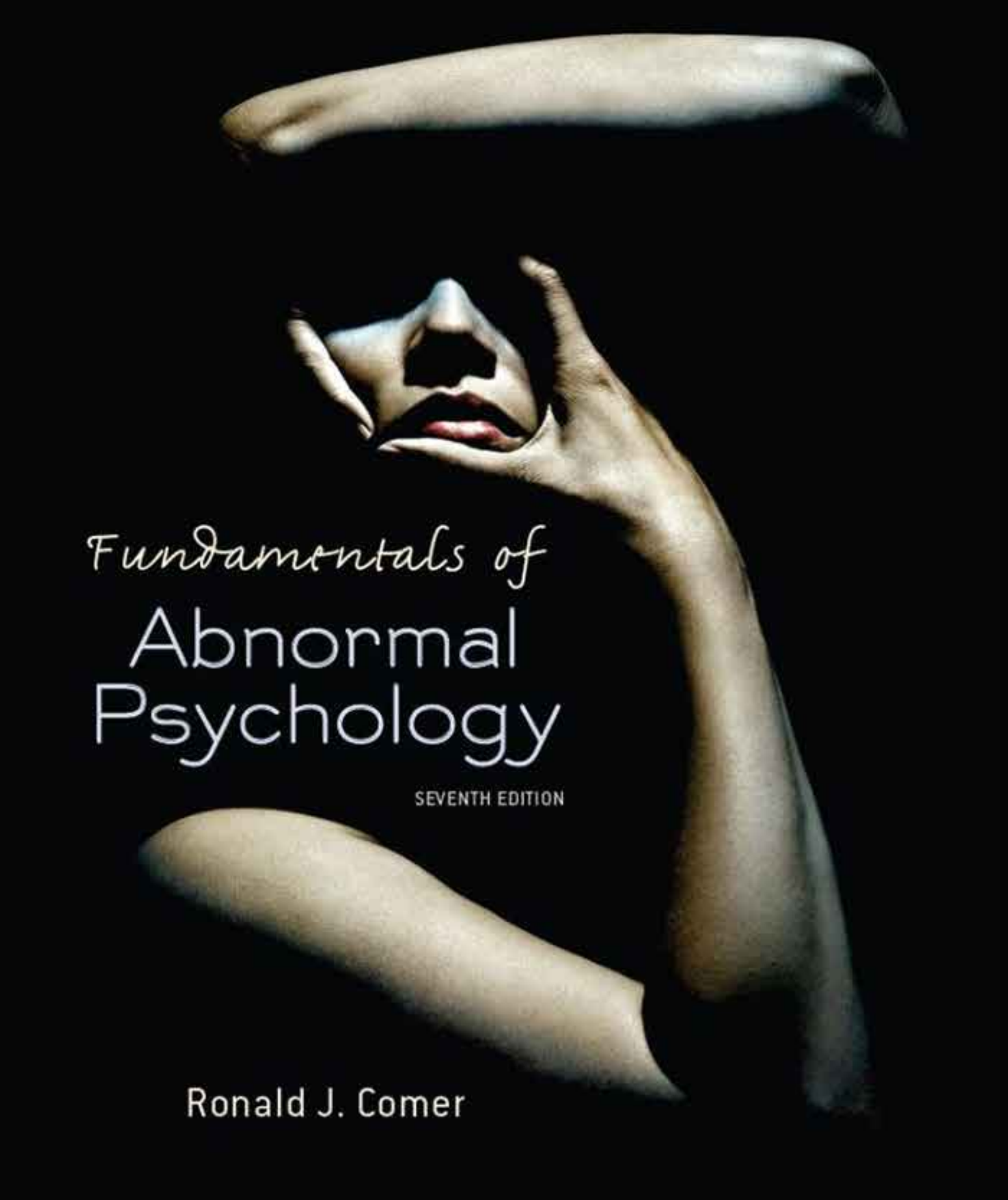
Fundamentals of
Abnormal
Psychology
SEVENTH EDITION
Ronald J. Comer

What's new in DSM-5*

PROBLEMS OF ANXIETY, COMPULSIVENESS, AND STRESS

- **REORGANIZATION** PTSD and Acute Stress Disorder (Chapter 5)
  - ▶ Grouped with *trauma- and stressor-related disorders*, not *anxiety disorders*.
- **REORGANIZATION** Obsessive-Compulsive Disorder (Chapter 4)
  - ▶ Grouped with *obsessive-compulsive and related disorders*, not *anxiety disorders*.
- **NEW CATEGORY** Hoarding Disorder (Chapter 4)
  - ▶ Features persistent need to save items and distress upon discarding them.
- **NEW CATEGORY** Excoriation (Skin-Picking) Disorder (Chapter 4)
  - ▶ Features persistent picking at one's skin, resulting in significant sores or wounds.
- **REORGANIZATION** Body Dysmorphic Disorder (Chapter 4)
  - ▶ Grouped with *obsessive-compulsive and related disorders*, not *somatic symptom disorders*.
- **REORGANIZATION** Hair-Pulling Disorder/ Trichotillomania (Chapter 4)
  - ▶ Grouped with *obsessive-compulsive and related disorders*, not *impulse-control disorders*.

PROBLEMS OF MEMORY AND IDENTITY

- **EXPANDED CATEGORY** Dissociative Amnesia (Chapter 5)
  - ▶ Combines past categories *dissociative amnesia* and *dissociative fugue*.
- **NEW NAME** Depersonalization-Derealization Disorder (Chapter 5)
  - ▶ Replaces past term *depersonalization disorder*.

MOOD PROBLEMS

- **NEW CATEGORY** Premenstrual Dysphoric Disorder (Chapter 6)
  - ▶ Features recurrent depression and related symptoms during the week prior to menses.
- **NEW CATEGORY** Disruptive Mood Dysregulation Disorder (Chapters 6, 14)
  - ▶ Features ongoing pattern of temper outbursts, depression, and anger.
- **POSSIBLE FUTURE CATEGORY** Suicidal Behavior Disorder (Chapter 7)
  - ▶ Features attempt(s) to commit suicide.
- **POSSIBLE FUTURE CATEGORY** Non-Suicidal Self-Injury (Chapter 7)
  - ▶ Features recurrent efforts to inflict damage to one's body (for example, cutting or burning).

PHYSICAL PROBLEMS

- **NEW CATEGORY** Somatic Symptom Disorder (Chapter 8)
  - ▶ Features excessive distress, concern, or anxiety about bodily symptoms or illnesses.
- **NEW NAME** Illness Anxiety Disorder (Chapter 8)
  - ▶ Replaces past term *hypochondriasis*.

EATING PROBLEMS

- **NEW CATEGORY** Binge-Eating Disorder (Chapter 9)
  - ▶ Features recurrent binge-eating episodes, but without symptoms of purging or other compensatory behaviors.

ADDICTION PROBLEMS

- **EXPANDED CATEGORY** Substance Use Disorder (Chapter 10)
  - ▶ Combines past categories *substance abuse* and *substance dependence*.
- **REORGANIZATION** Gambling Disorder (Chapter 10)
  - ▶ Grouped with *addictive disorders*, not *impulse-control disorders*.
- **POSSIBLE FUTURE CATEGORY** Internet Use Gaming Disorder (Chapters 4, 16)
  - ▶ Features excessive need for online gaming and/or other online activities.

PROBLEMS OF SEX AND GENDER

- **NEW NAME** Early Ejaculation (Chapter 11)
  - ▶ Replaces past term *premature ejaculation*.
- **NEW NAME** Delayed Ejaculation (Chapter 11)
  - ▶ Replaces past term *male orgasmic disorder*.
- **EXPANDED CATEGORY** Female Sexual Interest/Arousal Disorder (Chapter 11)
  - ▶ Combines past categories *female hypoactive sexual desire disorder* and *female sexual arousal disorder*.
- **NEW NAME** Gender Dysphoria (Chapter 11)
  - ▶ Replaces *gender identity disorder*.

PROBLEMS OF PSYCHOSIS

- **POSSIBLE FUTURE CATEGORY** Attenuated Psychosis Syndrome (Chapter 12)
  - ▶ Features psychotic symptoms that are milder and less problematic than those found in schizophrenia.

PROBLEMS OF PERSONALITY

- **POSSIBLE FUTURE CATEGORY** Personality Disorder Trait Specified (Chapter 13)
  - ▶ Features one or more problematic traits that significantly impair functioning (e.g., impulsivity, suspiciousness, or hostility).

LIFESPAN PROBLEMS

- **EXPANDED CATEGORY** Autism Spectrum Disorder (Chapter 14)
  - ▶ Combines past categories *autistic disorder, Asperger's disorder,* and *childhood disintegrative disorder*.
- **NEW NAME** Intellectual Developmental Disorder (Chapter 14)
  - ▶ Replaces past term *mental retardation*.
- **EXPANDED CATEGORY** Specific Learning Disorder (Chapter 14)
  - ▶ Combines past categories *reading disorder, mathematics disorder,* and *disorder of written expression*.

PROBLEMS OF COGNITION AND AGING

- **NEW NAME** Major Neurocognitive Disorder (Chapter 15)
  - ▶ Replaces past term *dementia*.
- **NEW CATEGORY** Mild Neurocognitive Disorder (Chapter 15)
  - ▶ Features mild cognitive impairments such as those found in early stages of Alzheimer's disease.

* Based on the APA-approved final version and announcements of DSM-5 (2013, 2012).

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Fundamentals of Abnormal Psychology

SEVENTH EDITION

Ronald J. Comer

Princeton University

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To Liz Widdicombe
Thank you for your support, friendship,
and trust over these many years

ABOUT THE AUTHOR

Ronald J. Comer has been a professor in Princeton University's Department of Psychology for the past 38 years, serving also as Director of Clinical Psychology Studies. His courses—Abnormal Psychology, Theories of Psychotherapy, Childhood Psychopathology, Educational Psychology, Experimental Psychopathology, and Controversies in Clinical Psychology—have been among the university's most popular offerings.

Professor Comer has received the President's Award for Distinguished Teaching at the university. He is also a practicing clinical psychologist and serves as a consultant to the Eden Institute for Persons with Autism and to hospitals and family practice residency programs throughout New Jersey.

In addition to writing *Fundamentals of Abnormal Psychology,* Professor Comer is the author of the textbook *Abnormal Psychology,* now in its eighth edition; co-author of the introductory psychology textbook *Psychology Around Us,* now in its second edition; and co-author of *Case Studies in Abnormal Psychology.* He is the producer of various educational videos, including *The Higher Education Video Library Series, Worth Video Anthology for Abnormal Psychology, Video Segments in Neuroscience, Introduction to Psychology Video Clipboard,* and *Developmental Psychology Video Clipboard.* He also has published journal articles in clinical psychology, social psychology, and family medicine.

Professor Comer completed his undergraduate studies at the University of Pennsylvania and his graduate work at Clark University. He lives in Lawrenceville, New Jersey, with his wife, Marlene. From there he can keep a close eye on the Philadelphia sports teams with which he grew up.

CONTENTS IN BRIEF

CONTENTS

CHAPTER 15

CHAPTER 16

PREFACE

I have been writing my textbooks, *Fundamentals of Abnormal Psychology and Abnormal Psychology,* for more than three decades—approximately half of my life. The current version, *Fundamentals of Abnormal Psychology,* Seventh Edition, represents the fifteenth edition of one or the other of the textbooks. I feel deeply privileged to have had the opportunity to help educate more than a half-million readers over the years.

This textbook journey truly has been a labor of love, but I also must admit that each edition has required enormous effort, ridiculous pressure, and too many sleepless nights to count. I mention these labors not only because I am a world-class whiner but also to help emphasize that I have approached each edition as a totally new undertaking rather than as a cut-and-paste update of past editions. My goal each time has been that the new edition is a fresh, comprehensive, and exciting presentation of the current state of this ever-changing field and that it includes enlightening and innovative pedagogical techniques. This "new book" approach to each edition is, I believe, the key reason for the continuing success of the textbooks.

That said, the current edition includes even more changes than in any of the textbook's previous editions, for several reasons: (1) The field of abnormal psychology has had a dramatic growth spurt over the past several years; (2) a significantly changed, new edition of the field's classification and diagnostic system, DSM-5, has now been introduced, the first such revision in 19 years; (3) the field of education has produced many new pedagogical tools; (4) the world of publishing has developed new, striking ways of presenting material; and (5) the world at large has changed dramatically, featuring a monumental rise in technology's impact on our lives, growing influence by the media, and near unthinkable economic, political, and societal events, including apparent increases in mass killings and other kinds of violence. Changes of this kind certainly should find their way into a book about the current state of human functioning, and I have worked hard to include them here in a meaningful way.

I believe I have produced a new edition of *Fundamentals of Abnormal Psychology* that will once again excite readers and speak to them and their times. I have again tried to convey my passion for the field of abnormal psychology, and I have built on the generous feedback of my colleagues in this undertaking—the students and professors who have used this textbook over the years.

New and Expanded Features

In line with the enormous changes that have occurred over the past several years in the fields of abnormal psychology, education, and publishing and in the world, I have brought the following new features and changes to the current edition.

•NEW• DSM-5: A FIELD IN TRANSITION With the publication of DSM-5, abnormal psychology is clearly a field in transition. To help students appreciate the field's current status and new directions, I present, integrate, and critique DSM-5 material throughout the textbook. Controversy aside, this is now the field's classification and diagnostic system, and it is important that readers understand and master its categories and criteria, appreciate its strengths and weaknesses, and recognize its assumptions and implications, just as past readers learned about the categories, quality, and implications of previous DSM editions. DSM-5 offers at least six kinds of changes, all of which are integrated into *Fundamentals of Abnormal Psychology,* Seventh Edition:

- **Name changes:** DSM-5 has changed the names of many disorders in order to overcome disparaging or misleading connotations. *Intellectual developmental disorder* (page 464), *neurocognitive disorder* (page 485), *illness anxiety disorder* (page 245), and

gender dysphoria (page 356) have replaced, respectively, terms like mental retardation, dementia, hypochondriasis, and gender identity disorder.

- **New categories:** A number of new categories—some quite controversial—have been added to DSM-5, including *hoarding disorder* (page 133), *binge eating disorder* (page 273), *excoriation (skin-picking) disorder* (page 133), *mild neurocognitive disorder* (page 485), *disruptive mood dysregulation disorder* (page 446), and *premenstrual dysphoric disorder* (page 175).
- **New criteria:** The criteria for many disorders have been changed in DSM-5, and some of the changes have also produced controversy in the field. Certain people experiencing bereavement, for example, may now qualify for a diagnosis of *major depressive disorder* (page 175). Such individuals were usually excluded from this diagnosis in the past.
- **Consolidation of categories:** DSM-5 has merged certain past categories. The previous categories of substance abuse and substance dependence have been combined into *substance use disorder* (page 294). Autistic disorder, Asperger's disorder, and childhood disintegrative disorder have merged into the single category of *autism spectrum disorder* (page 457). And reading disorder, mathematics disorder, and disorder of written expression have been fused into *specific learning disorder* (page 465).
- **Expansion of boundaries:** DSM-5 has expanded the boundaries of certain categories. *Gambling disorder,* which used to be considered an impulse problem, is now viewed as a "behavioral addiction," much like repeated substance misuse is considered to be an addiction (page 324). And a diagnosis of *somatic symptom disorder,* a variation of past disorders called somatoform disorders, may now be assigned to people with significant medical problems, if those individuals are judged to be psychologically overreacting to their physical ailments (page 240).
- **Future categories:** DSM-5 has designated certain categories for further study for possible inclusion in upcoming revisions of DSM-5, to be called DSM-5.1, DSM-5.2, and so on. These future possibilities include *personality disorder trait specified* (page 434), *attenuated psychosis syndrome, Internet use gaming disorder* (page 525), *non-suicidal self-injury* (page 211), and *suicidal behavior disorder* (page 208).

These important changes—as well as critiques and presentations of their logic, implications, and controversial nature—are offered in various ways throughout my textbook. First and foremost, the new categories, criteria, and the like are woven smoothly into the narrative of each and every chapter. Second, reader-friendly pedagogical tools, including numerous short, enlightening features located in margins throughout the book, called *DSM-5 Checklist* and *DSM-5 Controversy,* help students fully grasp the DSM-5 material. Third, periodic *PsychWatch* boxes highlight special DSM-5 issues and controversies, such as *Premenstrual Dysphoric Disorder: Déjà Vu All Over Again* (page 178) and *What Happened to Asperger's Disorder?* (page 458).

•NEW• REORGANIZATION OF TWO KEY CHAPTERS Two chapters in this new edition of *Fundamentals of Abnormal Psychology* have been restructured, partly to be consistent with certain DSM-5 changes, but more importantly because this reorganization helps the material to unfold in a more logical way for readers. All psychological disorders in which somatic symptoms are key features are now grouped together in Chapter 8, *Disorders Featuring Somatic Symptoms.* This chapter includes *factitious disorder, conversation disorder, somatic symptom disorder, illness anxiety disorder,* and *psychological factors affecting medical condition.* Similarly, psychological disorders that are triggered by extraordinary trauma and stress are now grouped together in Chapter 5*, Disorders of Trauma and Stress.* This chapter includes the *trauma- and stressor-related disorders* (*acute stress disorder, posttraumatic stress disorder,* and *adjustment disorders*) and *the dissociative disorders (dissociative amnesia, dissociative identity disorder, and depersonalization-derealization disorder).*

•NEW• THE IMPACT OF TECHNOLOGY The breathtaking rate of technological change that characterizes today's world has had significant effects—both positive and negative—on the mental health field, and it will undoubtedly affect the field even more in

coming years. In this edition I cover this impact extensively, including numerous discussions in the book's narrative, boxes, photographs, and figures. The book examines, for example, how the Internet, texting, and social networks have become convenient tools for those who wish to bully others or pursue pedophilic desires (pages 352 and 440); how social networking sites may provide a new source for social anxiety (page 524); and how today's technology has helped create new psychological disorders such as Internet addiction (pages 524–525). It also looks at troubling and dangerous new trends such as the posting of self-cutting videos on the Internet (page 415), live Web suicides (page 229), and pro-anorexia and pro-suicide Web sites (page 92). And it brings to life for the reader the growth of *cybertherapy* in its ever-expanding forms—from long-distance therapy using Skype to therapy enhanced by video game avatars and other virtual reality experiences to Internet-based support groups (page 525).

•NEW• ADDITIONAL SECTIONS Over the past several years, a number of topics in abnormal psychology have received special and intense attention. In this edition, I have provided new sections on such topics, including *the psychology of mass killings* (page 411); *the use of psychological debriefing at disaster scenes* (pages 153–154); *dialectical behavior therapy* (pages 417–419); *dimensional views of abnormal functioning* (pages 85–86); *the overuse of diagnoses such as PTSD, ADHD, and childhood bipolar disorder* (pages 168, 445–446, 452–453); and *sexism in the clinical field* (pages 178 and 345).

•NEW• ADDITIONAL "CUTTING-EDGE" BOXES In this edition, I have grouped the various boxes into two categories to better orient the reader. *PsychWatch* boxes examine text topics in more depth, emphasize the effect of culture on mental disorders and treatment, and explore examples of abnormal psychology in movies, the news, and the real world. *MediaSpeak* boxes offer provocative pieces by news, magazine, and Web writers on current issues and trends in abnormal psychology. In addition to updating the *PsychWatch* and *MediaSpeak* boxes that have been retained from the previous edition, I have added many new ones, including:

- *PsychWatch:* Mass Murders: Where Does Such Violence Come From? (Chapter 13)
- *MediaSpeak:* A Rorschach Cheat Sheet on Wikipedia? (Chapter 3)
- *PsychWatch:* Adjustment Disorders: A Category of Compromise? (Chapter 5)
- *MediaSpeak:* The Crying Game: Male Versus Female Tears (Chapter 6)
- *MediaSpeak:* Live Web Suicides: A Growing Phenomenon (Chapter 7)
- *MediaSpeak:* The Poverty Clinic (Chapter 8)
- *MediaSpeak:* A Mother's Loss, a Daughter's Story (Chapter 9)
- *MediaSpeak:* The Sugar Plum Fairy (Chapter 9)
- *MediaSpeak:* Enrolling at Sober High (Chapter 10)
- *MediaSpeak:* A Different Kind of Judgment (Chapter 11)
- *MediaSpeak:* "Alternative" Mental Health Care (Chapter 12)
- *MediaSpeak:* Videos of Self-Injury Find an Audience (Chapter 13)
- *MediaSpeak:* The Patient as Therapist (Chapter 13)
- *PsychWatch:* Have Multicultural Researchers Neglected Personality Disorders? (Chapter 13)
- *MediaSpeak:* Targets for Bullying (Chapter 14)
- *PsychWatch:* The Oldest Old (Chapter 15)
- *MediaSpeak:* Focusing on Emotions (Chapter 15)

•NEW• HIGHLIGHTED CRITICAL THINKING The seventh edition of *Fundamentals of Abnormal Psychology* has been redesigned strikingly to give it an open, clean, and modern look—one that helps readers better learn, enjoy, and think about the topics under discussion. In a new feature of this design, "critical thought questions" pop up within the

text narrative, asking students to pause at precisely the right moment and think critically about the material they have just read. At the same time, the design retains a fun and thought-provoking feature from past editions that has been very popular among students and professors—reader-friendly elements called "Between the Lines," consisting of text-relevant tidbits, surprising facts, current events, historical notes, interesting trends, enjoyable lists, and stimulating quotes.

•NEW• THOROUGH UPDATE In this edition I present current theories, research, and events, including more than 2,000 new references from the years 2010–2013, as well as hundreds of new photos, tables, and figures.

•EXPANDED COVERAGE• KEY DISORDERS AND TOPICS In line with the field's (and college students') increased interest in certain psychological problems and treatments, I have added or expanded the coverage of topics such as the psychology of mass killings (page 411); torture, terrorism, and psychopathology (pages 146–148); club drugs such as Ecstasy (page 308), crystal meth (page 306), and salvia (page 307); binge drinking (page 299); postpartum depression (page 195) and postpartum psychosis (page 373); cybertherapy and virtual reality treatments (page 51); the pill versus Viagra (page 345); race and eating disorders (pages 279–280); fashion, media, and eating disorders (pages 277–278); medical use of marijuana (page 311); fatal drug use among celebrities (pages 312–313); transgender issues (pages 356–359); self-cutting (page 415); antidepressant drugs and suicide risk (page 224); race and suicide (pages 212–213); music and suicide (page 217); live Web suicides (page 229); dark sites on the Internet (page 92); gay bullying (page 449); jailing people with mental disorders (page 393); Facebook and mental health (pages 524–525); serial murderers (page 519); and more.

•EXPANDED COVERAGE• PREVENTION AND MENTAL HEALTH PROMOTION In accord with the clinical field's growing emphasis on prevention, positive psychology, and psychological wellness, I have increased significantly the textbook's attention to these important approaches (for example, pages 16–17, 228–231, and 497).

•EXPANDED COVERAGE• MULTICULTURAL ISSUES Over the past 25 years, clinical theorists and researchers increasingly have become interested in ethnic, racial, gender, and other cultural factors, and my previous editions of *Fundamentals of Abnormal Psychology* certainly have included these important factors. In the twenty-first century, however, the study of such factors has, appropriately, been elevated to a broad perspective—the *multicultural perspective,* a theoretical and treatment approach to abnormal behavior that is, or should be, considered across all forms of psychopathology and treatment. Consistent with this clinical movement, the current edition includes broad *multicultural perspective* sections within each chapter (for example, pages 57–64), numerous boxes emphasizing multicultural issues (pages 281, 386, and 429), and numerous photographs, art, and case presentations that reflect our multicultural society. A quick look through the pages of this textbook will reveal that it truly reflects the diversity of our society and of the field of abnormal psychology.).

•EXPANDED COVERAGE• "NEW-WAVE" COGNITIVE AND COGNITIVE-BEHAVIORAL THEORIES AND TREATMENTS The traditional focus and treatment approaches of cognitive and cognitive-behavioral clinicians have been joined in recent years by "new-wave" cognitive and cognitive-behavioral theories and therapies that help clients "accept" and objectify those maladaptive thoughts and perspectives that are resistant to change. The current edition of *Fundamentals of Abnormal Psychology* has expanded its coverage of these "new-wave" theories and therapies, including *mindfulness-based cognitive therapy* and *Acceptance and Commitment Therapy* (ACT), presenting their propositions, techniques, and research in chapters throughout the text (for example, pages 105–106).

•EXPANDED COVERAGE• NEUROSCIENCE The twenty-first century has witnessed the continued growth and impact of remarkable brain-imaging techniques, genetic mapping strategies, and other neuroscience approaches, all of which are expanding our understanding of the brain. Correspondingly, the new edition of *Fundamentals of Abnormal Psychology* has expanded its coverage of how biochemical factors, brain structure, brain

function, and genetic factors contribute to abnormal behavior (for example, pages 35–37 and 177–179). It also offers more revealing descriptions of the neuroimaging techniques themselves and their role in the study of abnormal psychology (for example, pages 80–81), using a stimulating array of *brain scan* photos (for example, page 80) and enlightening anatomical art (for example, pages 35 and 132).

Continuing Strengths

In this edition I have also retained the themes, material, and techniques that have worked successfully and been embraced enthusiastically by past readers.

BREADTH AND BALANCE The field's many theories, studies, disorders, and treatments are presented completely and accurately. All major models—psychological, biological, and sociocultural—receive objective, balanced, up-to-date coverage, without bias toward any single approach.

INTEGRATION OF MODELS Discussions throughout the text, particularly those headed "Putting It Together," help students better understand where and how the various models work together and how they differ.

EMPATHY The subject of abnormal psychology is people—very often people in great pain. I have tried therefore to write always with empathy and to impart this awareness to students.

INTEGRATED COVERAGE OF TREATMENT Discussions of treatment are presented throughout the book. In addition to a complete overview of treatment in the opening chapters, each of the pathology chapters includes a full discussion of relevant treatment approaches.

RICH CASE MATERIAL I integrate numerous and culturally diverse clinical examples to bring theoretical and clinical issues to life. More than 25 percent of the clinical material in this edition is new or revised significantly.

MARGIN GLOSSARY Hundreds of key words are defined in the margins of pages on which the words appear. In addition, a traditional glossary is available at the back of the book.

"PUTTING IT TOGETHER" A section toward the end of each chapter, "Putting It Together," asks whether competing models can work together in a more integrated approach and also summarizes where the field now stands and where it may be going.

FOCUS ON CRITICAL THINKING The textbook provides tools for thinking critically about abnormal psychology. As I mentioned earlier, in this edition, "critical thought" questions appear at carefully selected locations within the text discussions. The questions ask readers to stop and think critically about the material they have just read.

STRIKING PHOTOS AND STIMULATING ILLUSTRATIONS Concepts, disorders, treatments, and applications are brought to life for the reader with stunning photographs, diagrams, graphs, and anatomical figures. All of the figures, graphs, and tables, many new to this edition, reflect the most up-to-date data available. The photos range from historical to today's world to pop culture. They do more than just illustrate topics: they touch and move readers.

ADAPTABILITY Chapters are self-contained, so they can be assigned in any order that makes sense to the professor.

Supplements

I have been delighted by the enthusiastic responses of both professors and students to the supplements that accompany my textbooks. This edition offers those supplements once again, revised and enhanced, and adds a number of exciting new ones.

FOR PROFESSORS

•NEW• *WORTH VIDEO ANTHOLOGY FOR ABNORMAL PSYCHOLOGY* (previously called *Abnormal Psychology Video Segments*). *Produced and edited by Ronald J. Comer, Princeton University, and Gregory Comer, Princeton Academic Resources. Faculty Guide included.* This incomparable video series offers 125 clips—more than one-third of them new to this edition—that depict disorders, show historical footage, and illustrate clinical topics, pathologies, treatments, experiments, and dilemmas. Videos are available within the Instructor Flash Drive for *Fundamentals of Abnormal Psychology,* Seventh Edition, or on DVD. I also have written an accompanying guide that fully describes and discusses each video clip, so that professors can make informed decisions about the use of the segments in lectures.

•NEW• INTERACTIVE PRESENTATION SLIDES FOR *ABNORMAL PSYCHOLOGY* *by Karen Clay Rhines, American Public University System.* This extraordinary series of "next-generation" Interactive Presentation Lectures gives instructors a dynamic, yet easy-to-use, new way to engage students during classroom presentations of core abnormal psychology topics. Each lecture provides opportunities for discussion and interaction and enlivens the psychology classroom with an unprecedented number of embedded video clips and animations. Each *Interactive Presentation Lecture* features:

- Embedded videos
- A number of activities
- Ready-to-use clicker questions
- Vivid images

Worth's Interactive Presentation Slides for *Abnormal Psychology* is available on a flash drive.

•NEW• INSTRUCTOR FLASH DRIVE FOR *FUNDAMENTALS OF ABNORMAL PSYCHOLOGY,* SEVENTH EDITION This flash drive includes prebuilt PowerPoint presentations for each chapter; a digital library of photographs, figures, and tables from the text; an electronic version of the Instructor's Resources and Lecture Guides; and the 125 video clips contained in the *Worth Video Anthology for Abnormal Psychology.*

CLINICAL VIDEO CASE FILE FOR *ABNORMAL PSYCHOLOGY* *Produced and edited by Ronald J. Comer and Gregory Comer. Faculty guide is available on the book companion Web site at www.worthpublishers.com/comer under Video Case File Faculty Guide.* I have also produced a set of 10 longer *video case studies* that bring to life particularly interesting forms of psychopathology and treatment. These in-depth and authentic videos are available on DVD.

THE BOOK COMPANION WEB SITE FOR *FUNDAMENTALS OF ABNORMAL PSYCHOLOGY,* SEVENTH EDITION, offers cutting-edge online activities that facilitate critical thinking and learning, as well as tools to help monitor student progress, create interactive presentations, and explore course management solutions. This password-protected instructor site includes a quiz gradebook, links to additional tools for campus course management systems, and a full array of teaching resources, including:

- **PowerPoint® Slides** *available at www.worthpublishers.com/comer.* These PowerPoint® slides featuring all chapter photos and illustrations can be used as is or customized to fit a professor's needs.
- **Digital Photo Library** *available at www.worthpublishers.com/comer.* This collection gives professors access to all the photographs from *Fundamentals of Abnormal Psychology,* Seventh Edition.
- ***Instructor's Resource Manual*** *by Karen Clay Rhines, American Public University System.* This comprehensive guide ties together the ancillary package for professors and teaching assistants. The manual includes detailed chapter outlines, lists of principal learning objectives, ideas for lectures, discussion launchers, classroom activities, extra credit projects, word searches, and crossword puzzles, and DSM criteria for each

of the disorders discussed in the text. It also offers strategies for using the accompanying media, including the video segments series, and the companion Web site. Finally, it includes a comprehensive set of valuable materials that can be obtained from outside sources—items such as relevant feature films, documentaries, teaching references, and Internet sites related to abnormal psychology.

ASSESSMENT TOOLS

PRINTED TEST BANK *by John H. Hull, Bethany College, and Debra B. Hull, Wheeling Jesuit University.* A comprehensive test bank offers more than 2,200 multiple-choice, fill-in-the-blank, and essay questions. Each question is graded according to difficulty, identified as factual or applied, and keyed to the topic and page in the text where the source information appears.

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One final note. As I mentioned in the preface of the previous edition, I have become increasingly aware of just how fortunate I am with each passing year. So, at the risk of sounding like a walking cliché, let me say once again, with a clarity that at the age of 65 is sharper and better informed than at earlier points in my life, how appreciative I am that I have the opportunity each day to work with so many interesting and stimulating students during this important and exciting stage of their lives. Similarly, I am grateful beyond words that I have a number of wonderful friends and an extraordinary family, particularly my terrific sons, Greg and Jon; my fantastic daughters-in-law, Emily and Jami; my perfect granddaughter, Delia; and my truly magnificent wife, Marlene.

Ron Comer
Princeton University
January 2013

ABNORMAL PSYCHOLOGY: PAST AND PRESENT

CHAPTER 1

Johanne cries herself to sleep every night. She is certain that the future holds nothing but misery. Indeed, this is the only thing she does feel certain about. "I'm going to suffer and suffer and suffer, and my daughters will suffer as well. We're doomed. The world is ugly. I hate every moment of my life." She has great trouble sleeping. She is afraid to close her eyes. When she does, the hopelessness of her life—and the ugly future that awaits her daughters—becomes all the clearer to her. When she drifts off to sleep, her dreams are nightmares filled with terrible images—bodies, decay, death, destruction.

Some mornings Johanne even has trouble getting out of bed. The thought of facing another day overwhelms her. She wishes that she and her daughters were dead. "Get it over with. We'd all be better off." She feels paralyzed by her depression and anxiety, overwhelmed by her sense of hopelessness, and filled with fears of becoming ill, too tired to move, too negative to try anymore. On such mornings, she huddles her daughters close to her and sits away the day in the cramped tent she shares with them. She feels she has been deserted by the world and left to rot. She is both furious at life and afraid of it at the same time.

During the past year Alberto has been hearing mysterious voices that tell him to quit his job, leave his family, and prepare for the coming invasion. These voices have brought tremendous confusion and emotional turmoil to Alberto's life. He believes that they come from beings in distant parts of the universe who are somehow wired to him. Although it gives him a sense of purpose and specialness to be the chosen target of their communications, the voices also make him tense and anxious. He does all he can to warn others of the coming apocalypse. In accordance with instructions from the voices, he identifies online articles that seem to be filled with foreboding signs, and he posts comments that plead with other readers to recognize the articles' underlying messages. Similarly, he posts long, rambling YouTube videos that describe the invasion to come. The online comments and feedback that he receives typically ridicule and mock him. If he rejects the voices' instructions and stops his online commentary and videos, then the voices insult and threaten him and turn his days into a waking nightmare.

Alberto has put himself on a sparse diet as protection against the possibility that his enemies may be contaminating his food. He has found a quiet apartment far from his old haunts, where he has laid in a good stock of arms and ammunition. After witnessing the abrupt and troubling changes in his behavior and watching his ranting and rambling videos, his family and friends have tried to reach out to Alberto, to understand his problems, and to dissuade him from the disturbing course he is taking. Every day, however, he retreats further into his world of mysterious voices and imagined dangers.

Most of us would probably consider Johanne's and Alberto's emotions, thoughts, and behaviors psychologically abnormal, the result of a state sometimes called *psychopathology, maladjustment, emotional disturbance,* or *mental illness.* These terms have been applied to the many problems that seem closely tied to the human brain or mind. Psychological abnormality affects the famous and the unknown, the rich and the poor. Celebrities, writers, politicians, and other public figures of the present and the past have struggled with it. Psychological problems can bring great suffering, but they can also be the source of inspiration and energy.

Because they are so common and so personal, these problems capture the interest of us all. Hundreds of novels, plays, films, and television programs have

TOPIC OVERVIEW

•**abnormal psychology**•The scientific study of abnormal behavior in an effort to describe, predict, explain, and change abnormal patterns of functioning.

•**norms**•A society's stated and unstated rules for proper conduct.

•**culture**•A people's common history, values, institutions, habits, skills, technology, and arts.

explored what many people see as the dark side of human nature, and self-help books flood the market. Mental health experts are popular guests on both television and radio, and some even have their own shows, Web sites, and blogs.

Why do actors and actresses who portray characters with psychological disorders tend to receive more awards for their performances?

The field devoted to the scientific study of the problems we find so fascinating is usually called **abnormal psychology.** As in any science, workers in this field, called *clinical scientists,* gather information systematically so that they may describe, predict, and explain the phenomena they study. The knowledge that they acquire is then used by *clinical practitioners,* whose role is to detect, assess, and treat abnormal patterns of functioning.

What Is Psychological Abnormality?

Although their general goals are similar to those of other scientific professionals, clinical scientists and practitioners face problems that make their work especially difficult. One of the most troubling is that psychological abnormality is very hard to define. Consider once again Johanne and Alberto. Why are we so ready to call their responses abnormal?

While many definitions of abnormality have been proposed over the years, none has won total acceptance (Pierre, 2010). Still, most of the definitions have certain features in common, often called "the four Ds": deviance, distress, dysfunction, and danger. That is, patterns of psychological abnormality are typically *deviant* (different, extreme, unusual, perhaps even bizarre), *distressing* (unpleasant and upsetting to the person), *dysfunctional* (interfering with the person's ability to conduct daily activities in a constructive way), and possibly *dangerous.* This definition offers a useful starting point from which to explore the phenomena of psychological abnormality. As you will see, however, it has key limitations.

Deviance

Abnormal psychological functioning is *deviant,* but deviant from what? Johanne's and Alberto's behaviors, thoughts, and emotions are different from those that are considered normal in our place and time. We do not expect people to cry themselves to sleep each night, hate the world, wish themselves dead, or obey voices that no one else hears.

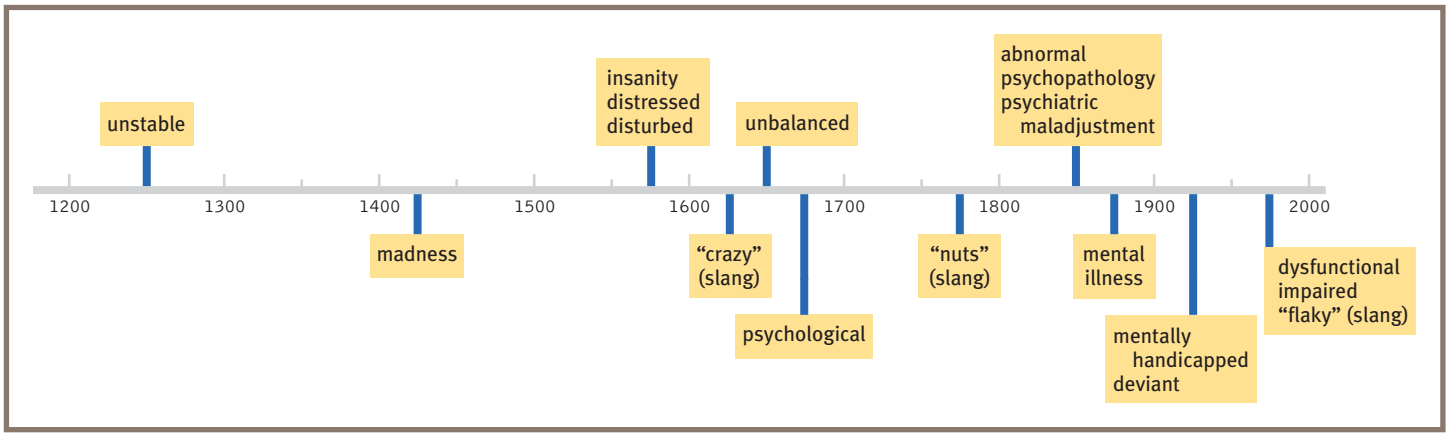
AP Photo/David Guttenfelder

Context is key
On the morning after Japan's devastating earthquake and tsunami in 2011, Reiko Kikuta, right, and her husband Takeshi watch workers try to attach ropes to and pull their home ashore. Anxiety and depression were common and seemingly normal reactions in the wake of this extraordinary disaster, rather than being clear symptoms of psychopathology.

PsychWatch

Verbal Debuts

We use words like "abnormal" and "mental disorder" so often that it is easy to forget that there was a time not that long ago when these terms did not exist. When did these and similar words (including slang terms) make their debut in print as expressions of psychological dysfunctioning? The *Oxford English Dictionary* offers the following dates.



In short, abnormal behavior, thoughts, and emotions are those that differ markedly from a society's ideas about proper functioning. Each society establishes **norms**—stated and unstated rules for proper conduct. Behavior that breaks legal norms is considered to be criminal. Behavior, thoughts, and emotions that break norms of psychological functioning are called abnormal.

Judgments of abnormality vary from society to society. A society's norms grow from its particular **culture**—its history, values, institutions, habits, skills, technology, and arts. A society that values competition and assertiveness may accept aggressive behavior, whereas one that emphasizes cooperation and gentleness may consider aggressive behavior unacceptable and even abnormal. A society's values may also change over time, causing its views of what is psychologically abnormal to change as well. In Western society, for example, a woman seeking the power of running a major corporation or indeed of leading the country would have been considered inappropriate and even delusional a hundred years ago. Today the same behavior is valued.

Judgments of abnormality depend on *specific circumstances* as well as on cultural norms. What if, for example, we were to learn that Johanne is a citizen of Haiti and that her desperate unhappiness began in the days, weeks, and months following the massive earthquake that struck her country, already the poorest country in the Western hemisphere, on January 12, 2010? The quake, one of history's worst natural disasters, killed 250,000 Haitians and left 1.5 million homeless. Half of Haiti's homes and buildings were immediately turned into rubble, and its electricity and other forms of power disappeared. Tent cities replaced homes for most people (MCEER, 2011; Wilkinson, 2011).

In the weeks and months that followed the earthquake, Johanne came to accept that she wouldn't get all of the help she needed and that she might never again see the friends and neighbors who had once given her life so much meaning. As she and her daughters moved from one temporary tent or hut to another throughout the country, always at risk of developing serious diseases, she gradually gave up all hope that her life would ever return to normal. In this light, Johanne's reactions do not seem quite so inappropriate. If anything is abnormal here, it is her situation. Many human experiences produce intense reactions—financial ruin, large-scale catastrophes and disasters, rape, child abuse, war, terminal illness, chronic pain (Ayub et al., 2012). Is there an "appropriate" way to react to such things? Should we ever call reactions to such experiences abnormal?

BETWEEN THE LINES

Statistically Deviant

42% People who attend church or synagogue weekly ‹‹

39% People who confess to snooping in their hosts' medicine cabinets ‹‹

30% Those who refuse to sit on a public toilet seat ‹‹

(Gallup, 2011; Kanner, 2004, 1995)

Chaideer Mahyuddin/AFP/Getty Images

Dealing with deviance
Each culture identifies and deals with deviant behavior in its own way. For example, uncomfortable with the deviant appearances of young punk rockers—mohawks, tattoos, nose piercings, tight jeans, and chains—sharia police in Aceh province on Sumatra Island in Indonesia arrested 60 such individuals in 2011 and forced them to undergo a 10-day "moral rehabilitation" camp. There the rockers were forced to have their heads shaved, bathe in a lake, wear traditional clothes, remove their piercings, and pray.

Distress

Even functioning that is considered unusual does not necessarily qualify as abnormal. According to many clinical theorists, behavior, ideas, or emotions usually have to cause *distress* before they can be labeled abnormal. Consider the Ice Breakers, a group of people in Michigan who go swimming in lakes throughout the state every weekend from November through February. The colder the weather, the better they like it. One man, a member of the group for 17 years, says he loves the challenge of man against nature. A 37-year-old lawyer believes that the weekly shock is good for her health. "It cleanses me," she says. "It perks me up and gives me strength."

Certainly these people are different from most of us, but is their behavior abnormal? Far from experiencing distress, they feel energized and challenged. Their positive feelings must cause us to hesitate before we decide that they are functioning abnormally.

Should we conclude, then, that feelings of distress must always be present before a person's functioning can be considered abnormal? Not necessarily. Some people who function abnormally maintain a positive frame of mind. Consider once again Alberto, the young man who hears mysterious voices. Alberto does experience distress over the coming invasion and the life changes he feels forced to make. But what if he enjoyed listening to the voices, felt honored to be chosen, loved sending out warnings on the Internet, and looked forward to saving the world? Shouldn't we still regard his functioning as abnormal?

Dysfunction

Abnormal behavior tends to be *dysfunctional;* that is, it interferes with daily functioning. It so upsets, distracts, or confuses people that they cannot care for themselves properly, participate in ordinary social interactions, or work productively. Alberto, for example, has quit his job, left his family, and prepared to withdraw from the productive life he once led.

Here again one's culture plays a role in the definition of abnormality. Our society holds that it is important to carry out daily activities in an effective manner. Thus Alberto's behavior is likely to be regarded as abnormal and undesirable, whereas that of the Ice Breakers, who continue to perform well in their jobs and enjoy fulfilling relationships, would probably be considered simply unusual.

Danger

Perhaps the ultimate in psychological dysfunctioning is behavior that becomes *dangerous* to oneself or others. Individuals whose behavior is consistently careless, hostile, or confused may be placing themselves or those around them at risk. Alberto, for example, seems to be endangering both himself, with his diet, and others, with his buildup of arms and ammunition.

Although danger is often cited as a feature of abnormal psychological functioning, research suggests that it is actually the exception rather than the rule (Hiday & Burns, 2010). Most people struggling with anxiety, depression, and even bizarre thinking pose no immediate danger to themselves or to anyone else.

The Elusive Nature of Abnormality

Efforts to define psychological abnormality typically raise as many questions as they answer. Ultimately, a society selects general criteria for defining abnormality and then uses those criteria to judge particular cases.

BETWEEN THE LINES

In Their Words

"I became insane, with long intervals of horrible sanity." ‹‹
Edgar Allen Poe

"I can calculate the motion of heavenly bodies but not the madness of people." ‹‹
Sir Isaac Newton

One clinical theorist, Thomas Szasz (2012, 2011, 1963, 1960), places such emphasis on society's role that he finds the whole concept of mental illness to be invalid, a *myth* of sorts. According to Szasz, the deviations that society calls abnormal are simply "problems in living," not signs of something wrong within the person. Societies, he is convinced, invent the concept of mental illness so that they can better control or change people whose unusual patterns of functioning upset or threaten the social order.

Even if we assume that psychological abnormality is a valid concept and that it can indeed be defined, we may be unable to apply our definition consistently. If a behavior—excessive use of alcohol among college students, say—is familiar enough, the society may fail to recognize that it is deviant, distressful, dysfunctional, and dangerous. Thousands of college students throughout the United States are so dependent on alcohol that it interferes with their personal and academic lives, causes them great discomfort, jeopardizes their health, and often endangers them and the people around them (Hingson & White, 2010). Yet their problem often goes unnoticed and undiagnosed. Alcohol is so much a part of the college subculture that it is easy to overlook drinking behavior that has become abnormal.

Conversely, a society may have trouble separating an abnormality that requires intervention from an *eccentricity,* an unusual pattern with which others have no right

PsychWatch

Marching to a Different Drummer: Eccentrics

- Writer **James Joyce** always carried a tiny pair of lady's bloomers, which he waved in the air to show approval.
- **Benjamin Franklin** took "air baths" for his health, sitting naked in front of an open window.
- **Alexander Graham Bell** covered the windows of his house to keep out the rays of the full moon. He also tried to teach his dog how to talk.
- Writer **D. H. Lawrence** enjoyed removing his clothes and climbing mulberry trees.

(ASIMOV, 1997; WEEKS & JAMES, 1995)

These famous persons have been called eccentrics. The dictionary defines an *eccentric* as a person who deviates from common behavior patterns or displays odd or whimsical behavior. But how can we separate a psychologically healthy person who has unusual habits from a person whose oddness is a symptom of psychopathology? Little research has been done on eccentrics, but a few studies offer some insights (Stares, 2005; Pickover, 1999).

Researcher David Weeks studied 1,000 eccentrics and estimated that as many as 1 in 5,000 persons may be "classic, full-time eccentrics" (Weeks & James, 1995). Weeks pinpointed 15 characteristics common to the eccentrics in his study: *nonconformity, creativity, strong curiosity, idealism, extreme interests and hobbies, lifelong awareness of being different, high intelligence, outspokenness, noncompetitiveness, unusual eating and living habits, disinterest in others' opinions or company, mischievous sense of humor, nonmarriage, eldest or only child,* and *poor spelling skills.*

Weeks suggests that eccentrics do not typically suffer from mental disorders. Whereas the unusual behavior of persons with mental disorders is thrust upon them and usually causes them suffering, eccentricity is chosen freely and provides pleasure. In short, "Eccentrics know they're different and glory in it" (Weeks & James, 1995, p. 14). Similarly, the thought processes of eccentrics are not severely disrupted and do not leave these persons dysfunctional. In fact, Weeks found that eccentrics in his study actually had fewer emotional problems than individuals in the general population. Perhaps being an "original" is good for mental health.

Lantee Mannion/Retna Ltd./Corbis

Musical eccentric Pop superstar Lady Gaga is known far and wide for her eccentric behavior, outrageous sense of fashion, and unusual performing style. Her millions of fans enjoy her unusual persona every bit as much as the lyrics and music that she writes and sings.

AP Photo/Katsumi Kasahara

Changing times
Just decades ago, a woman's love for race car driving would have been considered strange, perhaps even abnormal. Today, Danica Patrick (right) is one of America's finest race car drivers. The size difference between her first-place trophy at the Indy Japan 300 auto race and that of second-place male driver Helio Castroneves symbolizes just how far women have come in this sport.

to interfere. From time to time we see or hear about people who behave in ways we consider strange, such as a man who lives alone with two dozen cats and rarely talks to other people. The behavior of such people is deviant, and it may well be distressful and dysfunctional, yet many professionals think of it as eccentric rather than abnormal.

What behaviors might fit the criteria of deviant, distressful, dysfunctional, or dangerous but would not be considered abnormal by most people?

In short, while we may agree to define psychological abnormalities as patterns of functioning that are deviant, distressful, dysfunctional, and sometimes dangerous, we should be clear that these criteria are often vague and subjective. In turn, few of the current categories of abnormality that you will meet in this book are as clear-cut as they may seem, and most continue to be debated by clinicians.

Summing Up

WHAT IS PSYCHOLOGICAL ABNORMALITY? The field devoted to the scientific study of abnormal behavior is called abnormal psychology. Abnormal functioning is generally considered to be deviant, distressful, dysfunctional, and dangerous. Behavior must also be considered in the context in which it occurs, however, and the concept of abnormality depends on the norms and values of the society in question.

What Is Treatment?

Once clinicians decide that a person is indeed suffering from some form of psychological abnormality, they seek to treat it. **Treatment,** or **therapy,** is a procedure designed to change abnormal behavior into more normal behavior; it, too, requires careful definition. For clinical scientists, the problem is closely related to defining abnormality. Consider the case of Bill:

February: *He cannot leave the house; Bill knows that for a fact. Home is the only place where he feels safe—safe from humiliation, danger, even ruin. If he were to go to work, his co-workers would somehow reveal their contempt for him. A pointed remark, a quizzical look—that's all it would take for him to get the message. If he were to go shopping at the store, before long everyone would be staring at him. Surely others would see his dark mood and thoughts; he wouldn't be able to hide them. He dare not even go for a walk alone in the woods—his heart would probably start racing again, bringing him to his knees and leaving him breathless, incoherent, and unable to get home. No, he's much better off staying in his room, trying to get through another evening of this curse called life. Thank goodness for the Internet. Were it not for his reading of news sites and postings to blogs and online forums, he would, he knows, be cut off from the world altogether.*

July: *Bill's life revolves around his circle of friends: Bob and Jack, whom he knows from the office, where he was recently promoted to director of customer relations, and Frank and Tim, his weekend tennis partners. The gang meets for dinner every week at someone's house, and they chat about life, politics, and their jobs. Particularly special in Bill's life is Janice. They go to movies, restaurants, and shows together. She thinks Bill's just terrific, and Bill finds himself beaming whenever she's around. Bill looks forward to work each day and his one-on-one dealings with customers. He is taking part in many activities and relationships and more fully enjoying life.*

•**treatment**• A systematic procedure designed to change abnormal behavior into more normal behavior. Also called *therapy*.

Bill's thoughts, feelings, and behavior interfered with all aspects of his life in February. Yet most of his symptoms had disappeared by July. All sorts of factors may have contributed to Bill's improvement—advice from friends and family members, a new job or vacation, perhaps a big change in his diet or exercise regimen. Any or all of these things may have been useful to Bill, but they could not be considered treatment, or therapy. Those terms are usually reserved for special, systematic procedures for helping people overcome their psychological difficulties. According to clinical theorist Jerome Frank, all forms of therapy have three essential features:

1. A *sufferer* who seeks relief from the healer.
2. A trained, socially accepted *healer,* whose expertise is accepted by the sufferer and his or her social group.
3. A *series of contacts* between the healer and the sufferer, through which the healer . . . tries to produce certain changes in the sufferer's emotional state, attitudes, and behavior.

(Frank, 1973, pp. 2–3)

Despite this straightforward definition, clinical treatment is surrounded by conflict and confusion. Carl Rogers, a pioneer in the modern clinical field (you will meet him in Chapter 2), noted that "therapists are not in agreement as to their goals or aims. . . . They are not in agreement as to what constitutes a successful outcome of their work. They cannot agree as to what constitutes a failure. It seems as though the field is completely chaotic and divided."

Some clinicians view abnormality as an illness and so consider therapy a procedure that helps *cure* the illness. Others see abnormality as a problem in living and therapists as *teachers* of more functional behavior and thought. Clinicians even differ on what to call the person who receives therapy: those who see abnormality as an illness speak of the "patient," while those who view it as a problem in living refer to the "client." Because both terms are so common, this book will use them interchangeably.

Despite their differences, most clinicians do agree that large numbers of people need therapy of one kind or another. Later you will encounter evidence that therapy is indeed often helpful.

AP Photo/Paul White

Therapy . . . not
Recently, a hotel in Spain that was about to undergo major renovations invited members of the public to relieve their stress by destroying the rooms on one floor of the hotel. This activity may indeed have been therapeutic for some, but it was not *therapy.* It lacked, among other things, a "trained healer" and a series of systematic contacts between healer and sufferer.

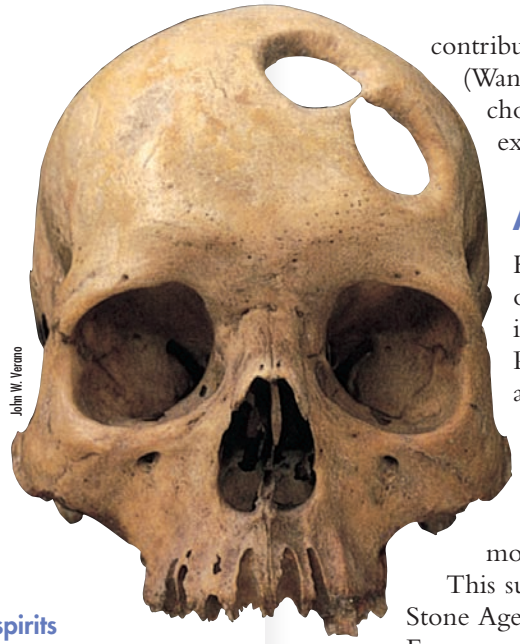
Summing Up

WHAT IS TREATMENT? Therapy is a systematic process for helping people overcome their psychological difficulties. It may differ from problem to problem and from therapist to therapist, but it typically includes a patient, a therapist, and a series of therapeutic contacts.

How Was Abnormality Viewed and Treated in the Past?

In any given year as many as 30 percent of the adults and 19 percent of the children and adolescents in the United States display serious psychological disturbances and are in need of clinical treatment (Lopez-Duran, 2010; Narrow et al., 2002). The rates in other countries are similarly high. Furthermore, most people have difficulty coping at various times and go through periods of extreme tension, dejection, or other forms of psychological discomfort.

It is tempting to conclude that something about the modern world is responsible for these many emotional problems—perhaps rapid technological change, the growing threat of terrorism, or a decline in religious, family, or other support systems (North, 2010; Comer & Kendall, 2007). Although the pressures of modern life probably do


John W. Verano

Expelling evil spirits
The two holes in this skull recovered from ancient times indicate that the person underwent trephination, possibly for the purpose of releasing evil spirits and curing mental dysfunctioning.

contribute to psychological dysfunctioning, they are hardly its primary cause (Wang et al., 2010). Every society, past and present, has witnessed psychological abnormality. Perhaps, then, the proper place to begin our examination of abnormal behavior and treatment is in the past.

Ancient Views and Treatments

Historians who have examined the unearthed bones, artwork, and other remnants of ancient societies have concluded that these societies probably regarded abnormal behavior as the work of evil spirits. People in prehistoric societies apparently believed that all events around and within them resulted from the actions of magical beings who controlled the world. In particular, they viewed the human body and mind as a battleground between external forces of good and evil. Abnormal behavior was typically interpreted as a victory by evil spirits, and the cure for such behavior was to force the demons from a victim's body.

This supernatural view of abnormality may have begun as far back as the Stone Age, a half-million years ago. Some skulls from that period recovered in Europe and South America show evidence of an operation called **trephination,** in which a stone instrument, or *trephine,* was used to cut away a circular section of the skull. Some historians have concluded that this early operation was performed as a treatment for severe abnormal behavior—either hallucinations, in which people saw or heard things not actually present, or melancholia, characterized by extreme sadness and immobility. The purpose of opening the skull was to release the evil spirits that were supposedly causing the problem (Selling, 1940).

Later societies also explained abnormal behavior by pointing to possession by demons. Egyptian, Chinese, and Hebrew writings all account for psychological deviance this way, and the Bible describes how an evil spirit from the Lord affected King Saul and how David pretended to be mad to convince his enemies that he was visited by divine forces.

In addition to exorcism, what other demonological explanations or treatments are still around today, and why do they persist?

The treatment for abnormality in these early societies was often *exorcism*. The idea was to coax the evil spirits to leave or to make the person's body an uncomfortable place in which to live. A *shaman,* or priest, might recite prayers, plead with the evil spirits, insult the spirits, perform magic, make loud noises, or have the person ingest bitter drinks. If these techniques failed, the shaman performed a more extreme form of exorcism, such as whipping or starving the person.

Greek and Roman Views and Treatments

In the years from roughly 500 B.C. to 500 A.D., when the Greek and Roman civilizations thrived, philosophers and physicians often offered different explanations and treatments for abnormal behaviors. Hippocrates (460–377 B.C.), often called the father of modern medicine, taught that illnesses had *natural* causes. He saw abnormal behavior as a disease arising from internal physical problems. Specifically, he believed that some form of brain pathology was the culprit and that it resulted—like all other forms of disease, in his view—from an imbalance of four fluids, or **humors,** that flowed through the body: *yellow bile, black bile, blood,* and *phlegm* (Zuckerman, 2011). An excess of yellow bile, for example, caused frenzied activity; an excess of black bile was the source of unshakable sadness.

To treat psychological dysfunctioning, Hippocrates sought to correct the underlying physical pathology. He believed, for instance, that the excess of black bile underlying sadness could be reduced by a quiet life, a diet of vegetables, exercise, celibacy, and even

•trephination• An ancient operation in which a stone instrument was used to cut away a circular section of the skull, perhaps to treat abnormal behavior.

•humors• According to the Greeks and Romans, bodily chemicals that influence mental and physical functioning.

bleeding. Hippocrates' focus on internal causes for abnormal behavior was shared by the great Greek philosophers Plato (427–347 B.C.) and Aristotle (384–322 B.C.) and by influential Greek and Roman physicians.

Europe in the Middle Ages: Demonology Returns

The enlightened views of Greek and Roman physicians and scholars were not enough to shake ordinary people's belief in demons. And with the decline of Rome, demonological views and practices became popular once again. A growing distrust of science spread throughout Europe.

From 500 to 1350 A.D., the period known as the Middle Ages, the power of the clergy increased greatly throughout Europe. In those days the church rejected scientific forms of investigation, and it controlled all education. Religious beliefs, which were highly superstitious and demonological, came to dominate all aspects of life. Once again behavior was usually interpreted as a conflict between good and evil, God and the devil. Deviant behavior, particularly psychological dysfunctioning, was seen as evidence of Satan's influence. Although some scientists and physicians still insisted on medical explanations and treatments, their views carried little weight in this atmosphere.

The Middle Ages were a time of great stress and anxiety—of war, urban uprisings, and plagues. People blamed the devil for these troubles and feared being possessed by him (Sluhovsky, 2011). Abnormal behavior apparently increased greatly during this period. In addition, there were outbreaks of *mass madness,* in which large numbers of people apparently shared absurd false beliefs and imagined sights or sounds. In one such disorder, *tarantism* (also known as *Saint Vitus' dance*), groups of people would suddenly start to jump, dance, and go into convulsions (Waller, 2009; Sigerist, 1943). All were convinced that they had been bitten and possessed by a wolf spider, now called a tarantula, and they sought to cure their disorder by performing a dance called a tarantella. In another form of mass madness, *lycanthropy,* people thought they were possessed by wolves or other animals. They acted wolflike and imagined that fur was growing all over their bodies.

How might Twitter, Facebook, text messages, the Internet, cable television, or other technologies facilitate current forms of mass madness?

Not surprisingly, some of the earlier demonological treatments for psychological abnormality reemerged during the Middle Ages. Once again the key to the cure was to rid the person's body of the devil that possessed it. Exorcisms were revived, and clergymen, who generally were in charge of treatment during this period, would plead, chant, or pray to the devil or evil spirit (Sluhovsky, 2011, 2007). If these techniques did not work, they had others to try, some amounting to torture.

It was not until the Middle Ages drew to a close that demonology and its methods began to lose favor. Towns throughout Europe grew into cities, and government officials gained more power and took over nonreligious activities. Among their other responsibilities, they began to run hospitals and direct the care of people suffering from mental disorders. Medical views of abnormality gained favor once again, and many people with psychological disturbances received treatment in medical hospitals, such as the Trinity Hospital in England (Allderidge, 1979).

The Renaissance and the Rise of Asylums

During the early part of the Renaissance, a period of flourishing cultural and scientific activity from about 1400 to 1700, demonological views of abnormality continued to decline. German physician Johann Weyer (1515–1588), the first physician to specialize in mental illness, believed that the mind was as susceptible to sickness as the body was. He is now considered the founder of the modern study of psychopathology.

Corbis-Bettman

Bewitched or bewildered?
A great fear of witchcraft swept Europe beginning in the 1300s and extending through the "enlightened" Renaissance. Tens of thousands of people, mostly women, were thought to have made a pact with the devil. Some appear to have had mental disorders, which caused them to act strangely. This individual is being "dunked" repeatedly until she confesses to witchery.

BETWEEN THE LINES

Historical Notes

From the Middle Ages through the 1800s, *barbers* sometimes performed the treatments, including *bloodletting,* for both medical and mental disorders. Today's striped barber poles originated back then, when they were staffs that patients would grip while being bled by a barber. ‹‹

Doctors who treated people with mental disorders in the eighteenth century were called "mad-doctors." ‹‹