S. residents aged 18 and older. We see percentages of individuals with diagnosable psychological disorders either during the past year or at some point in their lives for several major diagnostic categories. The mood disorders category includes major depressive episode, manic episode, and dysthymia (discussed in Chapter 7). Anxiety disorders include panic disorder, agoraphobia without panic disorder, social phobia, specific phobia, and generalized anxiety disorder (discussed in Chapter 5). Substance use disorders involving alcohol or other drugs are discussed in Chapter 8.

Source: Kessler, Chiu, Demler, & Walters, 2005; Kessler, Bergland, Demler, et al., 2005.



truth OR fiction

About one in ten American adults suffer from a diagnosable mental or psychological disorder in any given year.

FALSE It's actually about one in four American adults.

experience a diagnosable psychological disorder in any given year (Kessler, Chiu, Demler, & Walters, 2005). T / F

According to the World Health Organization, the United States has the highest rates of diagnosable psychological disorders among 17 countries they surveyed (Kessler et al., 2009). American women are more likely than men to suffer from psychological disorders, especially mood disorders (discussed in Chapter 7) ("Women More at Risk," 2012). In addition, twice as many young adults (ages 18–25) are affected by psychological disorders than are people over 50.

If we also include the mental health problems of our family members, friends, and coworkers and take into account those who foot the bill for treatment in the form of taxes and health insurance premiums as well as lost productivity due to sick days, disability leaves, and impaired job performance inflating product costs, then clearly all of us are affected to one degree or another.

The study of abnormal psychology is illuminated not only by the extensive research on the causes and treatments of psychological disorders reported in scientific journals but also by the personal stories of people affected by these problems. In this text, we will learn from these people as they tell their stories in their own words. Through first-person narratives, case examples, and video interviews, researchers enter the world of people struggling with various types of psychological disorders that affect their moods, thinking, and behavior. Some of these stories may remind you of the experiences of people close to you, or perhaps even yourself. We invite you to explore with us the nature and origins of these disorders and ways of helping people who face the many challenges they pose.

Let's pause for a moment to raise an important distinction. Although the terms *psychological disorder* and *mental disorder* are often used interchangeably, we prefer using the term *psychological disorder.* The major reason is that the term *psychological disorder* puts the study of abnormal behavior squarely within the purview of the field of psychology. Moreover, the term *mental disorder* (also called *mental illness*) is derived from the **medical model** perspective that views abnormal behavior patterns as symptoms of underlying illness. Although the medical model is a major contemporary model for understanding abnormal behavior, we believe we need to take a broader view of abnormal behavior by incorporating psychological and sociocultural perspectives as well.

SURGEON GENERAL'S REPORT ON MENTAL HEALTH The U.S. Surgeon General issued a report at the turn of the new millennium that is still pertinent today in terms of focusing the nation's attention on problems of mental health. Here are some key conclusions from the report (Satcher, 2000; U.S. Department of Health and Human Services, 1999):

- Mental health reflects the complex interaction of brain functioning and environmental influences.
- Effective treatments exist for most mental disorders, including psychological interventions such as psychotherapy and counseling and psychopharmacological or drug therapies. Treatment is often more effective when psychological and psychopharmacological treatments are combined. T / F
- Progress in developing effective prevention programs in the mental health field has been slow because we do not know the causes of mental disorders or ways of altering known influences, such as genetic predispositions. Nonetheless, some effective prevention programs have been developed.
- Although 15% of American adults receive some form of help for mental health problems each year, many who need help do not receive it.
- Mental health problems are best understood when we take a broader view and consider the social and cultural contexts in which they occur.
- Mental health services need to be designed and delivered in a manner that takes into account the viewpoints and needs of racial and ethnic minorities.

The Surgeon General's report provides a backdrop for our study of abnormal psychology. As we shall see throughout the text, we believe that understandings of abnormal behavior are best revealed through a lens that takes into account interactions of biological and environmental factors. We also believe that social and cultural (or *sociocultural*) factors need to be considered in the attempt to both understand abnormal behavior and develop effective treatment services.

In this chapter, we first address the difficulties of defining *abnormal behavior.* We see that throughout history, abnormal behavior has been viewed from different perspectives. We chronicle the development of concepts of abnormal behavior and its treatment. We see that in the past, treatment usually referred to what was done *to,* rather than *for,* people with abnormal behavior. We then describe the ways in which psychologists and other scholars study abnormal behavior today.

How Do We Define *Abnormal Behavior?*

We all become anxious or depressed from time to time, but is this abnormal? Anxiety in anticipation of an important job interview or a final examination is perfectly normal. It is appropriate to feel depressed when you have lost someone close to you or when you have failed at a test or on the job. So, where is the line between normal and abnormal behavior?

One answer is that emotional states such as anxiety and depression may be considered abnormal when they are not appropriate to the situation. It is normal to feel down when you fail a test, but not when your grades are good or excellent. It is normal to feel anxious before a college admissions interview, but not to panic before entering a department store or boarding a crowded elevator.

Abnormality may also be suggested by the magnitude of the problem. Although some anxiety is normal enough before a job interview, feeling that your heart might leap from your chest—and consequently your canceling the interview—is not. Nor is it normal to feel so anxious in this situation that your clothing becomes soaked with perspiration T / F.

Criteria for Determining Abnormality

Mental health professionals apply various criteria in making judgments about whether behavior is abnormal. The most commonly used criteria include the following:

1. *Unusualness.* Behavior that is unusual is often considered abnormal. Only a few of us report seeing or hearing things that are not really there; "seeing things" and "hearing things" are almost always considered abnormal in our culture, but such experiences are sometimes considered normal in certain types of spiritual

truth OR fiction

Although effective treatments exist for some psychological disorders, we still lack the means of effectively treating most types of psychological disorders.

☑ **FALSE** The good news is that effective treatments exist for most psychological disorders.

truth OR fiction

Unusual behavior is abnormal.

☑ **FALSE** Unusual or statistically deviant behavior is not necessarily abnormal. Exceptional behavior also deviates from the norm.

1.2 Identify criteria professionals use to determine whether behavior is abnormal.

experiences. Moreover, hearing voices and other forms of hallucinations under some circumstances are not considered unusual in some preliterate societies.

However, becoming overcome with feelings of panic when entering a department store or when standing in a crowded elevator is uncommon and considered abnormal. Uncommon behavior is not in itself abnormal. Only one person can hold the record for swimming the fastest 100 meters. The record-holding athlete differs from the rest of us but, again, is not considered abnormal. Thus, rarity or statistical deviance is not a sufficient basis for labeling behavior abnormal; nevertheless, it is often one of the yardsticks used to judge abnormality.

2. *Social deviance.* All societies have norms (standards) that define the kinds of behavior that is acceptable in given contexts. Behavior deemed normal in one culture may be viewed as abnormal in another. For example, people in our culture who assume that all male strangers are devious are usually regarded as unduly suspicious or distrustful. But such suspicions were justified among the Mundugumor, a tribe of cannibals studied by anthropologist Margaret Mead (1935). Within that culture, male strangers *were* typically malevolent toward others, and it was normal to feel distrustful of them. Norms, which arise from the practices and beliefs of specific cultures, are relative standards, not universal truths.

   Thus, clinicians need to weigh cultural differences when determining what is normal and abnormal. Moreover, what strikes one generation as abnormal may be considered normal by the next. For example, until the mid-1970s, homosexuality was classified as a mental disorder by the psychiatric profession (see the *Thinking Critically About Abnormal Psychology* feature on page 18). Today, however, the psychiatric profession no longer considers homosexuality a mental disorder, and many people argue that contemporary societal norms should include homosexuality as a normal variation in behavior.

   When normality is judged on the basis of compliance with social norms, nonconformists may incorrectly be labeled as mentally disturbed. We may come to brand behavior that we do not approve of as "sick" rather than accept that the behavior may be normal, even though it offends or puzzles us.

3. *Faulty perceptions or interpretations of reality.* Normally, our sensory systems and cognitive processes permit us to form accurate mental representations of the environment. Seeing things and hearing voices that are not present are considered hallucinations, which in our culture are generally taken as signs of an underlying mental disorder. Similarly, holding unfounded ideas or *delusions,* such as ideas of persecution that the CIA or the Mafia are out to get you, may be regarded as signs of mental disturbance—unless, of course, they *are real.* (As former U.S. Secretary of State Henry Kissinger is said to have remarked, "Even paranoid people have enemies.")

   It is normal in the United States to say that one talks to God through prayer. If, however, a person insists on having literally seen God or heard the voice of God—as opposed to, say, being divinely inspired—we may come to regard her or him as mentally disturbed.

4. *Significant personal distress.* States of personal distress caused by troublesome emotions, such as anxiety, fear, or depression, may be abnormal. As we noted earlier, however, anxiety and depression are sometimes appropriate responses to the situation. Real threats and losses do occur in life, and *lack* of an emotional response to them would be regarded as abnormal. Appropriate feelings of distress are not considered abnormal unless the feelings persist long after the source of anguish has been removed (after most people would have adjusted) or if they are so intense that they impair the individual's ability to function.

Is this man abnormal? Judgments of abnormality take into account the social and cultural standards of society. Do you believe this man's body adornment is a sign of abnormality or merely a fashion statement?

5. *Maladaptive or self-defeating behavior.* Behavior that leads to unhappiness rather than self-fulfillment can be regarded as abnormal. Behavior that limits one's ability to function in expected roles, or to adapt to one's environments, may also be considered abnormal. According to these criteria, heavy alcohol consumption that impairs health or social and occupational functioning may be viewed as abnormal. Agoraphobic behavior, characterized by intense fear of venturing into public places, may be considered abnormal in that it is both uncommon and maladaptive because it impairs the individual's ability to fulfill work and family responsibilities.
6. *Dangerousness.* Behavior that is dangerous to oneself or other people may be considered abnormal. Here, too, the social context is crucial. In wartime, people who sacrifice their lives or charge the enemy with little apparent concern for their own safety may be characterized as courageous, heroic, and patriotic. But people who threaten or attempt suicide because of the pressures of civilian life are usually considered abnormal.

When is anxiety abnormal? Negative emotions such as anxiety are considered abnormal when they are judged to be excessive or inappropriate to the situation. Anxiety is generally regarded as normal when it is experienced during a job interview, so long as it is not so severe that it prevents the interviewee from performing adequately. Anxiety is deemed to be abnormal if it is experienced whenever one boards an elevator.

Football and hockey players who occasionally get into fistfights or altercations with opposing players may be normal enough. Given the nature of these sports, unaggressive football and hockey players would not last long in college or professional ranks. But players involved in frequent altercations may be regarded as abnormal. Physically aggressive behavior is most often maladaptive in modern life. Moreover, physical aggression is ineffective as a way of resolving conflicts—although it is by no means uncommon.

Abnormal behavior thus has multiple definitions. Depending on the case, some criteria may be weighted more heavily than others. But in most cases, a combination of these criteria is used to define abnormality.

1.3 Apply these criteria to case examples discussed in the text.

APPLYING THE CRITERIA Let's return to the three cases we introduced at the beginning of the chapter. Consider the criteria we can apply in determining whether the behaviors reported in these vignettes are abnormal. For one thing, the abnormal behavior patterns in these three cases are unusual in the statistical sense. Most people do not encounter these kinds of problems, although we should add that these problems are far from rare. The problem behaviors also meet other criteria of abnormality, as we shall see.

Phil suffered from *claustrophobia,* an excessive fear of enclosed spaces. (This is an example of an anxiety disorder and is discussed more fully in Chapter 5.) His behavior was unusual (relatively few people are so fearful of confinement that they avoid flying in airplanes or riding on elevators) and was associated with significant personal distress. His fear also impaired his ability to carry out his occupational and family responsibilities. But he was not hampered by faulty perceptions of reality. He recognized that his fears exceeded a realistic appraisal of danger in these situations.

What criterion of abnormality applies in the case of the woman who cowered under the blankets? She was diagnosed with *bipolar disorder* (formerly called manic-depression), a type of mood disorder in which a person experiences extreme mood swings, from the heights of elation and seemingly boundless energy to the depths of depression and despair. (The vignette described the manic phase of the disorder.) Bipolar disorder, which is discussed in Chapter 7, is associated with extreme personal distress and difficulty functioning effectively in normal life. It is also linked to self-defeating and dangerous behavior, such as reckless driving or exorbitant spending during manic phases and attempted suicide during depressive phases. In some cases, like the one presented here, people in manic phases sometimes have faulty perceptions or interpretations of reality, such as hallucinations and delusions.

Thomas suffered from both schizophrenia and depression. It is not unusual for people to have more than one disorder at a time. In the parlance of the psychiatric profession, these clients present with *comorbid* (co-occurring) diagnoses. Comorbidity complicates treatment because clinicians need to design a treatment approach that focuses on treating

two or more disorders. Schizophrenia meets a number of criteria of abnormality, including statistical infrequency (it affects about 1% of the general population). The clinical features of schizophrenia include socially deviant or bizarre behavior, disturbed perceptions or interpretations of reality (delusions and hallucinations), maladaptive behavior (difficulty meeting responsibilities of daily life), and personal distress. (See Chapter 11 for more detail on schizophrenia.) Thomas, for example, was plagued by auditory hallucinations (terrorizing voices), which were certainly a source of significant distress. His thinking was also delusional, because he believed that "a presence" in his bedroom was "torturing good forces," surrounding him and causing him to make mistakes during the day. In Thomas's case, schizophrenia was complicated by depression that involved feelings of personal distress (irritability and feelings of dread). Depression is also associated with dampened or downcast mood, maladaptive behavior (difficulty getting to work or school or even getting out of bed in the morning), and potential dangerousness (possible suicidal behavior).

It is one thing to recognize and label behavior as abnormal; it is another to understand and explain it. Philosophers, physicians, natural scientists, and psychologists have used various approaches, or *models,* in the effort to explain abnormal behavior. Some approaches have been based on superstition; others have invoked religious explanations. Some current views are predominantly biological; others are psychological. In considering various historical and contemporary approaches to understanding abnormal behavior, let's first look further at the importance of cultural beliefs in determining which behavior patterns are deemed abnormal.

1.4 **Describe** the cultural bases of abnormal behavior.

Cultural Bases of Abnormal Behavior

As noted, behavior that is normal in one culture may be deemed abnormal in another. Australian aborigines believe they can communicate with the spirits of their ancestors and that other people, especially close relatives, share their dreams. These beliefs are considered normal within Aboriginal culture. But were such beliefs to be expressed in our culture, they would likely be deemed delusions, which professionals regard as a common feature of schizophrenia. Thus, the standards we use in making judgments of abnormal behavior must take into account cultural norms.

Kleinman (1987) offers an example of "hearing voices" among Native Americans to underscore the ways in which judgments about abnormality are embedded within a cultural context:

> Ten psychiatrists trained in the same assessment technique and diagnostic criteria who are asked to examine 100 American Indians shortly after the latter have experienced the death of a spouse, a parent or a child may determine with close to 100% consistency that those individuals report hearing, in the first month of grieving, the voice of the dead person calling to them as the spirit ascends to the afterworld. [Although such judgments may be consistent across observers] the determination of whether such reports are a sign of an abnormal mental state is an interpretation based on knowledge of this group's behavioural norms and range of normal experiences of bereavement. (p. 453)

A traditional Native American healer. Many traditional Native Americans distinguish between illnesses believed to arise from influences external to their own culture ("White man's sicknesses") and those that emanate from a lack of harmony with traditional tribal life and thought ("Indian sicknesses"). Traditional healers such as the one shown here may be called on to treat Indian sickness, whereas "White man's medicine" may be sought to help people deal with problems whose causes are seen as lying outside the community, such as alcoholism and drug addiction.

To these Native Americans, bereaved people who report hearing the spirits of the deceased calling to them as they ascend to the afterlife are normal. Behavior that is normative within the cultural setting in which it occurs should not be considered abnormal.

Concepts of health and illness vary across cultures. Traditional Native American cultures distinguish between illnesses that are believed to arise from influences outside the culture, called "White man's sicknesses," such as alcoholism and drug addiction, and those that emanate from a lack of harmony with traditional tribal life and thought, which are called "Indian sicknesses" (Trimble, 1991). Traditional healers, shamans, and medicine

men and women are called on to treat Indian sickness. When the problem is thought to have its cause outside the community, help is sought from "White man's medicine."

Abnormal behavior patterns take different forms in different cultures. Westerners experience anxiety, for example, in the form of worrying about paying the mortgage and losing a job. Yet "in a number of African cultures, anxiety is expressed as fears of failure in procreation, in dreams and complaints about witchcraft" (Kleinman, 1987). Australian aborigines can develop intense fears of sorcery, accompanied by the belief that one is in mortal danger from evil spirits (Spencer, 1983). Trancelike states in which young aboriginal women are mute, immobile, and unresponsive are also quite common. If these women do not recover from the trance within hours or, at most, a few days, they may be brought to a sacred site for healing.

The very words that we use to describe psychological disorders—words such as *depression* or *mental health*—have different meanings in other cultures, or no equivalent meaning at all. This doesn't mean that depression doesn't exist in other cultures. Rather, it suggests we need to learn how people in different cultures experience emotional distress, including states of depression and anxiety, rather than imposing our perspectives on their experiences. People in China and other countries in the Far East generally place greater emphasis on the physical or somatic symptoms of depression, such as headaches, fatigue, or weakness, than on feelings of guilt or sadness, as compared to people from Western cultures such as our own (Kalibatseva & Leong, 2011; Ryder et al., 2008; Zhou et al., 2011). T / F

These differences demonstrate how important it is that we determine whether our concepts of abnormal behavior are valid before we apply them to other cultures. Research efforts along these lines have shown that the abnormal behavior pattern associated with our concept of schizophrenia exists in countries as far flung as Colombia, India, China, Denmark, Nigeria, and the former Soviet Union, as well as many others (Jablensky, Sartorius, Ernberg, & Anker, 1992). Furthermore, rates of schizophrenia appear similar among the countries studied. However, differences have been observed in some of the features of schizophrenia across cultures (Myers, 2011).

Views about abnormal behavior vary from society to society. In Western culture, models based on medical disease and psychological factors are prominent in explaining abnormal behavior. But in traditional native cultures, models of abnormal behavior often invoke supernatural causes, such as possession by demons or the Devil. For example, in Filipino folk society, psychological problems are often attributed to the influence of "spirits" or the possession of a "weak soul" (Edman & Johnson, 1999).

truth OR fiction

Psychological problems like depression may be experienced differently by people in different cultures.

✓ **TRUE** For example, depression is more likely to be associated with the development of physical symptoms among people in East Asian cultures than in Western cultures.

Historical Perspectives on Abnormal Behavior

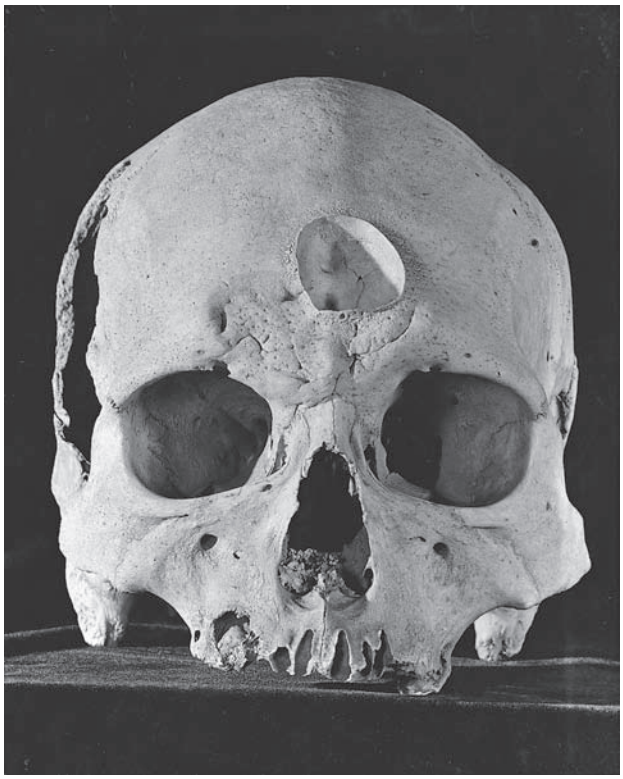
1.5 **Describe** the historical changes that have occurred in conceptualizations and treatment of abnormal behavior through the course of Western culture.

Throughout the history of Western culture, concepts of abnormal behavior have been shaped, to some degree, by the prevailing worldview of the particular era. For hundreds of years, beliefs in supernatural forces, demons, and evil spirits held sway. (And, as we've just seen, these beliefs still hold true in some societies.) Abnormal behavior was often taken as a sign of possession. In modern times, the predominant—but by no means universal—worldview has shifted toward beliefs in science and reason. In Western culture, abnormal behavior has come to be viewed as the product of physical and psychosocial factors, not demonic possession.

The Demonological Model

Why would anyone need a hole in the head? Archaeologists have unearthed human skeletons from the Stone Age with egg-sized cavities in the skull. One interpretation of these holes is that our prehistoric ancestors believed abnormal behavior was caused by the inhabitation of evil spirits. These holes might be the result of **trephination**—the drilling of the skull to provide an outlet for those irascible spirits. Fresh bone growth indicates that some people did survive this "medical procedure."

Just the threat of trephining may have persuaded some people to comply with tribal norms. Because no written accounts of the purpose of trephination exist, other explanations are possible. For instance, perhaps trephination was simply a form of surgery



Trephination. Trephination refers to a procedure by which a hole is chipped into a person's skull. Some investigators speculate that the practice represented an ancient form of surgery. Perhaps trephination was intended to release the "demons" responsible for abnormal behavior.

Source: Photo by Bierwert. American Museum of Natural History Library.

to remove shattered pieces of bone or blood clots that resulted from head injuries (Maher & Maher, 1985).

The notion of supernatural causes of abnormal behavior, or demonology, was prominent in Western society until the Age of Enlightenment. The ancients explained nature in terms of the actions of the gods: The Babylonians believed the movements of the stars and the planets expressed the adventures and conflicts of the gods. The Greeks believed that the gods toyed with humans, that they unleashed havoc on disrespectful or arrogant humans and clouded their minds with madness.

In ancient Greece, people who behaved abnormally were sent to temples dedicated to Aesculapius, the god of healing. The Greeks believed that Aesculapius would visit the afflicted while they slept in the temple and offer them restorative advice through dreams. Rest, a nutritious diet, and exercise were also part of the treatment. Incurables were driven from the temple by stoning.

Origins of the Medical Model: In "Ill Humor"

Not all ancient Greeks believed in the demonological model. The seeds of naturalistic explanations of abnormal behavior were sown by Hippocrates and developed by other physicians in the ancient world, especially Galen.

Hippocrates (ca. 460–377 B.C.E.), the celebrated physician of the Golden Age of Greece, challenged the prevailing beliefs of his time by arguing that illnesses of the body and mind were the result of natural causes, not possession by supernatural spirits. He believed the health of the body and mind depended on the balance of **humors,** or vital fluids, in the body: phlegm, black bile, blood, and yellow bile. An imbalance of humors, he thought, accounted for abnormal behavior. A lethargic or sluggish person was believed to have an excess of phlegm, from which we derive the word *phlegmatic.* An overabundance of black bile was believed to cause depression, or *melancholia.* An excess of blood created a *sanguine* disposition: cheerful, confident, and optimistic. An excess of yellow bile made people "bilious" and *choleric*—quick-tempered.

Though scientists no longer subscribe to Hippocrates's theory of bodily humors, his theory is important because of its break from demonology. It foreshadowed the modern medical model, the view that abnormal behavior results from underlying biological processes. Hippocrates made other contributions to modern thought and, indeed, to modern medical practice. He classified abnormal behavior patterns, using three main categories, which still have equivalents today: *melancholia* to characterize excessive depression, *mania* to refer to exceptional excitement, and *phrenitis* (from the Greek "inflammation of the brain") to characterize the bizarre behavior that might today typify schizophrenia. To this day, medical schools honor Hippocrates by having students swear an oath of medical ethics that he originated, the Hippocratic oath.

Galen (ca. 130–200 C.E.), a Greek physician who attended Roman emperor–philosopher Marcus Aurelius, adopted and expanded on the teachings of Hippocrates. Among Galen's contributions was the discovery that arteries carry blood, not air, as had been formerly believed.

Medieval Times

The Middle Ages, or medieval times, cover the millennium of European history from about 476 C.E. through 1450 C.E. After the passing of Galen, belief in supernatural causes, especially the doctrine of possession, increased in influence and eventually dominated medieval thought. This doctrine held that abnormal behaviors were a sign of possession by evil spirits or the Devil. This belief was part of the teachings of the Roman Catholic Church, the central institution in Western Europe after the decline

of the Roman Empire. Although belief in possession preceded the Church and is found in ancient Egyptian and Greek writings, the Church revitalized it. The Church's treatment of choice for possession was exorcism. Exorcists were employed to persuade evil spirits that the bodies of the "possessed" were no longer habitable. Methods of persuasion included prayer, incantations, waving a cross at the victim, and beating and flogging, even starving, the victim. If the victim continued to display unseemly behavior, there were yet more persuasive remedies, such as the rack, a device of torture. No doubt, recipients of these "remedies" desperately wished the Devil would vacate them immediately.

The Renaissance—the great revival of classical learning, art, and literature—began in Italy in the 1400s and spread throughout Europe. Ironically, although the Renaissance is considered the transition from the medieval to the modern world, the fear of witches also reached its height during this period.

Exorcism. This medieval woodcut illustrates the practice of exorcism, which was used to expel the evil spirits that were believed to have possessed people.

Witchcraft

The late 15th through the late 17th centuries were especially bad times to annoy your neighbors. These were times of massive persecutions, particularly of women, who were accused of witchcraft. Church officials believed that witches made pacts with the Devil, practiced satanic rituals, ate babies, and poisoned crops. In 1484, Pope Innocent VIII decreed that witches be executed. Two Dominican priests compiled a notorious manual for witch-hunting, called the *Malleus Maleficarum* (The Witches' Hammer), to help inquisitors identify suspected witches. Many thousands would be accused of witchcraft and put to death in the next two centuries.

Witch-hunting required innovative "diagnostic" tests. In the case of the water-float test, suspects were dunked in a pool to certify they were not possessed by the Devil. The test was based on the principle in smelting, during which pure metals settle to the bottom, whereas impurities bob up to the surface. Suspects who sank and drowned were ruled pure. Suspects who kept their heads above water were judged to be in league with the Devil. As the saying went, you were "damned if you do and damned if you don't."

Modern scholars once believed these so-called witches were actually people with psychological disorders who were persecuted because of their abnormal behavior. Many suspected witches did confess to bizarre behaviors, such as flying or engaging in sexual intercourse with the Devil, which suggests the types of disturbed behavior associated with modern conceptions of schizophrenia. Yet these confessions must be discounted because they were extracted under torture by inquisitors who were bent on finding evidence to support accusations of witchcraft (Spanos, 1978). We know today that the threat of torture and other forms of intimidation are sufficient to extract false confessions. Although some who were persecuted as witches probably did show abnormal behavior patterns, most did not (Schoenman, 1984). Rather, it appears that accusations of witchcraft were a convenient means of disposing of social nuisances and political rivals, of seizing property, and of suppressing heresy (Spanos, 1978). In English villages, many of the accused were poor, unmarried elderly women who were forced to beg for food from their neighbors. If misfortune befell the people who declined to give help, the beggar might be accused of having cast a curse on the household. If the woman was generally unpopular, an accusation of witchcraft was likely to follow.

Demons were believed to play roles in both abnormal behavior and witchcraft. However, although some victims of demonic possession were perceived to be afflicted as retribution for their own wrongdoing, others were considered to be innocent victims—possessed by demons through no fault of their own. Witches were believed to have renounced God and voluntarily entered into a pact with the Devil. Witches were generally seen as more deserving of torture and execution (Spanos, 1978).

The water-float test. This so-called test was one way in which medieval authorities sought to detect possession and witchcraft. Managing to float above the waterline was deemed a sign of impurity. In the lower right hand corner, you can see the bound hands and feet of one poor unfortunate who failed to remain afloat, but whose drowning would have cleared away any suspicions of possession.

Historical trends do not follow straight lines. Although the demonological model held sway during the Middle Ages and much of the Renaissance, it did not completely supplant belief in naturalistic causes. In medieval England, for example, demonic possession was only rarely invoked in cases in which a person was held to be insane by legal authorities (Neugebauer, 1979). Most explanations for unusual behavior involved natural causes, such as physical illness or trauma to the brain. In England, in fact, some disturbed people were kept in hospitals until they were restored to sanity (Allderidge, 1979). The Renaissance Belgian physician Johann Weyer (1515–1588) also took up the cause of Hippocrates and Galen by arguing that abnormal behavior and thought patterns were caused by physical problems.

truth OR fiction

A night's entertainment in London a few hundred years ago might have included gaping at the inmates at the local asylum.

☑ **TRUE** A night on the town for the gentry of London sometimes included a visit to a local asylum, St. Mary's of Bethlehem Hospital, to gawk at the patients. We derive the word *bedlam* from Bethlehem Hospital.

Asylums

By the late 15th and early 16th centuries, asylums, or madhouses, began to crop up throughout Europe. Many were former leprosariums, which were no longer needed because of the decline in leprosy after the late Middle Ages. Asylums often gave refuge to beggars as well as the mentally disturbed, but conditions were appalling. Residents were chained to their beds and left to lie in their own waste or to wander about unassisted. Some asylums became public spectacles. In one asylum in London, St. Mary's of Bethlehem Hospital—from which the word *bedlam* is derived—the public could buy tickets to observe the antics of the inmates, much as we would pay to see a circus sideshow or animals at the zoo **T / F**.

The Reform Movement and Moral Therapy

The modern era of treatment begins with the efforts of the Frenchmen Jean-Baptiste Pussin and Philippe Pinel in the late 18th and early 19th centuries. They argued that people who behave abnormally suffer from diseases and should be treated humanely. This view was not popular at the time; mentally disturbed people were regarded as threats to society, not as sick people in need of treatment.

From 1784 to 1802, Pussin, a layman, was placed in charge of a ward for people considered "incurably insane" at La Bicêtre, a large mental hospital in Paris. Although Pinel is often credited with freeing the inmates of La Bicêtre from their chains, Pussin was actually the first official to unchain a group of the "incurably insane." These unfortunates had been considered too dangerous and unpredictable to be left unchained. But Pussin believed that if they were treated with kindness, there would be no need for chains. As he predicted, most of the shut-ins were manageable and calm after their chains were removed. They could walk the hospital grounds and take in fresh air. Pussin also forbade the staff from treating the residents harshly, and he fired employees who ignored his directives.

"Bedlam." The bizarre antics of the patients at St. Mary's of Bethlehem Hospital in London in the 18th century were a source of entertainment for the well-heeled gentry of the town, such as the two well-dressed women in the middle of the painting.

Pinel (1745–1826) became the medical director for the incurables' ward at La Bicêtre in 1793 and continued the humane treatment Pussin had begun. He stopped harsh practices, such as bleeding and purging, and moved patients from darkened dungeons to well-ventilated, sunny rooms. Pinel also spent hours talking to inmates, in the belief that showing understanding and concern would help restore them to normal functioning.

The philosophy of treatment that emerged from these efforts was labeled *moral therapy.* It was based on the belief that providing humane treatment in a relaxed and decent environment could restore functioning. Similar reforms were instituted at about this time in England by William Tuke and later in the United States by Dorothea Dix. Another influential figure was the American physician Benjamin Rush (1745–1813)—also a signatory to the Declaration of Independence and an early leader of the antislavery movement. Rush, considered the father of American psychiatry, penned the first American textbook

on psychiatry, in 1812: *Medical Inquiries and Observations Upon the Diseases of the Mind.* He believed that madness is caused by engorgement of the blood vessels of the brain. To relieve pressure, he recommended bloodletting, purging, and ice-cold baths. He did advance humane treatment by encouraging the staff of his Philadelphia Hospital to treat patients with kindness, respect, and understanding. He also favored the therapeutic use of occupational therapy, music, and travel (Farr, 1994). His hospital became the first in the United States to admit patients for psychological disorders.

Dorothea Dix (1802–1887), a Boston schoolteacher, traveled about the country decrying the deplorable conditions in the jails and almshouses where mentally disturbed people were placed. As a result of her efforts, 32 mental hospitals devoted to treating people with psychological disorders were established throughout the United States.

The unchaining of inmates at La Bicêtre by 18th-century French reformer Philippe Pinel. Continuing the work of Jean-Baptiste Pussin, Pinel stopped harsh practices, such as bleeding and purging, and moved inmates from darkened dungeons to sunny, airy rooms. Pinel also took the time to converse with inmates, in the belief that understanding and concern would help restore them to normal functioning.

A Step Backward

In the latter half of the 19th century, the belief that abnormal behaviors could be successfully treated or cured by moral therapy fell into disfavor. A period of apathy ensued in which patterns of abnormal behavior were deemed incurable (Grob, 1994, 2009). Mental institutions in the United States grew in size but provided little more than custodial care. Conditions deteriorated. Mental hospitals became frightening places. It was not uncommon to find residents "wallowing in their own excrements," in the words of a New York State official of the time (Grob, 1983). Straitjackets, handcuffs, cribs, straps, and other devices were used to restrain excitable or violent patients.

Deplorable hospital conditions remained commonplace through the middle of the 20th century. By the mid-1950s, the population in mental hospitals had risen to half a million. Although some state hospitals provided decent and humane care, many were described as little more than human snake pits. Residents were crowded into wards that lacked even rudimentary sanitation. Mental patients in back wards were essentially *warehoused;* that is, they were left to live out their lives with little hope or expectation of recovery or a return to the community. Many received little professional care and were abused by poorly trained and supervised staffs. Finally, these appalling conditions led to calls for reforms of the mental health system. These reforms ushered in a movement toward **deinstitutionalization,** a policy of shifting the burden of care from state hospitals to community-based treatment setting, which led to a wholesale exodus from state mental hospitals. The mental hospital population across the United States has plummeted from nearly 600,000 in the 1950s to about 40,000 today ("Rate of Patients," 2012). Some mental hospitals were closed entirely.

Another factor that laid the groundwork for the mass exodus from mental hospitals was the development of a new class of drugs—the *phenothiazines.* This group of antipsychotic drugs, which helped quell the most flagrant behavior patterns associated with schizophrenia, was introduced in the 1950s. Phenothiazines reduced the need for indefinite hospital stays and permitted many people with schizophrenia to be discharged to halfway houses, group homes, and independent living.

The Role of the Mental Hospital Today

Most state hospitals today are better managed and provide more humane care than those of the 19th and early 20th centuries, but here and there, deplorable conditions persist. Today's state hospital is generally more treatment-oriented and focuses on preparing residents to return to community living. State hospitals function as part of an integrated, comprehensive approach to treatment. They provide a structured environment for people who are unable to function in a less-restrictive community setting. When hospitalization has restored patients to a higher level of functioning, the patients are reintegrated in the community and given follow-up care and transitional residences, if needed. If a community-based hospital is not available or if they require more extensive care, patients may be rehospitalized as needed in a state hospital. For younger and less intensely disturbed people,