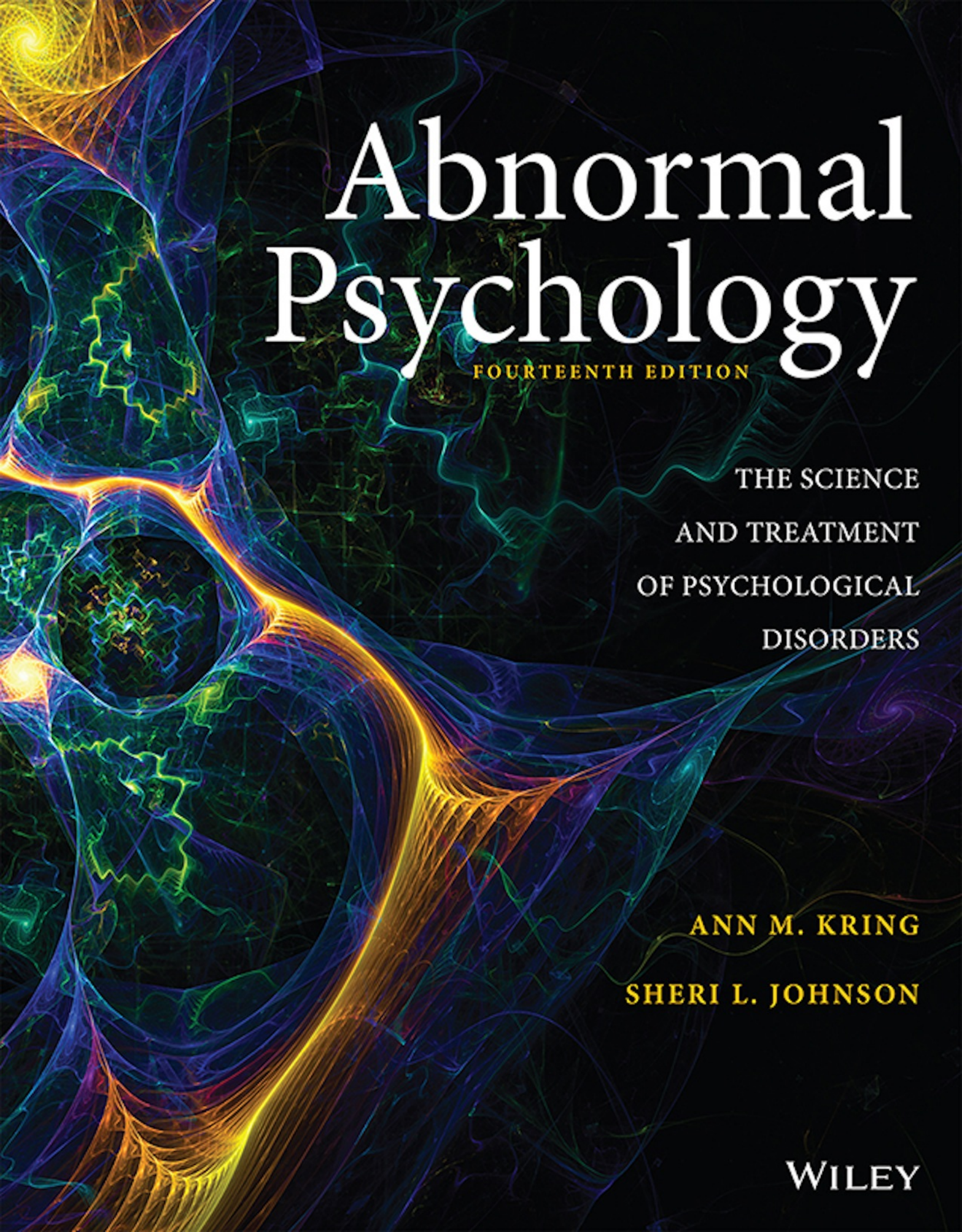
Abnormal Psychology
FOURTEENTH EDITION
THE SCIENCE AND TREATMENT OF PSYCHOLOGICAL DISORDERS
ANN M. KRING
SHERI L. JOHNSON
WILEY

Abnormal Psychology

The Science and Treatment of Psychological Disorders

Fourteenth Edition

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Fourteenth Edition

ANN M. KRING
University of California, Berkeley

SHERI L. JOHNSON
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To

Angela Hawk

Daniel Rose

About the Authors

Courtesy Angela Hawk

ANN M. KRING is Professor and Chair of Psychology at the University of California at Berkeley. She received her B.S. from Ball State University and her M.A. and Ph.D. from the State University of New York at Stony Brook. Her internship in clinical psychology was completed at Bellevue Hospital and Kirby Forensic Psychiatric Center, both in New York. From 1991 to 1998, she taught at Vanderbilt University. She joined the faculty at UC Berkeley in 1999 and served two terms as Director of the Clinical Science Program and Psychology Clinic. She received a Distinguished Teaching Award from UC Berkeley in 2008. She is on the editorial boards of *Schizophrenia Bulletin, Journal of Abnormal Psychology*, and *Psychological Science in the Public Interest*, and she is a former Associate Editor for *Journal of Abnormal Psychology, Cognition and Emotion,* and *Applied & Preventive Psychology*. She was elected President of the Society for Research in Psychopathology, and President of the Society for Affective Science.

She was awarded a Young Investigator Award from the National Alliance for Research on Schizophrenia and Depression (NARSAD) in 1997 and the Joseph Zubin Memorial Fund Award in 2006 in recognition of her research in schizophrenia. In 2005, she was named a fellow of the Association for Psychological Science. Her research has been supported by grants from the Scottish Rite Schizophrenia Research Program, NARSAD, and the National Institute of Mental Health. She is a co-editor (with Denise Sloan) of *Emotion Regulation and Psychopathology* (Guilford Press) and co-author (with Janelle Caponigro, Erica Lee, and Sheri Johnson) of *Bipolar Disorder for the Newly Diagnosed* (New Harbinger Press). She is also the author of more than 100 articles and book chapters. Her current research focus is on emotion and psychopathology, with a specific interest in the emotional features of schizophrenia, negative symptoms in schizophrenia, and the linkage between cognition and emotion in schizophrenia.

Courtesy Sheri Johnson

SHERI L. JOHNSON is Professor of Psychology at the University of California at Berkeley, where she directs the Cal Mania (CALM) Program. She received her B.A. from Salem College and her Ph.D. from the University of Pittsburgh. She completed an internship and postdoctoral fellowship at Brown University, and she was a clinical assistant professor at Brown from 1993 to 1995. From 1995 to 2008, she taught in the Department of Psychology at the University of Miami, where she was recognized three times with the Excellence in Graduate Teaching Award. In 1993, she received a Young Investigator Award from the National Alliance for Research in Schizophrenia and Depression. She is a consulting editor for *Clinical Psychological Science* and *Journal of Abnormal Psychology*, and she serves on editorial boards for six journals. She has served as the president for the Society for Research in Psychopathology and is a Fellow of the Academy of Behavioral Medicine Research, the Association for Behavioral and Cognitive Therapies, and the Association for Psychological Science.

For the past 25 years, her work has focused on understanding the factors that predict the course of mania and depression. She uses social, psychological, and neurobiological paradigms to understand these processes. Her work has been funded by the National Alliance for Research on Schizophrenia and Depression, the National Cancer Institute, the National Science Foundation, and the National Institute of Mental Health. She has published over 200 articles and book chapters, and her findings have been published in leading journals such as the *Journal of Abnormal Psychology, Psychological Bulletin*, and the *American Journal of Psychiatry*. She is co-editor or co-author of several books, including *Psychological Treatment of Bipolar Disorder* (Guilford Press), *Bipolar Disorder for the Newly Diagnosed* (New Harbinger Press), *Bipolar Disorder: Advances in Psychotherapy Evidence-Based Practice* (Hogrefe Publishing), and *Emotion and Psychopathology* (American Psychological Association).

A bit of history...

For the past 13 years, Ann Kring and Sheri Johnson have been the sole authors of this book, but its history dates back more than 40 years. The first edition was published in 1974, the result of conversations between Gerald Davison and John Neale about their experiences teaching the undergraduate abnormal psychology course at the State University of New York at Stony Brook that sparked their collaboration as textbook authors. Ann Kring joined the team in 2001, and she invited Sheri Johnson to join in 2004, when Kring and Johnson took over full authorship responsibilities. We are forever indebted to these two pioneering authors who developed and wrote many editions of this textbook. Near the end of our work on the twelfth edition, John Neale passed away after a long illness. He is greatly missed by many.

Courtesy of Christine McDowell

GERALD C. DAVISON is Professor of Psychology at the University of Southern California.

Courtesy of John M. Neale

JOHN M. NEALE was Professor of Psychology at the State University of New York at Stony Brook until his retirement in 2000.

Preface

From the beginning, the focus of this book has always been on the balance and blending of research and clinical application, on the use of paradigms as an organizing principle, and on the effort to involve the learner in the problem solving engaged in by clinicians and scientists. We continue to emphasize an integrated approach, showing how psychopathology is best understood by considering multiple perspectives and how these varying perspectives can provide us with the clearest accounting of the causes of these disorders as well as the best possible treatments.

With the fourteenth edition, we continue to emphasize the recent and comprehensive research coverage that has been the hallmark of the book. Of equal importance, however, we have worked to make the prose ever more accessible to a variety of students. Finally, Wiley has integrated this edition with the powerful capabilities of WileyPLUS for those who wish to have a resource-rich online learning environment to go along with the book.

WileyPLUS is an online teaching and learning platform that integrates text with interactive and multimedia content, online tools and resources to provide a contemporary and appealing learning experience. The complete program in WileyPLUS, along with a stand-alone eText and practical printed text options, offer the flexibility to suit any course format, whether it be face-to-face, a hybrid/blended learning environment, or an online class. Some of the resources and capabilities of WileyPLUS include:

- A **digital version** of the complete textbook with integrated media and quizzes.
- The **ORION** adaptive learning module, which maximizes study time.
- **Case Study Videos.** Available in WileyPLUS or for those who adopt the print version of the book, this collection of 7- to 10-minute videos presents an encompassing view of 16 psychological disorders. Produced by documentary filmmaker Nathan Friedkin in collaboration with Ann Kring and Sheri Johnson, each case study features people with psychological disorders and their families, describing symptoms from their own perspective. In addition, each video also provides concise information about the available treatment options and commentary from a mental health professional.
- **ScienCentral Videos.** This collection of clips applies the concepts of clinical psychology to current class material.
- **Review Questions.** These learning features give students a way to test themselves on course material before exams. Each review question contains fill-in-the-blank and multiple-choice questions that provide immediate feedback. Each question is also linked to a learning objective within the book to aid students in concept mastery.
- **Flashcards.** This interactive module gives students the opportunity to easily test their knowledge of vocabulary terms.
- **Web Resources.** Annotated web links put useful electronic resources for psychology into the context of your Abnormal Psychology course.

Goals of the Book

With each new edition, we update, make changes, and streamline features to enhance both the scholarly and pedagogical characteristics of the book. We also devote considerable effort to couching complex concepts in prose that is sharp, clear, and vivid. The domains of psychopathology and intervention continue to become increasingly multifaceted and technical. Therefore, good coverage of psychological disorders must engage students and foster the focused attention necessary to acquire a deep, critical understanding of the material. Some of the most exciting breakthroughs in psychopathology research and treatment that we present in the book have come in complex areas such as molecular genetics, neuroscience, and cognitive science. Rather than oversimplify these knotty issues, we have instead worked to make the explanations clear and accessible.

We strive to present up-to-date theories and research in psychopathology and intervention as well as to convey some of the intellectual excitement of the search for answers to some of the most puzzling questions facing us today. We encourage students to participate with us in a process of discovery as we sift through the evidence on the origins of psychopathology and the effectiveness of specific interventions.

As always, we continue to emphasize ways in which we can do away with the stigma that is unfortunately still associated with psychological disorders. Despite the ubiquity of psychopathology, such stigma can keep some individuals from seeking treatment, keep our legislatures from providing adequate funding for treatment and research, and keep myths about psychological disorders alive and well. A major goal for this book is to combat this stigma and present a positive and hopeful view on the causes and treatments of mental illness.

Another difference in our book is the broadening of our title. The term *abnormal psychology* is a vestige of the past in many ways, even though many courses covering the causes and treatment of psychological disorders retain this title. It is our hope that *abnormal psychology* will soon be replaced because it can perpetuate the stigma that people with psychological disorders are "abnormal" in many ways. Our contention is that people with psychological disorders are first and foremost people, and that the term *abnormal* can be overly broad and misconstrued to the detriment of people who have psychological disorders.

Organization of the Fourteenth Edition

In Chapters 1 through 4, we place the field in historical context, present the concept of paradigms in science, describe the major paradigms in psychopathology, describe the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), critically discuss its validity and reliability, provide an overview of major approaches and techniques in clinical assessment, and then describe the major research methods of the field. These chapters are the foundation on which the later chapters can be interpreted and understood. As in the thirteenth edition, specific psychological disorders and their treatment are discussed in Chapters 5 through 15.

Throughout the book, we discuss three major perspectives or paradigms: genetic, neuroscience, and cognitive behavioral. We also emphasize the importance of factors that are important to all paradigms: emotion, gender, culture, ethnicity, and socioeconomic status. A related issue is the use of more than one paradigm in studying psychological disorders. Rather than force an entire field into, for example, a cognitive behavioral paradigm, we argue from the available information that different problems in psychopathology are amenable to analyses within different frameworks. For instance, genetic factors are important in bipolar disorder and attention-deficit/hyperactivity disorder, but genes do their work via the environment. In disorders such as depression, cognitive behavioral factors are essential, but neurotransmitters also exert an influence. For still other disorders—for example, dissociative disorders—cognitive factors involving consciousness are important to consider. Furthermore, the importance of a diathesis–stress approach remains a cornerstone to the field. Emerging data indicate that nearly all psychological disorders arise from subtle interactions between genetic or psychological predispositions and stressful life events.

We continue to include considerable material on culture, race, and ethnicity in the study of causes and treatment of psychological disorders. In Chapter 2, we present a separate section that emphasizes the importance of culture, race, and ethnicity in all paradigms. We point to the important role of culture and ethnicity in the other chapters as well. For example, in Chapter 3, Diagnosis and Assessment, we discuss cultural bias in assessment and ways to guard against this selectivity in perception. We also add new information on the role of culture in anxiety and depression in Chapters 5, 6, and 7.

New to This Edition

The fourteenth edition has many new and exciting additions and changes. We no longer apologetically cover theories that don't work or don't have empirical support. As the research on each disorder has burgeoned, we've decided to highlight only the most exciting and accepted theories, research, and treatments. This edition, as always, contains hundreds (n = 831) of updated references. Throughout the book, we have streamlined the writing to increase the clarity of presentation and to highlight the key issues in the field. We have included new figures and tables to carefully illustrate various concepts. We have also included several new Clinical Cases to illustrate the ways in which psychological disorders are experienced by people.

We have continued to add additional pedagogy based on feedback from students and professors. For example, we have added new Focus on Discovery sections to showcase cutting-edge research on selected topics. In addition, we have modified and added new Check Your Knowledge questions in nearly all chapters so that students can do a quick check to see if they are learning and integrating the material. Drawing on evidence for the importance of generative thinking for learning, we also include open-ended questions. There are many new photos to provide students with additional real-world examples and applications of psychopathology, including examples of some of the highly successful and well-known people who have come forward in the past several years to discuss their own psychological disorders. The end-of-chapter summaries continue to be consistent across the chapters, using a bulleted format and summarizing the descriptions, causes, and treatments of the disorders covered.

New and Expanded Coverage

We are excited about the new features of this edition. Throughout the book, chapters have been restructured for smoother online presentation of material, which often involves more frequent Check Your Knowledge questions and section summaries. Material comparing DSM-IV to DSM-5 has been removed. The major new material in this edition is outlined by chapter here:

Chapter 1: Introduction and Historical Overview

- Chapter is refocused to concentrate on key moments in history that influence contemporary thinking
- Updated Focus on Discovery on stigma
- Added material on reducing stigma
- Streamlined the section defining abnormal/disorder
- Added two new Focus on Discovery sections covering Freud and neo-Freudians
- Streamlined the mental health professionals section

Chapter 2: Current Paradigms in Psychopathology

- Removed material from neuroscience sections not covered in later chapters
- Added new material on epigenetics, genome-wide association studies (GWAS), behavioral genetics, and cytokines
- Streamlined section on immune system to include material covered in later chapters
- Provided new information on cognitive science
- Included new information on culture

Chapter 3: Diagnosis and Assessment

- Entire chapter is streamlined to focus on diagnostic and assessment issues that are covered throughout the book
- Streamlined the discussion of validity
- Removed material on distinctions between DSM-IV-TR and DSM-5 (history of the DSM is still covered in a Focus on Discovery section)
- Updated and expanded discussion of internalizing versus externalizing disorders, and included very brief description of work on the p-factor
- New information on research domain criteria (RDoC)
- New information on culture
- Updated prevalence statistics from the World Mental Health Survey
- Removed neurotransmitter assessment, which is not covered in other chapters
- New information on connectivity analyses
- New information on single photon emission computed tomography (SPECT) as a neuroimaging technique
- Added new personality inventory: the Big Five Inventory-2 (BFI-2)
- New Focus on Discovery covering projective tests

Chapter 4: Research Methods in Psychopathology

- Removed Focus on Discovery on case studies
- Included evidence that lifetime prevalence estimates from epidemiological studies may be low due to failures of memory, as suggested by multiple large longitudinal studies
- Consolidated details on GWAS and association studies with the section on genetics in Chapter 2.
- Provided a more clinically relevant example of an experiment
- Simplified the discussion of treatment manuals
- Updated material on culture and ethnicity in psychological treatment
- Simplified the example of a single-case experiment
- Moved material on analogues, as not all are experiments
- Integrated and updated sections on efficacy and dissemination
- Added new section on reproducibility and replication

Chapter 5: Mood Disorders

- Removed specifiers section (except the Focus on Discovery coverage of seasonal affective disorder and anxious features)
- Provided more epidemiological data regarding income disparity, prevalence, treatment costs, medical and mortality outcomes of the mood disorders
- Updated research on creativity and bipolar disorder, including a study of over 1 million persons
- Updated and clarified findings on gender differences in depression
- Integrated literature on an internalizing factor to explain anxiety and depression overlap
- Expanded discussion of culture and somatic symptoms of depression
- Trimmed outdated case study on bipolar disorder; retained Kay Jamison Redfield autobiographical account of manic symptoms
- New data on gene-environment interactions in the prediction of major depressive disorder (MDD) onset.
- Reduced focus on interpersonal factors as an outcome of depression, given longitudinal predictive power of interpersonal effects
- Updated cortisol section focuses on cortisol awakening response rather than the Dex/CRH test
- New section on the mixed findings from imaging studies on neurotransmitters
- Removed tryptophan depletion studies
- New section on the lack of replicability of GWAS findings
- New material on connectivity in imaging studies
- Covered more longitudinal research on the hopelessness model of depression
- Simplified the discussion of rumination in depression
- Noted racial disparities in the treatment of bipolar disorder
- Updated findings on mindfulness treatment, Internet-based treatment, serotonin and norepinephrine reuptake inhibitors (SNRIs) for depression
- Removed deep brain stimulation after two major trials provided poor results
- Updated statistics and graph concerning the epidemiology of suicidality, including international as well as U.S. data

- New findings regarding the interpersonal predictors of non-suicidal self-injury (NSSI)
- Streamlined focus on major empirical research in suicidality, with reduced focus on myths of suicide and reasons to live
- Updated references on media and suicide, and on means-reduction approaches

Chapter 6: Anxiety Disorders

- Updated findings regarding prevalence and gender differences in anxiety disorders
- New evidence regarding culture and anxiety
- New material on heritability, neural circuity, SPECT and positron emission tomography (PET) findings regarding neurotransmitters, and behavioral indicators of responsivity to unpredictable threats
- NPSR1 gene findings removed due to inconsistent findings in relation to anxiety disorders
- Original Borkovec model replaced with newer contrast avoidance model of generalized anxiety disorder (GAD)
- Removed trauma exposure from the GAD section; appears to be a general risk factor
- New evidence that cognitive behavioral therapy (CBT) for anxiety disorders is helpful for Latino clients
- New evidence that mindfulness-based approaches are more helpful than placebo, but are best integrated with exposure-based treatment
- New mixed findings concerning psychodynamic therapy for panic disorder
- Removed d-cycloserine after failed trials

Chapter 7: Obsessive-Compulsive-Related and Trauma-Related Disorders

- Tables added to illustrate common obsessions and compulsions
- New material on culture shaping the prevalence and form of obsessive-compulsive disorder (OCD) symptoms
- New material on outcomes of OCD and hoarding
- Added new evidence from a large-scale twin study for shared genetic contributions to OCD, body-dysmorphic disorder (BDD), and hoarding.
- Removed yedasentience model
- Improved coverage of OCD-related treatments, including the addition of Internet-based treatment, recent trials, racial disparities, and effects on fronto-striatal abnormalities
- Updated information about the chronicity of posttraumatic stress disorder (PTSD) with evidence that some vets meet criteria in a 40-year follow-up
- New content about cross-national prevalence of PTSD and related risk factors
- Removed findings that have not been replicated, including smaller hippocampi among twins of those diagnosed with PTSD and specific forms of memory deficits in PTSD
- Updated treatment outcome research and dissemination for medications, exposure treatment, eye movement desensitization and reprocessing (EMDR), and Internet-based treatment of PTSD

Chapter 8: Dissociative Disorders and Somatic Symptom-Related Disorders

- New findings regarding sleep disturbance and dissociation
- New findings regarding false memories
- In the clinical description of dissociative identity disorder (DID), described relevant cultural experiences and symptom validity measures (moved from the etiology section)
- Moved material on epidemiology of the dissociative disorders integrated into one section.
- Removed information that is no longer supported, such as visual changes across alters or that very few clinicians diagnose DID
- Updated findings on the ability to role-play DID
- Removed the criticism that DSM-5 somatic symptom and related disorders would be overly diagnosed; research suggests that these conditions are more narrowly diagnosed than the DSM-IV-TR somatoform disorders.
- Noted that as many as two-thirds of medical complaints in primary care are not given a medical explanation
- Removed statement that all somatic symptom and related disorders are more common in women than men; this appears to be more specific to somatic symptom disorder in recent work
- Removed material on family illness and somatic symptoms; although effects are consistent, they appear quite small
- Described experimental evidence regarding the importance of beliefs and safety behaviors to the genesis of somatic symptoms
- Noted that findings on dissociation, stress, and trauma have been mixed for conversion disorder
- Updated information on the neuroscience of unconscious processing in conversion disorder
- Updated treatment findings to note that more than a dozen findings support CBT in the treatment of disorders involving health anxiety, and two randomized controlled trials (RCTs) support CBT for DID

Chapter 9: Schizophrenia

- New information on urbanicity and migration
- New and updated genetic information
- New and updated neurotransmitter information
- Streamlined section on symptom descriptions
- Streamlined section on medications
- New table on medication side effects

Chapter 10: Substance Use Disorders

- New organization for better comprehension
- New information on opioids
- Three new tables on prevalence rates of substance use and disorders
- New figure on drug use
- New Focus on Discovery on gambling disorder
- New Clinical Case on opioid use disorder
- Changed term *opiates* to *opioids* to be more consistent with reports about this category
- New table on prescription pain medicines
- New information on e-cigarettes
- New information on marijuana legalization
- New information on dopamine's role in substance use disorders

Chapter 11: Eating Disorders

- New information on obesity added to Focus on Discovery 11.1
- New information on medication and psychological treatments for eating disorders
- New information on stigma and eating disorders
- Removed older references to culture and eating disorder
- Updated information on prognosis for eating disorders
- New GWAS data on anorexia
- New information on the brain's reward system, dopamine, and eating disorders
- New information on perfectionism and negative emotions
- New information on prevention programs

Chapter 12: Sexual Disorders

- Updated information from newer community-based representative samples on sexual norms and gender differences in sexuality
- Updated information on outcomes of sexual reassignment surgery
- Updated research on the influence of sexual dysfunction on relationships, the effects of anxiety and depression on sexual dysfunction
- Reorganized and updated the material on treatment of sexual dysfunction
- Replaced two clinical cases illustrating sexual dysfunction
- Updated information from large-scale surveys on the prevalence of paraphilic interests
- Removed material on the prevalence, comorbidity, clinical characteristics, and outcomes of paraphilias drawn from biased samples
- Removed material on cognitive distortions in paraphilia
- Restructured the material on paraphilic disorder treatment outcome
- Shortened Focus on Discovery sections

Chapter 13: Disorders of Childhood

- New table on prevalence rate of mood and anxiety disorders
- New information on girls and attention-deficit/hyperactivity disorder (ADHD) and longitudinal outcomes
- New information on ADHD in adulthood
- New studies on ADHD treatment
- New information on genetics and conduct disorder
- New information on callous and unemotional traits in conduct disorder
- Updated information on treatments and prevention programs for conduct disorder
- Updated information on treating OCD in children and adolescents
- New information on separation anxiety disorder
- Updated information on disruptive mood dysregulation disorder
- New Quick Summary and Check Your Knowledge questions for dyslexia section
- New information on depression prevention
- Reorganized and streamlined section on specific learning disorders focusing on dyslexia
- Removed discussion of dyscalculia
- New information on autism spectrum disorder prognosis
- Updated information on autism spectrum disorder genetics
- Updated information on the brain and autism
- Updated information on medication treatment for autism

Chapter 14: Late Life and Neurocognitive Disorders

- New information about worldwide aging of populations
- More detailed information about the peak ages for different aspects of cognition
- New findings about the effects of negative stereotypes about aging
- Updated findings on polypharmacy and medications deemed dangerous in late life
- New section on adapting treatments of psychological conditions
- New section on neuropsychiatric syndromes in dementia
- Updated information on alternative diagnostic criteria for mild cognitive impairment
- New clinical case to illustrate mild cognitive impairment
- Updated information on the epidemiology of dementia
- Updated material on genetic risk and biomarkers, lifestyle variables, and depression related to Alzheimer's disease
- New material regarding treatment, including addressing cardiovascular disease, limited effects of antidepressants
- Basic research findings on electrical stimulation to improve memory
- Updated findings on behavioral interventions, exercise, and cognitive training

Chapter 15: Personality Disorders

- Added the DSM-5 general criteria for personality disorder
- Added a paragraph about culture and diagnosis
- New evidence for the clinical utility of the alternative DSM model of personality disorder
- Reduced emphasis on the personality disorders that were excluded from the DSM-5 alternative model of personality disorders, such as schizoid and dependent personality disorder. Case studies and etiological sections now focus on the six personality disorders that were retained in that system.
- Discussion of differential psychological correlates of antisocial personality disorder versus psychopathy
- Updated findings on neurobiology, parenting, and emotion vulnerability related to borderline personality disorder
- Reorganized material on narcissistic personality disorder to discuss social consequences of these symptoms as part of the clinical description
- Updated section on fragile self-esteem and narcissistic personality disorder
- Removed Focus on Discovery describing longitudinal changes in narcissistic personality disorder
- New data on the malleability of personality traits
- Removed discussion of cognitive therapy for borderline personality disorder because findings have been mixed.
- Noted that both dialectical behavior therapy (DBT) and psychodynamic therapy have received support for the treatment of borderline personality disorder.

Chapter 16: Legal and Ethical Issues

- Trimmed older material substantially
- New Focus on Discovery covers recent insanity verdicts
- New Focus on Discovery on the "Goldwater Rule"
- New information on violence and mental illness
- New information on ethics

Special Features for Students

Several features of this book are designed to make it easier for students to master and enjoy the material.

Clinical Cases We include Clinical Cases throughout the book to provide a clinical context for the theories and research that occupy most of our attention in the chapters and to help make vivid the real-life implications of the empirical work of psychopathologists and clinicians.

Focus on Discovery These in-depth discussions of selected topics appear as stand-alone features throughout the book, allowing us to involve readers in specialized topics without detracting from the flow of the main chapter text. Sometimes a Focus on Discovery expands on a point discussed in the chapter; sometimes it deals with an entirely separate but relevant issue—often a controversial one. We have added new Focus on Discovery elements and removed several older ones.

Quick Summaries We include short summaries of sections throughout the chapters to allow students to pause and assimilate the material. These should help students keep track of the multifaceted and complex issues that surround the study of psychopathology.

End-of-Chapter Summaries At the end of each chapter we review the material in bulleted summaries. In Chapters 5–15, we organize these by clinical descriptions, etiology, and treatment—the major sections of every chapter covering the disorders. We believe this format makes it easier for readers to review and remember the material. In fact, we even suggest that students read the summary before beginning the chapter itself to get a good sense of what lies ahead. Reading the summary again after completing the chapter will also enhance students'

understanding and provide an immediate sense of the knowledge that can be acquired in just one reading of the chapter.

Check Your Knowledge Questions Throughout each chapter, we provide three to seven sets of review questions covering the material discussed. These questions are intended to help students assess their understanding and retention of the material as well as to provide them with samples of the types of questions that often are found in course exams. We believe that these will be useful aids for students as they make their way through the chapters.

Glossary When an important term is introduced, it is boldfaced and defined or discussed immediately. Most such terms appear again later in the book, in which case they will not be highlighted in this way. All these terms are listed again at the end of each chapter, and definitions appear at the end of the book in a glossary.

DSM-5 Diagnoses We include a summary of the psychiatric nomenclature for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, known as DSM-5. This provides a handy guide to where disorders appear in the "official" taxonomy or classification. We make considerable use of DSM-5, though in a selective and sometimes critical manner. Sometimes we find it more effective to discuss theory and research on a problem in a way that is different from DSM's conceptualization.

To Learn More

To review samples of the rich program of teaching and learning material that accompanies **Abnormal Psychology: The Science and Treatment of Psychological Disorders**, please visit www.wileyplus.com or contact your Wiley account manager to arrange a live demonstration of WileyPLUS.

Acknowledgments

We are grateful for the contributions of our colleagues and staff, for it was with their assistance that this edition was able to become the book that it is. Sheri is deeply thankful to Kiara Timpano for her thoughts about exciting new findings; to Jennifer Pearlstein, Ben Swerdlow, and Manon Ironside for their suggestions regarding writing; and to Katie Mohr for her assistance with library research. We have also benefited from the skills and dedication of the folks at Wiley. For this edition, we have many people to thank. Specifically, we thank Editorial Director, Veronica Visentin and Associate Development Editor Courtney Luzzi; working with the two of you on this edition has been a delight.

From time to time, students and faculty colleagues have written us their comments; these communications are always welcome. Readers can e-mail us at kring@berkeley.edu, sljohnson@berkeley.edu.

Finally, and most important, our heartfelt thanks go to the most important people in our lives for their continued support and encouragement along the way. A great big thanks to Angela Hawk (AMK) and Daniel Rose (SLJ), to whom this book is dedicated with love and gratitude.

September 2017

ANN M. KRING,
Berkeley, CA

SHERI L. JOHNSON,
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Brief Contents

Contents

CHAPTER 1

Introduction and Historical Overview

LEARNING GOALS

1. Explain the meaning of stigma as it applies to people with psychological disorders.
2. Compare different definitions of psychological disorder.
3. Explain how the causes and treatments of psychological disorders have changed over the course of history.
4. Describe the historical forces that have helped to shape our current view of psychological disorders, including biological, psychoanalytic, behavioral, and cognitive views.
5. Describe the different mental health professions, including the training involved and the expertise developed.

Clinical Case

Jack

Jack dreaded family gatherings. His parents' house would be filled with his brothers and their families, and all the little kids would run around making a lot of noise. His parents would urge him to "be social" and spend time with the family, even though Jack preferred to be alone. He knew that the kids called him "crazy Uncle Jack." In fact, he had even heard his younger brother Kevin call him "crazy Jack" when he'd stopped by to see their mother the other day. Jack's mother admonished Kevin, reminding him that Jack had been doing very well on his new medication. "Schizophrenia is an illness," his mother had said.

Jack had not been hospitalized with an acute episode of schizophrenia for over 2 years. Even though Jack still heard voices, he learned not to talk about them in front of his mother because she would then start hassling him about taking his medication or ask him all sorts of questions about whether he needed to go back to the hospital. He hoped he would soon be able to move out of his parents' house and into his own apartment. The landlord at the last apartment he had tried to rent rejected his application once he learned that Jack had schizophrenia. His mother and father needed to cosign the lease, and they had inadvertently said that Jack was doing very well with his illness. The landlord asked about the illness, and once his parents mentioned schizophrenia, the landlord became visibly uncomfortable. The landlord called later that night and said the apartment had already been rented. When Jack's father pressed him, the landlord admitted he "didn't want any trouble" and that he was worried that people like Jack were violent.

Clinical Case

Felicia

Felicia didn't like to think back to her early school years. Elementary school was not a very fun time. She couldn't sit still or follow directions very well. She often blurted out answers when it wasn't her turn to talk, and she never seemed to be able to finish her class papers without many mistakes. As if that wasn't bad enough, the other girls often laughed at her and called her names. She still remembers the time she tried to join in with a group of girls during recess. They kept running away, whispering to each other, and giggling. When Felicia asked what was so funny, one of the girls laughed and said, "You are hyper, girl! You fidget so much in class, you must have ants in your pants!"

When Felicia started fourth grade, her parents took her to a psychologist. She took several tests and answered all sorts of questions. At the end of these testing sessions, the psychologist diagnosed Felicia with attention-deficit/hyperactivity disorder (ADHD). Felicia began seeing a different psychologist, and her pediatrician prescribed the medication Ritalin. She enjoyed seeing the psychologist because she helped her learn how to deal with the other kids' teasing and how to do a better job of paying attention. The medication helped, too—she could concentrate better and didn't seem to blurt out things as much anymore.

Now in high school, Felicia is much happier. She has a good group of close friends, and her grades are better than they have ever been. Though it is still hard to focus sometimes, she has learned several ways to deal with her distractibility. She is looking forward to college, hoping she can get into the top state school. Her guidance counselor has encouraged her, thinking her grades and extracurricular activities will make for a strong application.

We all try to understand other people. Determining why another person does or feels something is not easy to do. In fact, we do not always understand our own feelings and behavior. Figuring out why people behave in normal, expected ways is difficult enough; understanding seemingly abnormal behavior, such as the behavior of Jack and Felicia, can be even more difficult.

Psychological Disorders and Stigmas

In this book, we will consider the description, causes, and treatments of several different **psychological disorders**. We will also demonstrate the numerous challenges professionals in this field face. As you approach the study of **psychopathology**, the field concerned with the nature, development, and treatment of psychological disorders, keep in mind that the field is continually developing and adding new findings. As we proceed, you will see that the field's interest and importance are ever growing.

Our subject matter, human behavior, is personal and powerfully affecting. Who has not experienced irrational thoughts or feelings? Most of us have known someone, a friend or a relative, whose behavior was upsetting or difficult to understand, and we realize how frustrating it can be to try to understand and help a person with psychological difficulties.

Our closeness to the subject matter also adds to its intrinsic fascination; undergraduate courses in clinical or abnormal psychology are among the most popular in the entire college curriculum, not just in psychology departments. Our feeling of familiarity with the subject matter draws us to the study of psychopathology, but it also has a distinct disadvantage: We bring to the study our preconceived notions of what the subject matter is. Each of us has developed certain ways of thinking and talking about psychological disorders, certain words and concepts that somehow seem to fit. As you read this book and try to understand the psychological disorders it discusses, we may be asking you to adopt different ways of thinking about psychological disorders from those to which you are accustomed.

Perhaps most challenging of all, we must not only recognize our own preconceived notions of psychological disorders, but we must also confront and work to change the **stigma** we often associate with these conditions. Stigma refers to the destructive beliefs and attitudes held by a society that are ascribed to groups considered different in some manner, such as people with psychological disorders. More specifically, stigma has four characteristics (see **Figure 1.1**):

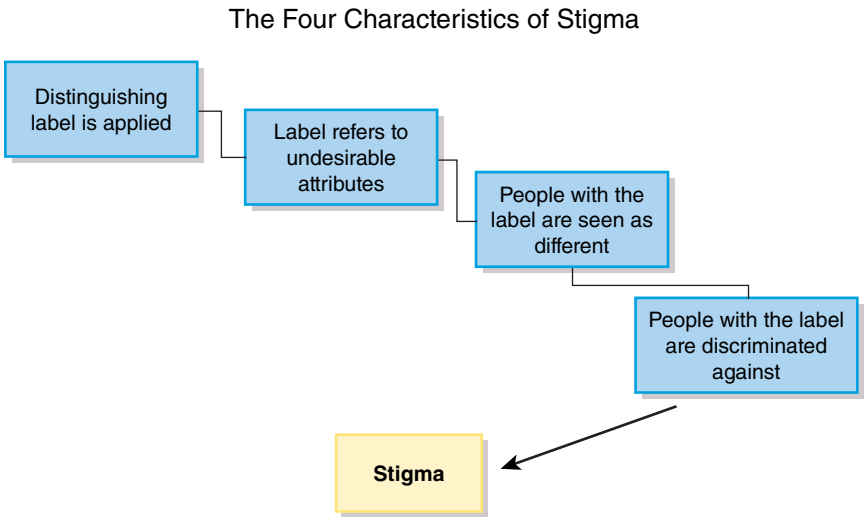


FIGURE 1.1 The four characteristics of stigma.

1. A label is applied to a group of people that distinguishes them from others (e.g., "crazy").
2. The label is linked to deviant or undesirable attributes by society (e.g., crazy people are dangerous).
3. People with the label are seen as essentially different from those without the label, contributing to an "us" versus "them" mentality (e.g., we are not like those crazy people).
4. People with the label are discriminated against unfairly (e.g., a clinic for crazy people can't be built in our neighborhood).

The case of Jack illustrates how stigma can lead to discrimination. Jack was denied an apartment because of his schizophrenia. The landlord believed Jack's schizophrenia meant he would be violent. This belief is based more in fiction than reality, however. A person with a psychological disorder is not necessarily any more likely to be violent than a person without such a disorder (Steadman, Mulvey, et al., 1998; Swanson, Holzer, et al. 1990), even though people with psychological disorders can be violent if they do not receive treatment (Torrey, 2014).

As we will see, the treatment of people with psychological disorders throughout recorded history has not generally been good, and this has contributed to their stigmatization, to the extent that they have often been brutalized and shunned by society. In the past, torturous treatments were held up to the public as miracle cures, and even today, terms such as *crazy*, *insane*, *retard*, and *schizo* are tossed about without thought of the people who have psychological disorders and for whom these insults and the intensely distressing feelings and behaviors they refer to are a reality of daily life. The cases of Jack and Felicia illustrate how hurtful using such careless and mean-spirited names can be.

Psychological disorders remain the most stigmatized of conditions in the twenty-first century, despite advances in the public's knowledge about the origins of psychological disorders (Hinshaw, 2007). In 1999, then Surgeon General of the United States David Satcher, in his groundbreaking report on mental illness, wrote that stigma is the "most formidable obstacle to future progress in the arena of mental illness and mental health" (U.S. Department of Health and Human Services, 1999). Sadly, this is still true today. In 2010, a staff person working with then Wisconsin gubernatorial candidate Scott Walker wrote dismissively about an election opponent's plan to make mental health care a focus of the campaign, "No one cares about crazy people." This awful phrase was turned into something hopeful when author Ron Powers opted to use it as the title of his book, an unflinchingly honest memoir about his two sons with schizophrenia and the current state of mental health care in the United States (Powers, 2017).

Throughout this book, we hope to fight this stigma by showing you the latest evidence about the nature and causes of these disorders, together with treatments, dispelling myths and other misconceptions as we proceed. As part of this effort, we will try to put a human face on psychological disorders by including descriptions of actual people with these disorders. Additional ways to fight stigma are presented in **Focus on Discovery 1.1**.

Focus on Discovery 1.1

Fighting Against Stigma: A Strategic Approach

In 2007, psychologist Stephen Hinshaw published a book entitled *The Mark of Shame: The Stigma of Mental Illness and an Agenda for Change.* In this important book, Hinshaw discusses several steps that can be taken to end stigma surrounding psychological disorders. Here we briefly discuss some of the key suggestions for fighting stigma in many arenas, including community, mental health professions, and individual/family behaviors and attitudes.

Community Strategies

Housing Options Rates of homelessness in people with psychological disorders are too high, and more programs to provide community residences and group homes are needed. However, many neighborhoods are reluctant to embrace the idea of people with a psychological disorder living among them. Lobbying legislatures and community leaders about the importance of adequate housing is a critically important step toward providing housing for people with psychological disorders and reducing stigma.

Education Educating people about psychological disorders (one of the goals of this book!) is an important step toward reducing stigma. Education alone won't completely eradicate stigma, however. By learning about psychological disorders, though, people may be less hesitant to interact with people who have different disorders. Many of you already know someone with a psychological disorder. Sadly, though, stigma often prevents people from disclosing their history with a psychological disorder. Education may help lessen people's hesitancy to talk about their illnesses.

Personal Contact Providing greater housing opportunities for people with psychological disorders will likely mean that people with these disorders will shop and eat in local establishments alongside people without these disorders. Research suggests that this type of contact—where status is relatively equal—can reduce stigma. In fact, personal contact is more effective than education in reducing stigma (Corrigan, Morris, et al., 2012). Informal settings, such as local parks and churches, can also help bridge the personal contact gap between people with and without psychological disorders.

Mental Health and Health Profession Strategies

Mental Health Evaluations Many children see their pediatricians for well-baby or well-child exams. The goal of these visits is to prevent illness before it occurs. Hinshaw (2007) makes a strong case for including similar preventive efforts for psychological disorders among children and adolescents by, for example, including rating scale assessments from parents and teachers to help identify problems before they become more serious.

Education and Training Mental health professionals should receive training in stigma issues. This type of training would undoubtedly help professionals recognize the pernicious signs of stigma, even within the very profession that is charged with helping people with psychological disorders. In addition, mental health professionals need to keep current on the descriptions, causes, and empirically supported treatments for psychological disorders. This would certainly lead to better interactions with people and might also help educate the public about the important work being done by mental health professionals.

Individual and Family Strategies

Education for Individuals and Families It can be frightening and disorienting for families to learn that a loved one has been diagnosed with an illness, and this may be particularly true for psychological disorders. Receiving current information about the causes and treatments of psychological disorders is crucial because it helps to alleviate blame and remove stereotypes families might hold about psychological disorders. Educating people with a psychological disorder is also extremely important. Sometimes termed *psychoeducation*, this type of information is built into many types of treatments, whether pharmacological or psychosocial. For people to understand why they should adhere to certain treatment regimens, it is important for them to know the nature of their illness and the treatment alternatives available.

Support and Advocacy Groups Participating in support or advocacy groups can be a helpful adjunct to treatment for people with psychological disorders and their families. Websites such as Mind Freedom International (http://www.mindfreedom.org) and the Icarus Project (http://www.theicarusproject.net) are designed to provide a forum for people with psychological disorders to find support. These sites, developed and run by people with psychological disorders, contain useful links, blogs, and other helpful resources. In-person support groups are also helpful, and many communities have groups supported by the National Alliance on Mental Illness (http://www.nami.org). Finding peers in the context of support groups can be beneficial, especially for emotional support and empowerment.

But you will have to help in this fight, for the mere acquisition of knowledge does not ensure the end of stigma (Corrigan, 2015). Many mental health practitioners and advocates have hoped that the more people learned about the neurobiological causes of psychological disorders, the less stigmatized these disorders would be. However, results from an important study show that this may not be true (Pescosolido, Martin, et al., 2010). People's knowledge has increased, but unfortunately stigma has not decreased. In the study, researchers surveyed people's attitudes and knowledge about psychological disorders at two points in time: 1996 and 2006. Compared with 1996, people in 2006 were more likely to believe that psychological disorders such as schizophrenia, depression, and alcohol addiction had a neurobiological cause, but stigma toward these disorders did not decrease. In fact, in some cases it increased.

For example, people in 2006 were less likely to want to have a person with schizophrenia as their neighbor compared with people in 1996. Clearly, there is work to be done to reduce stigma.

Recent efforts to reduce stigma have been quite creative in their use of social media and other means to get the message out that psychological disorders are common and affect us all in one way or another. Indeed, close to 44 million people in the United States (i.e., about 1 in 5 people) had some type of psychological disorder according to the Center for Behavioral Health Statistics and Quality (2015) report. For example, the site Bring Change to Mind (http://bringchange2mind.org) is a platform for personal stories that seeks to end stigma associated with psychological disorders, co-founded by the actress Glenn Close and her sister Jessie who has bipolar disorder (see Chapter 5) and her nephew Calen who has schizophrenia (see Chapter 9). Many blogs feature people talking poignantly about their lives with different psychological disorders, and these accounts help to demystify and therefore destigmatize it. For example, Allie Brosh wrote a blog called Hyperbole and a Half about her experiences with depression (http://hyperboleandahalf.blogspot.com) that culminated in a book (Brosh, 2013). The blog that is part of Strong365 (http://strong365.org) features stories of people living with different psychological disorders. The site Patients Like Me (http://www.patientslikeme.com) is a social networking site for people with all sorts of illnesses. Other creative efforts include the design of T-shirts by a graphic designer named Dani Balenson (http://danibalenson.com). In her work, she seeks to use color and graphics to depict the symptoms, behaviors, and struggles that characterize psychological disorders such as ADHD, obsessive-compulsive disorder, depression, and bipolar disorder (http://www.livingwith.co).

Celebrities or public figures with psychological disorders can also help reduce stigma. For example, the singer and songwriter Demi Lovato openly discusses her life with bipolar disorder and has joined the campaign BeVocal (http://www.bevocalspeakup.com/) to help reduce stigma.

In this chapter, we first discuss what we mean by the term *psychological disorder.* Then we look briefly at how our views of psychological disorders have evolved through history to the more scientific perspectives of today. We conclude with a discussion of the current mental health professions.

Tinseltown/Shutterstock

Quick Summary

This book focuses on the description, causes, and treatments of several different psychological disorders. It is important to note at the outset that the personal impact of our subject matter requires us to make a conscious, determined effort to remain objective. Stigma remains a central problem in the field of psychopathology. Stigma has four components that involve the labels for psychological disorders and their uses. Even the use of everyday terms such as *crazy* or *schizo* can contribute to the stigmatization of people with psychological disorders.

Check Your Knowledge 1.1
(Answers are at the end of the chapter.)

1. Characteristics of stigma include all the following *except*:
   - **a.** a label reflecting desirable characteristics
   - **b.** discrimination against those with the label
   - **c.** focus on differences between those with and without the label
   - **d.** labeling a group of people who are different
2. True/False

Psychological disorders remain the most stigmatized of conditions in the twenty-first century.

3. True/False

Close to 20 million people in the United States had some type of psychological disorder according to the Center for Behavior Health Statistics and Quality (2015) report.

Defining Psychological Disorder

A difficult but fundamental task facing those in the field of psychopathology is to define psychological disorder. The best current definition of psychological disorder is one that contains several characteristics. The definition of *mental disorder* presented in the fifth edition of the American diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), includes several characteristics essential to the concept of psychological disorder (Stein, Phillips, et al., 2010) as shown in **Table 1.1**.

In the following sections, we consider three key characteristics that should be part of any comprehensive psychological disorder definition: personal distress, disability/dysfunction, and violation of social norms (see **Figure 1.2**). We will see that no single characteristic can fully define the concept, although each has merit and each captures some part of what might be a full definition. Consequently, psychological disorder is usually determined based on the presence of several characteristics at one time.

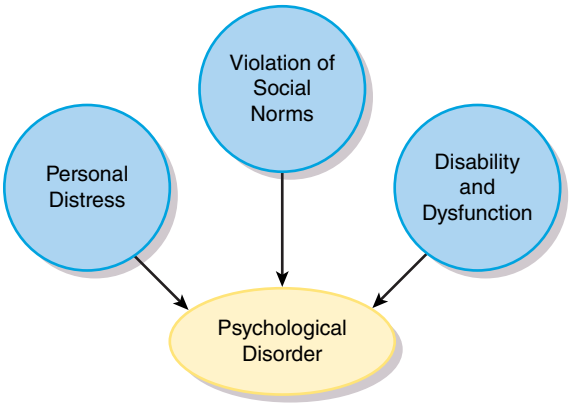
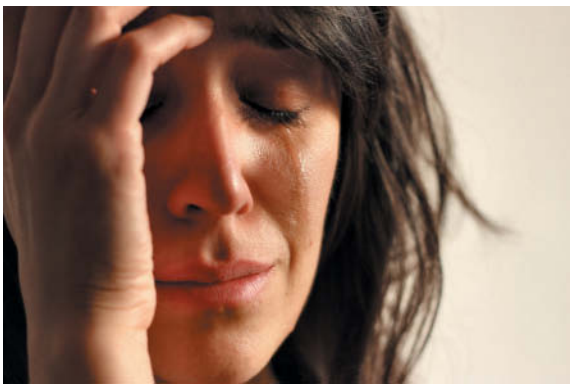


FIGURE 1.2 Three characteristics of a comprehensive definition of psychological disorder.



Personal distress can be part of the definition of psychological disorder.

Personal Distress

One characteristic used to define psychological disorder is personal distress—that is, a person's behavior may be classified as disordered if it causes him or her great distress. Felicia felt distress about her difficulty in paying attention and the social consequences of this difficulty—that is, being called names by other schoolgirls. Personal distress also characterizes many of the forms of psychological disorder considered in this book—people experiencing anxiety disorders and depression suffer greatly. But not all psychological disorders cause distress. For example, an individual with antisocial personality disorder may treat others coldheartedly and violate the law without experiencing any guilt, remorse, anxiety, or other type of distress. And not all behavior that causes distress is disordered—for example, the distress of hunger due to religious fasting or the pain of childbirth.

Disability and Dysfunction

Disability—that is, impairment in some important area of life (e.g., work or personal relationships)—can also characterize psychological disorder. For example, substance use disorders are defined in part by the social or occupational disability (e.g., serious arguments with one's spouse or poor work performance) created by substance abuse. Being rejected by

TABLE 1.1 The DSM-5 Definition of Mental Disorder

The DSM-5 was released in 2013. The definition of mental disorder includes the following:

- The disorder occurs within the individual.
- It involves clinically significant difficulties in thinking, feeling, or behaving.
- It usually involves personal distress of some sort, such as in social relationships or occupational functioning.
- It involves dysfunction in psychological, developmental, and/or neurobiological processes that support mental functioning.
- It is not a culturally specific reaction to an event (e.g., death of a loved one).
- It is not primarily a result of social deviance or conflict with society.

Clinical Case

José

José didn't know what to think about his nightmares. Ever since he returned from the war, he couldn't get the bloody images out of his head. He woke up nearly every night with nightmares about the carnage he witnessed as a soldier stationed in Fallujah. Even during the day, he would have flashbacks to the moment his Humvee was nearly sliced in half by a rocket-propelled grenade. Watching his friend die sitting next to him was the worst part; even the occasional pain from shrapnel still embedded in his shoulder was not as bad as the recurring dreams and flashbacks. He seemed to be sweating all the time now, and whenever he heard a loud noise, he jumped out of his chair. Just the other day, his grandmother stepped on a balloon left over from his "welcome home" party. To José, it sounded like a gunshot, and he immediately dropped to the ground.

His grandmother was worried about him. She thought he must have *ataque de nervios*, just like her father had back home in Puerto Rico. She said her father had been afraid all the time and felt like he was going crazy. She kept going to Mass and praying for José, which he appreciated. The army doctor said he had posttraumatic stress disorder (PTSD). José was supposed to go to the Veterans Administration (VA) hospital for an evaluation, but he didn't really think there was anything wrong with him. Yet his buddy Jorge had been to a group session at the VA, and he said it made him feel better. Maybe he would check it out. He wanted these images to get out of his head.

peers, as Felicia was, is also an example of this characteristic. Phobias can produce both distress and disability—for example, if a severe fear of flying prevents someone living in California from taking a job in New York. Like distress, however, disability alone cannot be used to define psychological disorder because some, but not all, disorders involve disability. For example, the disorder bulimia nervosa involves binge eating and compensatory purging (e.g., vomiting) to control weight, but it does not necessarily involve disability. Many people with bulimia lead lives without impairment, while bingeing and purging in private. Other characteristics that might, in some circumstances, be considered disabilities—such as being blind and wanting to become a professional race car driver—do not fall within the domain of psychopathology. We do not have a rule that tells us which disabilities belong in our domain of study and which do not.

Dysfunction refers to something that has gone wrong and is not working as it should. The DSM-5 definition, shown in Table 1.1, provides a broad concept of dysfunction, which is supported by our current body of evidence. Specifically, the DSM definition of dysfunction refers to the fact that developmental, psychological, and biological dysfunctions are all interrelated. That is, the brain impacts behavior, and behavior impacts the brain; thus, dysfunction in these areas is interrelated.

Violation of Social Norms

In the realm of behavior, social norms are widely held standards (beliefs and attitudes) that people use consciously or intuitively to make judgments about where behaviors are situated on such scales as good–bad, right–wrong, justified–unjustified, and acceptable–unacceptable. Behavior that violates social norms might be classified as disordered. For example, the repetitive rituals performed by people with obsessive-compulsive disorder (see Chapter 7) and the conversations with imaginary voices that some people with schizophrenia engage in (see Chapter 9) are behaviors that violate social norms. José's dropping to the floor at the sound of a popping balloon does not fit within most social norms. Yet this way of defining psychological disorder is both too broad and too narrow. For example, it is too broad in that criminals violate social norms but are not usually studied within the domain of psychopathology; it is too narrow in that highly anxious people typically do not violate social norms.

Also, of course, social norms vary a great deal across cultures and ethnic groups, so behavior that clearly violates a social norm in one group may not do so at all in another. For example, in some cultures but not in others, it violates a social norm to directly disagree with someone. In Puerto Rico, José's behavior would not likely have been interpreted in the same way as it would be in the United States. Throughout this book, we will address this important issue of cultural and ethnic diversity as it applies to the descriptions, causes, and treatments of psychological disorders.

Roger Spooner/Getty Images, Inc.

To some people, extreme tattoos are a violation of the social norm. However, social norm violations are not necessarily signs of a psychological disorder.

Quick Summary

Defining psychological disorder remains difficult. Several different definitions have been offered, but none can entirely account for the full range of disorders. Whether a behavior causes personal distress can be a characteristic of psychological disorder. But not all behaviors that we consider to be part of psychological disorders cause distress. Behaviors that cause a disability or are unexpected can be considered part of a psychological disorder. But again, some behaviors do not cause disability, nor are they unexpected. Behavior that violates social norms can also be considered part of a psychological disorder. However, not all such behavior is considered part of a psychological disorder, and some behaviors that are characteristic of psychological disorders do not necessarily violate social norms. Taken together, each definition of psychological disorder has something helpful to offer in the study of psychopathology.

Check Your Knowledge 1.2

1. True/False

Phobias can produce both distress and disability.

2. Which of the following definitions of psychological disorder is currently thought best?

- **a.** personal distress
- **b.** disability and dysfunction
- **c.** norm violation
- **d.** none of the above

3. What is an advantage of the DSM-5 definition of psychological disorder?

- **a.** It includes information about both violation of social norms and dysfunction.
- **b.** It includes many components, none of which alone can account for psychological disorder.
- **c.** It is part of the current diagnostic system.
- **d.** It recognizes the limits of our current understanding.

History of Psychopathology

Many textbooks begin with a chapter on the history of the field. Why? It is important to consider how concepts and approaches have changed (or not) over time, because we can learn from mistakes made in the past and because we can see that our current concepts and approaches are likely to change in the future. As we consider the history of psychopathology, we will see that many new approaches to the treatment of psychological disorders throughout time appear to go well at first and are heralded with much excitement and fanfare. But these treatments eventually fall into disrepute. These are lessons that should not be forgotten as we consider more contemporary approaches to treatment and their attendant excitement and fanfare.

Supernatural Explanations

Before the age of scientific inquiry, all good and bad manifestations of power beyond human control—eclipses, earthquakes, storms, fire, diseases, the changing seasons—were regarded as supernatural. Behavior seemingly out of individual control was also ascribed to supernatural causes. Many early philosophers, theologians, and physicians who studied the troubled mind believed that disturbed behavior reflected the displeasure of the gods or possession by demons.

Examples of supernatural explanations are found in the records of the early Chinese, Egyptians, Babylonians, and Greeks. Among the Hebrews, odd behavior was attributed to possession of the person by bad spirits, after God in his wrath had withdrawn protection. The New Testament includes the story of Christ curing a man with an unclean spirit by casting out the devils from within him and hurling them onto a herd of swine (Mark 5:8–13).

The belief that odd behavior was caused by possession led to treating it by **exorcism**, the ritualistic casting out of evil spirits. Exorcism typically took the form of elaborate rites of prayer, noisemaking, forcing the afflicted to drink terrible-tasting brews, and on occasion more extreme measures, such as flogging and starvation, to render the body uninhabitable to devils.

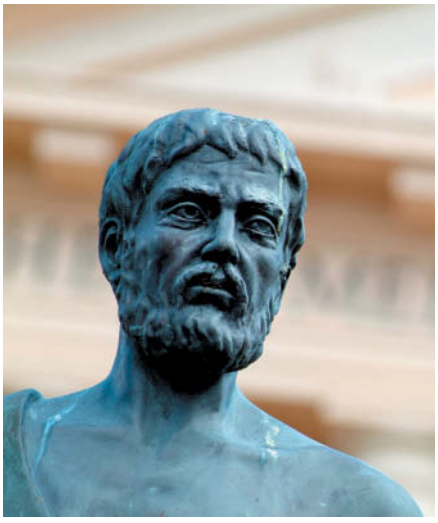
Early Biological Explanations

In the fifth century B.C., Hippocrates (460?–377? B.C.), often called the father of modern medicine, separated medicine from religion, magic, and superstition. He rejected the prevailing Greek belief that the gods sent mental disturbances as punishment and insisted instead that such illnesses had natural causes and hence should be treated like other, more common maladies, such as colds and constipation. Hippocrates regarded the brain as the organ of consciousness, intellectual life, and emotion; thus, he thought that disordered thinking and behavior were indications of some kind of brain pathology. Hippocrates is often considered one of the earliest proponents of the notion that something wrong with the brain contributes to psychological disorders.

Hippocrates (see photo) classified psychological disorders into three categories: mania, melancholia, and phrenitis, or brain fever. He believed that healthy brain functioning, and therefore mental health, depended on a delicate balance among four humors, or fluids of the body, namely, blood, black bile, yellow bile, and phlegm. An imbalance of these humors produced disorders. For example, if a person had a preponderance of black bile, the explanation was melancholia; too much yellow bile explained irritability and anxiousness; and too much blood, changeable temperament.

Through Hippocrates' teachings, the phenomena associated with psychological disorders became more clearly the province of physicians rather than religious figures. The treatments he suggested were quite different from exorcism. For melancholia, for example, he prescribed tranquility, sobriety, care in choosing food and drink, and abstinence from sexual activity. Because Hippocrates believed in natural rather than supernatural causes, he depended on his own keen observations and made valuable contributions as a clinician. He also left behind remarkably detailed records clearly describing many of the symptoms now recognized in seizure disorders, alcohol use disorder, stroke, and paranoia.

Hippocrates' ideas, of course, did not withstand later scientific scrutiny. However, his basic premise—that human behavior is markedly affected by bodily structures or substances and that odd behavior is produced by physical imbalance or even damage—did foreshadow aspects of contemporary thought. In the next seven centuries, Hippocrates' naturalistic approach to disease and disorder was generally accepted by other Greeks as well as by the Romans, who adopted the medicine of the Greeks after the Roman Empire became the major power in the ancient European world.



The Greek physician Hippocrates held a biological view of psychological disorders, considering psychological disorders to be diseases of the brain.

The Dark Ages: Back to the Supernatural

Historians have often pointed to the death of Galen (A.D. 130–200), the second-century Greek who is regarded as the last great physician of the classical era, as the beginning of the so-called Dark Ages in western European medicine and in the treatment and investigation of psychological disorders (see photo). Over several centuries of decay, Greek and Roman civilization ceased to be. The Church now gained in influence, and the papacy was declared independent of the state. Christian monasteries, through their missionary and educational work, replaced physicians as healers and as authorities on psychological disorder.[1]

The monks in the monasteries cared for and nursed the sick, and a few of the monasteries were repositories for the classic Greek medical manuscripts, even though the

Galen was a Greek physician who followed Hippocrates' ideas and is regarded as the last great physician of the classical era.

[1]The teachings of Galen continued to be influential in the Islamic world. For example, the Persian physician al-Razi (865–925) established a facility for the treatment of people with psychological disorders in Baghdad and was an early practitioner of psychotherapy.