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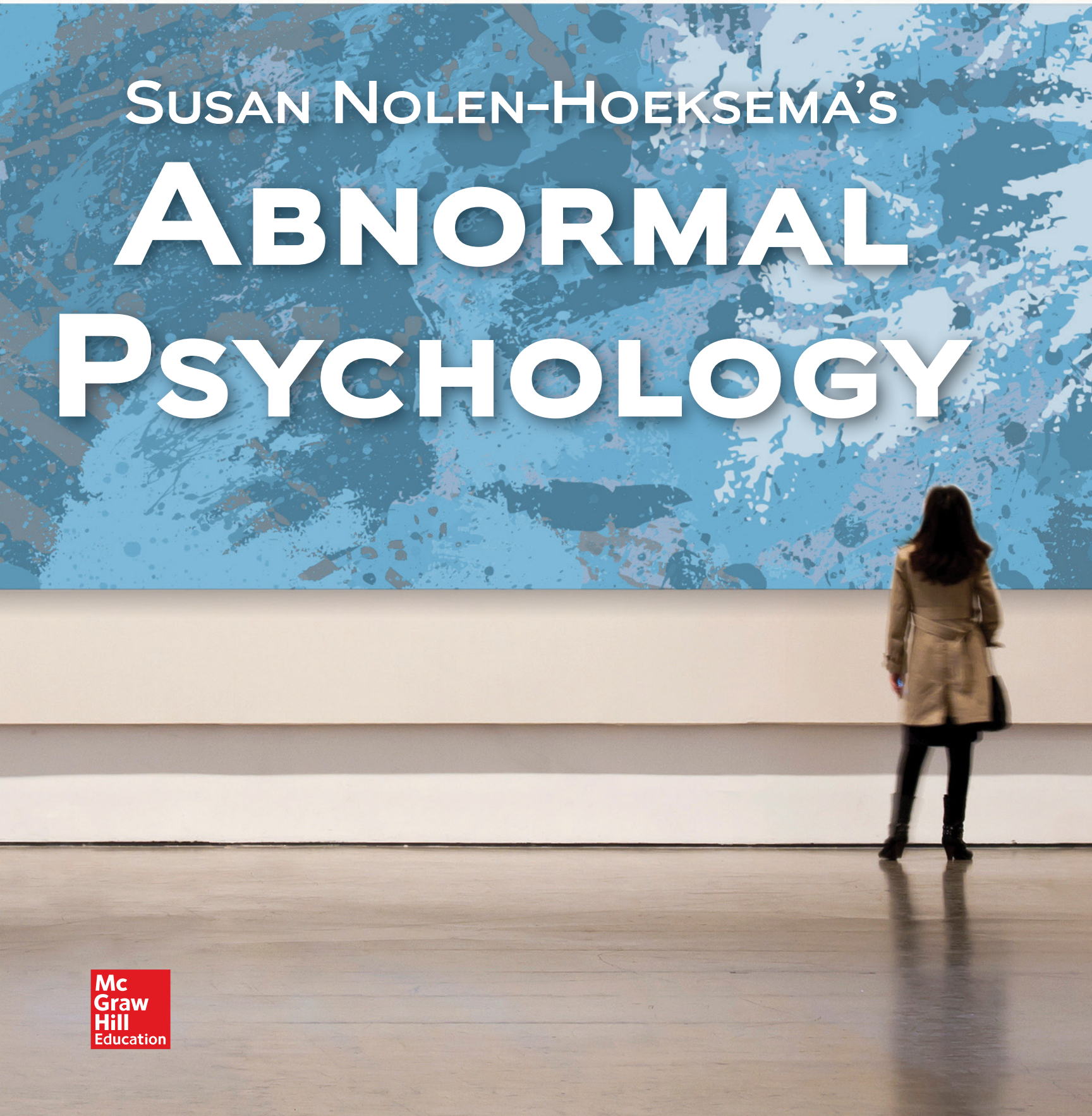

Susan Nolen-Hoeksema's Abnormal Psychology

Mc Graw Hill Education

Abnormal Psychology

Abnormal Psychology

Seventh Edition

Susan Nolen-Hoeksema

Yale University

Mc Graw Hill Education

ABNORMAL PSYCHOLOGY, SEVENTH EDITION

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ABOUT THE AUTHORS

Susan Nolen-Hoeksema (1959–2013) In January 2013 we lost our esteemed author and friend, Susan Nolen-Hoeksema. Susan was a renowned scholar, teacher, mentor, and academic leader. She was recognized internationally for her work on how people regulate their feelings and emotions and how particular patterns of thinking can make people vulnerable to and recover slowly from emotional problems, especially depression. Her research shaped the field's perspective on depression in women and girls, and countless empirical studies and theoretical contributions followed as she developed her groundbreaking theory of rumination and depression.

In her words: "My career has focused on two parallel goals. The first is to use empirical methods to address important social and mental health problems (depression, rumination, women's mental health). The second goal is to disseminate psychological science. I also believe in taking science to the public, through my textbook on Abnormal Psychology and books for the general public on women's mental health."

Susan taught at Stanford University, the University of Michigan, and Yale University. Susan's work focused on depression, mood-regulation, and gender, for which she was recognized and received the David Shakow Early Career Award from Division 12, the Distinguished Leadership Award from the Committee on Women of American Psychological Association, the James McKeen Cattell Fellow Award from the Association for Psychological Science, a Research Career Award, and multiple grants from the National Institute of Mental Health. In addition, she was the founding editor of the *Annual Review of Clinical Psychology,* now the most highly cited journal in the field of clinical psychology.

In addition to being an accomplished professor, scholar, teacher, and writer, Susan was a loving and devoted mother, wife, daughter, sister, friend, and mentor. Susan touched and inspired the lives of many people both professionally and personally, and she will be dearly missed.

Brett Marroquín is an assistant professor of psychology at Loyola Marymount University in Los Angeles, California. He received his Ph.D. in clinical psychology from Yale University under the mentorship of Susan Nolen-Hoeksema, and completed a National Institute of Mental Health (NIMH) postdoctoral fellowship in biobehavioral issues in physical and mental health at the University of California, Los Angeles. His research examines interpersonal influences on emotion, emotion regulation, and cognitive processing in healthy functioning and mood disorders. His current work focuses on the roles of social contexts and romantic relationships in emotional adjustment to negative events, including cancer diagnosis and treatment, and how effective or ineffective support from partners affects couples' physical and mental health.

BRIEF CONTENTS

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PREFACE

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- **At-Risk Student Reports:** The At-Risk report provides instructors with one-click access to a dashboard that identifies students who are at risk of dropping out of a course due to a low engagement level.
- **Category Analysis Reports:** The Category Analysis report is the place to go to find out how your students are performing relative to specific learning objectives and goals.
- **Connect Insight** is a one-of-a-kind visual analytics dashboard—now available for both instructors and students—that provides at-a-glance information regarding student performance.

- **The LearnSmart Reports** allow instructors and students to easily monitor progress and pinpoint areas of weakness, giving each student a personalized study plan to achieve success.

CONTENT CHANGES

Chapter 5: Trauma, Anxiety, Obsessive-Compulsive, and Related Disorders

Treatments for PTSD

- New coverage of exposure therapy and decreased symptoms of depression related to PTSD
- New information on the effectiveness of Internet-based treatments of PTSD and treatments for phobias
- Updated information on relapse rates after behavioral therapy

Theories of Social Anxiety Disorder

- New coverage of Acceptance and Commitment Therapy (ACT)
- Added coverage of cognitive-behavioral group therapy for treating social anxiety disorder

Panic Disorders

- Increased coverage of racial differences with respect to chronic social anxiety disorder and panic disorders

Theories of Generalized Anxiety Disorder (GAD)

- Revised coverage of childhood and adolescent environmental factors influencing GAD
- Added material on the relationship between stress of hypervigilance and maladaptive interpersonal behavior

Treatments for GAD

- Added coverage of CBT for treating the depression that commonly co-occurs with GAD

Separation Anxiety Disorder

- Added material on adult separation anxiety disorder and the revised *DSM-5*

Obsessive Compulsive Disorder

- New coverage of the controversial move by *DSM-5* of creating a separate nosological category for OCD
- Revised coverage on the irrationality of obsessions and compulsions

Treatments of OCD and Related Disorders

- New coverage of habit reversal training for skin-picking disorder and hair-pulling disorder

Chapter 7: Mood Disorders and Suicide

Diagnosing Depressive Disorders

- Added coverage of the biological and psychosocial factors of postpartum depression

Symptoms of Mania

- New material on the seasonal factors of bipolar disorder

Structural and Functional Brain Abnormalities in Depression

- New attention given to the differences in brain function emerging in childhood before occurrence of depressive episodes
- New coverage of gendered features of brain functioning and depression

Psychological Theories of Depression

- Integrated coverage of the psychosocial and biological accounts of depression, anhedonia, and behavioral withdrawal
- Revised coverage of ruminative thinking and depression

Interpersonal Theories of Depression

- Revised section on interpersonal theories of depression
- Increased coverage of ethnic and racial differences in depression

Theories of Bipolar Disorder

- Updated coverage of structural and functional brain abnormalities

Psychosocial Contributors to Bipolar Disorder

- Impact of irregular or disturbed sleep on bipolar disorder
- Updated research on neural and psychological systems and bipolar disorder

Biological Treatments of Mood Disorders

- Updated research on electroconvulsive therapy

Interpersonal and Social Rhythm Therapy and Family-Focused Therapy

- Revised coverage of interpersonal and social rhythm therapy, including more on sleep, relapse prevention, and the impact of social environments on psychosocial treatment

Comparison of Treatments of Mood Disorders

- New coverage on risk factors and prevention

Suicide in Older Adults

- Revised coverage, focusing on impairments in cognitive ability

Nonsuicidal Self-Injury

- Revised section

Treatment of Suicidal Persons

- Revised coverage of effects of repeated suicide attempts on future behavior

Suicide Prevention

- Increased coverage of nonsuicidal self-injury

Chapter 9: Personality Disorders

Paranoid Personality Disorder

- Increased coverage of social contributors, including discrimination, prejudice, childhood trauma, and socioeconomic background

Theories of Borderline Personality Disorder

- Updated and revised section

Alternative *DSM-5* Models for Personality Disorders

- Added coverage of general personality pathology common across multiple personality disorders
- Revised coverage of how models for defining and diagnosing personality disorders change over time
- New discussion on how new models for defining personality disorders help develop new treatment approaches
- Enhanced coverage of the dimensional model of understanding personality disorders

Chapter 13: Sexual Disorders

- Updated terminology
- Updated coverage of female sexual interest/arousal disorder
- Updated coverage of erectile disorder
- Updated coverage on techniques for treating pelvic muscle tightening
- Revised coverage of gender dysphoria

Chapter 15: Health Psychology

Introduction

- Reinforced coverage of how day-to-day experience can affect internal biological functioning and contribute to mental health problems.

Cultural Differences in Coping

- New coverage of religion and spirituality and coping

Cancer

- Strengthened coverage of psychosocial and cognitive strategies for enhancing cancer survivorship

Depression and Coronary Heart Disease

- Updated section

Internet-Based Health Interventions

- New coverage of Internet-based self-help regarding chronic health conditions

Sleep and Health

- Updated coverage of the impact of sleep deprivation on emotions
- Increased coverage of sleep problems and psychiatric disorders

Chapter Integration

- Increased coverage of how physical health problems affect other people, such as caregivers and other family members
- New coverage of doctor–patient communication

INSTRUCTOR SERVICES

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Abnormal Psychology

Chapter 1

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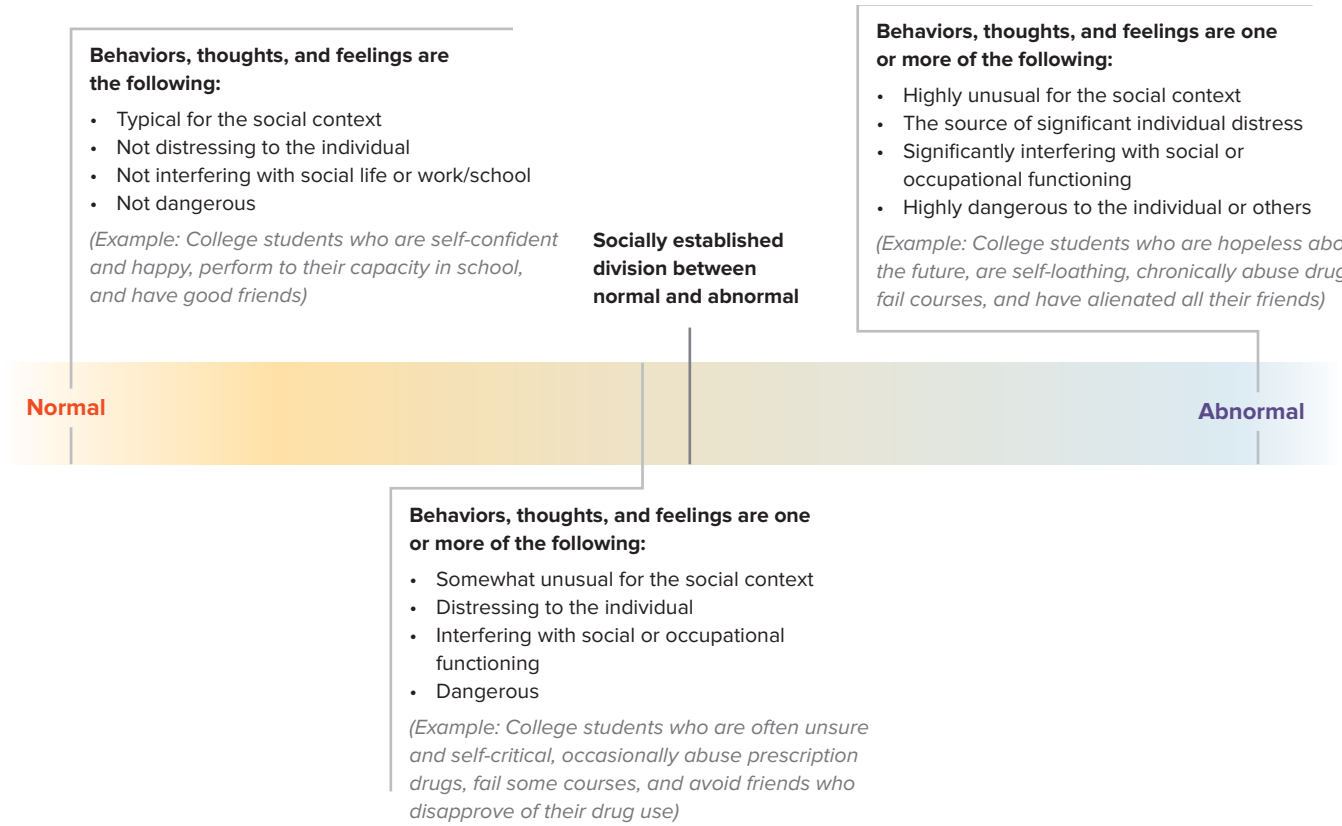
Looking at Abnormality

CHAPTER OUTLINE

Abnormality Along the Continuum



As humans, we think, we feel, we behave. Most of the time, our thoughts, feelings, and behaviors help us function in everyday life and are in the service of important goals or values we hold. Sometimes, however, we all have thoughts that upset us, experience feelings we'd rather not have, and act in ways that are self-defeating or detrimental to others. We may find ourselves in situations in which we can't think, feel or behave as others would—for example, we can't let go of a failed relationship. We may become upset over a situation that others don't find distressing, such as getting an average grade on an exam. Our thoughts, feelings, or behaviors may be interfering with our functioning in everyday life, for example, if we become afraid to walk alone after being mugged. Or we may be acting in ways that are dangerous to ourselves or others, such as driving a car when intoxicated.

Problems in thoughts, feelings, and behavior vary from normal to abnormal, as illustrated in the diagram above. We'd like to think there is a clear dividing line between normal variations in thoughts, emotions, and behaviors and what we would label "abnormal." Once an individual's behaviors or feelings crossed that line, we would be justified in saying that there is something wrong with that person or that he or she has a disorder. As we discuss in this chapter and throughout this book, however, there is increasing evidence that no such dividing line exists, perhaps for any of the mental health problems that are currently recognized. We make decisions about where to draw the line that indicates a sufficient amount of abnormality to warrant a diagnosis or treatment. You will see that this **continuum model of abnormality** applies to all the disorders we discuss in this book. In this chapter, we discuss some of the factors that influence how thoughts, emotions, and behaviors are labeled abnormal.

Extraordinary People

My illness began slowly, gradually, when I was between the ages of 15 and 17. During that time reality became distant and I began to wander around in a sort of haze, foreshadowing the delusional world that was to come later. I also began to have visual hallucinations in which people changed into different characters, the change indicating to me their moral value. For example, the mother of a good friend always changed into a witch, and I believed this to be indicative of her evil nature. Another type of visual hallucination I had at this time is exemplified by an occurrence during a family trip through Utah: The cliffs along the side of the road took on a human appearance, and I perceived them as women, bedraggled and weeping. At the time I didn't know what to make of these changes in my perceptions. On the one hand, I thought they came as a gift from God, but on the other hand, I feared that something was dreadfully wrong. However, I didn't tell anyone what was happening; I was afraid of being called insane. I also feared, perhaps incredibly, that someone would take it lightly and tell me nothing was wrong, that I was just having a rough adolescence, which was what I was telling myself.

Source: Anonymous, 1992.

The study of abnormal psychology is the study of people, like the young woman in the Extraordinary People feature, who suffer mental, emotional, and often physical pain, often referred to as **psychopathology.** Sometimes the experiences of people with psychopathology are as unusual as those this young woman describes. Sometimes, however, people with psychopathology have experiences that are familiar to many of us but more extreme, as when everyday sadness transforms into life altering depression.

In this book, we explore the lives of people with troubling psychological symptoms to understand how they think, what they feel, and how they behave. We investigate what is known about the causes of these symptoms and the appropriate treatments for them. The purpose of this book is not only to provide you with information, facts and figures, theories, and research but also to help you understand the experience of people with psychological symptoms. The good news is that, thanks to an explosion of research in the past few decades, effective biological and psychological treatments are available for many of the mental health problems we discuss.

DEFINING ABNORMALITY

In popular culture, there are a lot of words for people and behaviors that seem abnormal: around the bend, bananas, barmy, batty, berserk, bonkers, cracked, crazy, cuckoo, daft, delirious, demented, deranged, dingy, erratic, flaky, flipped out, freaked out, fruity, insane, kooky, lunatic, mad, mad as a March hare, mad as a hatter, maniacal, mental, moonstruck, nuts, nutty, nutty as a fruitcake, of unsound mind, out of one's mind, out of one's tree, out to lunch, potty, psycho, screw loose, screwball, screwy, silly, touched, unbalanced, unglued, unhinged, unzipped, wacky. People talk as if they have an intuitive sense of what abnormal behavior is. Let's explore some of the ways abnormality has been defined.

Mental Illness

A common belief is that behaviors, thoughts, or feelings can be viewed as pathological or abnormal if they are symptoms of a *mental illness.* This implies that a disease process, much like hypertension or diabetes, is present. For example, when many people say that an individual "has schizophrenia" (which is characterized by unreal perceptions and severely irrational thinking), they imply that he or she has a disease that should show up on some sort of biological test, just as hypertension shows up when a person's blood pressure is taken.

To date, however, no biological test is available to diagnose any of the types of abnormality we discuss in this book (Hyman, 2010). This is not just because we do not yet have the right biological tests. Modern conceptualizations of mental disorders view them not as singular diseases with a common pathology that can be identified in all people with the disorder. Rather, mental health experts view mental disorders as collections of problems in thinking or cognition, in emotional responding or regulation, and in social behavior (Hyman, 2010; Insel et al., 2010; Sanislow et al., 2011). Thus, for example, a person diagnosed with schizophrenia has a collection of problems in rational thinking and in responding emotionally and behaviorally in everyday life, and it is this collection of problems that we label schizophrenia. It is still possible, and in the case of schizophrenia likely, that biological factors are associated with these problems in thinking, feeling,

and behaving. But it is unlikely that a singular disease process underlies the symptoms we call schizophrenia.

Cultural Norms

Consider these behaviors:

1. A man driving a nail through his hand
2. A woman refusing to eat for several days
3. A man barking like a dog and crawling on the floor on his hands and knees
4. A woman building a shrine to her dead husband in her living room and leaving food and gifts for him at the altar

Do you think these behaviors are abnormal? You may reply, "It depends." Several of these behaviors are accepted in certain circumstances. In many religious traditions, for example, refusing to eat for a period of time, or fasting, is a common ritual of cleansing and penitence. You might expect that some of the other behaviors listed, such as driving a nail through one's hand or barking like a dog, are abnormal in all circumstances, yet even these behaviors are accepted in certain situations. In Mexico, some Christians have themselves nailed to crosses on Good Friday to commemorate the crucifixion of Jesus. Among the Yoruba of Africa, traditional healers act like dogs during healing rituals (Murphy, 1976). Thus, the context, or circumstances surrounding a behavior, influences whether the behavior is viewed as abnormal.

Cultural norms play a large role in defining abnormality. A good example is the behaviors people are expected to display when someone they love dies. In cultures dominated by Shinto and Buddhist religions, it is customary to build altars to honor dead loved ones, to offer them food and gifts, and to speak with them as if they were in the room (Stroebe, Gergen, Gergen, & Stroebe, 1992). In cultures dominated by Christian and Jewish religions, such practices would potentially be considered quite abnormal.

Cultures have strong norms for what is considered acceptable behavior for men versus women, and these gender-role expectations also influence the labeling of behaviors as normal or abnormal (Addis, 2008). In many cultures, men who display sadness or anxiety or who choose to stay home to raise their children while their wives work are at risk of being labeled abnormal, while women who are aggressive or who don't want to have children are at risk of being labeled abnormal.

Cultural relativism is the view that there are no universal standards or rules for labeling a behavior abnormal; instead, behaviors can be labeled abnormal only relative to cultural norms (Snowden & Yamada, 2005). The advantage of this perspective is that it honors the norms and traditions of different cultures, rather than imposing the standards of one culture on judgments of abnormality. Yet opponents of cultural relativism argue that dangers arise when cultural norms are allowed to dictate what is normal or abnormal. In particular, psychiatrist Thomas Szasz (1971) noted that, throughout history, societies have labeled individuals and groups abnormal in order to justify controlling or silencing them. Hitler branded Jews abnormal and used this label as one justification for the Holocaust. The former Soviet Union sometimes branded political dissidents mentally ill and confined them in mental hospitals. When the slave

In Mexico, some Christians have themselves nailed to a cross to commemorate the crucifixion of Jesus. © *AP Photo/Aaron Favila*

trade was active in the United States, slaves who tried to escape their masters could be diagnosed with a mental disease that was said to cause them to desire freedom; the prescribed treatment for this disease was whipping and hard labor (Cartwright, 1851, quoted in Szasz, 1971).

Most mental health professionals these days do not hold an extreme relativist view on abnormality, recognizing the dangers of basing definitions of abnormality solely on cultural norms. Yet even those who reject an extreme cultural-relativist position recognize that culture and gender have a number of influences on the expression of abnormal behaviors and on the way those behaviors are treated. First, culture and gender can influence the ways people express symptoms. People who lose touch with reality often believe that they have divine powers, but whether they believe they are Jesus or Mohammed depends on their religious background.

Second, culture and gender can influence people's willingness to admit to certain types of behaviors or feelings (Snowden & Yamada, 2005). People in Eskimo and Tahitian cultures may be reluctant to admit to feeling anger because of strong cultural norms against the expression of anger. The Kaluli of New Guinea and the Yanomamo of Brazil, however, value the expression of anger and have elaborate and complex rituals for expressing it (Jenkins, Kleinman, & Good, 1991).

Third, culture and gender can influence the types of treatments deemed acceptable or helpful for people exhibiting abnormal behaviors. Some cultures may view drug therapies for psychopathology as most appropriate, while others may be more willing to accept psychotherapy (Snowden & Yamada, 2005). Throughout this book, we will explore these influences of culture and gender on behaviors labeled abnormal.

When the slave trade was active, slaves who tried to escape were sometimes labeled as having mental illness and were beaten to "cure" them. © *Jean Baptiste Debret/Getty Images*

The Four Ds of Abnormality

If we do not want to define abnormality only on the basis of cultural norms, and if we cannot define abnormality as the presence of a mental illness because no singular, identifiable disease process underlies most psychological problems, how do we define abnormality? Modern judgments of abnormality are influenced by the interplay of four dimensions, often called "the four Ds": dysfunction, distress, deviance, and dangerousness. Behaviors, thoughts, and feelings are *dysfunctional* when they interfere with the person's ability to function in daily life, to hold a job, or to form close relationships. The more dysfunctional behaviors and feelings are, the more likely they are to be considered abnormal by mental health professionals. For example, thinking that is out of touch with reality (for example, believing you are Satan and should be punished) makes it difficult to function in everyday life and so is considered dysfunctional.

Behaviors and feelings that cause *distress* to the individual or to others around him or her are also likely to be considered abnormal. Many of the problems we discuss in this book cause individuals tremendous emotional and even physical pain; in other cases, the person diagnosed with a disorder is not in distress but causes others distress, for example, through chronic lying, stealing, or violence.

Highly *deviant* behaviors, such as hearing voices when no one else is around, lead to judgments of abnormality. What is deviant is influenced by cultural norms, of course. Finally, some behaviors and feelings are of potential harm to the individual, such as suicidal gestures, or to others, such as excessive aggression. Such *dangerous* behaviors and feelings are often seen as abnormal.

The four Ds together make up mental health professionals' definition of behaviors or feelings as abnormal or *maladaptive.* The experiences of the woman described in Extraordinary People presented at the beginning of this chapter would be labeled abnormal based on these criteria because the symptoms interfere with her daily functioning, cause her suffering, are highly unusual, and are potentially dangerous to her.

SHADES OF GRAY

Consider the following descriptions of two students.

In the year between her eighteenth and nineteenth birthdays, Jennifer, who is 5′6″, dropped from a weight of 125 pounds to 105 pounds. The weight loss began when Jennifer had an extended case of the flu and lost 10 pounds. Friends complimented her on being thinner, and Jennifer decided to lose more weight. She cut her intake of food to about 1,200 calories, avoiding carbs as much as possible, and began running a few miles every day. Sometimes she is so hungry she has trouble concentrating on her schoolwork. Jennifer values her new lean look so much, however, that she is terrified of gaining the weight back. Indeed, she'd like to lose a few more pounds so she could fit into a size 2.

Mark is what you might call a "heavy drinker." Although he is only 18, he has ready access to alcohol, and most nights he typically drinks at least five or six beers. He rarely feels drunk after that much alcohol, though, so he might also throw back a few shots, especially when he is out partying on Saturday nights. He's gotten caught a few times and received tickets for underage drinking, but he proudly displays them on his dorm wall as badges of honor. Mark's grades are not what they could be, but he finds his classes boring and has a hard time doing the work.

Do you find Jennifer's or Mark's behaviors abnormal? How would you rate their level of dysfunction, distress, deviance, and danger? (Discussion appears at the end of this chapter.)

We are still left making subjective judgments, however. How much emotional pain or harm must a person be suffering? How much should the behaviors be interfering with daily functioning? We return to the continuum model to acknowledge that each of the four Ds lies along its own continuum. A person's behaviors and feelings can be more or less dysfunctional, distressing, deviant, or dangerous. Thus, there is no sharp line between what is normal and what is abnormal.

HISTORICAL PERSPECTIVES ON ABNORMALITY

Across history, three types of theories have been used to explain abnormal behavior. The **biological theories** have viewed abnormal behavior as similar to physical diseases, caused by the breakdown of systems in the body. The appropriate cure is the restoration of bodily health. The **supernatural theories** have viewed abnormal behavior as a result of divine intervention, curses, demonic possession, and personal sin. To rid the person of the perceived affliction, religious rituals, exorcisms, confessions, and atonement have been prescribed. The **psychological theories** have viewed abnormal behavior as a result of traumas, such as bereavement, or of chronic stress. According to these theories, rest, relaxation, a change of environment, and certain herbal medicines are sometimes helpful. These three types of theories have influenced how people acting abnormally have been regarded in the society. A person thought to be abnormal because he or she was a sinner, for example, would be regarded differently from a person thought to be abnormal because of a disease.

Ancient Theories

Our understanding of prehistoric people's conceptions of abnormality is based on inferences from archaeological artifacts—fragments of bones, tools, artwork, and so on—as well as from ancient writings about abnormal behavior. It seems that humans have always viewed abnormality as something needing special explanation.

Driving Away Evil Spirits

Historians speculate that even prehistoric people had a concept of insanity, probably one rooted in supernatural beliefs (Selling, 1940). A person who acted oddly was suspected of being possessed by evil spirits. The typical treatment for abnormality, according to supernatural theories, was exorcism—driving the evil spirits from the body of the suffering person. Shamans, or healers, would recite prayers or incantations, try to talk the spirits out of the body, or make the body an uncomfortable place for the spirits to reside—often through extreme measures such as starving or beating the person. At other times, the person thought to be possessed by evil spirits would simply be killed.

One treatment for abnormality during the Stone Age and well into the Middle Ages may have been to drill holes in the skull of a person displaying abnormal behavior to allow the spirits to depart (Feldman & Goodrich, 2001). Archaeologists have found skulls dating back to a half-million years ago in which sections of the skull have been drilled or cut away. The tool used for this drilling is called a trephine, and the operation is called **trephination.** Some historians believe that people who were

Some scholars believe that holes found in ancient skulls are from trephination, a crude form of surgery possibly performed on people acting abnormally. © *Prisma/UIG via Getty Images*

seeing or hearing things that were not real and people who were chronically sad were subjected to this form of brain surgery (Feldman & Goodrich, 2001). Presumably, if the person survived this surgery, the evil spirits would have been released and the person's abnormal behavior would decline. However, we cannot know with certainty that trephination was used to drive away evil spirits. Other historians suggest that it was used primarily for the removal of blood clots caused by stone weapons during warfare and for other medical purposes (Maher & Maher, 1985).

Ancient China: Balancing Yin and Yang

Some of the earliest written sources on abnormality are ancient Chinese medical texts (Tseng, 1973). Nei Ching (Classic of Internal Medicine) was probably written around 2674 BCE by Huang Ti, the legendary third emperor of China.

Ancient Chinese medicine was based on the concept of yin and yang. The human body was said to contain a positive force (yang) and a negative force (yin), which confronted and complemented each other. If the two forces were in balance, the individual was healthy. If not, illness, including insanity, could result. For example, excited insanity was considered the result of an excessive positive force:

> The person suffering from excited insanity initially feels sad, eating and sleeping less; he then becomes grandiose, feeling that he is very smart and noble, talking and scolding day and night, singing, behaving strangely, seeing strange things, hearing strange voices, believing that he can see the devil or gods, etc. As treatment for such an excited condition withholding food was suggested, since food was considered to be the source of positive force and the patient was thought to be in need of a decrease in such force. (Tseng, 1973, p. 570)

Chinese medical philosophy also held that human emotions were controlled by internal organs. When the "vital air" was flowing on one of these organs, an individual experienced a particular emotion. For example, when air flowed on the heart, a person felt joy; when on the lungs, sorrow; when on the liver, anger; when on the spleen, worry; and when on the kidney, fear. This theory encouraged people to live in an orderly and harmonious way so as to maintain the proper movement of vital air.

Although the perspective on psychological symptoms represented by ancient texts was largely a biological one, the rise of Taoism and Buddhism during the Chin and T'ang dynasties (420–618 CE) led to some religious interpretations of abnormal behavior. Evil winds and ghosts were blamed for bewitching people and for inciting people's erratic emotional displays and uncontrolled behavior. Religious theories of abnormality declined in China after this period (Tseng, 1973).

Some of the earliest writings on mental disorders are from ancient Chinese texts. This illustration shows a healer at work.

Ancient Egypt, Greece, and Rome: Biological Theories Dominate

Other ancient writings on abnormal behavior are found in the papyri of Egypt and Mesopotamia (Veith, 1965). The oldest of these, a document known as the Kahun Papyrus after the ancient Egyptian city in which it was found, dates from about 1900 BCE. This document lists a number of disorders, each followed by a physician's judgment of the cause of the disorder and the appropriate treatment.

Several of the disorders apparently left people with unexplainable aches and pains, sadness or distress, and apathy about life, such as "a woman who loves bed; she does not rise and she does not shake it" (Veith, 1965, p. 3). These disorders were said to occur only in women and were attributed to a "wandering uterus." The Egyptians believed that the uterus could become dislodged and wander throughout a woman's body, interfering with her other organs. Later, the Greeks, holding to the same theory of anatomy,

named this disorder *hysteria* (from the Greek word *hystera,* which means "uterus"). These days, the term hysteria is used to refer to physiological symptoms that probably are the result of psychological processes. In the Egyptian papyri, the prescribed treatment for this disorder involved the use of strong-smelling substances to drive the uterus back to its proper place.

Beginning with Homer, the Greeks wrote frequently of people acting abnormally (Wallace & Gach, 2008). The physician Hippocrates (460–377 BCE) described a case of a common phobia: A man could not walk alongside a cliff, pass over a bridge, or jump over even a shallow ditch without feeling unable to control his limbs and having his vision impaired.

Most Greeks and Romans saw abnormal behavior as an affliction from the gods. Those afflicted retreated to temples honoring the god Aesculapius, where priests held healing ceremonies. Plato (423–347 BCE) and Socrates (469–399 BCE) argued that some forms of abnormal behavior were divine and could be the source of great literary and prophetic gifts.

For the most part, however, Greek physicians rejected supernatural explanations of abnormal behavior (Wallace & Gach, 2008). Hippocrates, often regarded as the father of medicine, argued that abnormal behavior was like other diseases of the body. According to Hippocrates, the body was composed of four basic humors: blood, phlegm, yellow bile, and black bile. All diseases, including abnormal behavior, were caused by imbalances in the body's essential humors. Based on careful observation of his many patients, which included listening to their dreams, Hippocrates classified abnormal behavior into four categories: epilepsy, mania, melancholia, and brain fever.

The treatments prescribed by the Greek physicians were intended to restore the balance of the four humors. Sometimes these treatments were physiological and intrusive, for example, bleeding a patient to treat disorders thought to result from an excess of blood. Other treatments consisted of rest, relaxation, a change of climate or scenery, a change of diet, or living a temperate life. Some nonmedical treatments prescribed by these physicians sound remarkably like those prescribed by modern psychotherapists. Hippocrates, for example, believed that removing a patient from a difficult family could help restore mental health. Plato argued that insanity arose when the rational mind was overcome by impulse, passion, or appetite. Sanity could be regained through a discussion with the individual designed to restore rational control over emotions (Maher & Maher, 1985).

Among the Greeks of Hippocrates' and Plato's time, the relatives of people considered insane were encouraged to confine their afflicted family members to the home. The state claimed no responsibility for insane people; it provided no asylums or institutions, other than the religious temples, to house and care for them. The state could, however, take rights away from people declared insane. Relatives could bring suit against those they considered insane, and the state could award the property of insane people to their relatives. People declared insane could not marry or acquire or dispose of their own property. Poor people who were considered insane were simply left to roam the streets if they were not violent. If they were violent, they were locked away. The general public greatly feared insanity of any form, and people thought to be insane often were shunned or even stoned (Maher & Maher, 1985).

Medieval Views

The Middle Ages (around 400–1400 CE) are often described as a time of backward thinking dominated by an obsession with supernatural forces, yet even within Europe supernatural theories of abnormal behavior did not dominate until the late Middle Ages, between the eleventh and fifteenth centuries (Neugebauer, 1979). Prior to the eleventh century, witches and witchcraft were accepted as real but were considered mere nuisances, overrated by superstitious people. Severe emotional shock and physical illness or injury most often were seen as the causes of bizarre behaviors. For example, English court records attributed mental health problems to factors such as a "blow received on the head," explained that symptoms were "induced by fear of his father," and noted that "he has lost his reason owing to a long and incurable infirmity" (Neugebauer, 1979, p. 481). While laypeople probably did believe in demons and curses as causes of abnormal behavior, there is strong evidence that physicians and government officials attributed abnormal behavior to physical causes or traumas.

Witchcraft

Beginning in the eleventh century, the power of the Catholic Church in Europe was threatened by the breakdown of feudalism and by rebellions. The Church interpreted these threats in terms of heresy and Satanism. The Inquisition was established originally to rid the Earth of religious heretics, but eventually those practicing witchcraft or Satanism also became the focus of hunts. The witch hunts continued long after the Reformation, perhaps reaching their height during the fifteenth to seventeenth centuries—the period known as the Renaissance (Mora, 2008).

Some psychiatric historians have argued that persons accused of witchcraft must have been mentally ill (Veith, 1965; Zilboorg & Henry, 1941). Accused