Eighth Edition

Abnormal Psychology

Susan Nolen-Hoeksema

Mc Graw Hill Education

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ABNORMAL PSYCHOLOGY, EIGHTH EDITION

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ABOUT THE AUTHOR

Courtesy of Susan Nolen-Hoeksema

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.

ABOUT THE CONTRIBUTOR

Courtesy of Brett Marroquín

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

CONTENTS

PREFACE

Abnormal Psychology connects proven scholarship with student performance. Through an integrated, personalized learning program, the eighth edition gives students the insight they need to study smarter and improve performance.

McGraw-Hill Education Connect® is a digital assignment and assessment platform that strengthens the link between faculty, students, and course work. Connect for *Abnormal Psychology* includes assignable and assessable videos, quizzes, exercises, and interactivities, all associated with learning objectives for *Abnormal Psychology,* Eighth Edition.

A PERSONALIZED EXPERIENCE THAT LEADS TO IMPROVED LEARNING AND RESULTS

How many students think they know everything about abnormal psychology but struggle on the first exam? Students study more effectively with Connect and SmartBook.

- SmartBook helps students study more efficiently by highlighting what to focus on in the chapter, asking review questions, and directing them to resources until they understand.
- Connect's assignments help students contextualize what they've learned through application, so they can better understand the material and think critically.
- SmartBook creates a personalized study path customized to individual student needs.
- Connect reports deliver information regarding performance, study behavior, and effort so instructors can quickly identify students who are having issues or focus on material that the class hasn't mastered.

Experience the Power of Data

Abnormal Psychology harnesses the power of data to improve the instructor and student experiences.

BETTER DATA, SMARTER REVISION, IMPROVED RESULTS

For this new edition, data were analyzed to identify the concepts students found to be the most difficult, allowing for expansion upon the discussion, practice, and assessment of challenging topics. The revision process for a new edition used to begin with gathering information from instructors about what they would change and what they would keep. Experts in the field were asked to provide comments that pointed out new material to add and dated material to review. Using all these reviews, authors would revise the material. But now, a new tool has revolutionized that model.

McGraw-Hill Education authors have access to student performance data to analyze and to inform their revisions. These data are anonymously collected from the many students who use SmartBook, the adaptive learning system that provides students with individualized assessment of their own progress. Because virtually every text paragraph is tied to several questions that students answer while using SmartBook, the specific concepts with which students are having the most difficulty are easily pinpointed through empirical data in the form of a "heat map" report.

POWERFUL REPORTING

Whether a class is face-to-face, hybrid, or entirely online, McGraw-Hill Connect provides the tools needed to reduce the amount of time and energy instructors spend administering their courses. Easy-to-use course management tools allow instructors to spend less time administering and more time teaching, while reports allow students to monitor their progress and optimize their study time.

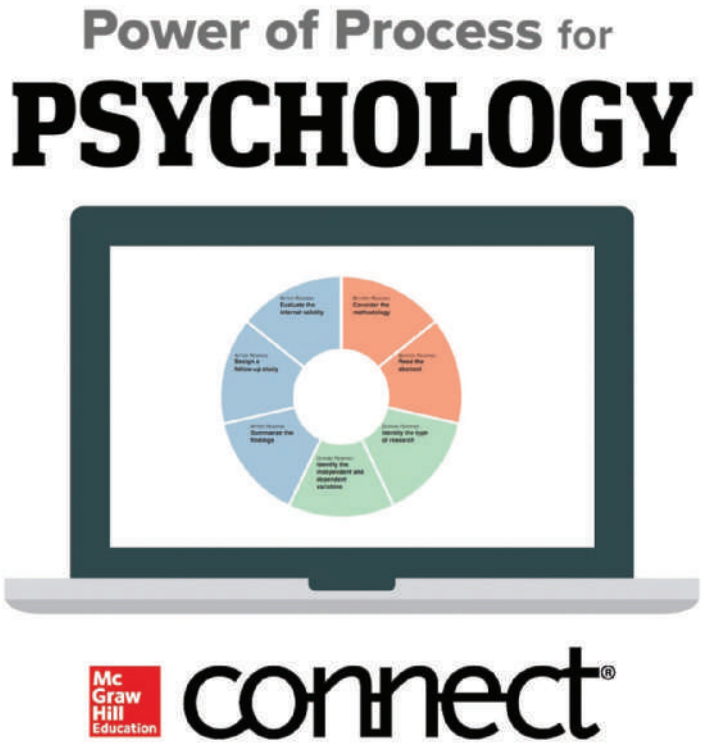
- The **At-Risk Student Report** provides instructors with one-click access to a dashboard that identifies students who are at risk of dropping out of the course due to low engagement levels.
- The **Category Analysis Report** details student performance relative to specific learning objectives and goals, including APA learning goals and outcomes and levels of Bloom's taxonomy.
- **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.

New to this edition, SmartBook is now optimized for mobile and tablet and is accessible for students with disabilities. Content-wise, it has been enhanced with improved learning objectives that are measurable and observable to improve student outcomes. SmartBook personalizes learning to individual student needs, continually adapting to pinpoint knowledge gaps and focus learning on topics that need the most attention. Study time is more productive and, as a result, students are better prepared for class and coursework. For instructors, SmartBook tracks student progress and provides insights that can help guide teaching strategies.

INFORMING AND ENGAGING

McGraw-Hill Connect offers several ways to actively engage students.

Power of Process guides students through the process of critical reading and analysis. Faculty can select or upload content, such as journal articles, and assign guiding questions to move students toward higher-level thinking and analysis.



Through the connection of psychology to students' own lives, concepts become more relevant and understandable. **NewsFlash** exercises tie current news stories to key psychological principles and learning objectives. After interacting with a contemporary news story, students are assessed on their ability to make the link between real life and research findings. Topics include brain chemistry and depression, eating disorders in boys, and criticisms of the *DSM*-5.

Thinking Critically About Abnormal Psychology

Updated with *DSM-5* content, **Faces of Abnormal Psychology** connects students to real people living with psychological disorders. Through its unique video program, Faces of Abnormal Psychology helps students gain a deeper understanding of psychological disorders and provides an opportunity for critical thinking.

Interactive Case Studies help students understand the complexities of psychological disorders. Co-developed with psychologists and students, these immersive cases bring the intricacies of clinical psychology to life in an accessible, gamelike format. Each case is presented from the point of view of a licensed psychologist, a social worker, or a psychiatrist. Students observe sessions with clients and are asked to identify major differentiating characteristics associated with each of the psychological disorders presented. Interactive Case Studies are assignable and assessable through McGraw-Hill Education's Connect.

SUPPORTING INSTRUCTORS WITH TECHNOLOGY

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McGraw-Hill Campus (www.mhcampus.com) provides faculty with true single-sign-on access to all of McGraw-Hill's course content, digital tools, and other high-quality learning resources from any learning management system. McGraw-Hill Campus includes access to McGraw-Hill's entire content library, including eBooks, assessment tools, presentation slides, and multimedia content, among other resources, providing faculty open, unlimited access to prepare for class, create tests/quizzes, develop lecture material, integrate interactive content, and more.

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Instructor Supplements

Instructor's Manual The instructor's manual provides a wide variety of tools and resources for presenting the course, including learning objectives and ideas for lectures and discussions.

Test Bank By increasing the rigor of the test-bank development process, McGraw-Hill Education has raised the bar for student assessment. A coordinated team of subject-matter experts methodically vetted each question and each set of possible answers for accuracy, clarity, effectiveness, and accessibility; each question has been annotated for level of difficulty, Bloom's taxonomy, APA learning outcomes, and corresponding coverage in the text. Organized by chapter, the questions are designed to test factual, conceptual, and applied understanding. All test questions are available within TestGen™ software and as Word documents.

PowerPoint Presentations The PowerPoint presentations, available in both dynamic lecture-ready and accessible WCAG-compliant versions, highlight the key points of the chapter and include supporting visuals. All of the slides can be modified to meet individual needs.

Image Gallery The Image Gallery features the complete set of downloadable figures and tables from the text. These can be easily embedded by instructors into their own PowerPoint slides.

CHAPTER-BY-CHAPTER CHANGES

Revisions based on the student heat map are reflected primarily in Chapters 2, 5, 7, 9, and 15. Other content changes include the following:

CHAPTER 1

- Updated coverage on the dimensions of abnormality on a continuum
- Revised coverage of the cognitive revolution
- Increased attention to disadvantages of deinstitutionalization
- Revised coverage on the role of correctional facilities
- Updated coverage of the Affordable Care Act and mental health

CHAPTER 2

- New statistics on benzodiazepines and overdoses
- Updated coverage of electroconvulsive therapy effects
- Updated research on brain stimulation
- Revised coverage on the difference between modeling and observational learning
- Revised coverage on the distinction between the pleasure principle and the reality principle
- Revised coverage of Freudian concepts
- Updated coverage of Dialectical Behavioral Therapy (DBT) adaptations and Acceptance and Commitment Therapy (ACT)
- Added coverage of Unified Protocol (UP)
- Added content on cultural competence
- New content on cultural adaptations of treatment

CHAPTER 3

- New coverage on computerized assessment
- Revised coverage of key *DSM* topics
- Revised coverage concept of *DSM* axes
- Updated research on *DSM*-5 reliability

CHAPTER 4

- Revised presentation of correlation
- Strengthened coverage (with new examples) of the difference between correlation and causation
- Revised presentation of demand characteristics
- New example for placebo control group for therapy
- Strengthened coverage on the limitations of laboratory studies
- Revised coverage of the types of genetic studies
- Revised presentation of adoption studies
- Strengthened coverage of meta-analysis
- Added coverage of Research Domain Criteria (RDoC)

CHAPTER 5

- Revised coverage with new example of dissociation in trauma
- Clarified distinction between *nervios* and *ataque de nervios*
- Revised presentation of neuroimaging findings related to trauma

- Strengthened presentation (with examples) of exposure therapy in cognitive-behavioral therapy (CBT)
- Revised coverage of prolonged exposure and cognitive processing therapy
- Strengthened coverage of exposure treatment for phobia
- Revised coverage of social anxiety disorder
- Revised coverage of panic disorder diagnosis
- New coverage of the cognitive aspect of panic
- Integrated coverage of cognitive factors of posttraumatic stress disorder (PTSD)
- Revised coverage of benzodiazepines in treating PTSD
- Improved coverage of general anxiety disorder definition (GAD)
- Added coverage of emotion regulation therapy (ERT) for GAD
- Revised presentation of obsessive compulsive disorder (OCD) diagnosis
- New example of compulsions
- Revised coverage of body dysmorphic disorder

CHAPTER 6

- Revised coverage of the reliability and controversies of *DSM-5*
- Updated treatment coverage
- Revised presentation of research on stress and maltreatment
- Updated coverage of prognosis relating to conversion disorders
- Updated coverage of the science on theories of dissociative identity disorder (DID)
- New coverage of treatment outcome research
- Revised coverage of dissociative fugue

CHAPTER 7

- Clarified definition and organization of subtypes of depression
- Revised coverage relating to the different bipolar disorders
- Strengthened coverage of bipolar episodes and diagnoses
- Revised presentation of cyclothymia
- New material on the distinction between episodes and general reactivity in bipolar disorder
- Improved coverage, with examples, of creativity in mood disorders
- Strengthened coverage of hopelessness in depression
- New material on the different bipolar disorders
- Revised coverage of cohort effects
- Revised coverage of gender differences in depression
- New material on puberty and gender differences in depression
- New material on racial and ethnic differences
- Updated material on genetic and brain findings relating to depression
- Added coverage of psychosocial contributors to bipolar disorders
- Added example of reward sensitivity
- Updated findings on selective serotonin reuptake inhibitors (SSRIs) and suicide
- Revised coverage of selective serotonin-norepinephrine reuptake inhibitors (SNRI)
- Revised coverage of the pros and cons of lithium
- Added lamotrigine to medical treatments for bipolar disorders
- Updated coverage of suicide epidemiology and demographics
- Added coverage of African American suicide rates and updated all coverage of ethnicity rates
- Added coverage of anxiety and suicide
- Added content on new media and suicide
- Updated research on impulsivity
- Added content on the interpersonal theory of suicide
- Added definitions of treatment vs. prevention
- Updated coverage of nonsuicidal self-injury

CHAPTER 8

- Added historical factors in discussion of delusions
- Updated research on hallucinations in general population
- Added research on anticipatory emotion
- Updated research on prognoses for psychotic disorders, including for suicide
- Integration of cognitive and biosocial theories of schizophrenia
- Added material on schizophrenia and bipolar family comorbidity
- Updated status of social drift research
- Updated status of stressful events research
- Updated evidence on treatment efficacy

CHAPTER 9

- New material on cognitive treatment for schizotypal personality disorder
- Added example of splitting
- Updated status of pharmacological treatment for borderline personality disorder
- Clarified coverage of therapy for histrionic personality disorder
- Revised coverage of narcissism subtypes
- Clarified difference between avoidant and schizoid personality disorders
- Clarified distinction between obsessive-compulsive personality disorder and obsessive-compulsive disorder
- Clarified and updated coverage of alternative dimensional models for personality disorders

CHAPTER 10

- Updated coverage of attention-deficit/hyperactivity disorder (ADHD)
- Updated status of psychosocial factors
- Update on cognitive-behavioral therapy for adult ADHD
- New material on genetic research
- Added research on name processing
- Updated status of autism spectrum disorder (ASD) medications
- Updated statistics on sports traumatic brain injury
- Added research on early identification
- Updated coverage of delirium research and treatment

CHAPTER 11

- Updated contradictory findings on physiological reactivity in conduct disorders
- Updated findings on Fast Track and conduct disorders
- Updated coverage on drugs are not first-line treatments for conduct disorder and oppositional defiant disorder
- New coverage of genetic and epigenetic findings in antisocial personality disorder
- Updated findings on amygdala and striatum

CHAPTER 12

- Updated with *DSM*-5 prevalence of anorexia nervosa
- Updated with *DSM*-5 prevalence of bulimia nervosa
- New research on leveling-out of prevalence of bulimia nervosa since 2000s
- Updated *DSM*-5 and international prevalence of binge-eating disorder
- Revised coverage of *DSM*-5 categories eating disorders not otherwise specified (EDNOS) and other specified feeding or eating disorder
- Updated coverage of obesity drugs
- Added coverage of male eating disorders and muscularity ideal
- Updated research on thinness ideal
- Revised coverage of the treatment of eating disorders
- New coverage of treatment access, Internet-based intervention, and prevention of eating disorders

CHAPTER 13

- New title: Sexual Disorders and Gender Diversity
- Updated coverage of sexual desire prevalence
- Added material on cognitions to include men
- New material on culture and gender roles
- Updated research on testosterone
- Updated research on biological treatments for women
- Revised heterosexual-specific language for early ejaculation treatment
- Revised heading of LGB section to separate sexual orientation from disorders
- Added unique considerations for LGB sexual dysfunction
- Revised coverage of nonpathological consensus and position on conversion therapy
- Emphasized continuum aspect of sadism/masochism
- Added evidence regarding sadism disorder in offenders
- Revised heading for treatment of paraphilic disorders to emphasize the disorders rather than the interests and behaviors
- Updated coverage of cognitive-behavioral therapy for paraphilias
- Significant revision of the gender dysphoria (GD) section to emphasize distress and impairment criteria
- Updated research on GD prevalence, associated psychopathology, and risk factors for HIV
- Added new coverage of gender diversity and transgender along the continuum
- Updated findings on brain in GD
- New coverage of GD in childhood and persistence into adulthood
- Added coverage of biological treatment of GD in children

CHAPTER 14

- Updated U.S. and world statistics throughout (prevalence of use, abuse, ER visits, and deaths)
- Increased emphasis on recent increases in use/abuse of methamphetamine and opioids
- Updated coverage of e-cigarettes
- Added coverage of opioid epidemic
- Updates on laws regarding medical and recreational uses of marijuana
- Updated coverage of gambling diagnosis and treatment
- Added coverage of Internet gaming disorder and other behavioral addictions

CHAPTER 15

- Updated epidemiology and statistics throughout
- Revised coverage of link between psychological diagnosis and physical health
- Updated cancer intervention research
- Updated status of research on psychosocial treatment and coronary heart disease (CHD)
- Streamlined coverage of depression and CHD
- Added discussion of culturally sensitive interventions
- New coverage of mobile health interventions (along with updates to Internet intervention)
- Clarified sleep brain-wave language
- Added examples for sleep study
- Updated research on narcolepsy as autoimmune problem
- Revised definition of hypoventilation

- Updated prevalence of sleep apnea
- Revised coverage of circadian rhythm disorders
- Revised coverage of arousal
- Increased coverage of confusional arousals
- Added examples for REM sleep disorder
- Added coverage of medications for nightmare disorder

CHAPTER 16

- Updated research on violence
- Added prevalence of incompetence to stand trial
- Revised coverage of states' use of insanity rules
- New introduction to section on justice system
- Updated rates of mental illness in prisons

ACKNOWLEDGMENTS

We are grateful to Brett Marroquín, Loyola Marymount University, for his invaluable contributions to this edition.

Chapter 1

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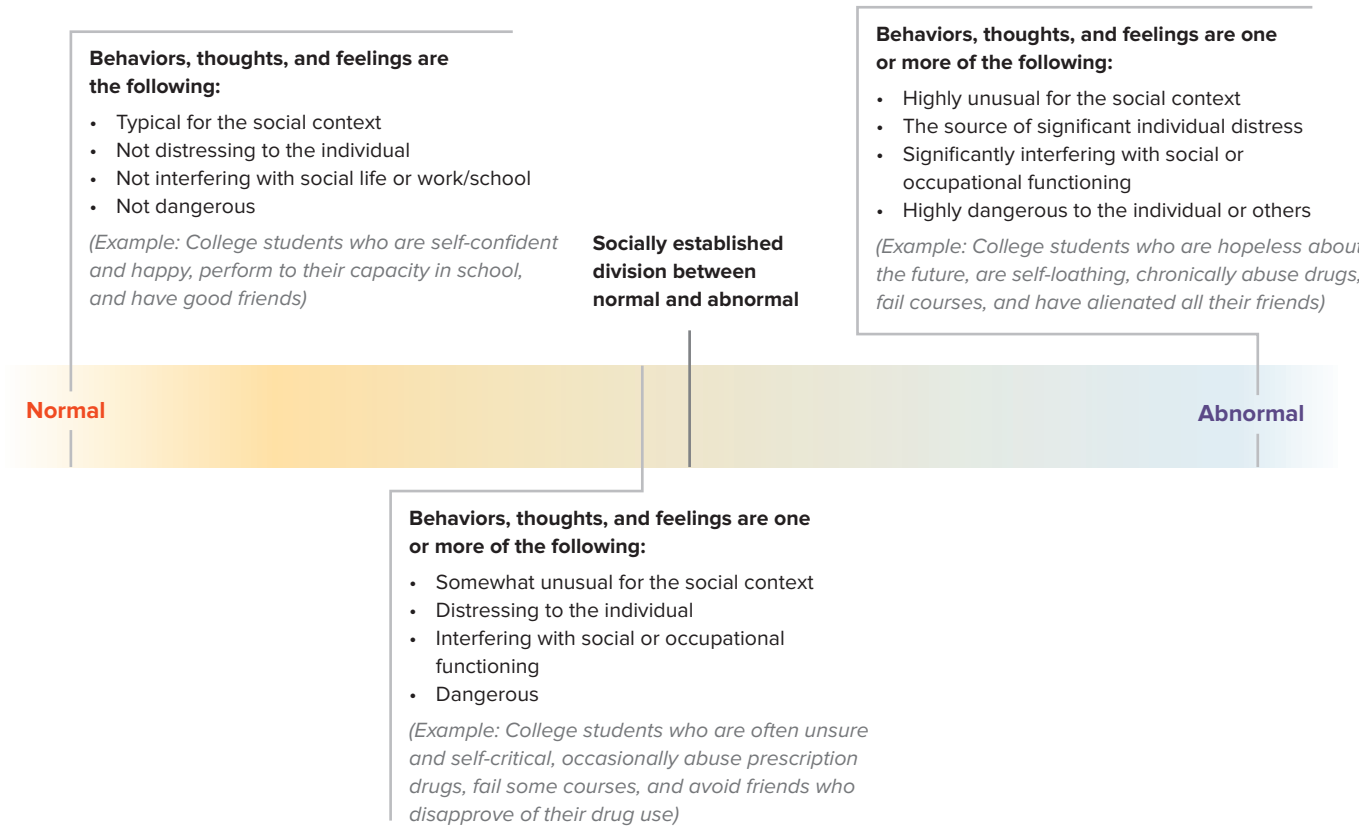
Looking at Abnormality

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—as when, 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. As you can see above, it can be hard to determine when behaviors, thoughts, and feelings become unusual, distressing, functionally impairing, or dangerous—key determinants of abnormality. 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. In modern conceptualizations, mental disorders are not viewed as singular diseases with a common pathology that can be identified in all people with the disorder. Instead, mental health experts view mental disorders as collections of problems in thinking or cognition, in emotional responding or regulation, and in social behavior (Cuthbert & Insel, 2013; Hyman, 2010). 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 might 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 (Rosenblatt, 2008). 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. 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 (1961, 2011) 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 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.

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

In Mexico, some Christians have themselves nailed to a cross to commemorate the crucifixion of Jesus. *©AARON FAVILA/AP Images*

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*

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.

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 (such as 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, such as suicidal gestures, are of potential harm to the individual, whereas other behaviors and feelings, such as excessive aggression, could potentially

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 been 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.)

harm others. 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.

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 (Tatagiba, Ugarte, & Acioly, 2015). 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 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).

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

Ancient China: Balancing Yin and Yang

Some of the earliest written sources on abnormality are ancient Chinese medical texts (Tseng, 1973). The *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, because 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. ©*Mary Evans Picture Library/The Image Works*

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 or his vision becoming impaired.

Most average 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, such as bleeding a patient to treat disorders that were 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 that was 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 many people thought to be insane 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 in the early Middle Ages 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 witches sometimes confessed to speaking with the devil, flying on the backs of animals, or engaging in other unusual behaviors. Such people may have been experiencing delusions (false beliefs) or hallucinations (unreal perceptual experiences), which are signs of some psychological disorders. However, confessions of such experiences may have been extracted through torture or in exchange for a stay of execution (Spanos, 1978).

In 1563, Johann Weyer published *The Deception of Dreams,* in which he argued that those accused of being witches were suffering from melancholy (depression) and senility. The Church banned Weyer's writings. Twenty years later, Reginald Scot, in his *Discovery of Witchcraft* (1584), supported Weyer's beliefs: "These women are but diseased wretches suffering from melancholy, and their words, actions, reasoning, and gestures show that sickness has affected their brains and impaired their powers of judgment" (Castiglioni, 1946, p. 253). Again, the Church—joined

Some people burned at the stake as witches may have had mental disorders that caused them to act abnormally. ©Bettmann/Getty Images