Chapter 1
What Is Abnormal Psychology?

Chapter Overview:

How Do We Define Abnormal Behaviour?

Criteria for Determining Abnormality

Various criteria are used to define abnormal behaviour. Psychologists generally consider behaviour as being abnormal when it meets some combination of the following criteria: (1) unusual or infrequent; (2) socially unacceptable or in violation of social norms; (3) fraught with misperceptions or misinterpretations of reality; (4) associated with states of severe personal distress; (5) maladaptive or self-defeating, or; (6) dangerous.

Cultural Bases of Abnormal Behaviour

The determination of which behaviour patterns are deemed abnormal depends on cultural beliefs and expectations. Concepts of health and illness may also have different meanings in different cultures. Abnormal behaviour patterns may take different forms in different cultures, and societal views of abnormal behaviour vary across cultures.

The Continuum between Normal and Abnormal Behaviour

Most behaviours can be placed on a continuum where individuals with no symptoms or those “struggling” do not meet criteria for abnormality, while individuals with mild, moderate, or severe display of symptoms meet criteria from abnormality. The present approach to diagnoses is categorical.

Historical Perspectives on Abnormal Behaviour

The Demonological Model

Ancient societies attributed abnormal behaviour to divine or supernatural forces, known as the demonological model. Stone Age skulls have shown that our prehistoric ancestors practice trephining – cutting a hole in a person’s skull – possibly as a means of releasing demons.

Origins of the Medical Model: An “Ill Humour”

There were some authorities in ancient times, such as the Greek physicians Hippocrates and Galen, who believed that abnormal behaviour reflected natural causes. Hippocrates, for example, proposed that abnormal behaviour was due to an imbalance of humours, or vital fluids: phlegm, black bile, blood, and yellow bile. The importance of this theory was that it foreshadowed the development of the modern medical model of abnormal behaviour by which disorder and disease are seen as resulting from underlying biological processes.
Medieval Times

The Middle Ages saw a return to the doctrine of possession, revitalized by the Roman Catholic Church.

Witchcraft

Exorcisms became a common practice to expel evil spirits or demons from affected individuals. Later, beginning in the 15th century, people who displayed abnormal behaviours were considered witches.

Asylums in Europe and the New World

Asylums, or “madhouses,” began to crop up throughout Europe in the late 15th and early 16th centuries, often on the site of former leprosariums. Conditions in these asylums were dreadful and in some, such as the Bethlehem Hospital in England, a circus atmosphere prevailed. With the rise of moral therapy in the 19th century, largely spearheaded by the Frenchmen Jean-Baptiste Pussin and Phillipe Pinel, conditions in mental hospitals improved.

The Reform Movement and Moral Therapy in Europe and North America

Proponents of moral therapy believed that mental patients could be restored to functioning if they were treated with dignity and understanding. The decline of moral therapy in the latter part of the 19th century led to a period of apathy and to the belief that the “insane” could not be successfully treated. Conditions in mental hospitals deteriorated, and they offered little more than custodial care.

Drugs and Deinstitutionalization: The Exodus from Provincial Psychiatric Hospitals

Not until the middle of the 20th century did public outrage and concern about the plight of mental patients mobilize legislative efforts toward the development of community mental health centres as alternatives to long-term hospitalization. This movement toward deinstitutionalization was spurred by the introduction of psychoactive drugs called phenothiazines, which curbed the more flagrant features of schizophrenia.

Deinstitutionalization in Canada has resulted in many homeless individuals with mental health issues who got lost in the transition from psychiatric institutionalization to largely inadequate community mental health services. In 2007, the federal government announced funding for the Canadian Mental Health Commission in order to implement a national mental health-care strategy.
The 19th century German physician Wilhelm Griesinger argued that abnormal behaviour was caused by diseases of the brain. He along with another German physician who followed him, Emil Kraepelin, were influential in the development of the modern medical model, which likens abnormal behaviour patterns to physical illnesses.

**Current Perspectives on Abnormal Behaviour**

Abnormal behaviour may be viewed from various contemporary perspectives. The medical model conceptualizes abnormal behaviour patterns like physical diseases, in terms of clusters of symptoms, called syndromes, which have distinctive causes that are presumed to be biological in nature.

**Biological Perspectives on Abnormal Behaviour**

Biological perspectives incorporate the medical model but refer more broadly to approaches that relate abnormal behaviour to biological processes and apply biologically based treatments.

**Psychological Perspectives on Abnormal Behaviour**

Psychodynamic perspectives reflect the views of Freud and his followers, who believed that abnormal behaviour stemmed from psychological causes involving underlying psychic forces. Freud developed psychoanalysis as a means of uncovering the unconscious conflicts dating back to childhood that he believed were at the root of mental disorders such as hysteria. Learning theorists posit that the principles of learning can be used to explain both abnormal and normal behaviour. Behaviour therapy is an outgrowth of the learning model. Humanistic-existential perspectives reject the determinism of psychodynamic theory and behaviourism. Humanistic and existential theorists believe that it is important to understand the obstacles that people encounter as they strive toward self-actualization and authenticity. Cognitive theorists focus on the role of distorted and self-defeating thinking in explaining abnormal behaviour.

**Sociocultural Perspectives on Abnormal Behaviour**

Sociocultural theorists believe that abnormal behaviour is rooted in social ills, such as poverty, societal stress, and institutionalized prejudice and discrimination, not in the individual. They believe that to eliminate “abnormality,” one must first correct the societal problems that caused it. Some sociocultural theorists argue that mental illness is a myth created to stigmatize people who do not conform to prevailing social standards.
Today, many theorists believe that multiple factors interacting in complex ways are involved in the development of abnormal behaviour patterns. The leading interactionist model, the diathesis-stress model, posits that some people have predispositions (diathesis) for particular disorders, but whether these disorders actually develop depends upon the type and severity of the stressors they experience.

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**Students Should Be Able to:**

1. Discuss the criteria used by mental health professionals to define abnormal behaviour.
2. Explain what psychological disorders are.
3. Discuss the relationships between cultural beliefs and norms in classifying abnormal behaviour.
4. Discuss how views about abnormal behaviour have changed over time.
5. Discuss how the treatment of people with psychological disorders has changed over time.
6. Understand the roles of psychiatric hospitals and present-day general hospital psychiatric units.
7. Understand the concept and success of deinstitutionalization.
8. Discuss the distinguishing features of the biological perspectives on abnormal behaviour.
9. Discuss the major psychological perspectives on abnormal behaviour.
10. Discuss the basic concepts underlying sociocultural perspectives.
11. Discuss the distinguishing feature of the interactionist perspectives.

**Lecture and Discussion Suggestions:**

1. **New terms.** A large number of new terms are introduced to students in this chapter. This may be a bit overwhelming to students so early in the class, yet many of the terms and concepts in this chapter form the backbone of the text. Providing students with a list of “key terms” and having students find their definitions from the text and then discussing their meaning in class can help clarify many of these new terms for students. In a subsequent session, you may want to give a short quiz on the terms discussed during this exercise.

2. **Explain the criteria for abnormal behaviour.** After stating that there is no clear and universally agreed upon definition of abnormal behaviour (or of normal behaviour, for that matter), explain and illustrate each of the six criteria of abnormal behaviour given in the text, including behaviour that is: (1) unusual, (2) socially unacceptable, (3) based on a misinterpretation or perception of reality, (4) personally distressful, (5) maladaptive or self-defeating, and (6) dangerous. Point out that clinicians use a combination of these criteria to identify abnormal behaviour in a particular person and situation. You might also point out that clinicians are often hesitant to label someone as “abnormal” based on the first two criteria alone. Many behaviours are statistically unusual but are not necessarily a sign of mental illness. Many behaviours may be socially unacceptable because they deviate from accepted social or cultural norms, not because the behaviour itself is inherently “sick” or a sign of illness. Many behaviours considered “normal” in our culture may be considered “abnormal” in other cultures, and vice-versa.
A good example of how one must be cautious in using the first two criteria is homosexuality. Homosexuality is statistically unusual in that only between 4% and 8% (maximum) of people are exclusively or primarily homosexual. It is also considered culturally and morally unacceptable to many people if not the majority of people in our culture. Yet psychologists and psychiatrists do not treat homosexuality, in and of itself as a mental illness.

3. **Distinguish between a “mental or psychological disorder” and abnormal behaviour.** According to the DSM-5, a mental disorder is a clinically significant behavioural or psychological pattern that occurs in a person and is associated with: (1) present distress, (2) disability in one or more areas of functioning, (3) significantly increased risk of suffering disability, pain, or death, and (4) an important loss of freedom or personal control. In addition, these features must not be merely an expectable response to a predictable event, such as grief over a loved one’s death. Thus, some behaviours, such as bathing nude at a public beach may be socially deviant without being classified as a mental disorder.

4. **Ask students to define “normal.”** While the concept of “normal” tends to be one of those concepts that people “know it when they see it,” in real-life behaviour, it can be very difficult to define operationally. Asking students to define “normal” and to discuss how they arrived at their definitions as well as what problems they see in each other’s definitions can be a fruitful exercise that leads them to see why psychologists have adopted the specific criteria for abnormality discussed in the text.

5. **Ask students how they personally determine when someone’s behaviour is abnormal.** To what extent do they rely on the six criteria identified in the text? Since the designation of abnormality is partly a social judgment; discuss the importance of how such a judgment is made as well as its subjective and irrational aspects.

   You might cite psychiatrist Thomas Szasz’s book *The Myth of Mental Illness*, including the point that psychological labels are often used as a convenient way of avoiding people who are different or threatening to us.

6. **Discuss supernatural explanations of abnormality.** Discuss how supernatural explanations of behaviour are still alive in the form of astrology, demonic possession, and satanic worship. You might point out that people resort to such explanations because of the difficulty understanding bizarre or evil behaviours in conventional medical and psychological terms. You might also point out that because of the power of selective perception, placebo effect, and the types of “Barnum statement” predictions made by these belief systems, they can be very difficult to debunk or refute.

7. **Discuss the popularity of supernatural explanations.** Many observers have noted that beliefs in the supernatural have increased in recent years. Given that, as a society, North Americans are better educated than ever before, one would think that belief in the supernatural would be declining rather than increasing. Do students believe this to be true? If so, why or why not?

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8. **Describe Hippocrates’ “four-fluids theory”**. While technically inaccurate, you might point out that Hippocrates’ general idea of imbalances in bodily fluid causing mental illness may have been more accurate than he is generally given credit for. Point out the number of “mental” illnesses, such as some types of depression, that are clearly linked to imbalances in neurotransmitters in the brain, and other disorders such as PMS which are linked to hormone fluctuations and imbalances in the body. While phlegm, black bile, and yellow bile are clearly not hormones or neurotransmitters, they are similar in that both represent bodily fluids of a sort.

You might also point out that not all of Hippocrates’ ideas were as accurate as this one, even at a very general level. His claims that hysteria in females was caused by a “wandering uterus” and could only be cured by marriage are clearly unsupported.

9. **Discuss some of the implications of holistic medicine for mental health**. The emphasis on positive physical health rather than sickness has led to greater concern for prevention, nutrition, fitness, and stress management. But to what extent has the emphasis on positive health affected our attitudes and practices in the area of mental health?

10. **Discuss whether or not neurotic discomfort is necessary to creativity** and originality. Many well-known historical and creative figures have displayed behaviours which were eccentric or deviant, but not maladaptive. At times such eccentricity and even some degree of neurosis has been seen as a necessary prerequisite for artistic genius to the point where some writers and artists have refused to seek therapeutic help for fear of eliminating the inner pain and turmoil which stoked their creative fires. Examples of such people are Renoir, Van Gogh, Edna St. Vincent Millay, and Edgar Allan Poe. These examples are all generally acknowledged to be highly creative but manifest some maladaptive behaviour.

11. **Describe the movement toward deinstitutionalization of mental patients**. Point out that a variety of factors led to this movement, including rising criticism of the inhumane treatment of mental patients as well as the discovery of powerful antipsychotic drugs, such as phenothiazines, that helped patients live outside the hospital.

You might discuss some of the pros and cons of deinstitutionalization, such as the establishment of community-based services (a plus) as well as the increased number of ex-patients who have swelled the ranks of the homeless people in nearby cities (a minus). The aim here is to stimulate students’ thinking about the mixed impact of deinstitutionalization.
12. **Describe ft. L. Rosenhan’s famous study “On Being Sane in Insane Places”** (Science, 1973, 179, pp. 250-257). In this study, eight mentally healthy people, several of them psychologists and psychiatrists, complained of hearing voices and were admitted to mental hospitals. Once inside, they acted normally again. Their normal behaviours were often misinterpreted as “hostile,” “aggressive,” or “deviant” by unsuspecting staff members. Ironically, many of the hospitalized patients realized that the impostors were faking, but none of the staff did. All impostors were labeled schizophrenics and their stays ranged from 7 to 52 days with an average stay of 19 days.

This study is useful because it offers a striking glimpse at how powerfully labels, setting, and expectations can affect how we perceive and judge the behaviours of others.

13. **Elaborate the role of neurotransmitters in abnormal behaviour.** Although the exact causal relationships have not always been determined, there is mounting evidence that neurotransmitters play a significant role in various abnormal behaviours. For instance, deficiencies in dopamine are linked to Parkinson’s disease, whereas excesses in dopamine reactivity are found in schizophrenia. The powerful antipsychotic drugs are thought to alleviate the symptoms of schizophrenia by blocking the action of dopamine. Excesses and deficiencies of norepinephrine which act as a neurotransmitter and a hormone, are involved in mood disorders and eating disorders; and serotonin may be linked with anxiety, insomnia, and mood disorders.

14. **Discuss the implications of unconscious motivation for everyday behaviour.** You might ask, “Can you love and hate the same person?” Most students will say yes but have a difficulty in explaining why. In contrast, psychodynamic theorists tend to explain this phenomenon in terms of the fundamental polarity of unconscious drives and the importance of ambivalence in our behaviour, especially in close relationships.

15. **Discuss the Psychoanalytic Theory and Sexism.** One of the most controversial of Freud’s views involves his notions about the phallic stage of development. A particularly controversial topic within this stage is his concept of penis envy. Briefly, Freud believes that when a little girl notices how she differs from little boys, she feels cheated. She blames her mother for her lack of a penis, and rejects the mother trying to displace her in father’s eyes — in effect, to become “daddy’s darling.” The hale girl unconsciously hopes that her father will give her a penis. When he does not, she compensates with the wish for a child. There are a number of important consequences of this process, each with applications for abnormal psychology:

   a. Women have weaker superegos than males.
   b. Women feel inferior to men and contemptuous of other women.
   c. Women become passive, vain, jealous, and masochistic.
   d. Women should give up infantile gratification from the clitoris and prepare for adult gratification through intercourse.
This view has been criticized for decades. Some believe it has helped instill a bias toward diagnosing more abnormal disorders among women. Others say that the concept has no validity. Still others believe that women are indeed envious—of the power and control males have traditionally enjoyed. This topic is likely to produce a lively debate among students.


16. **Discuss defense mechanisms and psychopathology.** An interesting way to apply the psychodynamic perspective to psychopathology is through the use of Valiant’s approach. In *Empirical Studies of Ego Mechanisms of Defense* (1986), Valiant relates ego-defense mechanisms to different levels of maturity and their association with various types of abnormal behaviour as follows: Level I defenses, such as repression, denial, and delusional projection are found in the psychoses. Level II defenses, such as assimilative projection, frequently occur in passive-aggressive behaviours. Level III defenses, such as displacement, isolation, intellectualism, and rationalization can be seen in various anxiety disorders. Level IV defenses, such as conscious suppression, impulse delay (inhibition), and sublimation are characteristic of normal, healthy human behaviours.

17. **How do students explain the relative lack of self-actualization in our lives?** This should elicit a wide range of responses. Possible reasons include: the fear of becoming our best (fear of success), the fear of not being accepted socially, too many work, school, and child-rearing demands on one’s time, the inner core of growth is relatively weak and undeveloped in many people, a lack of supportive circumstances, and conflicts between the desire for security and avoidance of risk.

18. **Discuss cognitive factors in abnormal behaviour.** Point out the mediating role of the cognitive approach in relation to the psychodynamic perspective and the behavioural perspective. Psychodynamic therapies tend to probe for deep-seated causes of behaviour, with the aim of bringing about change through increasing the client’s self-understanding. At the opposite extreme, classical and operant behaviour therapies rely on a functional analysis of the various stimuli associated with a given behaviour, minimizing the role of cognitive factors. However, the cognitive perspective, now more commonly characterized as a cognitive- behavioural approach, occupies a more “middle-of-the-road” position, and employs both cognitive and behavioural approaches to therapy.
19. Discuss the issue of free will versus determinism as it applies to mental illness and therapeutic treatment approaches. The issue of free will and determinism is an underlying theme in any discussion of mental illness and its treatment, and students often bring strong opinions about this subject into the course. At this point in the course it may be useful to ask the following questions:

a. What are the psychological implications of not believing in free will? Determinism implies a loss of control; belief in free will may be adaptive if it increases our self-efficacy. This issue can be related to the concept of internal vs. external locus of control. Is it healthier to believe in free will or to live as if we have free will, whether or not it exists?

b. Is the scientific study of human behaviour compatible with a belief in free will?

c. Is free will something that can be studied empirically? If so, how?

d. What view of human behaviour does our society hold, as evidenced by various religious and legal beliefs?

e. Can a psychopathologist who believes in free will logically support an exception for being not guilty by reason of insanity?

20. Discuss perspectives and abnormality. Students often enjoy and learn from applying the theoretical material in the course to actual cases. To facilitate this, you might divide the class into six groups, and have each group adopt one of the theoretical perspectives described in this chapter. Using a case from the text, or one from your own experience, have each group attempt to explain the “client’s” behaviour from the theoretical perspective they have adopted. After each group has presented its perspective, groups may then debate key questions and issues, each group trying to point out how its explanation is better supported than alternative explanations.

21. Discuss psychodynamic vs. learning approaches. Psychodynamic and learning advocates have long argued about the efficacy of each other’s therapeutic techniques. At issue is whether the behavioural “symptom” or the “underlying” cause should be treated. Consider the case of an autistic child with a pattern of repetitious, self-injurious behaviour. One could treat the behavioural symptom with operant conditioning techniques but would that be sufficient to prevent a relapse of the behaviour pattern, or some similar one, in the future? Or could it result in the substitution of a new, even more injurious behaviour pattern for the original behaviour that was eliminated? If there is an underlying cause and it is left untreated, might not a problem recur? If an underlying cause is identified and treated, how would this be done?
22. **Elaborate on personal perspectives.** The theoretical perspective of behaviour that a student adopts has an impact not just on the student’s view of psychology, but also on the student’s view of him or herself. Do I want to think of my own behaviour as being caused by unconscious processes, by my biological make-up, by past learning experiences, or by the way I construe the world? How can I change myself if I can change myself at all? Can I learn new ways of behaving? Must I have my biological make-up altered if I want to change? Will change only occur after many years of analysis, or do I really need some understanding and caring? While scientists and students are striving to be objective, personal values can influence the answers we seek and those we are willing to accept. At times, our values and perceptions may persuade us more than the objective data we find.

23. **Women and Witchcraft.** From the mid-sixteenth through the mid-seventeenth centuries, a kind of hysteria swept Europe, and also parts of the American colonies. Suddenly, large numbers of people were accused, tried, and often convicted of consorting with the devil and becoming witches. Some witchcraft accusations have been made from the beginning of civilization, but never before in such large numbers.

Not all of these accused women were mentally ill, as Schoeneman (1983) has pointed out. Many of these women were poor, without husbands, aged, and/or seen as troublemakers or having questionable knowledge. About a third of those accused were sentenced to death by burning. Some survived by confession and recanting. Others died while undergoing interrogations, such as the case in the “water-float test.”

What caused this upsurge and why was it directed mostly against women? The sixteenth century was an age of both intense religious belief and great, misery-producing disruption; in that age, witches were easily accepted as troublemakers. What is perhaps most interesting is why the accusations were so skewed against certain sorts of women. Some historians say that these women were essentially targeted not directly as women, but rather because they were poor and disruptive in an age that feared disorder and saw the poor as dangerous. It was just their bad luck that women without families to protect them were by far the most likely to be poor, and to have to challenge society’s “haves.” Others, however, point out that the most basic assumptions of the age also made women likely victims. Women were commonly seen as “weaker vessels,” with weaker reason and great sexual vulnerability, and so open to the devil’s temptations. Also (especially within Protestant lands), women’s one “natural” sphere was within the home under male authority, and anyone who operated outside of that hierarchy was naturally seen as disorderly and dangerous.

24. **Discuss insurance reimbursement and psychotherapy.** There has been a push to conduct more psychotherapy outcome research for a very practical reason: insurance companies that reimburse certain mental health professionals for conducting psychotherapy want to know that they are getting something for their money. As potential consumers of psychotherapy services (or as nonconsumers concerned about the high cost of insurance), what do students think about the provision of third-party payment for psychotherapy? Should only therapies that have been demonstrated to be effective be paid for by insurance companies? Should reimbursement cover lengthy psychoanalysis, which may involve several appointments a week over a number of years? Should only certain mental health professionals be reimbursed? What is the empirical justification for such a policy? Putting this discussion in the context of licensing laws and reimbursement policies in your own state will make it more relevant.

**Student Activities:**

1. **Irrational beliefs and problem behaviours.** Select one or more items from Ellis’ list of irrational beliefs (Such as “To be a good person, I must be perfect in everything I do,” or “Once something has negatively affected me, it will always affect me,” or “To be a good person, everyone in my life should like me.”) Then illustrate how this belief affects our behaviour. For example, you might take “life must go the way you want it to go.” How would this belief affect your reaction to a situation in which things do not turn out the way you expect, as so often happens? Now, convert the same statement to a rational one, such as “when things don’t turn out the way I want, it’s not the end of the world—have other options.” Discuss the difference this might make in your behaviour.

2. **Biological or environmental causes of abnormality.** Have students draw a Likert-type scale with “all biology” on one end of the scale and “all-environment” on the other end of the scale. Then ask them to place the various theorists discussed in chapter two on the appropriate point on the scale. While some theorists like Freud or Skinner should be relatively easy to place, others will be more difficult and should lead to some discussion of the differences in how the theories approach this dimension of personality. You might then ask students to discuss how theories that are highly biological in the theft perspective would necessarily differ in theft conceptualization of abnormality, and in the development of treatment, from those theories that are highly environmental in their orientation.

As an additional activity, you might ask students to draw another Likert scale with “all good” on one end of the scale and “all evil” on the other end of the scale and have students place the various theorists on the appropriate point on the scale for theft theoretical orientations. Again, you might ask how those theorists who view people as “inherently good” might differ in their conceptualizations and treatments of abnormality from those who view people as “inherently evil.”

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3. **Violating social norms.** Ask students to think of something that is unusual, such as dressing in a nonconforming way either in class or at a social gathering or doing something that is socially unacceptable, such as reading comic books in class or eating in a library, then have them engage in the behaviour. Caution them to avoid doing anything that is illegal or contrary to others’ rights. Ask them to report on how difficult it was to carry out the behaviour, their feelings about it, and others’ reactions. This exercise usually helps students appreciate the importance of social norms.

4. **Interview individuals exhibiting features of mental disorders.** Ask for several volunteers, each of whom will identify with a given mental disorder, like obsessive-compulsive disorder, schizophrenia, and bipolar disorder. Assist each volunteer to become familiar with some of the characteristic behaviours of his or her particular disorder, including verbal expressions and nonverbal behaviours. Then have members of the class as a whole interview each volunteer and try to guess that person’s mental disorder. This exercise may help students to appreciate the difficulties of assessing a person’s psychological problems.

5. **Discovering your own problems through social interaction.** Select various diagnostic labels from the text or the DSM-5, and write them on an 8 x 11 sheet of paper. Place them face down on a table and have each student draw one and have the instructor pin it on his or her back so that the individual cannot see his or her diagnostic label but everyone else can. Then allow about 20 minutes for students to mingle socially with the other students, trying to guess their own mental disorder. Students may ask questions such as “What are some of my complaints?” “Do I need medication?” “Have I ever been to a mental hospital?” Although this exercise serves as a good social mixer, it also underlines the importance of feedback and social comparison for our personal identity.

6. **Are we really scientific today?** As Chapter 1 illustrates, much of history has been coloured by superstitious views of human behaviour. Have students collect modern examples of less-than-scientific concepts about behaviour. Examples might be astrology, or headlines from the supermarket tabloids. A visit to a bookstore’s self-help or occult sections might also yield examples of unusual, and less-than-scientific prescriptions for happiness, adjustment, and meaning in life.

   It may also be interesting to have students track down research evidence that debunks certain beliefs. One example is the influence of the moon on abnormal behaviour (do the “crazies” really come out when the moon is full?). In 1978, D. K Campbell and J. L. Betts reviewed research in “Lunacy and the moon,” Psychological Bulletin, 85, 1123-1129.
7. **A Historical Talk Show.** An activity that can prove very interesting is to have students assigned to portray some of the historical figures discussed in Chapter 1. Each will have to do some research on the person’s views beyond what is in the text and will adopt that figure’s beliefs about the causes and cures of deviant behaviour. Select a mix of traditional and reform views—for example, Hippocrates might debate Skinner or some other figure from our time. Much like one of the daytime talk shows, the panel could be questioned by a moderator in the audience, who stops occasionally to solicit questions from the audience (class) members to the panel.

8. **What myths do people have about abnormal psychology?** Have students survey five of their friends about perceptions of abnormal behaviour. If time allows, you might solicit students’ input on the design of the questionnaire. Survey questions can include:

- Mental illness is due to emotional weakness. **Yes No**
- Bad parenting is a major cause of mental illness. **Yes No**
- Sinful behaviour is responsible for much mental illness. **Yes No**
- The mentally ill could recover if they really wanted to. **Yes No**
- The mentally ill are more violent than “normal” people. **Yes No**
- Mental illnesses are generally incurable. **Yes No**
- Mental illness has a biological cause. **Yes No**
- Most people who claim to be mentally ill are really just looking for attention or are faking to avoid responsibility for their behaviour. **Yes No**

**Online Discussion Questions:**

1. With our current understanding, defining abnormal is relatively straightforward. Give some possible reasons of why this is a straightforward (or not) task.

2. Abnormal behaviour results from a combination of biological (including genetic), behavioural, cognitive, and environmental factors.

3. Labeling people is the most helpful way for us to understand those suffering with mental disorders. Support your answer with procedures commonly used by mental health professionals in diagnosing their clients.

4. The deinstitutionalization of mental patients is almost always the best approach to treating those suffering from mental disorders.
Online Resources:

**Canadian Psychological Association (CPA)**
www.cpa.ca
This is the homepage for Canada’s national psychological association. It is the central source for information about the profession of psychology in Canada.

**Canadian Psychiatric Association (CPA)**
www.cpa-apc.org
This is the homepage for Canada’s national professional association for psychiatrists. It contains psychiatric e-journals and information on a variety of professional matters.

**Canadian Mental Health Association (CMHA)**
www.cmha.ca
The CMHA is a voluntary organization that is dedicated to the promotion of mental health for all Canadians. Its website contains a diverse selection of mental health resources.

**Mental Health Commission of Canada**
www.mentalhealthcommission.ca
The MHCC promotes mental health in Canada, and works with stakeholders to change the attitudes of Canadians toward mental health problems and to improve services and support. It contains reports and videos.

**Mental Health Page at Health Canada**
www.hc-sc.gc.ca/hl-vs/mental/index_e.html
This website provides convenient access to a range of online materials related to the promotion of mental health, mental health programs and services in Canada, and the mental health issues, problems, and disorders encountered by Canadians.

**Centre for Addiction and Mental Health (CAMH)**
www.camh.net
CAMH is Canada’s largest teaching and research centre for mental health and addiction problems. The site contains resources on a wide range of mental health and addiction concerns.

Video Resources:

*Abnormal Behaviour*, 26 mm. colour (CRM/McGraw-Hill). Shows selected types of abnormal behaviour, including the anxiety disorders and psychoses such as schizophrenia.

*Abnormal Behaviour: A Mental Hospital*, 28 mm. colour (CRM/McGraw-Hill). Portrays life in a modern psychiatric hospital, including views of schizophrenic patients as well as a scene of a patient receiving electroconvulsive therapy (ECT).

*Abnormal Psychology*, 29 min. colour (Coast Telecourses). Shows the difficulties in distinguishing between normal and abnormal behaviour in reference to the DSM system of classification.
Abnormal Psychology: The Psychoses, 22 min. colour (Harper & Row). Viewers see a tour of a ward of a mental hospital which includes interviews with patients and a discussion of their disorders and outlook for recovery.

Asylum, (Direct Cinema Limited). This documentary focuses on St. Elizabeth’s hospital in Washington, and traces the changes in treatment over time. There is a discussion of controversies such as deinstitutionalization, and the status of the homeless mentally ill.

B. F. Skinner and Behaviour Change, 45 min. colour (Research Press). Skinner and other renowned behaviour therapists discuss behavioural psychology and therapy.

Behaviour Therapy: An Introduction, 23 min. colour (Harper & Row). Demonstrates three basic behavioural procedures, including contingency management, counterconditioning, and role playing, as applied to three individuals.

Being Abraham Maslow, 30 min. colour (FLMLIB). Excerpts from an interview in which Maslow discusses factors that influenced his life and theory.

The Brain, Mind, and Behaviour, Spans, 60 min. each, colour (PBS Video). One part on the “Enlightened Machine” focuses on the mysteries of consciousness and the brain. Another part on Rhythms and Drives examines the effects of the brain and hormones on behaviour.

Brain waves, 60 min. (PBS Video). This is from a 5-part series Madness by Jonathon Miller. Miller begins in the late 18th century and describes the rise of physical explanations for abnormal behaviour.

Carl Gustav Jung, 38 min. (Time-Life Films). Includes a conversation with Jung about his work and his relationship with Freud. The total span of Jung’s life and work are covered.

Carl Rogers Conducts an Encounter Group, 70 min. colour (APGA). Rogers explains how groups should operate. The film shows the quality of Rogers personal interaction with people in the group.

Classical and Instrumental Conditioning, 20 min. colour (BAR). Defines, compares, and demonstrates these two learning principles.

Committed in Error: The Mental Health System Gone Mad, 52 min. (Films for the Humanities & Sciences). A man spends 55 years in mental institutions, although there was never anything wrong with him.

Dialogues: Dr. Carl Rogers, Parts I and II, 100 min. (UCEMC). Wide-ranging interview with Carl Rogers covering client-centered theory and some contemporary issues.

Discovering Psychology: The Responsive Brain, 30 min. colour (Annenberg/CPB Collection). Looks at the interaction of the brain, behaviour, and the environment. Also shows how brain structure and function are changed by behavioural and environmental factors.
Discovering Psychology: Understanding Research, 28 min. colour (Annenburg /CPB collection). This film explores the research methods and procedures of psychologists.

Everybody Rides the Carousel, 73 min. colour (PFP). Real-life episodes are used to illustrate Erikson’s eight stages of development.

Faith Healing and Witchcraft, 28 mm. colour (Films for the Humanities and Sciences).

Frankl and the Search for Meaning, 30 min. colour (Psychological Films). Victor Frankl discusses his approach to therapy.

Hurry Tomorrow, black & white (TFC). A documentary film in a Los Angeles psychiatric hospital depicting the attitudes of staff and patients and the treatment of patients.

Hypnosis: Can Your Mind Control Pain? 53 min. colour (BBC). Presents several case studies in which hypnosis is used as anesthesia.

Is Mental Illness a Myth? 29 mm. black and white (NMAC-T 2031). Debates whether mental illness is a physical disease or a collection of socially learned actions. Panelists are Thomas Szasz, Nathan Kline, and F. C. Redlich.

King of Hearts, colour (United Artists). A classic film about an English soldier scouting a French village behind German lines in WWI which has been abandoned by all but residents of the local insane asylum, who have escaped and taken over the town.

Madness and Medicine, 49 min. (2 parts) colour (CRM/McGraw Hill). Part I covers life in a mental hospital; Part II explores the pros and cons of the various types of treatment, including insight therapy and ECT.

Miracle Healers, 50 min. colour (ITVFP). Investigates alternative forms of healing such as psychic surgery, faith healing, and magnetism.

Mental Health: New Frontiers of Sanity, 22 min. colour (EMC). Documents the extent of mental health problems in North America, and traces the history of therapy.

Methodology: The Psychologist and the Experiment, 30 mm. colour (CRM/McGraw-Hill). This film overviews research methodologies used by psychologists.

Mysteries of the Mind 58 mm. (Films for the Humanities and Sciences). Examines the neurochemical and genetic components in various disorders.

To Define True Madness, 60 mm. (PBS Video). This is from the 5-part series Madness by Jonathon Miller. Miller examines views of mental illness throughout the history of Western society, and explores from various perspectives what it means to be a mentally ill patient.
The Otto Series, 27-29 min. each (5 parts) colour (lU). A series of films that begin with an open-ended dramatization of abnormality in a middle-aged man, then offers four perspectives for understanding and treatment: behavioural, phenomenological, psychoanalytic, and social.

Pavlov: The Conditioned Reflex, 25 min. black and white (Films for the Humanities). Accurate biography of Pavlov’s life and work.

Psychodynamic Considerations and Defense Mechanisms, 29 min. colour. (Health Sciences Consortium). Shows how the unconscious is manifested verbally and behaviourally.

The Psychology of Jung: Passions of the Soul, 4 parts, 60 to 90 min. each, colour (Films for the Humanities). In-depth exploration of Jung’s life and theory.

Psychotherapy, 26 min. colour (CRM/McGraw-Hill). Demonstrates the process of therapy with three different clients and therapists.


Sigmund Freud: His Office and Home, Vienna, 1938, 17 min. colour (Filmmaker’s Library).

What Makes Us Tick? 24 mm. (Films for the Humanities and Sciences). The relationship between genes and environment in the formation of human personality.