Unit 8 Contemporary Perspectives on Abnormal Psychology

Overview

In Unit 7 you were introduced to the notion of a personality disorder defined as, "An inflexible pattern of behaviour that leads to difficulty in social, educational, and occupational functioning." (Boyd & Bee, 2012, p. 348) Boyd and Bee identified some of the reasons why personality disorders occur. Among these are the stresses of young adulthood, presumably in combination with some biological factors, resulting in serious disturbances in cognitive, emotional and social functioning that are not easily treated. Other stressors or stress factors may cause the onset of the disorder. These stressors include the break-up of a long term relationship, physical illness can cause abnormal behaviour and it was also suggested that some cultural practices may cause personality disorders. Information on antisocial personality disorder was presented via a YouTube video presentation in Unit 7 to provide you with some background information for Unit 8. Five personality disorders were discussed in Unit 7: antisocial, paranoid, histrionic, narcissistic and borderline and their attendant characteristics were listed.

In Units 8, 9 and 10 there will be detailed exploration of the major themes associated with contemporary perspectives on abnormal psychology. What is abnormal psychology?

It is defined as the branch of psychology that deals with the description, causes, and treatment of abnormal behaviour patterns. (Nevid, Rathus & Greene, 2011) Nevid et al. noted that abnormal psychology also extends to diagnosable mental and psychological disorders. Thus abnormal psychology affects all of us in one way or another either because we know someone who suffers from it or because persons with disorders receive national attention when they commit heinous crimes such as gruesome murders. The purview of abnormal psychology is reflected in the range of topics that received empirical attention and have been published in the peer-reviewed Journal of Abnormal Psychology. The journal is supported by the American Psychological Association. Research questions investigated by abnormal psychologists include the following. Are impulsive adolescents differentially influenced by the good and bad of neighbourhood and family? (Barker, Trentacosta, & Salekin, 2011) Can psychopathic offenders discern moral wrongs? (Aharoni, Sinmott-Armstrong & Kiehl, 2012) Are anxiety and depression just as stable as personality during late adolescence? (Prenoveau, Craske, Zinbarg, Mineka, Rose & Griffith, 2011) Behind the wheel and on the map: Genetic and environmental associations between drink driving and other externalizing behaviors (Quinn & Harden, 2013). The findings published by psychologists have been applied in the clinical and legal domains

and the implications of some of these research findings will be discussed in this unit. The discussion of psychological findings will focus on identifying strategies and interventions that may help to reduce risky behaviour in persons.

Understanding the range, breath and scope of the sub-discipline of abnormal psychology will prepare learners for their career by developing the competencies, knowledge and skills-set expected for YDWCYP0263 'Enable young people to become active and responsible citizens;YDWCYP0323 'Assist young people with their personal development plans', YDWCYP0513 'Plan and implement programs to promote healthy lifestyles'. The issues examined in Unit 8 Session 8.1 will include the definition of abnormal psychology, the historical background of the discipline and identification of the research methods that are commonly used in the analysis of disorders. This is followed by an examination of how stressors or stress factors lead to mental illness. More importantly, in this session coping mechanisms will be presented as this is a skill set that could be taught to 'at risk' persons to help them to mitigate their stressful circumstances. The major perspectives in abnormal psychology will be critically reviewed. The major perspectives are biological, psychological, socio-cultural and biopsychosocial. In Session 8.2 the focus will be on using an applied approach to explaining abnormal psychology. In particular the perceptions and understanding of abnormal behaviour in a Caribbean context will be evaluated. Stigmas and taboos still exist in taking about and in diagnosing disorders and mental illness in the region and this in turn delays early treatment of potentially disruptive and criminal behaviour.

You are reminded to continue to look up any terms or concepts that you do not understand using your course textbook Boyd and Bee (2012) and the free-access on-line psychology dictionaries available at the links:

http://allpsych.com/dictionary/
http://www.merriam-webster.com/dictionary/psychology
http://dictionary-psychology.com/
http://www.apa.org

Competencies

1. YDWCYP0263: Enable young people to become active and responsible citizens.
2. YDWCYP0323: Assist young people with their personal development plans.
3. YDWCYP0413: Undertake research activities to support programme development.
4. YDWCYP0513: Plan and implement programmes to promote healthy lifestyles among youth.

Key Concepts in Unit 8: abnormal psychology, mental health, dependency, cognitive disorder, substance abuse, psychological disorder, biopsychosocial model, fixation, archetypes, psychosis, reality principle, ego psychology.

Structure of the Unit

This Unit is divided into two sessions as follows:

Session 8.1: The Role of Abnormal behavior as risk factors

- Abnormal behaviour: definitions and historical perspectives
- Research methods used to uncover abnormal behaviour.
- Stress, crisis and coping: role of stressors as risk factors
- Contemporary perspectives on abnormal behaviour (biological, psychological, socio-cultural, biopsychosocial)

Session 8.2: Cultural issues and differences in understanding abnormal behaviour

- Understanding abnormal behaviour in a Caribbean context
- Cultural sensitivities in assessment and treatment

Unit 8 Learning Objectives

By the end of this unit learners would be able to:

1. Critically evaluate the abnormal psychological developmental theories presented in the unit notes;
2. Incorporate the unit notes to suggest ways in which abnormal psychology can promote protective factors and minimize risk factors in young persons in tutorial discussions;
3. Apply the diagnostic tools outlined in the unit to frame policies for transforming at risk persons into functional and civic-minded citizens and post these ideas in the discussion forum;
4. Recognize the core features of selected disorders documented in the unit notes and explore the recommend readings in the unit notes to identify interventions to improve the circumstances of persons with these disorders;
5. Appreciate the need to work in ways that are socially and culturally sensitive when recommending interventions and programs for persons with mental disorders who require special support systems.

Session 8.1

The Role of Abnormal Behaviour as Risk Factors

Introduction

In the overview to this unit you would recall that abnormal psychology was defined as the branch of psychology that deals with the description, causes, and treatment of abnormal behaviour patterns. (Nevid, Rathus & Greene, 2011) Moreover, abnormal psychology also extends to diagnosable mental and psychological disorders. This definition raises two issues. First, what is the distinction between normal and abnormal behaviour? Second, what conditions can trigger the transition from normal to abnormal behaviour. More details are given in the section on stress, crisis, conflict, and coping but brief comments are given below. Answering the question what is normal and what is abnormal behaviour is not easy because the distinction reflects individual differences in behaviour and the influence of culture on acceptable norms and behaviour. If we accept that normal behaviour is in line with the average behaviour of the population this provides a working guidance on what is regarded as normal. One must be cautious that exceptions to average behaviour do not render a person abnormal. For example, highly intelligent prodigies (individuals of unusual or marvelous talents) possess high IQ scores that are beyond the average population; however, this does not render them as abnormal persons. Each culture sets limits on how unusual normal behaviours might be perceived. There are shifting barriers for acceptable behaviour. For instance, some people dress oddly but they are regarded as either displaying a sense of avant-garde fashion or showing a preference for dressing in an eccentric manner rather than displaying abnormal behaviour. Nudity on a nudist beach is acceptable but a person walking nude in a public space runs the risk for being charged for indecent exposure.

Session 8.1 Objectives

By the end of this session learners would be able to:

1. Define abnormal psychology.
2. Critically evaluate the major theories of abnormal psychology documented in the session.
3. Recognize the core characteristics of selected personality disorders, mental illness and the attendant treatments or interventions discussed in the session.
4. Use the session notes to reflect on policies that could promote protective factors and minimize risk factors in young persons.
5. Link the realization of life goals and development plans to the promotion of healthy lifestyles outlined in the session.

Definitions of abnormal behaviour vary but one definition of abnormal behaviour suggests that, "it is a term that is usually reserved for behaviour of people who have either or both of two characteristics: (1) they have difficulty functioning effectively or (2) they experience intensely unpleasant emotions." (Newman & Newman, 1983, p. 456) The YouTube presentations cited in Activity 8.1 provide the criteria for distinguishing between normal and abnormal behaviour as well as normal and abnormal personality. Newman and Newman also offer four criteria for distinguishing between normal and abnormal behaviour that is based upon effectively functioning and emotional sate that psychologists use to assess normality. First, the ability to *test reality* – many people claim to hear from time to time a voice in their head or to see something that they later realize was not actually present in the environment when they conduct a reality check. A person who has a mental disorder may experience a hallucination and conclude that it is real either because the person does not undertake a reality check or the person arrives at the wrong conclusion after undertaking a check. The second criterion is the ability to have *meaningful interpersonal relationships*. It is assumed that healthy growth and development over the lifespan is facilitated by the ability to have relationships, to form attachments and to bond with other human beings. Even though relationships may at times contain some element of dissatisfaction normally the people in our social network provide comfort, support and warmth. Yet there are persons who are severely withdrawn from others and they do not make the effort to develop relationships. This extreme withdrawal is unusual and an indication that all is not well. The third criterion that allows clinicians to distinguish between normal and abnormal behaviour is the *ability to take care of one's self*. Finally, normal behaviour is associated with the ability *to control one's behaviour* – this is manifested in the ability to refrain from outbursts of aggression, being able to participate in creative tasks and controlling emotions within acceptable limits. The persons who have great difficulty maintaining or controlling their behaviour are thought to have psychological problems. Activity 8.1 is designed to allow you the opportunity to reflect and to comment on behaviour that would not normally be regarded as typically behaviour.

Nevid et al. (2011) added other criteria for determining abnormality. These are listed below.

1. *Unusualness* – behaviour that is unusual is often considered abnormal. Generally speaking, only a few persons consistently report seeing and hearing things. However, these experiences have been found to be part of intense religious experiences and hearing voices was not considered abnormal or unusual in some pre-literate societies (Nevid et al., 2011:6).
2. *Social deviance* – all societies have norms or standards that define and describe patterns of behaviour and the contexts of these 'acceptable' behaviour. This meant that in some circumstances non-conformists were labeled as 'sick', unconventional and 'abnormal'.
3. *Significant personal distress* –states of personal distress caused by troublesome emotions such as anxiety, fear or depression may be abnormal particularly if the emotions of are an extreme nature and of a prolonged duration. It is assumed that under normal circumstances a well-adjusted person can overcome personal distress or cope with crises in ways that do not impair their daily effective functioning.

4. *Maladaptive or self-defeating behaviour* – behaviour that leads to unhappiness rather than self-fulfillment or actions that limit our ability to function properly can be regarded as abnormal. For instance, the excessive consumption of alcohol or a drug addiction can ruin the career, family life and health of the addict.
5. *Dangerousness* – behaviour that is dangerous to oneself or regarded as excessive and physically aggressive to other people may be considered abnormal. The two case studies in Activity 8.1 illustrate this point.

LEARNING ACTIVITY 8.1 • Tutorial Discussion

Please look at the YouTube videos cited below.

1. The Curious Classroom. (2013, May 29). Defining abnormality. [Video file]. Retrieved from http://www.youtube.com/watch?v=cwKJ0juPIrQ
2. LifeWorksGroup. (2013, Oct 7). Normal vs Abnormal Personality. [Video file]. Retrieved from http://www.youtube.com/watch?v=anu29BpVIFc

Incorporate the information from the video presentation and Units 1-8 in this activity.

Two cases are presented below for your reflection and discussion. The information was taken from court files as part of the data collected for the report by Hood and Seemugal (2006).

Case 1: High Court of Trinidad and Tobago, No. 19 of 2001

The Defendant 'A' a maxi-taxi driver was indicted for the murder of a 16 year old school boy passenger in his vehicle but 'A' was convicted of manslaughter. The sentence of the court was 30 years with hard labour. At the sentencing hearing the Court (Judge) told the defendant:

"The Jury has found you guilty of the lesser alternative offence of manslaughter. For the jury to have arrived at the decision that they have, they would have had to find that, that evening, you were provoked by the deceased. The evidence on which they could have found that you were provoked was that you were short paid by one dollar; that you brought this to the attention of the deceased, who was then a 16-year-old-man …sorry, boy, and the time when he had come out of your maxi taxi that you were driving, this is what he did and this is what he said to you. 'I came in at Arouca,' meaning that the fare that he had to pay was the correct fare and that the fare that you were demanding was the wrong fare. This is borne out by two prosecution witnesses. You insisted, against the weight of evidence, that you told him no, that he came in at Tunapuna, to which he replied, 'You are an old man, you stupid or what, I came in at Arouca. You must be drunk or what.' And after you told him you don't drink or smoke, he again replied, 'Is Arouca I come from, boy' and then you didn't say what the curse was, but you said that he cursed you. You then opened the driver's door, took out your key from the ignition, took a knife, which was exhibited in this court, which looking at it alone is enough to drive shivers into any human being, and you went up to him saying that you wanted your fucking money; this is you, a maxi taxi driver in this country, Priority Bus Route or no Priority Bus Route. You pushed him, according to you, with your hands and he said, 'All right, all right, I would pay you.' You got your money, your one dollar, and it was then, on the evidence, clear evidence it would seem to me, that you inflicted a stab wound in the heart of the deceased thereby ending 16 years of his life."

LEARNING ACTIVITY 8.1 • Tutorial Discussion Cont'd

Assignment 1: Would you regard the behaviour of the defendant outlined in case 1 as normal or abnormal behaviour. Discuss this question using your research and unit notes.

One person from your tutorial group will be required to post a summary of your discussions in 300 words in the forum for this topic in the course site. **Your Course Coordinator or Course Tutor will inform you when in week 10 this activity is due.**

Case 2: High Court of Trinidad and Tobago, No. 27 of 2000

The defence counsel for Defendant 'B' provided evidence to the court that 'B' was diagnosed with a disassociated disorder. He was medically treated at St. Anns Hospital (a hospital for mental and psychiatric illness) for three months and continues to be an outpatient. He is accused of murdering his wife. He was charged for manslaughter and convicted of manslaughter. The sentence of the court was 15 years with hard labour. At the sentencing hearing the Court (Judge) told the defendant:

"The jury has found you guilty of manslaughter. And during the course of conducting that enquiry, that trial within a trial, I heard two doctors testify as to your mental frame of mind. As far as I am concerned, I am quite aware of your mental state of mind. While it is your right to remain silent, as you did at the trial, there is no evidence before me that I could have put before the jury that you were provoked to do as you did. So that, as I understand it, the conviction was on the basis that you assaulted your wife, which is an unlawful act, and as a result of that, as a direct result of that assault, on your account, accepted by the jury, she struck her head and she died. That is manslaughter in the verdict of the jury.

What transpired afterwards leaves me to believe that you are, contrary to what your attorney has said, a heartless young man, one who has little regard for a human being, as demonstrated by what you did to the body of your deceased wife. You left the body of your wife in the home that you had found her in some 17 hours roughly. At 8 a.m. in the morning, when it is that you admitted committing the unlawful act, you did absolutely nothing to see whether there might have been a chance that you could have saved her. You then went on a mission of seeking to cover up your unlawful act. You waited until 1.00 am on your admission and you dragged the body of your wife into bushes, into an open field, where you placed her in the area of a ravine and there you turned your back on her remains, leaving it to the elements, including what Professor Dr. Chandu Lal (the pathologist) suggest might be animals, including dogs and corbeau and other animals. As a result her head found itself removed from the rest of the body. She was allowed to remain there and putrefy, to decompose, while you went about your legitimate business, telling your landlord that she had gone to Carlsen Field, lying to him. Eventually, some boys came upon her skull and later the police came upon her maggot-infested body. That is the woman who you, as a human being, no doubt shared a bed with as your wife. It shows that you are a callous human being, (with) little regard for even the dead."

Assignment 2:

1. What are associative disorders?
2. Was the behaviour of the defendant documented in case 2 consistent with what is documented in the literature regarding associative disorders?

***LEARNING ACTIVITY 8.1* • Tutorial Discussion Cont'd**

3. What do you regard as suitable punishment for this offender?

You can answer the questions using material from Units 1-8 and your own research including resources available from the Open Campus Library resources. One person from your tutorial group will be required to post a summary of your discussions in 300 words in the forum for this topic in the course site. **Learning activity 8.1 is due by Week 10.**

The Transition from The Supernatural to The Scientific

Historical accounts of abnormal behaviour have been pegged to beliefs in demons, ghosts, evil spirits and supernatural forces. In some societies these beliefs may still prevail but after the 18th Century, the age of reason and enlightenment, society turned to science to explain natural phenomena and human behaviour. The sciences of biology, physics, chemistry and psychology relied on knowledge that was derived from systematic methodologies such as experiments and observation. In today's society the diagnosis of abnormal behaviour relies mainly on clinical criteria rather than on religious experiences or cultural ones. Nevid et al. (2011) noted that the medical and the psychodynamic models prevail in contemporary society. The **medical model** is a biological perspective in which abnormal behaviour is viewed as symptomatic of underlying illness. The **psychodynamic model** of Freud and his followers stated that abnormal behaviour is the product of clashing and competing forces within the personality. This countered the medical model as the proponents of the psychodynamic model contended that organic factors alone could not explain the many forms of abnormal behaviour.

Research Methods in Abnormal Psychology

The transition from supernatural explanations for unusual or abnormal behaviour to scientific, rational and empirically derived explanations was based on the application of **the scientific method.** This was covered in detail in Unit 2. The importance of critical thinking was emphasized. This refers to the adoption of a questioning attitude and careful scrutiny of claims and arguments in light of evidence.

A brief description of the key methods for investigating abnormal psychology is provided as you are already familiar with the research methods utilized by psychologists that were documented in Unit 2. The common methods used by abnormal psychologists include:

1. *Naturalistic observation* – this is used by investigators to carefully observe behaviour under naturally occurring conditions. For example, psychologists can spend weeks observing the behaviour of homeless people in natural environments such as on the streets, bus stations and in homeless shelters. Psychologists who are in search for clues to obesity can observe how obese and slender people eat in fast food restaurants. The key limitation is that observation can provide details of how people behave but not the reasons for the behaviour.
2. *Correlational method* – this explores relationships between variables which may help to predict future behaviour. It is one of the primary methods utilized to investiage

abnormal behaviour. The main limitation is that it can identify associations between variables via statistical manipulation of data but it cannot prove causation as experiments can do.

3. *The longitudinal study* – this is a type of correlational study in which individuals are periodically tested or evaluated over lengthy periods of time, sometimes for decade. Investigating people over time allows psychologists to identify the events in the life of the observed that lead to the development of abnormal behaviour such as a depression or associated disorders.
4. *The experimental method* – this method of investigation is very robust as it allows psychologists to demonstrate causal relationships by manipulating the causal factor (the dependent variables) and measuring the effect or effects on the independent variables under controlled conditions that reduces the risk that other extraneous factors explained the results. For example, scientists might want to examine the effects of the dependent variables (activity levels, eating behaviour, smoking frequency) on how drug treatments (independent variables) affect disorders such as depression or antisocial personality disorder.
5. *Epidemiological studies* – this method of research tracks rates of occurrence of particular disorders among different population groups (e.g. males, females, adults, children, age groups and ethnic groups).
6. *Kinship studies* – this method of study aims to separate the role of heredity (nature) and the environment (nurture) in determining behaviour. The most popular types of kinship studies include research with twins and adoptee studies.
7. *Case studies* –a case study is a carefully drawn biography which provides a detailed and intensive account of a person (in clinical studies) or a firm/organization (in organizational psychology). You would recall Sigmund Freud relied on case studies of his patients to develop his psychoanalytic theory.

Stress, Conflict, Crisis and Coping

Given that normal and abnormal behaviours are to some extent determined by the level of success in which people cope with the stress factors, conflicts and crises in their lives the role of stress, conflict, crisis, and coping in precipitating abnormal behaviour will be discussed. Psychologists are in agreement that people differ in their responses to stress and also in their views or perceptions of what constitutes a stressful event. For example, divorce might be a more stressful life event for women more than men while some men and women may view a divorce with relief rather than with distress. **Stress** has been defined as, "A response to the broad range of demands that result in pain, uncertainty, or change for the living system." (Newman & Newman, 1983, p. 433) Despite this generic definition stress is a highly personalized experience because what is perceived to be a **stressor** to one individual may not be regarded as a stressor for another individual. A stress response also represents the response to the body for any demand; for instance, distress is regarded as threatening, unpleasant and harmful. There are physical responses to stress such as 'butterflies' or other discomfort in the stomach, light perspiration, elevated pulse and heart rate. If the source of the stress is not sufficiently well defined the body may prepare itself to fight or to flee. Contemporary society is filled with stressors including marriage,

divorce, the death of a partner, financial uncertainty, living in a conflicting or challenging relationship and burnout from one's job.

Conflict is one source of stress. It can result from causes inside the person and from the person's interactions with the environment. Examples of conflict from sources external to the person are numerous such as from a tumultuous relationship. Internal conflict can result when a person experiences cognitive dissonance. You would recall from earlier units in this course that cognitive dissonance refers to the psychological tension caused by two discrepant beliefs or a discrepancy between a belief and one's behaviour. Some conflicts arise because a person holds two incompatible motives that require a decision. You would recall the discussion of Freud's psychoanalytic theory outlined in the earlier units of this course. Sigmund Freud was a Viennese psychiatrist who used data from his patients who suffered from mental disorders to develop his theories and concepts. There is some element of conflict in the way in which the tripartite structure of the id, ego and superego functions. Specifically, the role of the ego is to satisfy the id impulses without violating the superego's moral rules of society. The ego is responsible for keeping the three concepts of the personality (id, ego and superego) in balance. According to Freud, "A person experiences tension when any of these three components is in conflict with another." (as cited in Boyd & Bee, 2012, p. 24) Additionally, if the ego has to violate the superego's moral rules to satisfy a need then the ego will generate defense mechanisms or ways of thinking about a situation that reduces anxiety (Boyd & Bee, 2012). You can access more information about *The Id, Ego, and Superego* on mydevelopmentlab.com (Boyd & Bee, 2012, p. 25)

A sense of conflict can cause a person to experience a sensation of being frozen, incapable of action or perhaps a sense of inertia (i.e. disinclination to move or act). There are classic views of conflict tension and conflict resolution which remain pertinent today. For example, Newman and Newman (1983) discussed three types of conflict: (1) **approach-approach conflict**, this is where the two conflicting options are desirable; (2) **avoidance-avoidance conflict**, having to choose between two negatives or the lesser of two evils; and (3) **approach-avoidance conflict,** a person has to choose between either a negative outcome or a positive outcome. To resolve this type of conflict the person has to heighten the positive aspect of the choice and seek to minimize the negative aspects. There are five ways in which people can resolve conflict (Janis & Mann, 1976 as cited in Newman & Newman, 1983, p. 439). First, *unconflicted adherence* –this is where the decision-maker chooses to continue to take a course of action that ignores the risk of losses. Second, *unconflicted change to a new course of action* – the decision maker uncritically adopts whichever a new course of action is most visible or most strongly recommended without examining the negative aspects of the choice. Third, *defensive avoidance* – the decision maker evades the conflict. This may be done by putting things off or shifting responsibility to someone else. Another strategy is to make up explanations that do not reflect reality. Fourth, *hypervigilance* –the decision maker searches frantically for a way out of the dilemma and impulsively seizes upon a solution without fully considering all the consequences. Fifth, *vigilance* –decision makers seek out information and include it in an objective manner. Alternatives are carefully evaluated.

Crisis represents an extreme source of stress. It is an event that brings about change and calls for adaptation on many levels at once. For instance, a person who is diagnosed with a

chronic disease might need to make radical changes to diet and exercise and to be prepared for a lengthy and costly course of medical interventions. Two factors can influence the way in which a crisis may lead to a crisis state: first, the person's interpretation of the crisis event; and second, the ability of the person to effectively cope with the crisis event.

Coping refers to what a person does in an effort to reduce stress or to solve difficult life challenges. (Newman & Newman, 1983, p. 445) Emphasis is on personal resources and competencies that are brought to bear on each challenge. There are two forms of coping: first, direct action which refers to taking steps to alter one's relationship with the source of stress. For example, increasing security in one's home in an effort to mitigate a high crime rate in one's country of residence. The second form of coping relates to palliation or the reducing or softening the impact of the stressor. This can be achieved through efforts to relax or to cognitively re-define the importance of the stressor. The most effective coping strategy involves both direct action and palliation. In light of psychology's focus of inquiry on individual differences in behaviour it is useful to consider that people are likely to differ in how seriously they treat a stressor, how they define the severity of the situation, and in how vulnerable they perceive themselves to be to the stressor. Some individuals may experience anxiety while others may display resilience in the face of adversity. Similar to the concept of emotional regulation discussed in Unit 4 in which persons are individuals can be taught how to express emotions in functional ways, early psychologists developed the concept of **emotional inoculation** which refers to the ability to work through feelings of anxiety or threat in anticipation of a stressful event (Janis, Mahl, Kagan, and Holt, 1969 as cited in Newman & Newman, 1983, p. 447).

Having outlined the relationship between stress, conflict, crisis, anxiety and possible mental illness, one can now appreciate the importance of coping as a factor to be considered when examining the psychology of the person. The connection between coping with a crisis and personal development has three aspects to it according to Newman and Newman (19883). First, the ability to cope with a crisis has important implications for personal development if the person in crisis is motivated to reduce the anxiety-inducing situation and to work towards improvement. Growth and development involves psychological tension as new situations produce uncertainty. Moving out of one's comfort zone is equally fraught with anxiety. Newman and Newman remind us that anxiety is not only a negative experience but it can be a positive one. You may be familiar with the popular expression 'No pain, no gain' suggesting that there can be a benefit to negative experiences and a specific benefit to character building. For example, the ability to successfully cope with anxiety-producing situations often facilitates the learning of new skills and strategies that can be utilized in future situations. A second dimension of how a stress and crisis can lead to growth is outlined by Erik Erikson in his concept of psychosocial crisis. Newman and Newman reminded us of the merits of Erikson's explanation for crisis resolution, "At every life stage, the discrepancy between societal demands and individual competencies produces a restructuring of personality that reflects a psychosocial crisis. Unpredictable crisis events would offer additional challenges at every life stage that might be met with coping efforts." (Newman & Newman, 1983, p. 451) The third and final dimension of coping is related to the fact that the way a person copes with a situation or a crisis could be highly individualized. In other words, coping styles and strategies appear to be a stable element of personality even if the crisis situations vary. For instance, if a person has an avoidance

approach to a crisis or to conflict then whatever the situation that arises some form of avoidance is likely to be the preferred mode for dealing with the event.

The focus of attention now turns to the theories of abnormal psychology; namely, the biological theory, psychological theory, socio-cultural theory and biopsychosocial theory. The critical review of these theories will also shed light on the relationship between stress, conflict, crisis, copying and abnormal behaviour. Abnormal behavior (AB) can reflect mental disorder (MD). Both AB and MD can be caused by biological factors, too much stress, or a product of a behavioural or social learning if the affected person is in an environment that precipitates poor mental health.

LEARNING ACTIVITY 8.2 • Summative Assessment 4

Please read the articles in the e-references cited below.

Thompson, P. (2011, Dec 19). Teenage boy 'whipped, starved and locked in a dog kennel by his mother and stepfather. *The Mail Online.* Retrieved from http://www.dailymail.co.uk/news/article-2076186/Teenage-boy-whipped-starved-locked-dog-kennel-mother-stepfather.html

The Daily Mail Reporter. (2011, Oct 26). Two children found locked in tiny wire dog kennels at mobile home. *The Mail Online.* Retrieved from http://www.dailymail.co.uk/news/article-2053631/Children-locked-wire-dog-kennels-faeces-strewn-mobile-home-stop-escaping-says-mother.html

Seelal, N. (2011, July 20). Boy, 12, locked in kennel with dog. Newsday. Retrieved from http://www.newsday.co.tt/news/0,163563.html

1. In light of the discussion on normal an abnormal behaviour in Unit 8 what comments would you make about the behavior of the 'caregivers' described in the articles? (5 marks, 400 words)
2. What role, if any, did stress play in the behaviours described in the articles? (5 marks, 400 words)
3. From your knowledge of developmental psychology what predictions can you make about the effects of the experiences described on the victims identified in the articles? (5 marks, 400 words)
4. What, in your view, are the psychologically common features of the behaviours described in these articles? You are required to source and cite two relevant peer reviewed published academic articles to assist in your discussions of questions 1-4. (5 marks, 400 words)
5. Oral BBC presentation: 5 marks – 15 minutes presentation time – Your presentation will be judged and marked by your course colleagues and you will have the opportunity to evaluate and to mark their presentation.

LEARNING ACTIVITY 8.2 • Summative Assessment 4 Cont'd

This assignment is worth a maximum of 25 marks and you must not write less than 1600 words. One member of the group must upload a word file, on behalf of the group, to the drop box for assignment 4. You must email your Power Point file for the BBC presentation (15 minutes presentation time) with your response to your e-tutor. Your Course Coordinator/ Course Tutor will inform you of the deadline date. Your score will contribute to your final course mark. Further rubrics for this assignment will also be posted in the Learning Exchange and distributed by your e-tutor. You will have the opportunity to contribute to the marking process. Because this is a group presentation, all members of the group will receive the same mark. **Please report any occurrence of social loafing in your group to your e-tutor** who will then intervene to resolve the issue.

Theories of abnormal psychology

You are encouraged to explore the theories of abnormal psychology using the link of the American Psychology Association (APA) http://www.apa.org/topics/index.aspx. A short critical review of these theories is presented below.

1. Biological

The biological perspective of abnormal psychology emerged in the 19th Century as a scientific counter response to the supernatural explanations previously offered for abnormal behaviour. The German physican Wilhelm Griesinger (1817-1868) claimed that abnormal behaviour was rooted in diseases of the brain. Similarly, Emil Kraepelin (1956-1926) linked mental disorders to physical diseases. The ideas of Griesinger and Kraepelin formed the genesis of the modern day **medical model** a biological perspective in which abnormal behaviour is viewed as symptomatic of underlying illness. Specifically, explanations of abnormal behaviour are pegged to underlying biological defects or abnormalities. However, it should be noted that not all proponents of the medical model believe that every mental disorder is a product of defective biology but they maintain that it is useful to classify patterns of mental disorder and abnormal behaviour according to their distinctive features and symptoms. According to the medical model, people behaving abnormally suffer from mental illnesses or disorders that can be classified, like physical illnesses, according to their distinctive causes and symptoms. There still remains a subtle difference between the medical model and the biological theory because one can speak of the biological theory without adhering to all of the premises of the medical model. Nevid et al. (2011) gave the example of shyness which may have a strong genetic or biological component but it would not be considered a symptom of a disorder or illness.

Kraepelin specified two main groups of mental disorders or diseases; the first is **dementia praecox** which translates to 'precocious or premature insanity' and is popularly called **schizophrenia.** This was believed to be caused by a bio-chemical imbalance. The second group of mental disorder is called manic-depressive psychosis which has been relabeled to *bipolar disorder.* This is believed to be caused by an abnormality in *body metabolism.*

Explanations that rely on biological theories to explain abnormal behaviour include linking depression to chemical imbalances in the brain involving irregularities in the functioning of neurotransmitters, especially serotonin which is a key brain chemical that regulates moods. "Two of the most widely used anti-depressant drugs – Prozac and Zoloft –belong to a class of drugs that increase the availability of serotonin in the brain." (Nevid et al., 2011, p. 38)

Kraepelin's major contribution to the discipline of abnormal psychology was the development of a classification system that forms the basis of current diagnostic systems. Much of the terminology used in abnormal psychology has been 'medicalized' according to Nevid et al. (2011) to the extent that people who display abnormal behavior are commonly referred to in society as being mentally ill. One of the limitations of the medical model is that there is a tendency to refer to the symptoms of abnormal behaviour rather to the features or characteristics of abnormal behaviour. Another limitation is that treatments are restricted to genetic and biochemical options, such as drug therapy, to treat disorders. A third limitation is that although disorders such as Alzheimer's disease have a direct causative link to biological forces the causes of most other disorders reflect an interaction between biological and environmental factors. You can gain detailed knowledge of dementia and Alzheimer if you watch the video *Alzheimer and Dementia* on mydevelopmentlab.com (Boyd & Bee, 2012, p. 446).

2. Psychological

Scientists who espoused the view that organic factors were not exclusively responsible for abnormal behaviour included the neurologist Jean-Martin Charcot (1825-1893). Charcot experimented with the use of hypnosis to treat **hysteria**, a condition characterized by paralysis or numbness that cannot be explained by any underlying physical cause. Freud (1856-1939) supported the ideas of his predecessor Charcot and proposed that if hysterical systems can be removed by mere suggestion via hypnosis then the underlying cause of hysteria was psychological rather than biological. The Freudian view states that abnormal behaviour patterns represent 'symptoms' of these dynamic struggles taking place within the unconscious mind. Within this model the explanation for hysteria revolves around the conversion of an unconscious psychological conflict into a physical problem. It is assumed that the patient is aware of the symptom but not the unconscious conflict that lies at its root.

The causative factors of abnormal behaviour were believed to be outside the awareness of conscious awareness and linked to unconscious motives and conflicts. This insight formed the basis of the first psychological perspective on abnormal behaviour that was labeled the **psychodynamic model.** This model was built using the conceptual framework of the id, the ego, the superego, defence mechanisms, the stages of psychosexual development which were discussed in earlier units in this course. Other psychodynamic theorists who shared the view that behaviour reflects unconscious motivation, inner conflict and a defence response to anxiety are Carl Jung (1875-1961); Alfred Adler (1870-1937); Karen Horney (1885-1952); Erik Erikson (1902-1994); and Margaret Mahler (1897-1985). Broadly speaking, the psychodynamic views on normality, abnormality and psychological disorders state that there is an imbalance in the psychic structures of people who manifest disorders. Hence unconscious impulses may 'leak' or produce anxiety which in turn can

deteriorate leading to hysteria or phobias. One of the major criticisms of Freud's pure psychodynamic model is his view of childhood sexuality as outlined in his model of psychosexual stages of development outlined in Unit 7. Detractors of the psychodynamic model are uncomfortable with Freud's view of children. Most persons generally perceived children to be innocent and free of sexual desire. Other criticisms of psychoanalytic theory were documented in Unit 7.

As you are aware from the discussion in the earlier units of this course the psychological group of theories extend beyond Freud's psychoanalytic theory and the psychodynamic model and it includes socio-cognitive theory, learning theory, cognitive theory, and humanistic theory. It is relevant to mention the perspectives of each these theories of abnormal psychology and abnormal behaviour. The *social-cognitive theorists* include Albert Bandura (1925 to the present time), Julian Rotter (1916 to the present time), and Walter Mischel (1930 to the present time). Within this perspective a fear or phobia of snakes – referred to as ophidiophobia – can occur through learning either by observing the fearful reactions of others in real life, on television, or in movies to snakes or perhaps via a personal experience such as being bitten by a snake or being close to one. If you would like to know more about ophidiophobia please click on the link at http://phobias.about.com/od/phobiaslist/a/ophidiophobia.htm

The learning or the behavioural approach also offers a model of therapy for people to change their behaviour so that persons with phobias can be assisted to overcome them. Social cognitive theories explain that factors within a person are responsible for certain behaviors. For example, people who have positive expectations of taking illegal drugs (e.g. blocking out problems and producing 'the high' that is associated with euphoria) are more likely to abuse drugs that persons who have less positive expectations of drug use. *Humanistic* theories emerged around the mid 20th Century and they were made popular by Carl Rogers (1902-1987) and Abraham Maslow (1908-1970). You would recall from the earlier units in this course that humanistic psychology focuses on people's need to self actualize, to reach the full potential and "to strive to become all they are capable of being." (Nevid et al., 2011, p. 54) Within this framework abnormal behaviour is believed to occur because of the roadblocks that people encounter in striving for self-actualization and authenticity. You would remember that humanistic psychology also flags the importance and relevance of subjective experiences of the self. Hence the ways in which people deal with the roadblocks in their life, either in self-enhancing or self-defeating ways, would to some extent predict and explain normal or abnormal behavioural patterns. The humanist Rogers felt that abnormal behaviour resulted from a distorted concept of self. He also suggested that parents have a significant role to play in developing the sense of self, self-concept and self-esteem in their children When parents show their children **unconditional positive regard**, in effect they prize them and show them that they are worthy of love and praise irrespective of their behaviour at any given time. This contrasts with **conditional positive regard** which means accepting other people only when they behave in the positive way that is expected. According to Nevid et al. Rogers felt that the pathway to self-actualization involves a process of self-discovery and self-acceptance, of getting in touch with our true feelings, accepting them as our own, and acting in ways that genuinely reflect. These are the goals of Roger's method of psychotherapy, called *client-centered therapy* or *person-centered therapy.*

The work cognitive was derived from the Latin word cognitio which means knowledge. The earlier units stated that cognitive theory examine the cognitions – the thoughts, beliefs, expectations and attitudes –that underlie or are manifested with abnormal behaviour. The emphasis is on how our sense of reality, our biases and other ways in which we process information, or sense of place in the world collectively contribute to abnormal behaviour. The key point in the cognitive model is that it is the interpretation of the events in our lives, and not the actual events themselves, that distinguish abnormal from normal behaviour. Prominent cognitive theorists who are associated with abnormal psychology include Albert Ellis and Aaron Beck. Ellis believed that negative emotions arise from the judgments we make about the events we experience, not from the events themselves. Beck focused on how errors in thinking, or cognitive distortions, set the stage for negative emotional reactions in the face of unfortunate events. The cognitive approach has influenced many therapeutic approaches; for example, the cognitive-behavioural therapy (CBT) – a form of therapy that focuses on modifying self-defeating beliefs as well as overt behaviors.

3. Sociocultural

This model considers the broader social context that is at the root of abnormal behaviour. The failure of society, rather than the failure of the person, is assumed to be the causative agent for abnormal behaviour. Stressors associated with the failures in society include unemployment, poverty, break down in family life, injustice and ageing. Sociocultural factors flag the relationship between mental health and social factors such as gender, social class, age, ethnicity and lifestyle. An example is the problem of depression. Boyd and Bee (2012) suggested that older adults are at a higher risk for this disorder than any other age group. For a more comprehensive discussion of depression in late adulthood watch the video *Depression in Later Life* on mydevelopmentlab.com (Boyd & Bee, 2012, p. 448).

The sociocultural perspective also raised the very important issue of the stigmatization of persons with mental illness who appear to carry the label for life as it is difficult to remove. "It also distorts other people's responses to the 'patient'. Mental patients are stigmatized and marginalized. Job opportunities may disappear, friendships may dissolve, and the 'patient' may feel increasingly alienated from society." (Nevid et al., 2011, p. 18) Radical psycho-social theorists such as Thomas Szasz denied the existence of psychological disorders or mental illness arguing instead that the concept 'abnormal' is merely a label society attaches to people whose behaviour deviates from accepted social norms. The label is used to stigmatize social deviants.

Similar to the sociocultural approach is the **social causation model** which predicts that people from the lower socio-economic strata of society are at greater risk of developing severe behaviour problems because living in poverty subjects them to a greater level of social stress, than those in better economic circumstances. (e.g. Costello et al., 2003 as cited in Nevid et al., 2011, p. 60) Another view that is pegged to socio-cultural theory and one that relates severe behavioral problems to a low socio-economic status is the **downward drift hypothesis.** This hypothesis noted that problem behaviours, such as alcoholism, lead alcoholics to drift downwards in social status. Socio-cultural theories focused on much needed attention on the social stressors that may lead to abnormal behaviour. This view also considers how issues relating to race, culture, and ethnicity affect the therapeutic

process.

4. Biopsychosocial

This theoretical model reflects the belief that abnormal behaviour is too complex to be explained by any of the three preceding theories so a combination of approaches is ideal. The biopsychological model, also known as the interactionist model, takes a broader view than the previously discussed models by considering the interaction of biological, psychological and sociocultural factors in the development of psychological disorders. Although one may not expect to fully understand all the factors that actually lead to abnormal behaviour, the biosocial psychological approach to understanding abnormal behaviour has the advantage of actually considering all possible pathways, factors, influences and interactions. Hence some disorders that are primarily biological may be influenced by psychological factors. Phobias can be the result of learned behaviour as previously discussed in relation to ophidiophobia. Nevid et al. (2011) claimed that some people may inherit certain traits that make them susceptible to the development of acquired or conditioned phobias. The main point to remember from this subsection is that one of the leading examples of the biopsychosocial model labeled the **diathesis-stress model** proposes that psychological disorders arise from the interaction of vulnerable factors (primarily biological in nature) with stressful life experiences. This model has recently been applied to depression, and attention-deficit hyerpactivity disorder (ADHD). This multipronged approach also influences the treatment of mental disorders.

This session was comprehensive because it provided the theoretical foundation for the applied approach that will be the focus of Session 8.2. The main points relate to the criteria for the distinction between normal and abnormal behaviour; the role of stress, conflict, crisis and coping in either improving or impairing mental wellbeing; and four main perspectives or theories on abnormal behaviour. These perspectives are summarized in Table 8.1.

Review and Reflect

Review

Approach	Model	Model Focus	Key Questions
Biological Perspective	Medical Model	Biological underpinnings of abnormal behaviour.	What role is played by neurotransmitters in abnormal behaviour? By genetics? By brain abnormalities?
Psychological Perspective	Psychodynamic Model	Unconscious conflicts and motives underlying abnormal behaviour.	How do particular symptoms represent or symbolize unconscious conflicts? What are the childhood roots of a person's problem?

	Learning Model	Learning experiences that shape the development of abnormal behaviour	How are abnormal patterns of behaviour learned? What role does the environment play in explaining abnormal behavior
	Humanistic Model	Roadblocks that hinder self-awareness and self-acceptance.	How do a person's emotional problems reflect a distorted self-image? What roadblocks did the person encounter in the path toward self-acceptance and self-realization?
	Cognitive Model	Faulty thinking underlying abnormal behaviour	What styles of thinking characterize people with particular types of psychological disorders? What role do personal beliefs, thoughts and ways of interpreting events play in the development of abnormal behaviour patterns?
Sociocultural Perspective		Social ills, such as poverty, racism, and prolonged unemployment, contributing to the development of abnormal behaviour; relationships between abnormal behavior and ethnicity, gender, culture, and socioeconomic level	What relationships exist between social class status and risks of psychological disorders? Are there gender or ethic group differences in various disorders? How are these explained? What are the effects of stigmatization of people who are labeled mentally ill?

Biopsychosocial Perspective		Interactions of biological, psychological, and sociocultural factors in the development of abnormal behaviour	How might genetic or other factors predispose individuals to psychological disorders in the face of life stress? How do biological, psychological, and sociocultural factors interact in the development of complex patterns of abnormal behavior?

Table 8.1: Perspectives on Abnormal Behaviour (adapted from Nevid, Rathus & Greene, 2011, p. 62)

Reflect

SELF-ASSESSMENT EXCERISE

What response would you give to the following questions or statements?

1. What is a phobia?.....
2. What is a crisis? .....
3. How does coping reflect emotional development?.....
4. With which abnormal psychological perspective was Emil Kraepelin associated?
   .....
5. Define unconditioned positive regard.....
6. Define hierarchy of needs.....
7. What do you understand by the term downward drift hypothesis?.....
8. State two characteristics of the biological perspective.....
9. What is the medical model?.....
10. Name two research methods utilized by abnormal psychologist to collect data.

Key Points

1. Abnormal psychology is a term that is usually reserved for the behaviour of people who have either or both of two characteristics: (1) they have difficulty functioning effectively or (2) they experience intensely unpleasant emotions.
2. The criteria for assessing abnormality are based on unusualness, social deviance, significant personal distress, maladaptive or self-defeating behaviour, as well as dangerousness.

Key Points

3. Historical accounts of abnormal behaviour based on demons, ghosts, evil spirits and supernatural forces turned to scientific explanation of behaviour during the18th Century.
4. Research methods utilised in the study of abnormal psychology include naturalistic observation, correlational method, longitudinal study, experimental method, epidemiological studies, kinship studies and case studies.
5. Stress defined as a response to the broad range of demands that result in pain, uncertainty, or change for the living system is a highly personalized experience because what is perceived to be a stressor to one individual is not a stressor for another individual
6. Two main groups of mental disorders or diseases were identified dementia praecox which translates to 'precocious or premature insanity' and manic-depressive psychosis.
7. Four perspectives on abnormal behaviour were critical reviewed: biological; psychological, sociocultural, and biopsychosocial.

Session 8.1 Summary

In Session 8.1 the discussion began by defining abnormal psychology and by distinguishing between abnormal and normal psychology. A key learning objective of Unit 8 was to provide a scientific understanding of abnormal psychology which in turn would enable learners to enable young people and adults to become active and responsible citizens and also to plan and implement programmes to promote healthy lifestyles among youths. This was achieved by illuminating the relationship between stress, crisis, conflict and coping and by critically reviewing the four perspectives on abnormal behavior which was summarized in Table 8.1. Collectively, the information presented paves the way for understanding abnormal psychology in a Caribbean context and for detailing the cultural sensitivities in assessment and treatment.

Session 8.2

Cultural Issues and differences in understanding abnormal behaviour

Introduction

In Session 8.1 socio-cultural theory was offered as an explanation for understanding abnormal behaviour. You would recall that social ills, such as poverty, were believed to be a contributing factor to the development of abnormal behaviour. An example of the nature of the research question that this theory would inform would be, "What are the effects of stigmatization of people who are labeled mentally ill?" This issue is illustrated in the article by the Trinidadian social psychologist, Professor Ramesh Deosaran, titled *Being Human with Community Mental Health* to be discussed below. It is equally important to consider how knowledge of abnormal psychology can be used to improve the quality of life of citizens. By the end of this session learners would be in a better positioned to help young people and youths to plan and to implement programs (competency YDWCYP0323) and to promote healthy lifestyles (competency YDWCYP0513). Activity 8.3 is designed to introduce you to cultural abnormal psychology.

Session 8.2 Objectives

By the end of this session learners would be able to:

1. Explain in the unit activities why it is important to consider cultural sensitivities when discussing abnormal psychology and abnormal behaviour.
2. Discuss in tutorials the key points in the multi media presentation on cultural abnormal psychology cited in the unit.
3. Identify from the session notes the link between mental wellbeing and the regional concern with street dwelling.
4. Document in the unit activities how culture impacts upon the design and evaluation of polices and interventions required to address abnormal behaviour.

LEARNING ACTIVITY 8.3 • Tutorial Discussion

Please view the YouTube presentation cited below.

Veras, C. (2010, Nov 30). Abnormal Culture & Abnormal Behaviour. [Video file]. Retrieved from http://www.youtube.com/watch?v=9m_0QOHqp-Q

After viewing the video consider other examples of the interface between culture and abnormal psychology in your country of residence.

Now read the Powerpoint notes on Chapter 11 'Culture and Abnormal Psychology' available at the hyperlink http://www.perser.org/031450/PPT/Chapter%2011%20Abnormal%20PSY.pdf

How does knowledge of the influence of culture assist you in (1) understanding the term abnormal behaviour, (2) diagnosing abnormal behaviour and (3) designing and /or evaluating relevant policies and interventions to address abnormal behaviour?

Your tutor will assign one person from the tutorial group to prepare a 300 word summary of the discussion and to post the answers to the following questions in the Learning Exchange. In this way you will be contributing to the on-line community of enquiry. **Learning activity 8.3 is due by Week 10**

Understanding Abnormal Behaviour in a Caribbean Context

There is growing empirical evidence that the biopsychosocial perspective on abnormal behaviour informs research questions, studies and policy formulation more than the medical model. In their presentation on preventative healthcare Baron, Branscombe and Bryne (2009) noted that exposure to organisms that cause disease plays a role in ill-health, but so do health-related attitudes, beliefs and the kind of lifestyle that we adopt. One's lifestyle has the potential to either discourage excellent health or to promote it, adding years to our lifespan. The author Wolfgang Strobe (2000) elaborated upon the relationship between psychology and health in more detail in his e-book titled *Social Psychology and Health.* He considered major topics of health psychology from a social psychological perspective. This approach reflects the significant changes that have taken place in conceptions of health and illness during recent decades and the move away from purely biomedical models of illness. In line with this broadening perspective, health psychology has become a dominant force in the health sciences, a field to which social psychological theories and empirical research evidence have much to offer. Strobe addressed two major factors detrimental to health and well-being; namely, health-impairing behaviours and stressful life events, and argues for an integrative approach that combines psychological, economic and environmental interventions to reduce behavioural risk factors. Strobe's discussion focused on obesity, sexual-risk behaviour and preventative health care

The points raised by Baron et al. (2009) as well as Strobe (2000) are illustrated in the Jamaican survey undertaken by Hutchinson, Simeon, Bain and Wyatt (2004) *Social and Health Determinants of well being and life satisfaction in Jamaica*. This major study sought the views of 2580 respondents in Jamaica. The researchers relied on interviews as part of

their sexual decision-making survey to effectively measure the attitudes of persons 15 to 50 years in their sample of Jamaican citizens. The study's aims, objectives and findings depict perfectly the relationship between social psychology and health. The authors wrote, "Psychological well being and the degree of satisfaction with life are likely to affect a range of social behaviours and determine uptake of health and social services." (Hutchinson, Simeon, Bain & Wyatt, 2004, p.1) In their literature review Hutchison et al. summarized some of the empirical evidence that confirmed a direct link between social psychology and health and the authors also highlighted the implications for national policy. These are listed below along with the source of their information.

1. An appreciation of the psychological well being of individuals is now considered fundamental to the understanding of individual and group behaviour (Shen & Lai, 1998).
2. Health and psychological well being are intimately related and also impact on socio-economic indicators such as employment since depression and the resultant low level of psychological well being has been shown to decrease the chances of obtaining and maintaining employment (Alexandre & French, 2001).
3. Keyes (1998) described the concept of social well being as an achievement facilitated by educational attainment and age, but also affected by social integration and acceptance.
4. In terms of public health and social policy, it is important to pay attention to people's perceptions of their own health, partly because of the interactions between social relationships and physical and mental health. These interactions are even more significant when one considers how well being and satisfaction with life are inextricably linked to social and economic factors. Health policy therefore has to be seen in the framework of social and economic development (Steptoe & Wardle, 2001).

Hutchinson et al. reported first, that their empirical evidence confirmed a direct link between psychology and health; second, they highlighted the implications for national policy; third, women had lower levels of psychological well being and satisfaction with life; and fourth, their overall conclusion was that health variables were more important for psychological well being while social circumstances were more significant for satisfaction with life.

Cultural Sensitivities in Mental Health Assessment and Treatment: Application to Street Dwellers

The following newspaper articles suggest a connection between the street dwellers in our society and a range of mental health problems, some of which are very severe and require permanent treatment so that the homeless in our midst do not pose a danger either to themselves or to others in the community. However, dealing with this mushrooming Caribbean problem is a challenge as the case has been made that 'vagrants' or street dwellers have human rights which prevent them from being forcibly removed from the streets. You do not need to read all of the articles cited in Activity 8.4 as reading one or two of them would give you a general idea of the problem and allow you to answer the questions contained in Activity 8.4.

LEARNING ACTIVITY 8.4 • Tutorial Discussion

Formulate a plan to rehabilitate the homeless/street dwellers in your country of residence using the articles listed below, your exploration of the evidence using UWI*linC* and your local knowledge of the situation. Y**our plan will be used for discussion in the BBC session in Week 11.**

5. Allaham, A. (2010, Nov 28). …Anti-vagrancy plan 'cruel and inhumane' *Trinidad Express.* Retrieved from http://www.trinidadexpress.com/news/___Anti-vagrancy_plan__cruel_and_inhumane_-110950024.html
6. Baboolal, Y. (2013, Nov 3). Street dwellers still posing threat to road users. *Trinidad Guardian*. Retrieved from http://guardian.co.tt/news/2013-05-04/street-dwellers-still-posing-threat-road-users
7. Editorial. (2013, Dec 23). That home for the destitute. *Kaieteur News Online*. Retrieved from http://www.kaieteurnewsonline.com/2013/12/23/that-home-for-the-destitute-2/
8. Author unknown. (2012, Aug 31). Strategies in place to address homelessness. *Caribbean Analysis*. Retrieved from http://www.caribbeananalysis.com/strategies-in-place-to-address-homelessness/

Having read the above cited articles you will undoubtedly have your own impressions about the discussion topic "being human with community mental health". The recommended e-articles collectively, clearly demonstrate the dilemmas health care professional and political administrators face when dealing the issue of vagrancy. For example, one writer, Allaham (Nov 28, 2010) in the Trinidad Express newspaper stated below,

> *"CRUEL" and "inhumane" are the words being used by psychiatrists to describe the attempts by Port of Spain Mayor Louis Lee Sing to remove street dwellers from the city.*
>
> *The remarks were made by president of the Association of Psychiatrists of Trinidad and Tobago (APTT), Dr Hazel Othello, during the Tenth International Conference in Psychiatry at the Crowne Plaza Hotel in Port of Spain yesterday. Entitled "Mental Health Services - The Way Forward", the conference sought to address the ills faced by mental health practitioners in Trinidad and Tobago and across the region when it comes to treating those affected.*
>
> *Speaking at the event, Othello said society believes that once anyone is presumed to have a mental illness they should be locked away.*
>
> *"We have seen over the past months the reinstitution of a most cruel and inhumane approach to the task of ridding our public spaces of homeless persons," Othello said.*
> *"As a result, several persons who have never suffered from a mental illness and several persons with mental disorders who were at the time stable on treatment have been rounded up, taken to court, charged with loitering and involuntarily admitted via court order to the psychiatric hospital."*

Let us now consider the main points of what the Trinidadian social psychologist, Professor Ramesh Deosaran, had to say about 'being human with community mental health' in 1992 and assess to what extent his observations are relevant to our contemporary challenges. Remember that these comments largely reflect biopsychosocial perspective on abnormal behaviour.

1. The plans for improving mental health depend a lot on community acceptance. The issues surrounding mental health programming include attitudes held by both public and the professionals themselves. Deosaran also noted that the practice of seeking help from the church to assist in the rehabilitation of the mentally is highly predominant (Deosaran, 1992, p. 109).
2. There is an urgent need for more positive attitudes towards mental illness and the necessity for relatives of the mentally ill to co-operate in rehabilitation programs.
3. The preventative aspects of psychiatry should receive emphasis especially in the matter of stable family environments and good child rearing practices.

Deosaran sought to explain and address the problems of mental health within a social psychological framework. The main point is that social psychology inquires into the social nature of man and his interrelationships with the environment. Relevant social psychological questions about mental health and community programmes include: How does the social system (family or hospital) collide with, modify, or challenge personality predispositions of the mentally ill or the homeless person? How do those in need of community care adapt to, or accept, new social programs such as a community outreach programme? Freeman and Giovannani (1968) as cited by Deosaran (1992:113) stated:

> *"Where the dependent variable constitutes some measure of mental health, to be considered as a social-psychological variable the definition of health must have some social-psychological content; a characteristics of interaction, for example, or a measure of role performance or a measure of the social personality or attitudes of the given individual. … With few exceptions, most social psychologists would agree that measures reflecting social interactionism, the performance or role, or values of attitudes fall within their domain."*

The purpose of Session 8.2 was to place the theories of abnormal behaviour identified and critically reviewed in Session 8.1 into an applied context and to explain how knowledge of psychology can be utilized to empower people to become motivated, active, responsible and functional citizens. Moreover, the material presented in this session demonstrated how theories and empirical findings can be utilized to explain, prevent and possible resolve the region's psycho-social challenges and transform risky behaviour – such as sexual behaviours, crime, substance abuse, homelessness – to risk adverse ones.

Reflect and Review

Reflect

To help you to think critically about the potential for abnormal psychology to explain both normal and abnormal behaviour and to inform policy creating and evaluation critically think about the following questions.

- ◊ Give an example either from your own behaviour or from others in your society that illustrates what you know about the socio-cultural perspective.
- ◊ Why is it necessary to consider multiple perspectives in explaining abnormal behaviour?
- ◊ How can the interactionist approach be used to inform national policies on physical and mental well being?

◊ What are the two views on the influence of culture on psychopathology identified in the reading on Culture and Abnormal Psychology?

Review

Key Points

1. Baron, Branscombe and Bryne (2009) claimed that exposure to organisms that cause disease plays a role in ill-health. Equally important are health-related attitudes, beliefs and the kind of lifestyle that individuals choose to adopt.
2. The conceptions of health and illness during recent decades moved away from purely biomedical models of illness. Precedence is now given to the socio-cultural and the biopsychosocial perspectives.
3. There are universalities in the underlying psychological mechanisms and subjective experiences of many psychological disorders. Culture plays a role in behavioral manifestations of abnormal behavior. For example, the universal symptoms of schizophrenia include lack of insight, auditory and verbal hallucinations, and ideas of reference. Cross-cultural differences occur in the domains of rate of recovery and in the manifestations or the expressions of symptoms.
4. Using emic (culture-specific) approaches, several culture-specific disorders have been identified. For example, Sinbyong in Korea; Amok in Malaysia, Philippines, and Thailand and Anorexia nervosa in the West (now spreading to other countries).
5. The plans for improving mental health depend a lot on community acceptance. The issues surrounding mental health programming include attitudes held by both public and the professionals themselves

Unit Summary

Unit 8 focussed on contemporary perspectives on abnormal psychology and abnormal behaviour. In Session 8.1 the discussion began by defining the scope and content of abnormal psychology. You would recall that the working definition cited in this unit defined abnormal psychology as the branch of psychology that deals with the description, causes, and treatment of abnormal behaviour patterns. Given that the distinction between normal and abnormal behaviour can be colored by cultural norms and values psychologists identified a check list for abnormality. This list included reality testing, the ability to have meaningful relationships, as well as the ability to control one's emotions and behaviour. The check list also included actions that related to unusualness, social deviance, significant personal distress, maladaptive or self-defeating behaviour, as well as dangerousness. The discussion included examination of the research methods that are commonly utilised in the study of abnormal psychology. These include naturalistic observation, correlational method, longitudinal study, experimental method, epidemiological studies, kinship studies and case studies. Four perspectives on abnormal behaviour namely, biological, psychological, socio-cultural and biopsychsocial were critically reviewed and summarized in Table 8.1. Throughout Unit 8 the approach taken was to link theory and practice. Hence, the theoretical perspectives in Session 8.1 were linked to contemporary issues such as risky sexual practices, community approach to mental health and to the issue of street

dwellers, a proportion of whom are mentally ill, in Session 8.2. A multi media approach using YouTube videos, mydevelopmentlab.com activities and readings from electronic resources were incorporated in the unit. Collectively, these extra resources demonstrate abnormal psychology in action. A multi-media approach to course delivery served to bring the text material to life and it helped you to understand as well as to remember the key points and concepts in the unit. You are also better able to relate the key points and concepts identified, explored and mentioned in the two sessions to real world situations.

A key learning objective of Unit 8 was to provide a scientific understanding of the topics of abnormal psychology and abnormal behaviour which form the structural framework for the discussion in Unit 9 titled *Classification and Assessment of Abnormal Behaviour* and Unit 10 titled *Abnormal Behaviour: Approaches to Treatment and Therapy.* You now have an enhanced awareness of the support systems and interventions that will be required to empower citizens and to transform risky behaviour and attitudes to risk adverse ones.

Key Points

1. Four abnormal psychological theories were discussed: biological, psychological (including psychodynamic, learning, humanistic, and cognitive), socio-cultural and biopsychosocial.
2. A checklist of eight criteria can be used to distinguish between normal and abnormal behaviour: reality testing, the ability to have meaningful relationships, the ability to control one's emotions and behaviour, actions that related to unusualness, social deviance, significant personal distress, maladaptive or self-defeating behaviour, as well as dangerousness.
3. Two main groups of mental disorders or diseases were identified by Kraepelin: the first is dementia praecox which translates to 'precocious or premature insanity' and is popularly called schizophrenia. The second group of mental disorder is called manic-depressive psychosis which has been relabeled to bipolar disorder.
4. Research methods utilised in the study of abnormal psychology include naturalistic observation, correlational method, longitudinal study, experimental method, epidemiological studies, kinship studies and case studies
5. There is growing empirical evidence that the biopsychosocial perspective on abnormal behaviour informs research questions, studies and policy formulation more than the medical model.
6. Policies, strategies and interventions to facilitate mental health and wellbeing should be multi-pronged and incorporate the role of the family, the community, the social, health and welfare systems.
7. Given the evidence that genetic and social factors can predispose an adult or child to displaying abnormal behaviour, punishment is not a suitable form of treatment to minimize or eliminate abnormal behaviour.

References

Aharoni, E., Sinnott-Armstrong, W. & Kiehl, K.A. (2012). Can psychopathic offenders discern moral wrongs? A new look at the moral/conventional distinction. *Journal of Abnormal Psychology*, 121 (2), 484–497.

Allaham, A. (2010, Nov 28). …Anti-vagrancy plan 'cruel and inhumane' *Trinidad Express.* Retrieved from http://www.trinidadexpress.com/news/___Anti-vagrancy_plan__cruel_and_inhumane_-110950024.html

Alzheimer and Dementia on mydevelopmentlab.com (Boyd & Bee, 2012, p. 446).

American Psychology Association (APA) http://www.apa.org/topics/index.aspx

Author unknown. (2012, Aug 31). Strategies in place to address homelessness. *Caribbean Analysis*. Retrieved from http://www.caribbeananalysis.com/strategies-in-place-to-address-homelessness/

Author unknown (n. d.). Chapter 11: Culture and Abnormal Psychology [PowerPoint slides]. Retrieved from http://www.perser.org/031450/PPT/Chapter%2011%20Abnormal%20PSY.pdf

Baboolal, Y. (2013, Nov 3). Street dwellers still posing threat to road users. *Trinidad Guardian*. Retrieved from http://guardian.co.tt/news/2013-05-04/street-dwellers-still-posing-threat-road-users

Barker, E.D., Trentacosta, C.T. & Salekin, R.T. (2011). Are impulsive adolescents differentially influenced by the good and bad of neighborhood and family? *Journal of Abnormal Psychology*, 120 (4), 981–986.

Baron, R.A, Branscombe, N.R & Bryne, D. (2009). Social Psychology, 12 (Ed.) Boston M.A.: Pearson Education, Inc.

Boyd, D. & Bee, H. (2012) *Life-span Development*, Pearson Education, Inc.

Carlson, N. (1990). Psychology. (3rd Ed.) M.A.: Allyn and Bacon.

Deosaran, R. (1992). Social Psychology in the Caribbean: Directions for Theory and Research. Essays in the psychology of political power, law, education, race and culture, mental health and youth. Trinidad: Longman Publishing Company.

Depression in Later Life on mydevelopmentlab.com (Boyd & Bee, 2012, p. 448).

Editorial. (2013, Dec 23). That home for the destitute. *Kaieteur News Online*. Retrieved from http://www.kaieteurnewsonline.com/2013/12/23/that-home-for-the-destitute-2/

Goleman, D. (1998). Working with Emotional Intelligence. New York, USA: Bantam Books.

Hood, R. & Seemungal, F. (2006). A Rare and Arbitrary Fate: Conviction for Murder, the Mandatory Death Penalty and the Reality of Homicide in Trinidad and Tobago, Centre for Criminology: Oxford University. http://www.deathpenaltyproject.org/content_pages/26

Hutchinson, G., Simeon, D. T., Bain, B.C., & Wyatt, G.E. (2004). Social and health determinants of well being and life satisfaction in Jamaica, *The International Journal of Social Psychiatry*, 50 (1). 43-53. http://isp.sagepub.com/content/50/1/43.full.pdf+html (Unit 2 reading folder)

Johnson, P.B. & Malow-Iroff. (2008). Adolescents and Risk: Making Sense of Adolescent Psychology, CT USA: Praeger Publishers

Life Works Group. (2013, Oct 7). Normal vs Abnormal Personality. [Video file]. Retrieved from http://www.youtube.com/watch?v=anu29BpVIFc

Nevid, .J.S., Rathus, S.A., & Greene, B. (2011). Abnormal Psychology in a Changing World (8th Ed.) Upper Saddle River, N.J.: Pearson Education, Inc.

Newman, P.R. & Newman, B.M. (1983). Principles of Psychology. Illinois: The Dorsey Press.

Prenoveau, J.M, Craske, M.G., Zinbarg, R.E., Mineka, S., Rose, R.D., & Griffith, J.W. (2011). Are anxiety and depression just as stable as personality during late adolescence? Results from a three-year longitudinal latent variable study. *Journal of Abnormal Psychology*, 120 (4), 832–843.

Quinn, P. D. & Harden, P. K. (2013). Behind the wheel and on the map: Genetic and environmental associations between drunk driving and other externalizing behaviours. *Journal of Abnormal Psychology*, 122(4), 1166–1174.

Santrock, J. W. (2008). Life-Span Development. (11th Ed.) New York: McGraw- Hill

Seelal, N. (2011, July 20). Boy, 12, locked in kennel with dog. Newsday. Retrieved from http://www.newsday.co.tt/news/0,163563.html

Strobe, W. (2000). Social Psychology and Health. (2nd Ed.) Buckingham: Open University Press. Retrieved from http://www.mcgrawhill.co.uk/openup/chapters/0335199216.pdf

The Curious Classroom. (2013, May 29). Defining abnormality. [Video file]. Retrieved from http://www.youtube.com/watch?v=cwKJ0juPIrQ

The Daily Mail Reporter. (2011, Oct 26). Two children found locked in tiny wire dog kennels at mobile home. *The Mail Online.* Retrieved from http://www.dailymail.co.uk/news/article-2053631/Children-locked-wire-dog-kennels-faeces-strewn-mobile-home-stop-escaping-says-mother.html

The Id, Ego, and Superego on mydevelopmentlab.com(Boyd & Bee, 2012, p. 25)

Thompson, P. (2011, Dec 19). Teenage boy 'whipped, starved and locked in a dog kennel by his mother and stepfather. *The Mail Online.* Retrieved from http://www.dailymail.co.uk/news/article-2076186/Teenage-boy-whipped-starved-locked-dog-kennel-mother-stepfather.html

Veras, C. (2010, Nov 30). Abnormal Culture & Abnormal Behaviour. [Video file]. Retrieved from http://www.youtube.com/watch?v=9m_0QOHqp-Q

Glossary of Terms Used in Unit 8

Source: A Dictionary of Psychology, Andrew M.Coleman, Oxford University Press, 2nd ed. 2006.

Other free access on-line psychology dictionaries are available at the following links http://allpsych.com/dictionary/ and http://www.merriam-webster.com/dictionary/psychology

Antisocial Personality Disorder	A personality disorder characterized by a consistent pattern of such behaviours as truancy, delinquency, lying, promiscuity, drunkenness or substance abuse, theft, vandalism, and fighting.
Biopsychosocial Model	An integrative model for explaining abnormal behaviour in terms of the interaction of biological, psychological, and socio-cultural factors.
Conditional Positive Regard	Means valuing other people on the basis of whether their behaviour meets one's approval.
Conflict	An incompatibility of motives or goals.
Coping	Efforts to reduce stress and to find new solutions to life challenges.
Crisis	An event or period that brings rapid change, usually involving more than one area of functioning.
Critical Thinking	This refers to the adoption of a questioning attitude and the careful scrutiny of claims and arguments in light of evidence.
Defence Mechanism	In psycho-analytic theory, techniques which attempt to alleviate anxiety caused by the conflicting theories of the id and superego (e.g. repression, projection, displacement).
Dementia Praecox	The term given by the German physician to the disorder now called schizophrenia
Depression	A state of extreme sadness, usually characterized by slow thoughts and movements but sometimes by restless agitation.
Diathesis	This is a vulnerability or predisposition to a particular disorder.
Diathesis-Stress Model	This model contends that abnormal behaviour problems involve the interaction of a vulnerability or a predisposition and stressful life events or experiences.
Dispositional Factors	A cause of behaviour that is related to one's personality characteristics and preferences.

Distress	A threatening unpleasant demand
Downward Drift Hypothesis	The theory that explains the link between low socio-economic status and behaviour problems by suggesting that problem behaviours lead people to drift downward in social status.
Emotional Inoculation	The ability to work through feelings of anxiety or threat in anticipation of a stressful event
Heredity	The proportional contribution of genetic factors to the total variance of a trait.
Hysteria	A condition characterized by paralysis or numbness that cannot be explained by any underlying physical cause.
Medical Model	A biological perspective in which abnormal behaviour is viewed as symptomatic of underlying illness.
Personality	The integrated and organized characteristics and behaviour tendencies of a person that determine the unique ways the person interacts with his or her environment.
Personality Disorders	Impairment in work or social behaviour due to rigid, maladaptive personality traits
Phobia	Phobia is a persistent irrational fear of an object, situation, or activity that the person feels compelled to avoid.
Psychodynamic Model	The theoretical model of Freud and his followers, in which abnormal behaviour is viewed as the product of clashing forces within the personality.
Schizophrenia	This is characterized by severely disturbed behaviour, thinking, emotions, and perceptions involving a break with reality (psychosis). It is caused by biological factors, including genetic factors, neurotransmitters, irregularities, and brain abnormalities and/or by psychosocial factors interacting with genetic factors. It can be treated with antipsychotic drugs; learning based treatments, such as the token economy and social skills training; psychosocial rehabilitation services such as residential treatment facilities; and family intervention programs to improve communication and reduce conflicts.
Scientific Method	A systematic method of conducting scientific research in which theories or assumptions are examined in light of evidence.
Stressor	This represents any unusual or intense demand.
Stress Response	The non-specific response of the body to any demand.
Unconditional Positive Regard	This means valuing other people as having basic worth regardless of their behaviour at a particular time.