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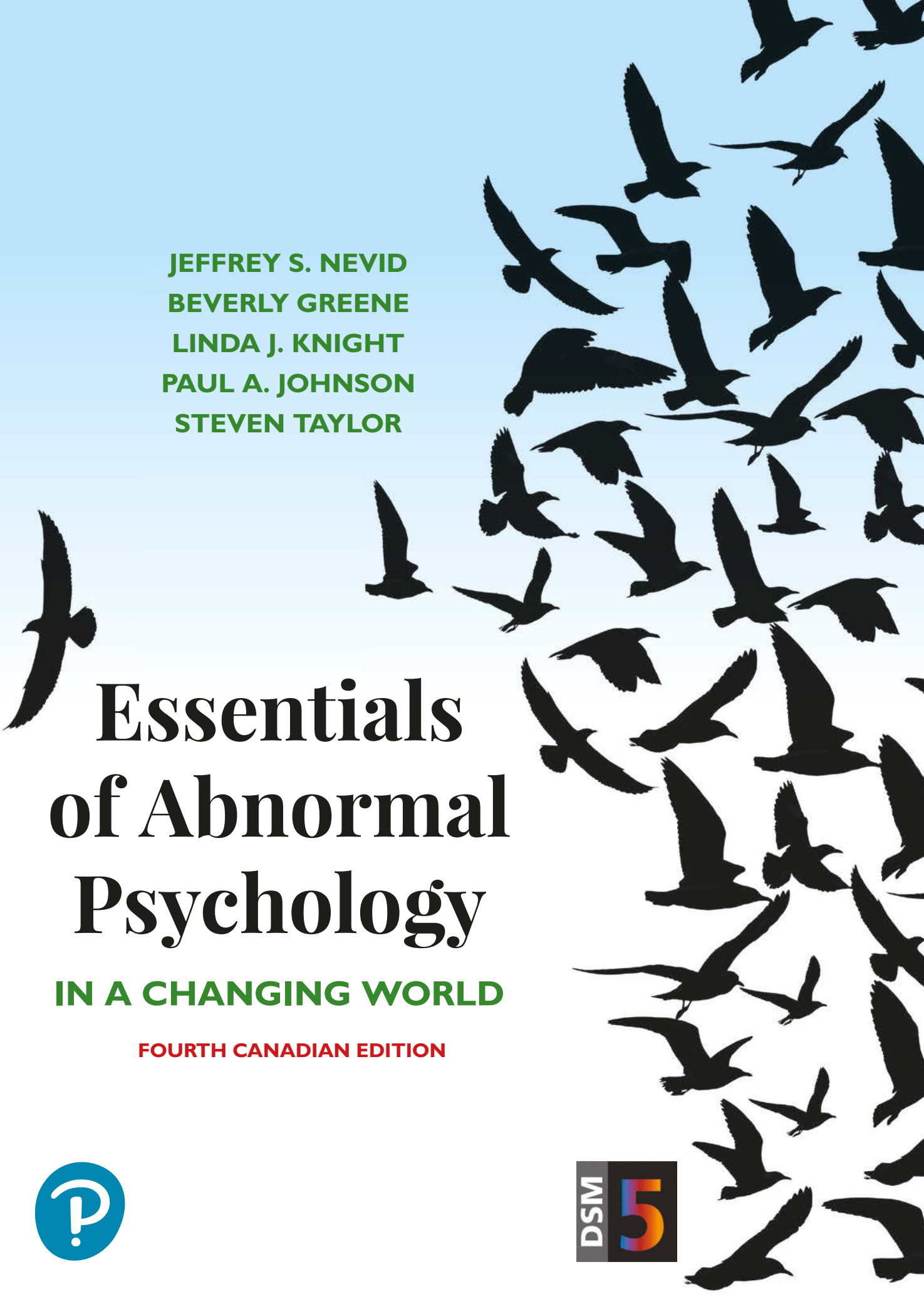

Essentials of Abnormal Psychology

IN A CHANGING WORLD

FOURTH CANADIAN EDITION

DSM 5

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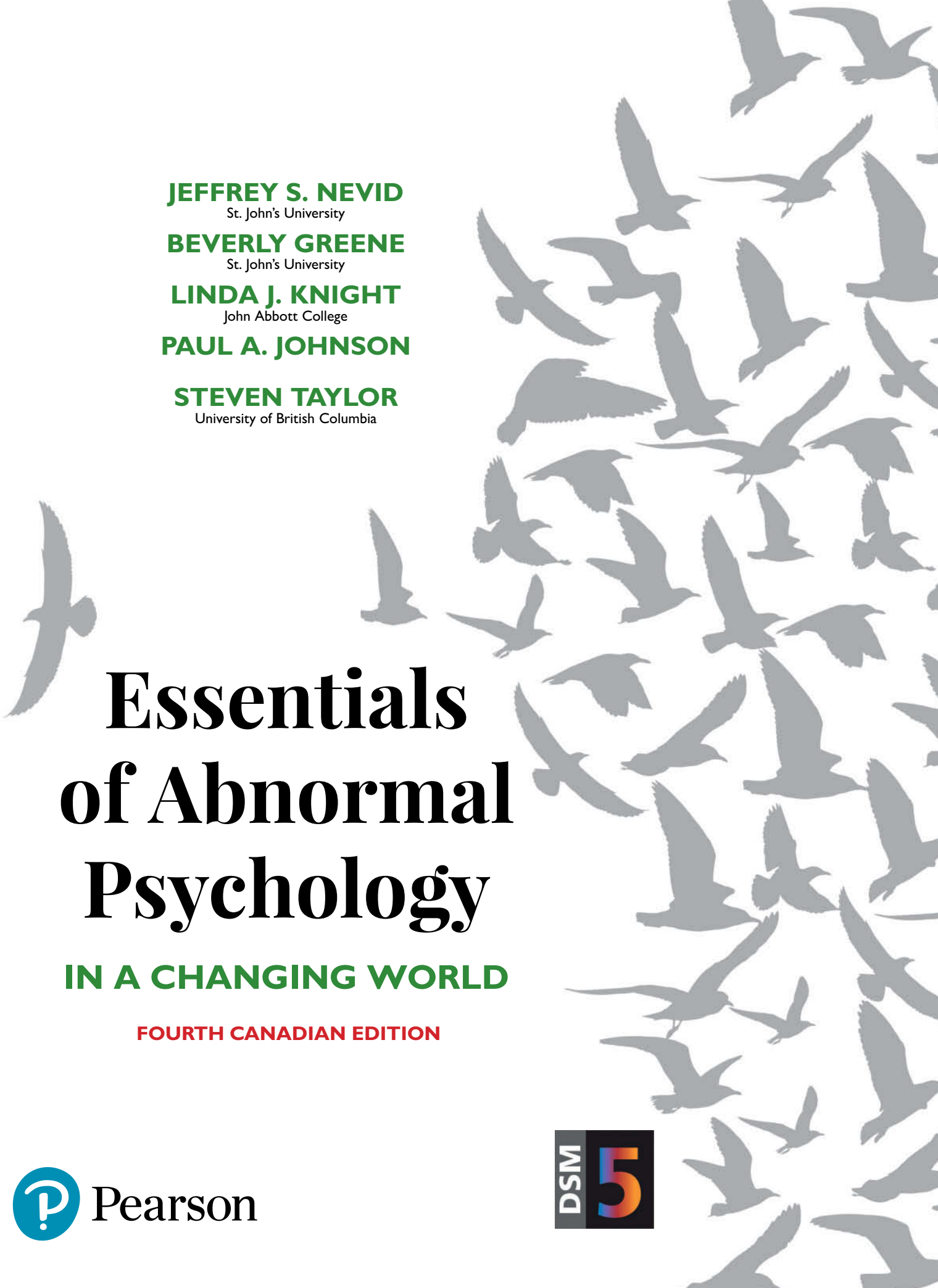

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To Sam, Scott, and Derek
—LK

To Anna, Alex, and Amy
—ST

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BRIEF CONTENTS

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CONTENTS

PREFACE

Abnormal psychology is among the most popular areas of study in psychology for good reason. The problems it addresses are of immense personal and social importance—problems that touch the lives of us all in one way or another. They include problems that are all too pervasive, such as depression, anxiety, sexual dysfunctions, and alcohol and substance use disorders. They include problems that are less common but have a profound impact on all of us, such as schizophrenia.

The problems addressed in this book are thus not those of the few. The majority of us will experience one or more of them at some time or another, or a friend or loved one will. Even those who are not personally affected by these problems will be touched by society's response—or lack of response—to them. We hope that this text will serve both as an educational tool and as a vehicle to raise awareness among students and general readers alike.

Essentials of Abnormal Psychology in a Changing World, Fourth Canadian Edition, uses case examples and self-scoring questionnaires; a clear and engaging writing style that is accessible but does not compromise rigour; research-based and comprehensive coverage; superior pedagogy; and integration of sociocultural material throughout, including coverage of issues relating to Canadian cultural diversity, gender, and lifestyle.

Essentials of Abnormal Psychology provides students with the basic concepts in the field in a convenient 11-chapter format. These chapters cover historical and theoretical perspectives, approaches to psychological assessment and treatment, and the major types of psychological disorders—including eating disorders, anxiety disorders, depressive and bipolar disorders, substance-related disorders, personality disorders, gender dysphoria and sexual dysfunctions, schizophrenia, and disorders of childhood, adolescence, and aging. Throughout the text, we highlight important Canadian research, case examples, and societal and legal perspectives on abnormal psychology. We also present the best international research from a Canadian perspective.

NEW TO THE FOURTH CANADIAN EDITION

Welcome to the fourth Canadian edition of *Essentials* of *Abnormal Psychology in a Changing World*. We continue to bring readers the latest research developments that inform contemporary understandings of abnormal behaviour in a way that both stimulates student interest and makes complex material understandable. Highlights of this new edition include the following:

- **Enhanced Integration of DSM-5**
  This new edition has been revised to better reflect the organizational structure of DSM-5.
- **A Continued Focus on Mental Health in Canada**
  Since our third edition, Canada has made significant strides in recognizing and planning for the mental health needs of our population, including the homeless and Indigenous communities.
- Here is a sample of the documents that have been recently released and that are integrated into this new edition:
  - Employment and Social Development Canada:
    - Homelessness Partnering Strategy Coordinated Canadian Point-in-Time Count
    - Highlights of the National Shelter Study 2005–2014

- Mental Health Commission of Canada:
  - Changing Directions, Changing Lives: The Mental Health Strategy for Canada
  - Informing the Future: Mental Health Indicators for Canada, 2015
  - Advancing the Mental Health Strategy for Canada: A Framework for Action (2017–2022)
  - National At Home/Chez Soi Project Final Report
- Public Health Agency of Canada:
  - Report from the Canadian Chronic Disease Surveillance System: Mental Illness in Canada, 2015
- Canadian Institute for Health Information:
  - Care for Children and Youth with Mental Disorders, 2015
- Statistics Canada:
  - Mental and Substance Use Disorders in Canada
  - Prevalence and Correlates of Marijuana Use in Canada, 2012
  - 2011 National Household Survey Aboriginal Demographics, Educational Attainment and Labour Market Outcomes
  - Immigration and Ethnocultural Diversity in Canada, 2016
  - First Nations & Inuit Health, 2016
  - Population Size and Growth in Canada: Key Results from the 2016 Census

- **Integration of Latest Scientific Developments**
  The text integrates the latest research findings and scientific developments in the field that inform our understanding of abnormal psychology. We present these research findings in a way that makes complex material engaging and accessible to the student.

- **Integration of Social and Cultural Diversity**
  We examine abnormal behaviour patterns in relation to factors of diversity, such as ethnicity, culture, and gender. We believe students need to understand how issues of diversity affect the conceptualization of abnormal behaviour as well as the diagnosis and treatment of psychological disorders.
  Here are a few examples:
  - Cultural factors in defining and assessing mental illness
  - Eating disorders in non-Western countries
  - Sociocultural perspective on depression in women
  - Differences in youth suicide rates across various countries
  - The psychological effects of female genital mutilation
  - Sociocultural issues in gender dysphoria
  - The Indigenous healing perspective
  - Traditional Indigenous ceremonies and practices
  - The Canadian Indigenous suicide crisis

- **Emphasis on Mental Illness as a Continuum**
  - Continuum Chart
    We recognize that mental illnesses are on a continuum and that the delineation between "normal" and "abnormal" is not always clear. In order to emphasize this continuum, we have introduced a continuum chart at the beginning of each chapter to emphasize the dimensional aspect of mental disorders.
  - Dimensional versus Categorical Approach to Diagnoses
    Our present method of diagnosing (DSM) continues to be categorical despite increasing criticisms and debates. In order to promote critical thinking, we introduce students to these controversial issues and alternative approaches.

- **Increased Emphasis on Student Learning**
  - Interactive Concept Maps
    Students learn best when they are actively engaged in the learning process. To engage students in active learning, we converted the Concept Maps in this edition to an interactive format. The maps are presented in a matching format in which key words and terms are omitted so that students can fill in the missing pieces to complete these knowledge structures.
  - Multiple-choice questions have also been added to the end of each chapter.

GENERAL APPROACH

We approached the writing of this text with the belief that a textbook should do more than offer a portrait of a field of knowledge. It should be a teaching device—a means of presenting information in ways that arouse interest and encourage understanding and critical thinking. To these ends, we speak to the reader in a clear expository style. We attempt to render complex material accessible. We put a human face on the subjects we address by including many case examples drawn from our own clinical files, those of other mental health professionals, and those from DSM casebooks. We stimulate and involve students through carefully chosen pedagogical features, questionnaires, highlights, and applications. We also include built-in study tools designed to help students master difficult material. And yes, we keep abreast of our ever-changing subject by bringing to our readers a wealth of new scientific information drawn from leading scientific journals and organizations. To summarize the material covered in each chapter in an easy-to-remember visual format, we also include Concept Maps at the end of each chapter.

Essentials of Abnormal Psychology exposes students to the multiple perspectives that inform our present understandings of abnormal behaviour—the psychological, sociocultural, and biological domains. We adopt an interactionist approach, which recognizes that abnormal behaviour typically involves a complex interplay of multiple factors representing different domains. Because the concept of integrating diverse perspectives is often difficult for beginning students to grasp, the unique "Tying It Together" features interspersed through the text help students explore how multiple factors interact in the development of psychological disorders.

FEATURES OF THE TEXT

Textbooks walk balance beams, as it were, and they can fall off in three directions, not just two. That is, they must do justice to their subject matter while also meeting the needs of both instructors and students.

In subject matter, *Essentials of Abnormal Psychology* is comprehensive, providing depth and breadth as well as showcasing the most important new research discoveries. It covers the history of societal response to abnormal behaviours, historical and contemporary models of abnormal behaviours, methods of assessment, psychological and biological models of treatment, contemporary issues, the comprehensive range of problem behaviours set forth in the DSM, and a number of other behavioural problems that entail psychological factors—most notably in the interfaces between psychology and health.

Canadian Content

The fourth Canadian edition of *Essentials of Abnormal Psychology in a Changing World* showcases a wealth of Canadian content. We chose to do this for several reasons. First and foremost, there is a great deal of important, internationally acclaimed Canadian work being done on the research and treatment of abnormal behaviour. In other words, we have tried to present the best research on abnormal psychology while at the same time

alerting our readers to the fact that much of this work comes from Canada. Why would we do this? The answer is to help our readers understand that there is important, relevant research being conducted right where they live, and quite likely on their own campus. Our Canadian focus helps readers understand that key research does not originate just in other countries—it's happening in students' own backyards, perhaps being done by the professor who is teaching their course.

The second reason for highlighting Canadian content is to refute the myth that mental disorders are things that happen to people who live someplace else, such as in other regions or countries. Mental disorder touches all of us; there are people in our country and communities and on our campuses who are afflicted with psychological problems. By citing Canadian examples of people who have battled psychological problems, we hope to bring home the fact that mental illness can reach any of us. Fortunately, effective treatments are available for many of these disorders.

Our third reason for a Canadian focus is pragmatic. The prevalence of mental disorders differs from country to country, as do the treatments of and laws regarding mental disorders and patient rights. Some disorders, such as dependence on crack cocaine, are much more common in the United States than in Canada. Substance use disorders in Canada more commonly involve other substances. The health-care system in Canada is also different from systems in other countries. Accordingly, it is important to have a Canadian focus so that readers can understand how people with mental health problems are treated in Canada.

Finally, the issues regarding mental disorders and the law are different in Canada than in many other countries. For example, in the United States, a person might be deemed to be "not guilty by reason of insanity." In Canada, such a judgment would be "not criminally responsible on account of a mental disorder." In other words, the Canadian courts often recognize that an accused is guilty of a given crime but not responsible because he or she is under the influence of a mental disorder.

This text illustrates the important fact that abnormal psychology does not occur in a cultural vacuum; the expression and treatment of psychological problems are strongly influenced by cultural factors. Our task of updating and Canadianizing this text was made much easier by the fact that so much of the key research on abnormal behaviour has been conducted in Canada.

"Did You Know That" Chapter Openers

Each chapter begins with a set of "Did You Know That" questions designed to whet students' appetites for specific information contained in the chapter and to encourage them to read further. These chapter-opening questions (e.g., "Did You Know That . . . you can become psychologically dependent on a drug without becoming physically addicted?" or ". . . as many as 17% of people will suffer from an anxiety disorder at some point in their lives?") also encourage students to think critically and evaluate common conceptions in light of scientific evidence.

"Normal/Abnormal" Features

Instructors often hear the question "So what is the difference between normal behaviour and a psychological disorder?" In an effort to bring the material back to real life and to separate normal emotional distress from a psychological disorder, we've introduced case comparisons called "Normal/Abnormal Behaviour"—for example, "Alcohol Use: No Disorder" and "Alcohol Abuse: Disorder," "Normal Perfectionism: No Disorder" and "OCPD: Disorder." These have been written to inspire discussion and engagement with students in class. Students will encounter a variety of symptom severities and can discuss the differences between the cases. These cases are not meant to encourage labelling but are designed to show real-life examples written in nonclinical language. The cases have been written by Dr. Karen Rowa, Assistant Professor,

McMaster University, and Associate Director at St. Joseph's Healthcare Clinical Psychology Residency Program.

"Focus on Diversity" Features

The fourth Canadian edition of *Essentials of Abnormal Psychology* helps broaden students' perspectives so that they understand the importance of issues relating to gender, culture, ethnicity, and lifestyle in the diagnosis and treatment of psychological disorders. Students will see how behaviour deemed normal in one culture could be labelled abnormal in another, how states of psychological distress might be experienced differently in other cultures, how some abnormal behaviour patterns are culture-bound, and how therapists can cultivate a sensitivity to cultural factors in their approach to treating people from diverse backgrounds. Multicultural material is incorporated throughout the text and is highlighted in boxed "Focus on Diversity" features that cover specific topics, including the following:

- Mental Health Issues in Canadian Indigenous Communities (Chapter 1)
- Culture-Bound Syndromes (Chapter 2)
- Traditional Indigenous Ceremonies and Practices (Chapter 2)
- Canadian Multicultural Issues in Psychotherapy (Chapter 2)
- Koro and Dhat Syndromes: Asian Somatic Symptom Disorders? (Chapter 5)
- Ethnicity and Alcohol Abuse (Chapter 7)

"A Closer Look" Features

The Closer Look features highlight cutting-edge developments in the field (e.g., virtual reality therapy) and in practice (e.g., suicide prevention) that enable students to apply information from the text to their own lives. Here is a quick preview of features:

- Canadian Mental Health Promotion (Chapter 1)
- The Homeless in Canada (Chapter 1)
- DSM-5: Points of Controversy (Chapter 2)
- A New Vision of Stigma Reduction and Mental Health Support for Young Adults (Chapter 2)
- Virtual Therapy (Chapter 3)
- Concussions, Depression, and Suicide Among NHLers (Chapter 4)
- Suicide Prevention (Chapter 4)
- Personality Disorders—Categories or Dimensions? (Chapter 6)
- The Controlled Social Drinking Controversy (Chapter 7)
- Correctional Service Canada's National Sex Offender Programs (Chapter 9)
- A New View of Women's Sexual Dysfunctions? (Chapter 9)
- Psychosis Sucks! Early Psychosis Intervention Programs (Chapter 10)
- A Canadian Definition of Learning Disabilities (Chapter 11)

Self-Scoring Questionnaires

Self-scoring questionnaires (for example, "The Body Shape Questionnaire" in Chapter 8 and the "An Inventory of Dissociative Experiences" in Chapter 5) involve students in the discussion at hand and permit them to evaluate their own behaviour. In some cases, students may become more aware of troubling concerns, such as states of depression or problems with drug or alcohol use, which they may wish to bring to the attention of a professional. We have screened the questionnaires to ensure that they will provide students with useful information to reflect on and to serve as a springboard for class discussion.

Review It: In-Chapter Study Breaks

Essentials of Abnormal Psychology contains a built-in study break for students. These in-chapter study breaks conclude each major section in the chapters. This feature provides students with the opportunity to review the material they have just read and gives them a review break before moving on to a new section.

Define It: End-of-Chapter Glossary Terms

Key terms introduced throughout the text are listed here, with page references for easy retrieval and to help students as they study.

Think About It: End-of-Chapter Discussion Material

End-of-chapter questions ask students to think critically about the issues that were raised in the preceding passages of the text and invite students to relate the material to their own experiences.

Recall It

End-of-chapter multiple-choice questions enable students to test their understanding of the material.

Concept Maps

Concept Maps are diagrams at the end of each chapter that summarize key concepts and findings. Refreshed and revised for this edition, the Concept Maps provide readers with a "big picture" and are a useful way of understanding and remembering the material covered in each chapter.

SUPPLEMENTS

No matter how comprehensive a textbook is, today's instructors require a complete educational package to advance teaching and comprehension. These instructor supplements are available for download from a password-protected section of Pearson Canada's online catalogue (https://pearson.com/higher-education). Navigate to your book's catalogue page to view a list of those supplements that are available. Speak to your local Pearson Canada sales representative for details and access.

Essentials of Abnormal Psychology is accompanied by the following supplements:

MYTEST from Pearson Canada is a powerful assessment generation program that helps instructors easily create and print quizzes, tests, and exams, as well as homework or practice handouts. Questions and tests can all be authored online, allowing instructors ultimate flexibility and the ability to efficiently manage assessments at any time, from anywhere. MyTest for *Essentials of Abnormal Psychology in a Changing World*, Fourth Canadian Edition, includes over 3500 fully referenced multiple-choice, true/false, and essay questions. Each question is accompanied by a difficulty level, type designation, topic, and answer justification. Instructors can access MyTest at "http://www.pearsonmytest.com".

TEST ITEM FILE. The MyTest questions in multiple-choice, true/false, and essay formats are also provided in a Word document.

INSTRUCTOR'S RESOURCE MANUAL The Instructor's Resource Manual is a true "course organizer," integrating a variety of resources for teaching abnormal psychology. It includes a summary discussion of the chapter content, a full chapter outline, lecture and discussion questions, a list of learning goals for students, demonstrations, and activities.

POWERPOINT® PRESENTATIONS Students often learn visually, and in a world where multimedia is almost an expectation, a full set of PowerPoint presentations will help you present course material to students.

IMAGE LIBRARY Electronic versions of key figures and tables in the text are available for your use.

LEARNING SOLUTIONS MANAGERS Pearson's Learning Solutions Managers work with faculty and campus course designers to ensure that Pearson technology products, assessment tools, and online course materials are tailored to meet your specific needs. This highly qualified team is dedicated to helping schools take full advantage of a wide range of educational resources by assisting in the integration of a variety of instructional materials and media formats. Your local Pearson Canada sales representative can provide you with more details on this service program.

ACKNOWLEDGMENTS

The field of abnormal psychology is a moving target, because the literature base that informs our understanding is continually expanding. We are deeply indebted to a number of talented individuals who helped us hold our camera steady in taking a portrait of the field, focus in on the salient features of our subject matter, and develop our snapshots through prose.

First, we thank Tracey Carr at the University of Saskatchewan, who reviewed and updated the previous edition to address changes in the DSM-5 criteria.

Second, we thank our professional colleagues, who reviewed chapters from earlier Canadian editions: Mark Benner, Fanshawe College; Beverley Bouffard, York University; Kristen Buscaglia, Niagara College; Kathy Foxall, Wilfrid Laurier University; Stephane Gaskin, Dawson College; Stuart Keenan, Sir Sandford Fleming College; Thomas Keenan, Niagara College; Ronald Laye, University of the Fraser Valley; Jocelyn Lymburner, Kwantlen University College; Rajesh Malik, Dawson College; Jillian Esmonde Moore, Georgian College; Karen Moreau, Niagara College; Ravi Ramkissoonsingh, Niagara College; Joanna Sargent, Georgian College; Sandy Schlieman, Algonquin College; Dana Shapero, University of Windsor; Carolyn Szostak, University of British Columbia-Okanagan; and Abe Worenklein, Dawson College.

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ABOUT THE AUTHORS

JEFFREY S. NEVID is Professor of Psychology at St. John's University in New York, where he directs the Doctoral Program in Clinical Psychology, teaches at the undergraduate and graduate levels, and supervises doctoral students in clinical practicum work. He received his PhD in Clinical Psychology from the State University of New York at Albany and was a staff psychologist at Samaritan Hospital in Troy, New York. He later completed a National Institute of Mental Health Post-Doctoral Fellowship in Mental Health Evaluation Research at Northwestern University. He holds a Diplomate in Clinical Psychology from the American Board of Professional Psychology, is a Fellow of the American Psychological Association and the Academy of Clinical Psychology, and has served on the editorial boards of several journals and as Associate Editor of the *Journal of Consulting and Clinical Psychology*. His publications have appeared in journals such as *Journal of Consulting and Clinical Psychology*, *Health Psychology*, *Journal of Occupational Medicine*, *Behavior Therapy*, *American Journal of Community Psychology*, *Professional Psychology: Research and Practice*, *Journal of Clinical Psychology*, *Journal of Nervous and Mental Disease*, *Teaching of Psychology*, *American Journal of Health Promotion*, and *Psychology and Psychotherapy*. Dr. Nevid is also author of the book *Choices: Sex in the Age of STDs* and the introductory psychology text *Psychology: Concepts and Applications*, as well as several other college texts in the fields of psychology and health co-authored with Dr. Spencer Rathus. Dr. Nevid is also actively involved in a program of pedagogical research focusing on helping students become more effective learners.

BEVERLY GREENE is Professor of Psychology at St. John's University, a fellow of seven divisions of the American Psychological Association, and a fellow of the American Orthopsychiatric Association and the Academy of Clinical Psychology. She holds a Diplomate in Clinical Psychology and serves on the editorial boards of numerous scholarly journals. She received her PhD in Clinical Psychology from Adelphi University and worked in public mental health for over a decade. She was founding co-editor of the APA Society for the Study of Lesbian, Gay, and Bisexual Issues series, *Psychological Perspectives on Lesbian, Gay and Bisexual Issues*. She is also co-author of the recent book *What Therapists Don't Talk About and Why: Understanding Taboos That Hurt Ourselves and Our Clients* and has more than 80 professional publications that are the subject of nine national awards. Dr. Greene was recipient of the APA 2003 Committee on Women in Psychology Distinguished Leadership Award; 1996 Outstanding Achievement Award from the APA Committee on Lesbian, Gay, and Bisexual Concerns; the 2004 Distinguished Career Contributions to Ethnic Minority Research Award from the APA Society for the Study of Ethnic Minority Issues; the 2000 Heritage Award from the APA Society for the Psychology of Women; the 2004 Award for Distinguished Senior Career Contributions to Ethnic Minority Research (APA Division 45); and the 2005 Stanley Sue Award for Distinguished Professional Contributions to Diversity in Clinical Psychology (APA Division 12). Her co-edited book *Psychotherapy with African American Women: Innovations in Psychodynamic Perspectives and Practice* was also honoured with the Association for Women in Psychology's 2001 Distinguished Publication Award. In 2006, she was the recipient of the Janet Helms Award for Scholarship and Mentoring from the Teacher's College, Columbia University

Cross Cultural Roundtable, and of the 2006 Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology (APA Division 12). In 2009, she was honoured as recipient of the APA Award for Distinguished Senior Career Contribution to Psychology in the Public Interest. She is an elected representative to the APA Council and member at large of the Women's and Public Interest Caucuses of the Council.

LINDA J. KNIGHT has been teaching psychology at John Abbott College in Sainte-Anne-de-Bellevue, Quebec, since 2001. She teaches in both the Psychology Department and the Youth & Adult Correctional Intervention department and supervises students in clinical practicum work. She served on the Innovative Research and Development Committee and the Teaching and Learning Environmental Committee. She received her PhD in Clinical Psychology from Queen's University in Kingston, Ontario, and was a staff psychologist at the London Psychiatric Hospital, London, Ontario, and the Child and Family Assessment and Treatment Centre of Brant County, Brantford, Ontario. She also practised as a clinical psychologist in Vancouver, British Columbia, and in Montreal, Quebec. In addition to a private practice, she conducted intake and parole assessments at various correctional facilities in Quebec. Dr. Knight served as a reviewer for the first three Canadian editions of *Essentials of Abnormal Psychology in a Changing World*.

PAUL A. JOHNSON has 25 years' experience in post-secondary education as a professor, program co-ordinator, and curriculum and program validation adviser at Confederation College. Paul recently served on the Ontario Ministry of Training, Colleges and Universities (MTCU) committee that developed the new provincial college curriculum standards for general education and essential employability skills. He has received international recognition for academic leadership from the Chair Academy and the National Institute for Staff and Organizational Development (NISOD). Paul has also practised psychology in the Psychotherapy and Psychiatric departments of St. Joseph's Hospital in Thunder Bay. As well, he has been a health-promotion consultant in his community for many years. Along with Helen Bee and Denise Boyd, Paul co-authored *Lifespan Development* (Pearson Education Canada), now in its fourth Canadian edition.

STEVEN TAYLOR, PHD, ABPP, is a professor and clinical psychologist in the Department of Psychiatry at the University of British Columbia and is editor-in-chief of the *Journal of Cognitive Psychotherapy*. He serves on the editorial board of several journals, including the *Journal of Consulting and Clinical Psychology*. He has published over 200 journal articles and book chapters, and over a dozen books on anxiety disorders and related topics. Dr. Taylor has received career awards from the Canadian Psychological Association, the British Columbia Psychological Association, the Association for Advancement of Behaviour Therapy, and the Anxiety Disorders Association of America. He is a fellow of several scholarly organizations, including the Canadian Psychological Association, the American Psychological Association, the Association for Psychological Science, and the Academy of Cognitive Therapy. His clinical and research interests include cognitive-behavioural treatments and mechanisms of anxiety disorders and related conditions, as well as the behavioural genetics of these disorders.

1

What Is Abnormal Psychology?

CHAPTER OUTLINE

Did You Know That...

- About one in five adults in Canada will be diagnosed with a psychological disorder at some point in their lives?
- Behaviour we consider abnormal may be perceived as perfectly normal in another culture?
- The modern medical model of abnormal behaviour can be traced to the work of a Greek physician some 2500 years ago?
- A night on the town in London, Ontario, in the 19th century may have included peering at the residents of a local asylum?
- At one time, there were more patients occupying psychiatric hospital beds than there were patients in hospital beds due to all other causes?

Tomek Sikora/The Image Bank/Getty Images

clinical psychologist Person with graduate training in psychology who specializes in abnormal behaviour. He or she must be registered and licensed with a provincial psychological regulatory body in order to provide psychological services in that province.

psychiatrist Physician who specializes in the diagnosis and treatment of mental disorders.

psychological disorders Disturbances of psychological functioning or behaviour associated with states of personal distress or impaired social, occupational, or interpersonal functioning. Also called *mental disorders.*

abnormal psychology Branch of psychology that deals with the description, causes, and treatment of abnormal behaviour patterns.

medical model Biological perspective in which abnormal behaviour is viewed as symptomatic of underlying illness.

Abnormal behaviour might appear to be the concern of only a few. After all, only a minority of the population will ever be admitted to a psychiatric hospital. Most people never seek the help of a **clinical psychologist** or **psychiatrist**. Only a few people plead not criminally responsible on account of a mental disorder. Many of us have what we call an "eccentric" relative, but few of us have relatives we would consider truly bizarre.

The truth of the matter is abnormal behaviour affects virtually everyone in one way or another. Abnormal behaviour patterns that involve a disturbance of psychological functioning or behaviour are classified as **psychological disorders** (also called *mental disorders*). According to the Canadian Community Health Survey, about 33% of Canadians experience a psychological disorder at some time in their lives. The survey also reported psychological disorders were most common among people in the 45- to 64-year age range, followed by those in the 25- to 44-year range (Statistics Canada, 2012b). In 2015, the Mental Health Commission of Canada (MHCC) released a document titled "Informing the Future: Mental Health Indicators for Canada," which provided a snapshot of mental health and mental illness in Canada. According to this report, close to 12% of Canadian adults in 2011/2012 between the ages of 20 and 64 were diagnosed as having either an anxiety or a depressive disorder. These rates were two and a half times greater among lesbian, gay, and bisexual individuals. In this same year, over 322 000 individuals in Canada were providing care for a family member with a mental illness (MHCC, 2015). So if we include the mental health problems of our family members, friends, and co-workers, then perhaps none of us remains unaffected.

Abnormal psychology is the branch of the science of psychology that addresses the description, causes, and treatment of abnormal behaviour patterns. Let's pause for a moment to consider our use of terms. We prefer to use the term *psychological disorder* when referring to abnormal behaviour patterns associated with disturbances of psychological functioning, rather than *mental disorder*. There are a number of reasons why we have adopted this approach. First, *psychological disorder* puts the study of abnormal behaviour squarely within the purview of the field of psychology. Second, the term *mental disorder* is generally associated with the **medical model** perspective, which considers abnormal behaviour patterns to be symptoms of underlying mental illnesses or disorders. Although the medical model remains a prominent perspective for understanding abnormal behaviour patterns, we shall see that other perspectives, including psychological and sociocultural perspectives, also inform our understanding of abnormal behaviour. Third, *mental disorder* as a phrase reinforces the traditional distinction between mental and physical phenomena. As we'll see, there is increasing awareness of the interrelationships between the body and the mind that calls into question this distinction.

In this chapter, we first address the task of defining abnormal behaviour. We see that throughout history, and even in prehistory, abnormal behaviour has been viewed from different perspectives or according to different models. We chronicle the development of concepts of abnormal behaviour and its treatment. We see that, historically speaking, *treatment* usually referred to what was done *to*, rather than *for*, people with abnormal behaviour. Finally, we'll introduce you to current perspectives on abnormal behaviour.

HOW DO WE DEFINE ABNORMAL BEHAVIOUR?

Most of us become anxious or depressed from time to time, but our behaviour is not deemed abnormal. It is normal to become anxious in anticipation of an important job interview or a final examination. It is appropriate to feel depressed when you have lost someone close to you or when you have failed at a test or on the job. But when do we cross the line between normal and abnormal behaviour?

One answer is emotional states like anxiety and depression may be considered abnormal when they are not appropriate to the situation. It is normal to feel down because of failure on a test, but not when one's grades are good or excellent. It is normal to feel anxious during a job interview, but not whenever entering a department store or boarding a crowded elevator.

Abnormal behaviour may also be suggested by the magnitude of the problem. Although some anxiety is normal enough before a job interview, feeling your heart hammering away so relentlessly that it feels like it might leap from your chest—and consequently cancelling the interview—is not. Nor is it normal to feel so anxious in this situation that your clothing becomes soaked with perspiration.

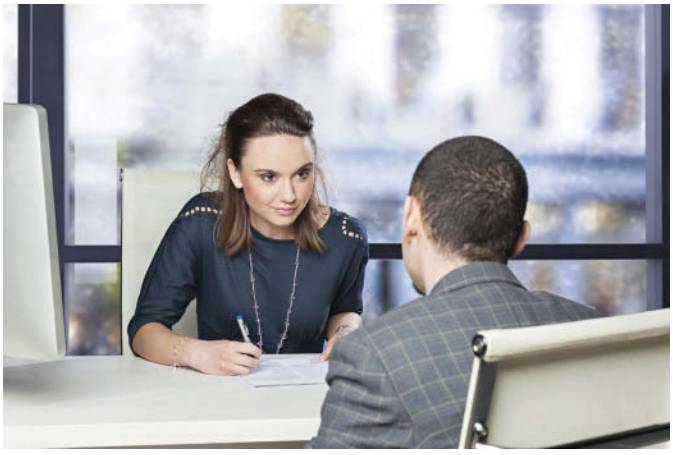
Criteria for Determining Abnormality

Abnormal behaviour thus has multiple definitions. Depending on the case, some criteria may be weighted more heavily than others. But in most cases, a combination of these criteria is used to define abnormality. Precisely how mental health professionals assess and classify abnormal behaviour is described in Chapter 2, "Assessment, Classification, and Treatment of Abnormal Behaviour."

Psychologists generally apply some combination of the following criteria in making a determination that behaviour is abnormal:

1. *Behaviour is unusual.* Behaviour that is unusual is often considered abnormal. Only a few of us report seeing or hearing things that are not really there; "seeing things" and "hearing things" are almost always considered abnormal in our culture, except, perhaps, in cases of religious experience. Yet **hallucinations** are not deemed unusual in some non-Western cultures. Being overcome with feelings of panic when entering a department store or when standing in a crowded elevator

hallucinations Perceptions that occur in the absence of an external stimulus and that are confused with reality.



Eviled/Shutterstock

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When is anxiety abnormal? Negative emotions such as anxiety are considered abnormal when they are judged to be excessive or inappropriate to the situation. Anxiety is generally regarded as normal when it is experienced during a job interview, so long as it is not so severe that it prevents the interviewee from performing adequately. Anxiety is deemed to be abnormal if it is experienced whenever one boards an elevator.

is also uncommon and considered abnormal. But uncommon behaviour is not in itself abnormal. Only one person can hold the record for swimming or running the fastest 100 metres. The record-holding athlete differs from the rest of us but, again, is not considered abnormal.

2. *Behaviour is socially unacceptable or violates social norms.* All societies have norms (standards) that define the kinds of behaviours acceptable in given contexts. Behaviour deemed normal in one culture may be viewed as abnormal in another. In our society, standing on the street corner and repeatedly shouting "Kill 'em!" to passersby would be labelled abnormal; shouting "Kill 'em!" in the arena at a professional wrestling match is usually within normal bounds.

   Although the use of norms remains one of the important standards for defining abnormal behaviour, we should be aware of some limitations of this definition.

   One implication of basing the definition of abnormal behaviour on social norms is that norms reflect relative cultural standards, not universal truths. What is normal in one culture may be abnormal in another. For example, Canadians who assume strangers are devious and will try to take advantage are usually regarded as distrustful, perhaps even **paranoid**. But such suspicions were justified among the Mundugumor, a tribe of cannibals in Papua New Guinea studied by anthropologist Margaret Mead (1935). Within that culture, male strangers, even the male members of one's own family, *were* typically spiteful toward others.

   paranoid Having irrational suspicions.

   Clinicians such as psychologists and psychiatrists need to weigh cultural differences in determining what is normal and abnormal. In the case of the Mundugumor, this need is more or less obvious. Sometimes, however, differences are subtler. For example, what is seen as normal, outspoken behaviour by most Canadian women might be interpreted as brazen behaviour when viewed in the context of another, more traditional culture. Moreover, what strikes one generation as abnormal may be considered by others to fall within the normal spectrum. For example, until the mid-1970s, homosexuality was classified as a mental disorder by the psychiatric profession (see Chapter 9, "Gender Dysphoria, Paraphilic Disorders, and Sexual Dysfunctions"). Today, however, the psychiatric profession no longer considers homosexuality a mental disorder. Indeed, roughly two thirds of Canadians now express approval of same-sex relationships (Bibby, 2006). Another implication of basing normality on compliance with social norms is the tendency to brand nonconformists as mentally disturbed.

3. *Perception or interpretation of reality is faulty.* Normally speaking, our sensory systems and cognitive processes permit us to form fairly accurate mental representations of the environment. But seeing things or hearing voices that are not present are considered hallucinations, which in our culture are often taken as signs of an underlying disorder. Similarly, holding unfounded ideas or **delusions**, such as **ideas of persecution** that the Mounties or the Mafia are out to get you, may be regarded as signs of mental disturbance—unless, of course, they *are*.

   delusions Firmly held but inaccurate beliefs that persist despite evidence they have no basis in reality.

   ideas of persecution A form of delusional thinking characterized by false beliefs that one is being persecuted or victimized by others.

   It is normal in Canada to say one "talks" to God through prayer. If, however, a person claims to have literally seen God or heard the voice of God—as opposed to, say, being divinely inspired—we may come to regard her or him as mentally disturbed.

4. *The person is in significant personal distress.* States of personal distress caused by troublesome emotions, such as anxiety, fear, or depression, may be considered abnormal. As noted earlier, however, anxiety and depression are sometimes appropriate responses to a situation. Real threats and losses occur from time to time, and the *lack* of an emotional response to them would be regarded as abnormal. Appropriate feelings of distress are considered normal unless they become prolonged or persist long after the source of anguish has been removed (after most people would have adjusted) or if they are so intense they impair the individual's ability to function.

Christof Stache/AP Photo/CP Images

Is this abnormal? One of the criteria used to determine whether behaviour is abnormal is whether it deviates from acceptable standards of conduct or social norms. The behaviour and attire of these spectators might be considered abnormal in the context of a classroom or workplace, but perhaps not at a sporting event.

5. *Behaviour is maladaptive or self-defeating.* Behaviour that leads to unhappiness rather than self-fulfillment can be regarded as abnormal. Behaviour that limits our ability to function in expected roles or to adapt to our environments may also be considered abnormal. According to these criteria, then, heavy alcohol consumption that impairs health or social and occupational functioning may be viewed as abnormal. **Agoraphobia**, behaviour characterized by an intense fear of venturing into public places, may be considered abnormal in that it is uncommon and also maladaptive because it impairs the individual's ability to fulfill work and family responsibilities.
6. *Behaviour is dangerous.* Behaviour that is dangerous to oneself or other people may be considered abnormal. Here, too, social context is crucial. In wartime, people who sacrifice themselves or charge the enemy with little apparent concern for their own safety may be characterized as courageous, heroic, and patriotic. But people who threaten or attempt suicide because of the pressures of civilian life are usually considered abnormal.

   Football and hockey players (and even adolescents) who occasionally get into altercations may be normal enough. Given the cultural demands of these sports, nonaggressive football and hockey players would not last long in varsity or professional ranks. But individuals involved in frequent unsanctioned fights may be regarded as abnormal.

   Let's look more in depth at the importance of cultural beliefs and expectations in determining which behaviour patterns are deemed abnormal.

agoraphobia A fear of places and situations from which it might be difficult or embarrassing to escape in the event of panicky symptoms or of situations in which help may be unavailable if such problems occur.

Cultural Bases of Abnormal Behaviour

As noted, behaviour that is normal in one culture may be deemed abnormal in another. Australian Aborigines believe they can communicate with the spirits of their ancestors and that other people, especially close relatives, share their dreams (Glaskin, 2011). These beliefs are considered normal within Aboriginal culture. But were such

beliefs to be expressed in a Western culture, they would likely be deemed delusions, which professionals regard as a common feature of schizophrenia. Thus, the standards we use in making judgments of abnormal behaviour must take into account cultural norms.

Abnormal behaviour patterns take different forms in different cultures. According to Hofmann and Hinton (2014), these differences may reflect cultural beliefs of how the body functions. During an anxiety attack, Westerners' catastrophic cognitions usually centre on symptoms associated with a heart attack. Cambodians, in contrast, fear death from the blockage of "tubes" that carry blood and wind throughout the body. As a result, symptoms of anxiety for Cambodians include tightness and soreness in the legs, cold hands and feet, and a sore neck.

The very words we use to describe psychological disorders—words such as *depression* or *anxiety*—have different meanings in other cultures, or no equivalent meaning at all. This doesn't mean that depression or anxiety doesn't exist in other cultures. Rather, it suggests we need to learn how people in different cultures experience emotional distress rather than imposing our perspectives on their experiences. People in China and other countries in the Far East generally place greater emphasis on the physical or somatic symptoms of depression, such as headaches, fatigue, or weakness, than on feelings of guilt or sadness, as compared to people from Western cultures (Ryder et al., 2008; Zhou et al., 2011).

Cultural differences in how abnormal behaviour patterns are expressed lead us to realize we must ensure our concepts of abnormal behaviour are recognizable and valid before we apply them to other cultures. The reverse is equally true. The concept of "soul loss" may characterize psychological distress in some non-Western societies but has little or no relevance to North Americans. Research efforts along these lines have shown that the abnormal behaviour pattern associated with our concept of schizophrenia exists in countries as wide-ranging as Colombia, India, China, Denmark, Nigeria, and the former Soviet Union, as well as many others (Jablensky, Sartorius, Ernberg, & Anker, 1992; Vespia, 2009). Furthermore, rates of schizophrenia appear similar among the countries studied. However, differences have been observed in some of the features of the disorder across cultures (Myers, 2011).

Societal views or perspectives on abnormal behaviour also vary across cultures. In our society, models based on medical disease and psychological factors have achieved prominence in explaining abnormal behaviour. But in traditional cultures, concepts of abnormal behaviour often invoke supernatural causes, such as possession by demons or the devil (Stefanovics et al., 2016). For example, in Filipino folk society, psychological problems are often attributed to the influence of "spirits" or the possession of a "weak soul" (Edman & Johnson, 1999). In Nigeria, over 30% of individuals surveyed in a community sample attributed mental illness to possession by evil spirits (Adewuya & Makanjuola, 2008).

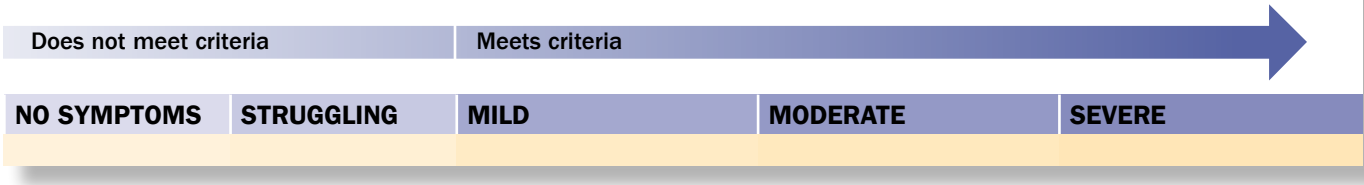
The Continuum between Normal and Abnormal Behaviour

Although our discussion has centred on how to determine whether or not a behaviour pattern is considered abnormal, it is important to recognize that most behaviours are on a continuum from normal to abnormal, and a precise line delineating the threshold between the two is not clear (Cuijpers, 2014). Keep in mind that you may have experienced some of the symptoms of the disorders discussed in the following chapters, but not necessarily in the range that would be considered abnormal. For this reason, we will introduce a continuum chart at the beginning of each chapter to emphasize the dimensional aspect of mental disorders. As you will see in Chapter 2, our present approach to diagnosis is categorical, in that an individual either meets the criteria for a particular mental disorder or does not.

It is one thing to recognize and label behaviour as abnormal; it is another to understand and explain it. Philosophers, physicians, natural scientists, and psychologists have

Continuum between Normal and Abnormal Behaviour

CHAPTER 1 • CONTINUUM CHART



used various approaches, or *models*, in an effort to explain abnormal behaviour. Some approaches have been based on superstition; others have invoked religious explanations. Some current views are predominantly biological; others are psychological. Let's now consider various historical and contemporary approaches to understanding abnormal behaviour.

FOCUS ON DIVERSITY

Mental Health Issues in Canadian Indigenous Communities

Canadian census data show our Indigenous population continues to be the fastest-growing segment of the population. The highest concentrations of Canada's more than 1.4 million Indigenous peoples are in the North and West, and more than half are now living in urban centres throughout Canada (Statistics Canada, 2013a). Along with rapid population growth, there is evidence of the resurgence of Canadian Indigenous cultures, especially in the arts, the media, education, commerce, and health (Aboriginal Planet, 2002; Arthur & Stewart, 2001; Letendre, 2002).

Despite this optimistic outlook, Indigenous peoples in Canada are still dealing with the effects of generations of physical, mental, emotional, and spiritual distress caused by the decimation of their communities, lands, and cultural identities. Consequently, both on- and off-reserve Indigenous peoples have to contend with extensive mental health, addiction, and medical issues in their communities as compared to the rest of Canadians. In particular, Canadian Indigenous peoples suffer from disproportionately higher rates of major depression, anxiety, posttraumatic stress disorder, alcoholism and substance abuse, sexual abuse, family violence, chronic disease such as heart disease and diabetes, lower life expectancy, and suicide (Kielland & Simeone, 2014).

According to Menzies (2014), the trauma experienced by one generation affects subsequent generations. Centuries of extreme social, cultural, and geographic disruption have contributed to the distress suffered by Indigenous peoples. The arrival of European settlers resulted in an estimated 90% decline in Indigenous populations (Trigger & Swagerty, 1996). The remaining Indigenous people were exposed to widespread, inescapable social and cultural disruption caused by government-sanctioned separation of children from their parents and communities plus systematic efforts to force Indigenous people to take on non-Indigenous cultural values at the cost of becoming disconnected from their own. This process of cultural assimilation was enforced by the relocation and social regrouping of Indigenous peoples onto remote reserves, by placing Indigenous children into residential boarding schools, and by unwittingly creating a forced dependence on government support. Poverty and powerlessness further marginalized Indigenous peoples and their cultural traditions from mainstream society (Poonwassie & Charter, 2001). Indigenous peoples' survival of and recovery from this long-standing personal and social devastation are a testament to their strength and long-suffering determination. Moreover, it gives credence to the significance and legitimacy of their perception of life.

On June 11, 2008, Prime Minister Stephen Harper apologized, on behalf of the Government of Canada, to former students of Indian residential schools (IRS). An Indian Residential Schools Resolution Health Support Program was established to provide mental health services to former IRS students and their families. Health Canada continues to work collaboratively with the Assembly of First Nations and the Inuit Tapiriit Kanatami to develop and implement mental health, addiction, and youth suicide prevention strategies (Health Canada, 2015a).

REVIEW IT

How Do We Define Abnormal Behaviour?

- **What are the criteria used by mental health professionals to define abnormal behaviour?** Psychologists generally consider behaviour abnormal when it meets some combination of the following criteria: (1) unusual; (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; and (6) dangerous.
- **What are psychological disorders?** Psychological disorders (also called *mental disorders*) involve abnormal behaviour patterns associated with disturbances in mental health or psychological functioning.
- **How are cultural beliefs and norms related to the classification and understandings of abnormal behaviour?** Behaviours deemed normal in one culture may be considered abnormal in another. Concepts of health and illness may have different meanings in different cultures. Abnormal behaviour patterns may also take different forms in different cultures, and societal views or models explaining abnormal behaviour vary across cultures as well.

HISTORICAL PERSPECTIVES ON ABNORMAL BEHAVIOUR

worldview Prevailing view of the times. (English translation of the German *Weltanschauung*.)

possession In demonology, a type of superstitious belief in which abnormal behaviour is taken as a sign that the individual has become possessed by demons or the devil, usually as a form of retribution or the result of making a pact with the devil.

trephining Harsh prehistoric practice of cutting a hole in a person's skull, possibly as an ancient form of surgery for brain trauma, or possibly as a means of releasing the demons prehistoric people may have believed caused abnormal behaviour in the afflicted individuals.

demonological model The model that explains abnormal behaviour in terms of supernatural forces.

Throughout the history of Western culture, concepts of abnormal behaviour have been shaped, to some degree, by the prevailing **worldview** of the time. Throughout much of history, beliefs in supernatural forces, demons, and evil spirits held sway. Abnormal behaviour was often taken as a sign of **possession**. In more modern times, the predominant—but by no means universal—worldview has shifted toward beliefs in science and reason. Abnormal behaviour has come to be viewed in our culture as the product of physical and psychosocial factors, not demonic possession.

The Demonological Model

Let's begin our journey with an example from prehistory. Archaeologists have unearthed human skeletons from the Stone Age with egg-size cavities in the skulls. One interpretation of these holes is our prehistoric ancestors believed abnormal behaviour reflected the invasion of evil spirits. Perhaps they used this harsh method—called **trephining**—to create a pathway through the skull to provide an outlet for those irascible spirits. Fresh bone growth indicates some people managed to survive the ordeal.

Threat of trephining may have persuaded people to comply with group or tribal norms to the best of their abilities. Because no written records or accounts of the purposes of trephination exist, other explanations are possible. Perhaps trephination was used as a primitive form of surgery to remove shattered pieces of bone or blood clots that resulted from head injuries (Maher & Maher, 1985).

Explanation of abnormal behaviour as a result of supernatural or divine causes is termed the **demonological model**. Ancient peoples explained natural forces in terms of divine will and spirits. The ancient Babylonians believed the movements of the stars and planets were fashioned by the adventures and conflicts of the gods. The ancient Greeks believed their gods toyed with humans; when aroused to wrath, the gods could unleash forces of nature to wreak havoc on disrespectful or arrogant humans, even clouding their minds with madness.

Origins of the Medical Model: An "Ill Humour"

Not all ancient Greeks believed in the demonological model. The seeds of naturalistic explanations of abnormal behaviour were sown by Hippocrates and developed by other physicians in the ancient world, especially Galen.

Hippocrates (ca. 460–377 BC), the celebrated physician of the Golden Age of Greece, challenged the prevailing beliefs of his time by arguing that illnesses of the body and mind were the result of natural causes, not of possession by supernatural spirits. He believed the health of the body and mind depended on the balance of **humours** or vital fluids: phlegm, black bile, blood, and yellow bile. An imbalance of humours, he thought, accounted for abnormal behaviour. A lethargic or sluggish person was believed to have an excess of phlegm, from which we derive the word **phlegmatic**. An overabundance of black bile was believed to cause depression, or **melancholia**. An excess of blood created a **sanguine** disposition: cheerful, confident, and optimistic. An excess of yellow bile made people "bilious" and **choleric**—that is, quick tempered.

Hippocrates's theory of bodily humours is of historical importance because of its break from demonology. It also foreshadowed the development of the modern medical model, the view that abnormal behaviour results from underlying biological processes. Medical schools continue to pay homage to Hippocrates by having new physicians swear the Hippocratic oath in his honour.

humours Four fluids in the body: phlegm, black bile, blood, and yellow bile. Hippocrates believed the health of the body and mind depended on their balance.

phlegmatic Slow and stolid.

melancholia State of severe depression.

sanguine Cheerful.

choleric Having or showing bad temper.

Medieval Times

The Middle Ages, or medieval times, cover the millennium of European history from about AD 476 through AD 1450. Belief in supernatural causes, especially the doctrine of possession, increased in influence and eventually dominated medieval thought. The doctrine of possession held that abnormal behaviours were a sign of possession by evil spirits or the devil. This belief was embodied within the teachings of the Roman Catholic Church, which became the unifying force in Western Europe following the decline of the Roman Empire. Although belief in possession dates from before the Church and is found in ancient Egyptian and Greek writings, the Church revitalized it. The treatment of choice for abnormal behaviour was **exorcism**. Exorcists were employed to persuade evil spirits that the bodies of their intended victims were basically uninhabitable. Their methods included prayer, waving a cross at the victim, beating and flogging, and even starving the victim. If the victim still displayed unseemly behaviour, there were yet more powerful remedies, such as the rack, a device of torture. It seems clear that recipients of these "remedies" would be motivated to behave acceptably as much as possible.

exorcism Ritual intended to expel demons or evil spirits from a person believed to be possessed.

Witchcraft

The late 15th through the late 17th centuries were especially dangerous times to be unpopular with your neighbours. These were times of massive persecutions of people, particularly women, who were accused of witchcraft. Officials of the Roman Catholic Church believed witches made pacts with the devil, practised satanic rituals, and committed heinous acts such as eating babies and poisoning crops. In 1484, Pope Innocent VIII decreed witches must be executed. Two Dominican priests compiled a manual for witch hunting, called the *Malleus Maleficarum* ("The Witches' Hammer"), to help inquisitors identify suspected witches. More than 100 000 accused witches were killed in the next two centuries.

Modern scholars once believed the so-called witches of the Middle Ages and the Renaissance were actually people who were mentally disturbed. They were believed to have been persecuted because their abnormal behaviour was taken as evidence they were in league with the

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Exorcism. This medieval woodcut illustrates the practice of exorcism, which was used to expel evil spirits who were believed to have possessed people.