

CHAPTER ONE

UNDERSTANDING ABNORMALITY: A LOOK AT "CRAZY"

LEARNING OBJECTIVES

- ▶ Examine thoughts about "crazy" and myths of abnormality
- ▶ Identify goals in studying abnormal psychology
- ▶ List various myths about abnormality
- ▶ Define normality and abnormality
- ▶ Differentiate abnormality and mental illness
- ▶ Discuss and identify criteria of abnormality
- ▶ Apply the criteria of abnormality
- ▶ Examine historical perspectives of abnormality
- ▶ Explore the connection between understanding and responding to abnormality
- ▶ Explain the dynamic aspects of abnormality
- ▶ List various mental health professionals
- ▶ Recognize the differences between psychologists and psychiatrists

CHAPTER OUTLINE

- ▶ Thinking about "Crazy"
- ▶ Myths
- ▶ Defining Abnormality
- ▶ Mental Illness
- ▶ The 4 Fs of Abnormality
- ▶ Historical Perspectives of Abnormality
- ▶ Supernatural Perspectives
- ▶ Biological Perspectives
- ▶ Psychological Perspectives
- ▶ Integrationist Perspectives
- ▶ Psychopathology as Dynamic
- ▶ Professionals in Mental Health

Thinking about "Crazy"

Think about the craziest thing you have ever seen or experienced. What are the things that made it crazy? Write down the three most abnormal things you have ever seen or experienced and what contributed to them being labeled as abnormal.

You develop many ideas about "crazy" from a variety of sources. We are fascinated with "crazy" but from afar. One of the most common ways that people construct ideas of abnormality is through media. Films provide you with entertainment mediums for which you can observe abnormality, from a distance. There are numerous films that attempt to depict abnormality (Gabbard & Gabbard, 1999; Wedding & Niemiec, 2014) and usually do so with entertaining Hollywood twists. This conveys a representative view of abnormal psychology, in which it is the study of patients who are locked in a padded room contained in a straight-jacket. While abnormal psychology does include the examination of disorders and their occurrence within psychiatric facilities, it encompasses much more.

ALL RIGHTS
RESERVED

HOW ABOUT THESE THINGS? ARE THESE ABNORMAL?



What about these behaviors, thoughts, or feelings?

1. Developing multiple homicidal personalities.
2. Not leaving your apartment because you are worried that a deadly killer will get you.
3. Having visions of dark figures leads to frenzied dance performances and ultimately ends in suicide.
4. Avoid stepping on cracks because it may be bad luck.
5. Lack of emotional expression and repetitively watching the same court show while being able to count, within seconds, the exact number of fallen toothpicks from a full box.

Some of the above-mentioned behaviors are depicted in films. You may enjoy watching films and media of abnormality because it leads to you feeling

Social Comparison

Comparing yourself to others to elevate your worth or motivate upward change

better about yourself or confirming that you are not "crazy" like other people, deemed **social comparison**. Social comparison is the social psychology phenomenon in which you compare yourself to others in attempts to elevate your worth or encourage upward change (Festinger, 1954). Thus, watching films may be associated with a normalizing process in which you feel normal when you compare yourself to characters who depict "crazy" in film. One of the reasons you may have been interested in taking an abnormal psychology class is to satisfy your curiosity for vicariously experiencing abnormality. Another reason may be to confirm that you are, indeed, normal.

While films are entertaining and may lead us to feel good about our position, they carry a risk of propagating myths and misconceptions. Wedding and Niemiec (2014) suggested that movies are "important in influencing the public perception of mental illness [and] have a greater influence than any other art form" (p. 2). Byrne (2009) listed five rules of movie psychiatry and discussed how these have led to cinematic misrepresentations. He strongly urges mental health professionals to actively engage in discussion of film and psychopathology rather than disregarding it or advocating censorship (Byrne, 2009).

Some Myths

There are various myths found within abnormal psychology. Myths come from a variety of sources. Many myths also contribute to a lack of understanding of psychopathology and its treatment. Consider the following list and if you have heard or believe any of these ideas and if they are accurate or inaccurate (some of these were collected from Lilienfeld, Lynn, Ruscio, & Beyerstein, 2010):

- ▶ There is no such thing as normal.
- ▶ Happiness is the goal of therapy.
- ▶ All therapists practice the same way.
- ▶ Are people with schizophrenia dangerous?
- ▶ Schizophrenia means having multiple personalities.
- ▶ Autism is on the rise and it's contagious.
- ▶ Too many people rely on drugs to fix their problems.
- ▶ Bipolar disorder means that you are happy one moment and then completely enraged the next.
- ▶ Suicide is the result of being depressed.
- ▶ Are people who have alcohol-related abuse problems capable of drinking in moderation?
- ▶ Is ADHD real?
- ▶ Do people with depression just need to get over it and go outside?
- ▶ Do psychologists and psychiatrists merely create labels to pathologize people who are normal?

How did you develop these ideas? Did you learn about abnormality through an entertaining film? Did you have experiences with someone who seemed odd (like you noted previously)? As you are presented with information about various psychological disorders, consider how your ideas developed. To assist you in doing this, think of **myths**. Reflect on movies, media, and your own experiences with regard to how you understand psychological disorders. Then talk with someone or journal about how these movies or experiences have shaped your understanding of abnormal psychology. You will examine your current understanding of psychopathology alongside what you learn about abnormal psychology.

Myths

Stories or constructions of ideas

M **Movies**

Y **Your experience**

T **Talk about the differences**

H **How does this relate to what you have learned about abnormality?**

Much of the time our perceptions of people and **attributions** of their behaviors affect our behaviors and shape our thoughts of abnormality. Attributions are the tendency to seek out and explain the reasons for others' behaviors (Heider, 1958). Social psychology has taught us that we are more likely to make **dispositional attributions** about others' behaviors (Ross, 1977). Dispositional attributions are used when explaining a person's behaviors by aspects of who they are (Heider, 1958). Thus, when we observe people behaving in a way that we have not seen before, or that fits with the majority of behaviors, do we think about how they are "crazy"? Essentially, are you prone to make dispositional attributions for abnormal behavior and providing people with a general label?

Attributions

Tendency to seek out and explain the reasons for others' behaviors

Dispositional Attributions

Tendency to explain a person's behaviors by aspects of who they are

Psychopathology

Various psychological disorders or atypical illnesses that affect people

Along with challenging the ideas you hold about **psychopathology**, you will develop an understanding of various disorders. Psychopathology is the examination of various psychological disorders or atypical illnesses that affect people. This term will be used interchangeably with abnormality. You will challenge previously held beliefs about psychopathology and refine your current understanding to achieve more accurate images of individuals who have various disorders.

As you consider influences that shape your understanding of disorders, also think about your attitudes toward people that have disorders. Do you tend to think negatively of people with disorders? Do you tend to avoid someone who you might think has a disorder? Are you fearful that someone with a disorder might harm you? Do you refer to someone suffering with a disorder merely by the label of the disorder? All of these questions get at how we view abnormality. The goal is to reflect on the humanity within abnormality rather than reducing people to a label and making them sub-human.

When attending a psychology conference, one of the authors observed a man from the conference hotel window. The man was disheveled, his hair was unkempt, and he was walking on a sidewalk talking to people who were not physically present. The assumption was that this man was experiencing some features of psychosis due to his behaviors. The more striking feature of this scene was not the man talking to imaginary people but others' reactions. People who were walking on the same side of the road would abruptly walk into the street, keeping distance, as soon as they noticed the man's behaviors. It was apparent that others were fearful or wanted to at least avoid being in close proximity to this man.

Language is another important aspect of understanding. Language can shape thinking (Whorf & Carroll, 1998). You often give things a generalized or catch-all label when you do not understand it. The tendency to call people crazy, is the tendency to state that a lack of understanding of disorders warrants a general label. For example, the word crazy, along with other words such as insane, mad, nuts, wacko, deranged, lunatic, and weirdo are misnomers.

Some of these labels have developed from various myths. For example, the label of lunatic comes from the ancient Greek philosopher Aristotle, who believed that the brain was affected by the moon, deemed the lunar lunacy effect (Arkowitz & Lilienfeld, 2009). Thus, lunatic became the label for people who display some mental illness or aberrant behaviors due to the influence of the moon. Arkowitz and Lilienfeld (2009) discussed how this belief has been perpetuated in movies that display scary or violent behaviors occurring during full-moon nights. This myth has strongly been believed by many people despite evidence from a meta-analysis of 37 studies revealing that the moon does not account for much of people's behavior (Rotton & Kelly, 1985). These labels are potentially detrimental because they often elicit

stigma, meaning that the labels are used with a derogatory or negative attitude toward individuals suffering from disorders labels. Language can also lead to dehumanization. Dehumanization involves removing human attributes or characteristics that can be in extreme forms of violence or in subtle everyday forms (Haslam, Loughnan, Reynolds, & Wilson, 2007). Zimbardo (2007) discusses lessons from his classic Stanford Prison Experiment that led to dehumanization from randomly assigned labels. Labels have the power to strip away humanity and influence our behavior.

Stigma

Negative attitudes associated with a label

When taking a look into abnormality, one of the things that you will notice is that abnormality is not outside of humanity. This means that abnormality is not behaviors that have rarely or never been witnessed, or people who are completely different from you. Rather, with imposed criteria, abnormality is often people who display difficulties in functioning, or stress brought about from behaviors, thoughts, and emotions that are similar to yours. You will be confronted with the idea that abnormality is not exemplified by "crazies" in a straight-jacket, void of coherent words, but rather people, with humanity, who are often suffering, feeling immense pain, or have impaired functioning in their life.

Defining Abnormality: What Is Normal?

[O]ne out of every four people is suffering from a mental illness.
Look at your three best friends. If they're ok, then it's you.

—Susan Musgrave (1994, p. 47)

Am I normal? This question is one of the reasons that people may struggle with defining abnormality. Sometimes, the difficulty for people in defining abnormality may be due to the cognitive effort to pin down a comprehensive definition. Also, people may avoid defining it because it may lead to them judging others as abnormal and a fear of ostracizing or stigmatizing them. However, many people may avoid defining abnormality because it may challenge how they think of themselves.

To consider abnormality is often reflecting on the status of your normality. Most people ask themselves if they are normal as a common occurrence with developmental phases of life. Specifically, this question is more apparent within the particular developmental stage posed by Erikson (1980), Identity versus Role Confusion. During the adolescent to early adulthood years, people seek to discover their identity in comparison to others, and ask about their



normality while considering their identity. It is the classic teenage stereotypical questions of "Who am I?" and "Am I normal?"

Relativism

A view that promotes subjective value

Thus, people may opt out of considering definitions of abnormality and gravitate toward a relativist approach. **Relativism** is affirming that there are no absolutes and promoting the subjective value of things. Relativism may lend itself to you saying and thinking things such as "What is normal anyway?" or "We are all abnormal in our own way." A popular cliché often used that represents this abandonment of intentionally seeking a definition, is that "normal is a setting on a dryer." This approach affirms the notion that abnormality does not exist or that it is relative and unable to be defined. Saying that there is no such thing as normality allows you to avoid its discussion and circumvent answering the initial question, as to whether you are normal.

Conceptualization

Process of understanding and imagining the various aspects of psychopathology

Defining abnormality does not have to be daunting or even challenge self-perceptions. People throughout time and cultures have sought to explain and understand abnormality. Moreover, how one understands abnormality affects what they do with it. More formally, **conceptualization** of abnormality affects treatment. Conceptualization is the process of understanding and imagining the various aspects of psychopathology. This will be looked at further when examining historical perspectives of abnormality. For now, let's turn to defining abnormality and looking first at its development.

Mental Illness

One popular view of abnormality was set up as a dichotomy, mentally ill or not. Abnormality might be more simply understood if it were a function of determining whether people were mentally ill. However, abnormal psychology consists of more dimensions than this dichotomous view.

Neurotransmitters

The chemical messengers in the brain that are used in communicating from neurons

Two opposing popular views have discussed mental illness as a standard for abnormality, Thomas Szasz and David Ausubel (Lilienfeld, 1994). Thomas Szasz vehemently argues that mental illness is a myth. The most pressing case against mental illness is that there are no biological tests that can currently determine if someone is mentally ill. This does not mean that there are no biological tests to determine the levels of **neurotransmitters** in a person. Neurotransmitters are chemical messengers in the brain that are used in communicating from neurons. This will be discussed further in subsequent chapters. There are ways to determine the levels of neurotransmitters for an individual. However, what this means is that neurotransmitters alone are not sufficient to determine whether an individual has a mental illness. In other words, you are unable to merely provide your blood or urine and someone else determine that you have a mental illness based on that sample.

The difficulty with using mental illness as a criterion is that it offers nothing more than the dichotomous label of either the person being fine mentally or not. The picture of mental illness does not help elicit nomenclature or

understanding for individuals who exhibit psychopathology. Thus, there is a necessity to further elaborate on the dimensions of abnormality.

The 4 Fs of Abnormality: Frequency, Function, Feeling Pain, and Fatal

When considering what constitutes abnormality it is crucial to impose four criteria, or the four Fs. The four Fs are concepts that will illuminate the conceptual differences between normative behavior and abnormal behavior as well as the difference between being eccentric and having a disorder. Further, these criteria will be referenced and revisited when considering various disorders.

Other authors have proposed similar criteria for distinguishing between mental disorders and normal behaviors. Nolen-Hoeksema (2007) initially posited that abnormality could be understood and assessed by using three Ds: dysfunction, distress, and deviance. Later, she included a fourth dimension by which mental health professionals use for discerning abnormality: deviance, distress, dysfunction, and danger (Nolen-Hoeksema, 2011, 2014). Frances (2013) noted that definitions of mental disorders consist of features involving distress, disability, dysfunction, dyscontrol, and disadvantage.

One of the commonly referred to instruments used for clinical assessment and understanding of disorders is titled *The Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5; American Psychiatric Association; APA, 2013). Due to the prominence of the DSM-5 within the psychotherapeutic profession, it will be referenced throughout this book, especially when considering diagnostic features of various disorders. More discussion of its development and use will be given attention in Chapter 3. The DSM-5 emphasizes that to meet diagnostic criteria for most disorders there is evidence of distress and impairment in social, occupational, or other areas of functioning (APA, 2013). The DSM-5 also indicates that deviance in the frequency of the thoughts, behaviors, or emotions is outside of what may be expected or culturally sanctioned (APA, 2013). The DSM-5 (2013) provides the example that grief experienced from the death of a loved one does not qualify as a mental disorder.

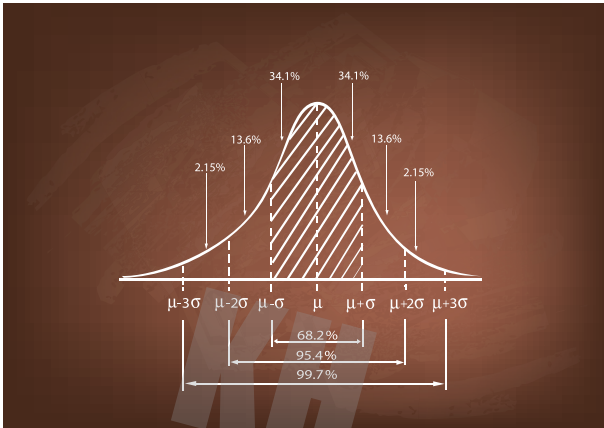
The four Fs of abnormality: frequency, function, feeling pain, and fatal encompass some of the same conceptual aspects of the dimensions proposed by other authors, though the current labels are more congruent with, and descriptive of, the dimensions. Further, these Fs serve to augment conceptualization of psychopathology by complementing the DSM-5 definition of abnormality and offering imposed criteria. Specifically, the DSM-5 suggests that behavior that is merely a deviation from social norms is not sufficient to qualify as a disorder; the behavior needs to also result in some impairment in functioning (APA, 2013).

The Diagnostic and Statistical Manual of Mental Disorders

Mental health professionals' instrument used for clinical assessment and understanding of disorders

Frequency

In understanding abnormality it is useful to reflect on normality. So, what is normal? How about this?



NORMAL BELL CURVE

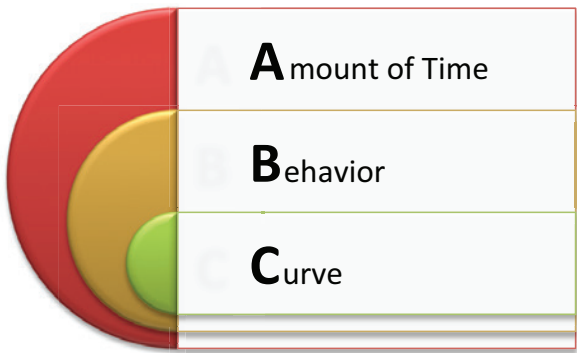
©lamnee/Shutterstock.com

Normal Distribution

A statistical perspective of normality

If you have taken a statistics class and seen this before, then it will be an imperative to not elicit any further stress that this may be associated with. Let's think through this with the application for abnormality. This picture represents normality and is referred to as a normal bell curve or the **normal distribution** (Gauss & Davis, 1963). The normal distribution is a statistical perspective of normality that represents a bell-shaped curve.

So how does this help us understand anything about people and abnormality? The bell curve represents a normal distribution. This represents normality with a frequency distribution. For example, do you wash your hands at least once every day or two? How about at least five times per day? What about 1,000 times per day, most days of the year? This illustrates the ABC's of Frequency: amount of time, behavior, and the curve.



Courtesy of Authors

The first component of frequency is the amount of time that behavior persists. Essentially, how long do the thoughts, feelings, or behavior endure? Washing your hands excessively within one day may not pose any concerns. However, washing your hands a large number of times each day for most days of your life can lead to feeling pain, impaired function, and can even be fatal. Thus, frequency involves the amount of time that the behavior is experienced. For example, feeling intense sadness, pain, and a loss of an appetite shortly after the loss of a loved one may be normative for many people who experience grief. However, if you continue to not eat or barely eat for several months after the loss, then other concerns related to your health may arise.

Next is the frequency of the behavior as an indicator of abnormality. How often does the behavior occur? Abnormality, as discussed before, is not outside of humanity, in that hand-washing behaviors represent behavior of a majority of individuals. When imposing the frequency criteria, you may notice that a high frequency of hand-washing behaviors (over 100 times per day) to reduce anxiety about thoughts of cleanliness may demonstrate features of a disorder. In fact, you will revisit this disorder in detail in Chapter 8. This example illustrates how a high frequency of behavior is deemed abnormal or disordered. Low frequencies may also serve as indicators. For example, someone who only experiences pleasure from an activity once a year may exhibit a low frequency of behavior. The idea is that many behaviors are normally distributed in terms of their frequency.

Lastly, is the curve, the normative bell curve that is. How many people struggle with this issue? When considering the frequency by which people wash their hands, then you may notice a low frequency or small percentage of people engage in washing their hands over 100 times per day. Further, a low percentage of people would be identified who never wash their hands. This depicts the idea of the normative distribution. When you look at the normative distribution, the line in the middle represents average, or the mean. Using this with people, you would be able to state that a majority of people, 68%, fall within one standard deviation of the mean and most people, 96%, fall within two standard deviations of the mean. So, what does it all mean?

Apply the idea of intelligence. The average **intelligence quotient (IQ)** is 100. An IQ is the score that represents a person's intelligence compared to a normative sample. Many people have an average IQ, ranging between 85–115, one standard deviation. Moreover, most people have an IQ falling between 70–130, two standard deviations. Thus, it would be normative in frequency to have an IQ between 70–130. You could expect 96% of the population to have an IQ within this range. Therefore, it is fewer people that you would expect to have an IQ less than 70, which would be indicative of an intellectual disability.

Intelligent Quotient

A score that represents a person's intelligence compared to a normative sample

Much of psychology is concerned with the majority, or the 96% of the normative distribution. Essentially, many psychology experiments look at what affects most people. Abnormal psychology is concerned with the small percentage of the population, the 2% that is two standard deviations below the mean. Abnormal psychology focuses on smaller number of people or smaller percentage of the population, for example those who wash their hands excessively to mitigate anxiety. However, it is important to note that frequency alone does not completely paint the picture of abnormality or disorder.

Function

How about this picture?

This may be an example of behavior that does not occur often within society, unless you are at a child's *Toy Story*-themed birthday party. Either way, this behavior may not represent the majority of what people do—even at a birthday party. Frequency alone does not provide enough to establish abnormality.

Let's examine some other "strange" behaviors. Is staring someone in the eyes in an elevator an abnormal behavior? It usually feels uncomfortable for many people because it defies **social norms**. Social norms are implicit instructions for social behavior based on the social situation (Sherif, 1936). For

example, when in an elevator there are numerous social norms including facing forward, looking down or up at the floor numbers, and not engaging in lengthy dialogues with others. Bringing a chair from outside an elevator and sitting down in it in the middle of an elevator would defy social norms for elevator behaviors. Thus, behaviors such as these, by default, tend to be rare because they don't align with the majority.

Along with frequency, it is very important to consider functioning as criteria for disorders. Individuals who defy social norms by wearing alien hats on their face or by sitting in a chair in the middle of an elevator do not necessarily show dysfunction resulting from, or related to, their behaviors. Individuals who represent a smaller percentage of the population but evidence no impairment in function may be seen as **eccentric** or expressive rather than possessing a disorder or exhibiting abnormality. Eccentric behavior would be behavior that may violate social norms but does not impair function, elicit pain, or carry a likelihood of fatality. Eccentricity is not equivalent to abnormality.

There are times when you engage in behaviors that few other people do, such as sitting in a chair in an elevator or requesting foot-claps when



Photo © Rachel Curtis

Social Norms

Implicit instructions for social behavior based on the social situation

Eccentric

Behavior that may violate social norms but is not a disorder

meeting people, as opposed to handshakes. Many people yearn for expressing their identity through attempting to be unique or an iconoclast. Sometimes people will intentionally engage in non-majority behaviors to do this. People may seek a number of methods to express individuality including dying their hair various colors, tattoos, or body modifications. However, if engaging in those behaviors does not impair functioning or other criteria, then you might refer to yourself as eccentric, or the behavior as odd rather than disordered or psychopathological.



©Cora Reed/Shutterstock.com

This is also where there is a need to consider cultural influences. Individuals who have various cultural influences, such as a different ethnicity than the majority need consideration. Some behaviors viewed as normative in a person's ethnicity of origin may be viewed as deviant from behaviors represented by the majority or dominant ethnicity.

These are some of the reasons that deviance as a criteria does not hold by itself and why the DSM-5 suggests that deviance without impaired functioning should not be used to implicate a disorder. An impairment in functioning means that you are unable to fulfill or meet the demands of life or self-established goals. Areas of functioning could include academic, occupational, relational, social, and personal domains. More specifically, this could be seen as not making it to work, being late for a class, failing a class, relationship difficulties, or not taking baths or maintain personal hygiene.

When people engage in behaviors that are not represented by the high frequency of the distribution, and these behaviors are causing a lack of functioning, then the picture of abnormality is beginning to develop. For example, when someone feels compelled to wash their hands 100 times per day (high frequency) in order to reduce any anxiety which leads to them being late for work and ultimately losing their job, then function has been affected.

Feeling Pain

One of the core features for many individuals who experience a disorder is feeling some pain or distress from their thoughts, behaviors, or emotions. The DSM-5 suggests that there must be evidence of distress for a num-

ber of psychological disorders (APA, 2013). This feature of abnormality is extremely important to underscore because it highlights the humanity of people who are suffering from a disorder rather than the “monsters” that we may believe them to be. In fact, most individuals who voluntarily seek mental health professionals are feeling some level of pain brought on by the symptoms or disorder. A number of people who seek counseling might be experiencing great levels of pain because they may have sought other alternatives before therapy.

Feeling pain, in addition to other criteria, reveals that abnormality is not just some eccentric behavior that may lead to someone being late. Feeling pain as a criterion, points to the real burden a person is experiencing from the behaviors, thoughts, or emotions. The pain experienced may be a result of physical, emotional, or psychological pain. Newer research examining pain has turned its attention to examining the intersections of cognitive, social, and physical mechanisms of pain (Wasan & Edwards, 2008). Thus, the pain felt from people who have a disorder may be present in any of these areas.

Let's revisit the hand-washing behavior. An individual who washes their hands around 100 times per day, leading to functioning being impaired and scarring, may experience significant pain from this behavior. The pain may be experienced as a direct result of the physical pain from the behavior or an emotional pain related to feeling compelled to engage in the behavior.

That being said, there are individuals who may not voluntarily seek mental health services and meet diagnostic criteria for a disorder. For example, an individual who has a specific personality disorder may harm others with a lack of remorse and show no signs of pain from behaviors resultant of their personality. These few exceptions for the criteria of feeling pain indicate that it is not sufficient as a criterion by itself.

Fatal

The last criterion is the one that tends to be perceived as the most dire and immediate. Does the person's thoughts, actions, or emotions place themselves or others in fatal situations? Essentially, is the behavior likely to be fatal to the person displaying the behavior or to others? Fatality can consist of threats to a person's life or health.

Someone who is experiencing a lack of motivation to do anything or get out of bed for most days, resulting in diminished functioning and feeling emotional pain, may threaten their physical health by not eating or not exercising. Another example can be found in someone who is driving, and is extremely worried about everything that could go wrong while driving—feeling as though they are putting themselves or others at risk for an automobile accident.

Fatality is also a criterion that is imposed on some behaviors of abnormality where feeling pain may be present. For example, an individual who actively seeks to manipulate or harm others without remorse would meet the criterion for fatality but not necessarily feeling pain. Further, there are some features of disorders where people experience euphoria or great pleasure, however, the feelings influence people to put themselves or others in high-risk situations.



Case Vignette

THE 4 FS

A 22-year-old male, named Felix, who is attending college has recently experienced a relational break-up. His relationship ended due to his girlfriend stating that she was no longer interested in him and wanted to date other people. Felix was deeply upset by this news. He lost his appetite for food and stopped eating. He stopped going to his classes. Felix even stopped taking care of his hygiene by not bathing, brushing his teeth, and wearing the same clothes for several consecutive days. Felix began to drink alcohol more than he ever had. When his friends expressed concern, he stated that he drank so much to just forget about his girlfriend. Felix began to have blackouts from binge drinking. One night, four weeks after the break-up, he went to a party, drank almost two bottles of whiskey and several beers, and then insisted on trying to jump off a two-story ledge. He told his friends that he did not care if he would survive the jump because it would be better than dealing with the pain of losing his girlfriend. Felix later felt embarrassed by this event and slowly retreated from his friends and occasionally drank alcohol by himself. He began to loathe himself and wished that he didn't feel as if he had to drink. Felix was failing his courses, not responding to his friends' attempts to hang out with him, and rarely left his apartment. He carried on drinking alcohol, often several drinks of liquor after an hour of waking up, most days for several months.

Reflect on the case above. According to the criteria of the 4 Fs, would Felix exhibit symptoms of abnormality? If so, which of the Fs are present and how? Write down your responses.

A Look Into the Past: Historical Perspectives of Abnormality

Since there have been humans, abnormality has been found. Abnormality has existed for a long time. Through history, there is documentation of human struggles, how humans have understood their concerns and struggles, and means for alleviating their concerns. Benjamin and Baker (2004) state “one can find evidence of psychological interventions dating to the beginnings of recorded history” (p. 3). Thus, people have understood human struggles and psychopathology and have implemented various interventions taking many forms and labels.

More importantly, how people have understood abnormality is key to realizing how it is dealt with. Examining historical perspectives of abnormality is much more than just filling the pages with how things came to be, rather it greatly informs understanding of abnormality. One of the gems gleaned from studying historical perspectives of abnormality is the understanding of how others viewed abnormality. Why is this important? As mentioned previously, how people view abnormality affects how they respond to it. In other words, how people understand abnormality affects treatment and interventions. This is illustrated in the figure below (see Figure 1.1).



FIGURE 1.1 **UNDERSTANDING ABNORMALITY**
Courtesy of Authors

Thus, in reviewing various historical perspectives, attend to how these views influence responses to abnormality. You will notice that people’s understanding of abnormality is tied directly to their responses. This foundation will be built upon when considering current psychological perspectives. Historically, people have understood abnormality in a few different contexts: supernatural, biological, and psychological.

Releasing the Demons and Evil: Supernatural Perspectives

In the Stone Age, abnormality was viewed as a source of spiritual possession. People who displayed psychopathology were believed to have had some spirit possess them. As a result, the treatment to cure this abnormality was to rid the person of the spirit. This was done through a practice called

trefphination. Trefphining a surgical treatment in which a tool was used to drill a hole in the head of a person in an attempt to release the spirit that possessed the person.

Much of trefphination understanding is credited to archaeologist Ephraim Squier, and Paul Broca (popularly known for identifying Broca's area in the brain), however there are early accounts of trefphining from Hippocrates (Gross, 1999). Gross discussed the history of trefphining as it occurred within Neolithic primitive tribes. Research on the trefphined skulls indicated that the skulls were not a result of trauma or accidents but appeared more intentional with evidence supporting that individuals survived the trefphination process. In the 17th century, trefphination was a procedure implemented to release evil air from the brain or head and was later used as a means to treat mental illness (Gross, 1999).

How people viewed abnormality affected what they did with it. When the source of psychopathology was seen as a spiritual possession, it then made sense to treat the psychopathology with a supernatural treatment, by releasing the spirit from the individual.

Some tribes and groups of people in history had healers, medicine men, or shamans who dealt with issues of mental and physical illness (Frances. 2013). In Frances' discussion of the history of psychiatry he describes the ancient traditions and practices of these shamans. Shamans used magic to assess and diagnose individuals. Diagnoses involved curses and spirits that resulted in some psychopathology. Treatment and healing practices involved chants, dancing, singing, and other means that would challenge the spirits or encourage individuals with

Trefphination

A surgical treatment in which a tool is used to drill a hole in the head of a person



Alton S. Tobey; 1966 mural: *Inca Trefphination* installed at Hall of Physical Anthropology, The Smithsonian Institution, Washington DC; www.altontobey.com/trefph.html.

Turning our attention to another historical and cultural reference point, Greeks and Romans, we see more examples of supernatural understandings of psychopathology. Gods and goddesses were at the pinnacle of existence within ancient Greek and Roman culture. Greek mythology contains a variety of stories that depict abnormality through gods, goddesses, and heroes and heroines. These understandings of psychopathology have continued to have an impact on abnormal psychology. One hero in Greek mythology, who is known for being so beautiful that he fell in love with his own reflection, Narcissus (Hamilton, 1942), is referenced as a personality disorder. The personality disorder essentially involves being consumed with one's self.

Phrenology

Have you ever heard or stated that depression was a chemical imbalance? If so, then you have heard of a biological perspective of understanding psychopathology. In fact, this idea of a chemical imbalance is not a new idea, it dates back to Hippocrates. Sticking with the trephination example, from the Hippocratic perspective, it was a process used to release one of the humors, blood (Gross, 1999). Hippocrates viewed the sources of abnormality from a biological lens, in that there was an imbalance of humors: in the body (Frances, 2013). Thus, how you understand psychopathology affects what you do with it. For Hippocrates, a result of abnormality being understood as a biological imbalance of fluids, led to treatments such as bloodletting. Trephination was one of these practices where blood was released from an individual's skull to resolve psychopathology.

©Photo-Jope/Shutterstock.com



PhrenologyBust

Phrenology became a popular view and practice. From this, some individuals even established businesses that incorporated phrenology busts to help people become trained in phrenology.

It's in Your Head: Psychological Perspectives

Out of the development of philosophical examination and the movement toward science, a number of psychological perspectives began to emerge. Psychological perspectives sought to explain abnormality as a source of psychological rather than supernatural or natural causes. In other words, psychological perspectives sought to examine psychopathology from the individual rather than religious/spiritual and biological understandings.

Psychology is a newer science. Its formal beginnings get attributed to Wilhelm Wundt with its official year being 1879. From around this time onward, psychological perspectives began taking shape and influencing how people viewed sources of abnormality. Sources of psychopathology were viewed as problems with unconscious conflicts, deficiencies in reinforcement contingencies or schedules of reinforcements, faulty belief systems, inability to express and regulate emotional experiences, and struggles with life's givens or with meaning making. Psychotherapy theories became ever present to explore abnormality and treat it. There are a variety of psychological perspectives and theories that you will read about in the next chapter. Many of these popular perspectives include:

- ▶ Behavioral
- ▶ Psychoanalytic
- ▶ Experiential
- ▶ Cognitive

You will see how each of these psychological perspectives and theories are tied directly to treatments for psychological disorders. Further, these perspectives have also been integrated and used within integrationist frameworks, meaning that a number of psychological perspectives of abnormality which include one, or more than one of the abovementioned.

Are We There Yet? Integrationist Perspectives

A number of mental health professionals will operate on integrationist frameworks, such as the **biopsychosocial model**. The biopsychosocial model was established to move beyond a biomedical framework and toward attending to the humanness of patients (Engel, 1996). The biopsychosocial model allows practitioners to understand psychopathology from the interplay of an individual's biology (e.g., genetics, neurotransmitters), psychology (e.g., thoughts, feelings, behaviors), and social (e.g., relationships, relational patterns) aspects.

Biopsychosocial Model

A perspective that promoted attending to the humanness of patients

The idea of accommodating multiple theoretical frameworks can also be found in the DSM-5 (APA, 2013). The DSM-5 indicates that it is used by practitioners and researchers from various theoretical backgrounds and it seeks to use language that is appropriate for any of these perspectives (APA, 2013).

Some areas of integration have not been so readily integrated until recently. Integration of psychological and spiritual perspectives did occur, but they were not given much credence. William James, arguably the father of American psychology, sought to integrate supernatural and psychological perspectives (Benjamin & Baker, 2004). However, the bulk of psychological perspectives did not include supernatural, or religious perspectives. Freud, himself, held to this notion. He believed religion was a crutch, though as a crutch, he affirmed that it was helpful for many people (Freud, Strachey, Freud, Rothgeb, & Richards, 1900).

Religion and practice are even found on the big screen. The movie titled *The Exorcism of Emily Rose*, depicts the tension between psychology and religion. Broadly, the movie sets apart religion and science. The movie setup depicts a priest on trial for performing an exorcism on a woman named Emily Rose, who died (Rosenberg et al., 2005). The trial portrays the priest as a person who understood Emily's behaviors from a spiritual lens of demonic possession, which led to the intervention of an exorcism. A psychiatrist states Emily had displayed signs of schizophrenia and needed to be treated with antipsychotics. Thus, the film depicts the conflict between two seemingly opposing views. Why are they opposing? Seemingly, because of how they view the source of abnormality, but also with respect to treatment. The reason the priest is on trial is because of his treatment, not his views. So, does religion and spirituality hold a place in psychology?

Some areas of psychology have recently sought to integrate not only biological perspectives, but also supernatural perspectives, namely religion. This approach to teaching faith with psychological perspectives, is done through means such as teaching faith and science, applied integration, or advocacy (Watson, & Eveleigh, 2014). A number of therapists deem that religion is important for mental health, even though about 26% of clinical psychologists are not religious (Bergin, 1991). More recently, clinical competencies for working with religion and spirituality have been suggested as a part of clinical training (Vieten et al., 2016). Thus, we see history within the current approaches and movements toward future integrationist models.

So, what are your thoughts? Do religious and spiritual understandings hold a place in understanding psychopathology? What about biological perspectives? Do you think that too many people are just prescribed drug cocktails for their problems?

Psychopathology Is Dynamic

Let's revisit the phrase "Depression is a chemical imbalance." As mentioned, this idea is not a newer idea. As you have already read about Hippocrates and Galen, psychopathology was understood to be an imbalance of the four humors. Thus, depression as a chemical imbalance pre-dates current notions. The main difference is that current notions of depression discuss the chemical imbalance of depression due to an imbalance of neurotransmitters.

This statement often comes with unclear understandings about abnormality. When people say this statement they often mean that depression is only the result of an imbalance of neurotransmitters, affirming **genetic determinism**. Genetic determinism is an idea that individuals and their behaviors are solely the product of their genetics. People may believe that depression is the result of one's genes and therefore there is nothing that they can do to change or escape depression.

Genetic Determinism

The idea that individuals and their behaviors are solely the product of their genetics

The view of psychopathology resultant from only one source is faulty because it is much more dynamic. Examining the neurotransmitter systems related to depression is important but only offers one account of abnormality and is not exclusive from other accounts. When examining depression, there will be some neurotransmitter systems that are involved and related to depression. However, neurotransmitters are one piece of the puzzle (see Figure 1.2).

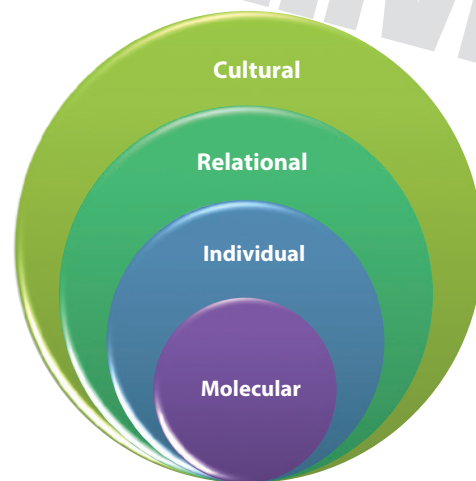


FIGURE 1.2 DYNAMIC ASPECTS OF PSYCHOPATHOLOGY
Courtesy of Authors

Another aspect of psychopathology is the individual. Psychopathology at the individual level may involve a person's thoughts, feelings, and behaviors. People who experience major depressive disorder will also hold particular beliefs, express certain emotions, and engage in some behaviors more than others. For example, a person with depression may believe that they are the most worthless person, feel sadness, and not leave their bed for much of the day. To illustrate the dynamic aspect, when considering these thoughts, feelings, and behaviors, you may see various neurotransmitters affected.

People are also social creatures. You have a number of relationships, some more close than others. Thus, psychopathology involves relationships. People's thoughts, feelings, and behaviors may affect their relationships and relationships may influence people's thoughts, feelings, and behaviors. For example, a person who was told they were worthless and a failure by his or her parents throughout their childhood, may believe these messages and think these things about him or herself.

Lastly, people are shaped by cultural and societal influences. It may be more acceptable for someone from one ethnicity or gender to express sadness compared to other cultural identities. Thus, the expression or internalization of beliefs may be culturally influenced and can be understood within one's cultural framework.

Therefore, psychopathology is dynamic and not categorically exclusive. As you consider the various disorders, you will be encouraged to reflect on the dynamic pieces that contribute to understanding abnormality.

Who Is Involved? Professionals in Mental Health

There are numerous players in the area of mental health. Some of these professionals include psychologists, psychiatrists, licensed professional counselors, licensed psychological associates, licensed chemical dependency counselors, licensed marriage and family therapists, psychiatric nurses, and social workers. These professionals are frequently working with issues of mental health to varying capacities and within different employment settings.

Applied psychologists developed subsequently from exclusivity of practice through licensure and the official establishment of psychology as a science to be practiced (Benjamin & Baker, 2004). The role of a therapist was enhanced by the conflict



between experimental psychology and applied psychology (Benjamin, 1997). Applied psychologists began to follow a training model known as the **Boulder Model**, which came about from a synthesis of the experimental and applied psychology (Baker & Benjamin, 2000). The merging of the two areas of psychology allowed for a more unified field. Applied psychology grew by utilizing empirical research to inform its practice and experimental psychology was provided with another area of research questions.

Boulder Model

Training model that synthesized experimental and applied psychology

Psychiatrist or Psychologist? Have you ever been confused about the difference between psychiatrist or psychologist, or have you never really cared? Often, people confuse these two professions or will use the names interchangeably. Applied psychologists have a distinct role as mental health professionals. Clinical and counseling **psychologists** typically possess a Ph.D. or Psy.D., work in mental health settings, and provide assessments, diagnosis, and treatment through psychotherapy. These markers separate psychologists from other mental health providers. Psychologists typically evaluate a client's presenting concern and formulate a treatment tailored to the client's needs. If the treatment required for the client is outside of the scope of psychotherapy, then the psychologist will refer for the appropriate services.

Psychologists

Possess a Ph.D. or Psy.D. and typically provide psychotherapy

In contrast to clinical and counseling psychologists, **psychiatrists** are trained as medical doctors, possessing an M.D. and specializing in the practice of medicine related to psychopathology. Psychiatrists may provide psychotherapy as a treatment, but unlike clinical and counseling psychologists (with the exceptions of New Mexico and Louisiana), psychiatrists are able to prescribe medicine for their patients. As medical doctors, psychiatrists have been traditionally trained in biological understandings and treatment of psychopathology. However, as you read previously, the establishment of the biopsychosocial model encouraged psychiatrists to move toward a dynamic approach to understanding psychopathology.

Psychiatrists

Possess a M.D. and typically practice medicine related to psychopathology

Conclusion

Understanding abnormality is dynamic and requires you to evaluate a number of preconceived ideas you may have about disorders, psychologists, treatments, and crazy. Learning to critically examine your own beliefs and biases will assist you in correctly understanding psychopathology. Abnormal psychology is not a study of other but rather a look into many behaviors that may overlap with your own. The distinction between abnormality lies within the frequency of those behaviors, how behaviors impair functioning, lead to feeling pain, and may result in fatality. These criteria along with the DSM-5, sheds light onto understanding of how people may suffer from a mental disorder. Through this understanding, professionals have dedicated years of training and science to provide treatment for these various disorders.

CHAPTER REVIEW

QUESTIONS

1. How do people understand and explain the reasons of others' behaviors? Labeling someone as "crazy" to explain their behavior would be best explained by what kind of attribution?
2. People may possess a number of negative attitudes toward others with mental disorders, which is referred to as? How might this affect relationships or behaviors with people who suffer from a mental disorder?
3. There are four criteria that help distinguish normative behavior from abnormal behavior. What are these four criteria?
4. What is the most commonly used instruments for understanding and classification of disorders?

KEY TERMS

Social Comparison

Myths

Attributions

Dispositional Attributions

Psychopathology

Stigma

Relativism

Conceptualization

Neurotransmitters

The Diagnostic and Statistical Manual of Mental Disorders

Normal Distribution

Intelligent Quotient

Social Norms

Eccentric

Trephination

Phrenology

Biopsychosocial Model

Genetic Determinism

Boulder Model

Psychologists

Psychiatrists



Movies



Your experience



Talk about the differences



**How does this relate to what you
have learned about abnormality?**

KH
ALL RIGHTS
RESERVED