Abnormal Psychology 18th edition Hooley Solutions Manual

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Chapter 1: Abnormal Psychology: Overview and Research Approaches

Learning Objectives

1.1 Explain how we define abnormality and classify mental disorders.
1.2 Describe the advantages and disadvantages of classification.
1.3 Explain how culture affects what is considered abnormal, and describe two different culture-specific disorders.
1.4 Distinguish between incidence and prevalence, and identify the most common and prevalent mental disorders.
1.5 Discuss why abnormal psychology research can be conducted in almost any setting.
1.6 Describe three different approaches used to gather information about mental disorders.
1.7 Explain why a control (or comparison group) is necessary to adequately test a hypothesis.
1.8 Discuss why correlational research designs are valuable, even though they cannot be used to make causal inferences.
1.9 Explain the key features of an experimental design.

Chapter Overview/Summary

A precise definition of *abnormality* remains elusive. Elements that can be helpful in considering whether something is abnormal include subjective distress, maladaptiveness, statistical deviancy, violation of societal norms, social discomfort, irrationality and unpredictability, and dangerousness. The *DSM* employs a category type of classification similar to that used in medicine. Disorders are regarded as discrete clinical entities, though not all clinical disorders may be best considered in this way. Even though it is not without problems, the *DSM* provides us with working criteria that help clinicians and researchers identify and study specific difficulties that affect the lives of many people. It is far from a "finished product," but familiarity with the *DSM* is essential to significant study of the field.

Classifying disorders provides a common language as well as a communication shorthand. It also allows us to structure information in an efficient manner and provides us with an organizational framework. This facilitates research and treatment. In addition, classification defines the domain of what is considered to be pathological. From a practical perspective, it delineates the types of psychological difficulties that warrant insurance reimbursement and identifies the disorders that mental health professionals treat. When we classify, we lose detailed personal information about the individual with the disorder. Classification can also facilitate

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stigma, stereotyping, and labeling, although we should keep in mind that these problems are not caused by the classification system itself. Fear of being viewed negatively or being discriminated against may lead some people to avoid seeking treatment.

Culture shapes the presentation of clinical disorders in some cases. Culture also provides the backdrop against which we must evaluate whether a particular behavior is abnormal or not. Certain disorders appear to be highly culture specific. *Taijin kyofusho* is an anxiety disorder that is quite prevalent in Japan. It involves the fear that one's body, body parts, or body functions may offend, embarrass, or make others feel uncomfortable. *Ataque de nervios* is another culturally rooted expression of distress. It is found in people of Latino descent, especially those from the Caribbean. This condition does not have a clear counterpart in the *DSM*. Symptoms can include crying, trembling, fainting, uncontrollable screaming, and a general feeling of loss of control.

Epidemiology involves the study of the distribution and frequency of disorders. Incidence is the number of *new* cases that occur in a given period of time. Prevalence refers to the total number of cases in a population during any specified period of time. Just under 50 percent of people will experience some form of mental disorder during their lifetime. Mood disorders and anxiety disorders are particularly common.

Studying and drawing inferences from past case studies alone often leads to erroneous thinking, as we often focus on data that confirm our ideas of how things are. Research prevents us from being misled by natural errors in thinking and can be conducted in clinics, hospitals, schools, prisons, and on the street. It is not the setting that determines whether a given research project may be undertaken. The importance lies in the researcher's methodology.

Information about mental disorders can be collected through case studies, self-report data, and observational approaches. Case studies can be a valuable source of new ideas and serve as a stimulus for research. They also may provide insight into unusual clinical conditions that are too rare to be studied in a more systematic way. Self-report data allows us to study behavior in a more rigorous manner. This type of research often involves having research participants complete questionnaires of various types or conducting interviews with them. When we collect information in a way that does not involve asking people directly, we are using some form of observational approach. Exactly how we go about this depends on what it is we seek to understand.

Unless there is a control or comparison group, researchers cannot test their hypothesis adequately. The control group must be comparable in all major respects (e.g., age, educational level, proportion of males and females) to the criterion group, except for the fact that they do not exhibit the disorder of interest. The control group could be made up of psychologically healthy people or people with a different disorder. Only when they are using a suitable control or comparison group can researchers compare the two groups on the variables of interest to see if there are significant differences.

Correlational research examines factors as they currently are, allowing us to identify factors that appear to be associated with certain disorders. Just because two variables are correlated does not mean that there is a causal relationship between them. Correlation does not equal causation. The direction of the relationship or the possibilities of a third variable bias are not accounted for in correlational studies.

Experimental research involves manipulating one variable (the independent variable) and observing the effect this manipulation produces with regard to another variable (the dependent variable). Because the experimenter is changing the experimental conditions, experimental

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research designs permit causal inferences to be made. Although most experiments involve the study of groups, single-case experimental designs (e.g., ABAB designs) may also be used to make causal inferences in individual instances.

Detailed Chapter Outline

INTRODUCTION

1. **Abnormal psychology** is concerned with understanding the nature, causes, and treatment of mental disorders.

2. **Family aggregation** is whether a disorder runs in families.

I. WHAT DO WE MEAN BY ABNORMALITY?

Learning Objective 1.1: Explain how we define abnormality and classify mental disorders.

A. Indicators of Abnormality

1. No one behavior or single indicator is enough to define abnormality. However, the more that someone has difficulties in the following areas, the more likely it is that they have some form of mental disorder:

   a. **Subjective distress:** If people suffer or experience psychological pain, we are inclined to consider this indicative of abnormality; however, although subjective distress is an element of abnormality in many cases, it is neither a sufficient condition nor even a necessary condition for us to consider that something is abnormal.

   b. **Maladaptiveness:** Any behavior that is maladaptive for the individual or toward society (e.g., anorexia) is maladaptive.

   c. **Statistical deviancy:** The word *abnormal* literally means "away from the normal." Just because something is statistically common or uncommon, though, does not reflect abnormality (e.g., having an intellectual disability, which is statistically rare, represents a deviation from the normal).

   d. **Violation of the standards of society:** All cultures have rules. Some of these are formalized as laws; others form the norms and moral standards that we are taught to follow. When people fail to follow the conventional social and moral rules of their cultural group, we may consider their behavior to be abnormal (e.g., the Amish of Pennsylvania not driving cars or watching television).

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e. **Social discomfort:** Not all rules are explicit, and it doesn't bother us when some rules are violated. However, when someone breaks a social rule and those around this individual experience a sense of discomfort or unease (e.g., if you are sitting on an almost empty bus and someone gets on and sits directly next to you), it may be considered an abnormal behavior.

f. **Irrationality and unpredictability:** People are expected to behave in socially acceptable ways and abide by social rules. For example, if someone next to you started screaming and yelling obscenities at nothing, this behavior would be viewed as unpredictable, disorganized, and irrational.

g. **Dangerousness:** This describes someone who is clearly a danger to himself or another person. Therapists are required to hospitalize suicidal clients, and if they have a client who makes an explicit threat to harm another person, they are required to contact both the police and the person who is the target of the threat. But if we rely only on dangerousness as our sole feature of abnormality, we will run into problems. For example, someone who engages in high-risk sports such as free diving or base jumping is not immediately considered mentally ill.

2. Decisions about abnormality involve social judgments. Therefore, culture plays a role in determining what is abnormal.

B. The *DSM-5* and the Definition of Mental Disorder

1. In the United States, the accepted standard for defining various types of mental disorders is the American Psychological Association's *Diagnostic and Statistical Manual of Mental Disorders.*

2. Commonly referred to as *DSM*, it is revised and updated from time to time. The current version, *DSM-5*, was published in 2013; it contains a total of 541 diagnostic categories.

3. The World Health Organization publishes the *International Classification of Diseases* for use in countries outside the United States. The 11th edition is the most recent.

4. Within *DSM-5*, a mental disorder is defined as a syndrome that is present in an individual and involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for mental functioning.

5. *DSM-5* also recognizes that mental disorders are usually associated with significant distress or disability in key areas of functioning, such as social, occupational, and other activities.

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a. Predictable or culturally approved responses to common stressors or losses (such as the death of a loved one) are excluded.

b. The dysfunctional pattern of behavior must not stem from social deviance or conflicts that the person has with society as a whole.

c. This new *DSM-5* definition of mental illness was based on input from various *DSM-5* work groups as well as other sources.

d. Keep in mind that any definition of abnormality or mental disorder must be somewhat arbitrary.

II. CLASSIFICATION AND DIAGNOSIS

Learning Objective 1.2: Describe the advantages and disadvantages of classification.

1. At the most fundamental level, classification systems provide us with a **nomenclature** (a naming system). This gives clinicians and researchers both a *common language* and *shorthand terms* for complex clinical conditions.

2. Classification systems enable us to *structure information* in a more helpful manner. They facilitate research, which gives us more information and facilitates greater understanding about what causes various disorders and how they might best be treated.

3. *Defining the domain* of what is considered pathological establishes the range of problems that the mental health professional can address, and thus delineates which types of psychological difficulties warrant insurance reimbursement and the extent of such reimbursement.

A. What Are the Disadvantages of Classification?

1. Using any form of shorthand inevitably leads to a loss of information.

2. As we simplify through classification, we lose personal details about the actual individual with the disorder.

3. **Stigma**, or disgrace, is still associated with having a psychiatric diagnosis.

4. **Stereotyping**, or forming automatic beliefs about other people, may lead to incorrect inferences about those who have been diagnosed.

   a. We unavoidably learn stereotypes as a result of growing up in a particular culture (e.g., people who wear glasses are more intelligent; New Yorkers are rude).

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5. A stigma could be perpetuated by the problem of **labeling.**

    a. It is important to keep in mind that classification systems don't classify people; they classify the disorders that people have.

6. When someone has an illness, we should take care not to define them by that illness. Respectful and appropriate language should be used instead. For example, it was once quite common for mental health professionals to describe a patient as "a schizophrenic" or "a manic-depressive." Now it is more widely acknowledged that it is more accurate and considerate to use "person-first language"—"a person with schizophrenia" or "a person with bipolar disorder."

B. How Can We Reduce Prejudicial Attitudes Toward People Who Are Mentally Ill?

1. Prejudicial attitudes are common.

2. The results of a study by Arthur and colleagues (2010) suggest that stereotyping, labeling, and stigma toward people with mental illness are not restricted to industrialized countries.

3. For a long time, it was thought that educating people that mental illnesses were "real" brain disorders might be a solution, but sadly this does not seem to be the case. Increases in the proportion of people who understand that mental disorders have neurological causes have not resulted in decreases in stigma.

4. Stigma does seem to be reduced by having more contact with people in the stigmatized group. However, studies suggest that people may tend to avoid those with mental illness because of the psychophysiological arousal and distress they may experience.

III. CULTURE AND ABNORMALITY

Learning Objective 1.3: Explain how culture affects what is considered abnormal, and describe two different culture-specific disorders.

1. There is considerable variation in the way that different cultures describe psychological distress.

2. The way some disorders present themselves may depend on culturally sanctioned ways of articulating distress.

3. Culture can shape the clinical presentation of disorders like depression, which are present across cultures around the world.

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4. Despite progressively increasing cultural awareness, we still know relatively little concerning cultural interpretation and expression of abnormal psychology.

5. The vast majority of the psychiatric literature originates from Euro-American countries (i.e., Western Europe, North America, and Australia/New Zealand).

6. Research published in languages other than English tends to be disregarded.

7. Some types of psychopathology appear to be highly culture-specific. For example, *taijin kyofusho* is an anxiety disorder that is quite prevalent in Japan, and *ataque de nervious*, an "attack of nerves," is found in people of Latino descent.

8. Certain unconventional actions and behaviors, such as hearing voices, laughing at nothing, defecating in public, drinking urine, and believing things that no one else believes, are almost universally considered abnormal behaviors.

IV. HOW COMMON ARE MENTAL DISORDERS?

Learning Objective 1.4: Distinguish between incidence and prevalence, and identify the most common and prevalent mental disorders.

1. How many and what sort of people have diagnosable psychological disorders is a significant question. It is essential for planning and establishing mental health services, and it provides valuable cues as to the causes of these disorders.

A. Prevalence and Incidence

1. **Epidemiology** is the study of the distribution of diseases, disorders, or health-related behaviors in a given population.

2. **Prevalence** is the number of active cases in a population during any given period of time (i.e., the percentage of the population that has the disorder).

3. **Point prevalence** refers to the estimated proportion of actual, active cases of a disorder in a given population at a given point in time.

4. **1-year prevalence** refers to everyone who experienced a particular disorder throughout an entire year.

5. **Lifetime prevalence** is an estimate of the number of people who have had a particular disorder at some time in their lives (even if they have now recovered). Lifetime prevalence estimates tend to be higher than other kinds of prevalence estimates.

6. **Incidence** refers to the number of new cases that occur over a period of time (typically one year).

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B. Prevalence Estimates for Mental Disorders

1. The most comprehensive source of prevalence estimates for adults in the United States diagnosed with mental disorders is the National Comorbidity Survey Replication (NCS-R), which sampled the entire adult population using a number of sophisticated methodological strategies. As indicated in Table 1.1, the study's findings included:

    a. Anxiety disorders have an estimated lifetime prevalence of 28.8 percent and a 1-year prevalence of 18.01 percent.

    b. The lifetime prevalence for any mood disorder is 20.8 percent, and the 1-year prevalence is 9.5 percent.

2. The lifetime prevalence of having any *DSM-IV* disorder is 46.4 percent, and the 1-year prevalence is 26.2 percent.

    a. This may be an underestimate, as the NCS-R study did not assess for certain disorders, including eating disorders, schizophrenia, and autism. It also did not include measures of most personality disorders.

    b. The most common individual disorders were major depressive disorder, alcohol abuse, and specific phobias (see Table 1.2).

    c. Although the lifetime and 1-year rates of mental disorders appear to be quite high, the duration of an individual's disorder may be relatively brief. Also, many people who meet the criteria for a disorder will not be seriously affected by it.

    d. Because the NCS-R is well over a decade old, another survey, the National Survey on Drug Use and Health (NSDUH), is conducted every year.

3. **Comorbidity** is the presence of two or more disorders in the same person. It is especially high—50 percent—in people who have severe forms of mental disorders; those with milder forms have only a 7 percent rate.

C. The Global Burden of Disease

1. Worldwide, mental and substance use disorders account for over 7 percent of the global burden of disease.

2. Because they are so common, anxiety disorders, depressive disorders, and substance use disorders together account for 184 million disability-adjusted years of life (DALYs), where one DALY can be thought of as the loss of one year of otherwise "healthy" life.

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3. Depression accounts for more than 40 percent of DALYs.

4. Estimates indicate that worldwide, mental disorders will cost $16 trillion—or about 25 percent of global GDP in 2010—over the next 20 years. This number does not include the costs of treatment—or the personal, emotional costs that living with a mental disorder can cause an individual and their family.

5. There is a need to find better ways to provide mental health services, particularly in developing countries.

D. Treatment

1. Although there are many available treatments for psychological disorders—from medication to psychotherapy—not all people with disorders receive treatment. Some deny or minimize their problems; others fear the stigma of diagnosis; and many delay treatment, even if they recognize they need help (half of those with depression delay seeking treatment for 6 to 8 years; for those with anxiety disorders, the delay ranges from 9 to 23 years). In addition, some are treated by their family physician rather than by a mental health specialist.

2. Hospitalization and inpatient care are the preferred options for people who need more intensive treatment than can be provided on an outpatient basis.

3. Admissions to mental hospitals have decreased substantially over the past 45 years, due in part to the increased development of medications that control symptoms of severe disorders, budget cuts that have forced many large state or county facilities to close, and hospital stays not being authorized by insurance companies, forcing patients to seek treatment elsewhere.

4. Deinstitutionalization has had many unintended consequences, as described in Chapter 2.

E. Mental Health Professionals

1. When individuals receive inpatient treatment, several different mental health professionals often work as a team to provide the necessary care. A psychiatrist may prescribe medications and monitor the patient for side effects, a clinical psychologist may provide individual therapy, a clinical social worker may help the patient resolve family problems, and a psychiatric nurse may check in with the patient on a daily basis to provide support.

2. Patients treated in outpatient settings may also work with a team of professionals, but the number of mental health specialists involved is typically much smaller. For example, a patient might receive all treatment from a psychiatrist, who will prescribe medication and provide psychotherapy; or they may receive medications

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from a psychiatrist and see a psychologist or clinical social worker for regular therapy sessions.

V. RESEARCH APPROACHES IN ABNORMAL PSYCHOLOGY

Learning Objective 1.5: Discuss why abnormal psychology research can be conducted in almost any setting.

1. We need to conduct research in order to study the characteristics, or nature, of disorder.

2. Through research we can learn about the symptoms of a disorder, its prevalence, whether it tends to be either **acute** (short in duration) or **chronic** (long in duration), and the problems and deficits that often accompany it.

3. Research also allows us to further understand the **etiology** (or causes) of disorders.

4. Abnormal psychology research can take place in clinics, hospitals, prisons, and highly unstructured contexts, such as natural observations of homeless people on the street.

VI. SOURCES OF INFORMATION

Learning Objective 1.6: Describe three different approaches used to gather information about mental disorders.

A. Case Studies

1. Much can be learned when skilled clinicians use the **case study** method.

   a. Psychiatrists Emil Kraepelin and Eugen Bleuler provided detailed accounts of patients whom researchers today would easily recognize as having disorders such as schizophrenia and manic depression.

   b. Alois Alzheimer depicted a patient with an unusual clinical picture that subsequently became known as Alzheimer's disease.

   c. Sigmund Freud published multiple clinical cases describing what we now recognize as phobia and obsessive-compulsive disorder.

2. The information presented in case studies is subject to **bias** because the writer of the case study selects which information to include and omit.

3. Another concern is that the material in a case study is often relevant only to the individual being described, meaning that the conclusions drawn have low

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generalizability—that is, they cannot be used to draw conclusions about other cases when those cases involve people with a seemingly similar abnormality.

B. Self-Report Data

1. **Self-report data** might involve having research participants complete questionnaires of various types. Or the data could originate in interviews, where the researcher asks a series of questions and records what the person says.

2. Self-reports can be misleading because they ask about the rater's own subjective states of experiences.

C. Observational Approaches

1. When we collect information in a way that does not involve asking people directly (self-report), we are using some form of observational approach.

2. For example, **Direct observation** would be used, for example, if you were trying to observe aggression in children's behavior. Observers would record the number of times children hit, bit, pushed, punched, or kicked their playmates. Information about biological variables (e.g., heart rate and cortisol) might also be collected.

3. Brain-imaging technology—such as functional magnetic resonance imaging (fMRI) and transcranial magnetic stimulation (TMS)—allows us to observe how the brain works.

4. In practice, much clinical research involves a mix of self-report and observational methods

VII. FORMING AND TESTING HYPOTHESES

Learning Objective 1.7: Explain why a control (or comparison group) is necessary to adequately test a hypothesis.

1. A **hypothesis** is an effort to explain, predict, or explore something.

2. Anecdotal accounts such as case studies can be very valuable in helping us develop hypotheses, although they are not well suited for testing the hypotheses they may have inspired.

3. Other sources of hypotheses are unusual or unexpected research findings.

4. Hypotheses are vital because they frequently determine the therapeutic approaches used to treat a particular clinical problem.

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A. Sampling and Generalization

1. Studies that examine groups of people are valued over single cases. Group studies may identify multiple causes for disorders, and they can generalize results to other cases.

2. **Sampling** is the careful selection of a subgroup that is representative of a larger population for close study.

3. The more representative the sample, the more able we are to generalize. Ideally, we would be able to use random sampling to avoid potential biases, as erroneous conclusions can emerge from faulty sampling.

B. Internal and External Validity

1. **External validity** is the extent to which we can generalize our findings beyond the study itself.

2. **Internal validity** reflects how confident we can be in the results of a given study

C. Criterion and Comparison Groups

1. To test their hypotheses, researchers use a **comparison group** (sometimes called a **control group**). This may be defined as a group of people who do not exhibit the disorder being studied but who are comparable in all other major respects to the criterion group

2. People with the disorder being studied are the **criterion group**.

VIII. CORRELATIONAL RESEARCH DESIGNS

Learning Objective 1.8: Discuss why correlational research designs are valuable, even though they cannot be used to make causal inferences.

1. A **correlational research design** involves studying the world as it is.

2. Correlational research does not involve any manipulation of variables.

3. We use correlational design any time we study the differences between individuals who do and do not have a particular disorder.

A. Measuring Correlation

1. The strength of a **correlation** is measured by a **correlation coefficient**, which is denoted by the symbol *r*. A correlation runs from 0 to 1, with a number closer to 1

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representing a stronger association between the two variables. The + sign or – sign indicates the direction of the association between the two variables.

2. **Positive correlation** is when measures vary together in a direct, corresponding manner. For example, higher scores on one variable are associated with higher scores on another variable.

3. With **negative correlation**, there is an inverse correlation between the variables of interest. For example, as scores on one variable go up, scores on the other variable tend to go down.

B. Statistical Significance

1 The notation $p < .05$ is an example of how the level of **statistical significance** is depicted. This means that the probability of the correlation occurring purely by chance is less than 5 out of 100. Researchers consider correlations that have $p < .05$ to be statistically significant and worthy of attention.

2. Statistical significance is influenced not only by the magnitude or size of the correlation between the two variables but also by the sample size.

C. Effect Size

1. The **effect size** reflects the size of association between two variables, independent of the sample size.

2. An effect size of zero means that there is no association between the variables.

D. Meta-Analysis

1. A **meta-analysis** is a statistical approach that calculates and then combines the effect sizes from numerous studies.

2. Within a meta-analysis, each separate study can be thought of as being equivalent to an individual participant in a conventional research design.

E. Correlations and Causality

1. Correlation does not mean causation.

2. A might cause B, or B might cause A; or A and B might both be caused by C. A and B are involved in a complex web of relationships with other variables.

3. The **third variable problem** is when some unknown, third variable might be causing both events to happen

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F. Retrospective Versus Prospective Strategies

1. A **retrospective research** strategy involves looking back in time. In other words, we would try to collect information about how the patients behaved earlier in their lives, with the goal of identifying factors that might be associated with what went wrong later.

2. A **prospective research** strategy involves looking ahead in time. The idea is to identify individuals who have a higher-than-average likelihood of becoming psychologically disordered, and to focus research attention on them before a disorder manifests.

3. A study with a **longitudinal design** follows people over time and tries to identify factors that predate the onset of a disorder

IX. THE EXPERIMENTAL METHOD IN ABNORMAL PSYCHOLOGY

Learning Objective 1.9: Explain the key features of an experimental design.

1. Correlational research does not allow us to draw any conclusions about directionality This is known as the *direction of effect problem*. To draw conclusions about causality and resolve questions of directionality, an **experimental research** approach must be used. In such studies, scientists control all factors except one—the factor that could have an effect on a variable or outcome of interest.

2. The factor that is manipulated is referred to as the **independent variable**.

3. If the outcome of interest—the **dependent variable**—is observed to change as the manipulated factor changes, then that independent variable can be regarded as a cause of the outcome.

A. Studying the Efficacy of Therapy

1. In treatment research, it is important that the treated and untreated groups be as equivalent as possible, except for the presence or absence of the proposed active treatment.

2. Patients are typically randomly assigned. **Random assignment** means that every research participant has an equal chance of being placed in the treatment or the no-treatment condition.

3. The ethics of withholding effective treatment may lead to an alternative research design in which two or more treatments are compared in differing yet comparable groups. This is called a *standard treatment comparison study*.

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4. In a **double-blind study**, neither the subjects nor the experimenter working with them knows who is receiving the genuine treatment.

5. **Placebo treatment** conditions enable experimenters to control for the possibility that simply believing one is getting an effective type of treatment may produce benefits.

B. Single-Case Experimental Designs

1. In **single-case research designs**, the same individual is studied over a period of time. Behavior or performance at one point in time can then be compared to behavior or performance at a later time, after a specific intervention or treatment has been introduced.

2. One of the most basic experimental designs in single-case research is the **ABAB design**. The letters refer to different phases of the intervention: The first A is the baseline condition; the first B is the introduction of the treatment.

C. Animal Research

1. Using animal subjects, we are able to perform studies that would not be possible to implement with humans. Nonetheless, ethical considerations still apply.

2. One major assumption is that findings from animal studies can be generalized to humans. Experiments of this kind are generally known as **analogue studies**, where we study not the true item of interest but an approximation to it.

3. Analogue studies may also involve humans (e.g., when we try to study depression by studying healthy research participants whom we have made mildly and transiently sad).

4. Findings from animal research have provided impetus for the learned helplessness model of depression.

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Key Terms

ABAB design
abnormal psychology
acute
analogue studies
bias
case study
chronic
comorbidity
comparison or control group
correlation
correlation coefficient
correlational research
criterion group
dependent variable
direct observation
double-blind study
effect size
epidemiology
etiology
experimental research
external validity
family aggregation
generalizability
hypothesis
incidence
independent variable
internal validity
labeling
lifetime prevalence
longitudinal design
meta-analysis
negative correlation
nomenclature
1-year prevalence
placebo treatment
point prevalence
positive correlation
prevalence
prospective research
random assignment
retrospective research
sampling
self-report data
single-case research design
statistical significance
stereotyping
stigma
third variable problem

Lecture Suggestions and Activities

Learning Objective 1.1: Explain how we define abnormality and classify mental disorders.

LECTURE SUGGESTIONS

Why Are You Taking This Course?
Students taking abnormal psychology often have a variety of reasons for doing so. These range from satisfying a degree requirement to a desire for enhanced personal insight. The expectations of the students regarding the course, and what they may or may not get out of it, are interesting issues to explore at the very outset. Students should be encouraged to volunteer their reasons for enrolling in the course. Common answers that usually arise include: to learn more about my own behavior, to understand others, and to learn about the different mental health professions. Hearing other peoples' answers to this question can also help students expand their ambitions in the course beyond the ones they originally held. This discussion can also provide a good opportunity to present the rationale behind studying abnormal psychology and how the scientific tradition assists

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in increasing our understanding of behavior and its determinants. After this discussion, students should have a clear understanding of the demands and expectations of this course and how their expectations fit into the course design. Students can also write one reason anonymously on a piece of paper and designate a couple of students or the professor to read them aloud.

The Various Ways Abnormality Is Defined
Begin the in-class discussion with the various ways in which abnormal behavior is defined and classified so that researchers and mental health professionals can communicate with each other about the people they see. Again, as a reminder, the textbook defines abnormal behavior as encompassing subjective distress, maladaptiveness, statistical deviancy, violation of the standards of society, social discomfort, irrationality and unpredictability, and dangerousness.

Evolutionary Psychology
If you have a background that includes evolutionary psychology, you may want to discuss adaptive value and ask students to generate possible reasons why we would see maladaptive behaviors not die out. Because one of the main tenets of evolutionary psychology is that behaviors that persist must in some way be or have been adaptive, how does this explain the disorders we see today? One example can be built on the example above on the "adaptive value" of schizophrenia. Ask students if someone lived in a remote tribe in South America or Africa and they reported talking to God, how would their village receive them? Could there be other situations with other disorders where some of these behaviors are actually adaptive in some way?

Evolving Conceptualizations of Homosexuality
Prior to the publication of *DSM-III* in 1980, homosexuality was considered a mental illness. In *DSM-III* it was considered a disorder only if the homosexual person was emotionally troubled by it—that is, only if it was ego-dystonic. In *DSM-IIIR* (1987) it moved into a general category of sexual disorders "not otherwise specified," where it was recast as "persistent and marked distress about one's sexual orientation," for ego-dystonic heterosexuality as well as homosexuality. These transitions were not driven by scientific research but by evolving societal norms and political pressure. Evolving conceptualizations of homosexuality provide interesting material for discussing diagnosis, science, and politics. It is also sometimes quite interesting to discuss the kinds of research that could be conducted to establish the diagnostic status of behaviors, including homosexuality. Are there data that would certify behaviors as abnormal, or are societal values absolutely necessary?

ACTIVITY

Defining Abnormality
To initiate a class discussion of abnormality, ask students the following question: "How would you define abnormal behavior?" A number of different answers will be generated, and these should be recorded on the blackboard. The instructor should challenge each of the answers in order to illustrate the concepts expressed in the text. The responses generated by the students can then be categorized into the different areas identified in Chapter 1—for example, the view that abnormality is always dangerous or that mental disorder is something to be scorned. Through the course of the discussion, students should come to appreciate the problem in defining abnormal behavior and gain an insight into factors affecting the labeling of abnormality.

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Learning Objective 1.2: Describe the advantages and disadvantages of classification.

LECTURE SUGGESTION

Invite a Student with a Disability
You may want to consider asking students with disabilities to come in and participate in a short discussion on what it is like for many of the students on your campus with disabilities. The discussion of labeling and stereotyping lends itself well to more general discussions on labeling of all forms. Many students in abnormal psychology classes, more so than other classes, often self-disclose diagnoses and other forms of personal information. This discussion may make students more sensitive to others in the class who have been "labeled" and how that in and of itself has affected them**.**

ACTIVITIES

Hospitalization
Using a PowerPoint slide or a whiteboard, write the following question and answer choices: "Your city is planning to create a half-way house for adult men who have been hospitalized for paranoid schizophrenia. Where would be the best place to put this home? A. Next door to your home; B. In your neighborhood; C. Anywhere in town would be fine; D. In the next town." Asking students to answer privately on their own paper prior to beginning any discussion of this topic is typically necessary.

Stereotypes in the Media
Stereotypes and stigma often originate in media portrayals of both the mentally ill and the professionals who treat and study them. Television and the movies consistently use psychological labels to describe unpleasant and dangerous characters. The written media likewise often use lurid descriptions of crimes, including psychological diagnoses and terms. Most students in the class will be able to cite examples of such portrayals from their own experience. An excellent way to combat erroneous beliefs about abnormal psychology is to rebut these salient portrayals. Asking students to bring examples to class can readily accomplish this. Each student can be required to bring at least one newspaper or magazine article, video clip, or even Web site portraying some aspect of abnormal psychology. The class can be asked to comment on these materials before the instructor points out what is generally representative and accurate, given the scientific literature on the topic, versus what is not representative or even inaccurate. For instance, a student might bring a clip from A Beautiful Mind, which provides vivid images of visual hallucinations, even though these are much less common in schizophrenia than auditory hallucinations. This film also provides a good opportunity to discuss medications and the prospects for overcoming schizophrenia through mere effort of will. Large classes can be broken into groups that can compile materials and present their observations and questions to the rest of the class.

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Learning Objective 1.3: Explain how culture affects what is considered abnormal, and describe two different culture-specific disorders.

LECTURE SUGGESTIONS

What's Your Frame of Reference?
The concept of social labeling provides an excellent topic for a lecture/discussion session. Any number of cultural groups can be used as examples to provide contrasts in how societies label pathology. Students can be asked to generate their own examples of social labeling, using experiences with subcultural groups. The behaviors found among different age groups are often labeled as abnormal by the dominant age group in our society. For instance, street slang may be evaluated as maladaptive by the school system, yet it provides rich communication in its own subcultural context. The behavior of adolescents may be labeled as pathological by adults who see the behavior as maladaptive (e.g., body piercing or tattooing). Students should find the discussion of social labeling an interesting one, because they can contribute experiences from their own subcultural group. In-class lecture can illustrate that, although social labeling can be a powerful process, some behaviors (such as depression) are generally assumed to be maladaptive in all subcultures and societies. Students can be asked to identify other behaviors whose maladaptiveness transcends cultural boundaries. An easy way to begin a discussion of this type might be to ask students the number of piercings that they have. Tally the number of students who report 0, 1, 2, 3, 4, 5 or more piercings, and talk about how the acceptance of piercing has changed in the past few years in our culture.

Cultural Relativity
Students sometimes view stigma, cultural relativity, and social causation as rather weak compared to biological factors and cultural universals. The force of cultural and social phenomena can be established experientially by assigning students to violate an innocuous norm in a way that would be inconsequential elsewhere. Caution them to avoid illegal activities or ones that infringe on the rights of others. For instance, if social and interpersonal forces are innocuous, it should be inconsequential to wear a football helmet all day or to carry around a houseplant adorned with Christmas ornaments.

ACTIVITY

Researching Culture-Bound Syndromes
Have students work in groups to conduct online research on a culture-bound syndrome found in a different country or region of the world. For each syndrome, students can present the syndrome and why it might be present in that region but not considered abnormal in the United States.

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Learning Objective 1.4: Distinguish between incidence and prevalence, and identify the most common and prevalent mental disorders.

LECTURE SUGGESTION

Rates of Incidence
Here you may want to again discuss the issue of rates of incidence with students. Do they feel these numbers include everyone? What about gender differences? Do they think one gender may be diagnosed more? Why or why not? Perhaps one sex is more likely to seek help? What about disorders like substance abuse? Will everyone be represented in the data?

ACTIVITIES

Exploring Prevalence Rates Online
Have students guess what the most prevalent psychological disorders are. Then have them conduct online research on prevalence numbers. Have them compare and contrast 1-year prevalence and point prevalence. They could also contrast the prevalence numbers by region and ethnicity. Finally, have students discuss why the statistics vary by source.

Handout: What Is Abnormal?
For each of the behaviors listed, indicate whether you think it would be considered distressful, maladaptive, deviant, a violation of the standards of society, socially uncomfortable, irrational, and/or dangerous. You may select none or more than one for each.

	Distressful	Maladaptive	Deviant	Violation of Society Standards	Socially Uncomfortable	Irrational	Dangerous
A man talking to himself as he walks down the street							
A strong preference for yellow socks							
Owning 25 cats							
Washing hands over 50 times a day							
A man telling you that God has asked him to help you							
Having to sit in the same seat in every class you take							
Believing that all your neighbors are plotting against you							
Not eating solid foods for one week							
Becoming extremely tense and jittery before an exam							

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Learning Objective 1.5: Discuss why abnormal psychology research can be conducted in almost any setting.

LECTURE SUGGESTIONS

On Being Sane in Insane Places
Rosenhan (1973) published a classic abnormal psychology study in the extremely high-profile journal *Science* (vol. 179, pp. 250–258). This study raises many interesting questions about research methods, definitions of abnormality, and the ability of mental health professionals to distinguish actual from feigned mental illness. In this study, eight healthy volunteers, several of them psychologists and psychiatrists, went to mental hospitals and complained of hearing voices saying "empty," "hollow," or "thud." These pseudo-patients acted normally in every way except for the reported auditory hallucinations. As soon as they were admitted, they stopped complaining of these symptoms. Although many of the real hospitalized patients suspected the pseudo-patients were faking, none of the hospital staff apparently did. All pseudo-patients were labeled schizophrenic and their stays ranged from 7 to 52 days, with an average stay of 19 days. Originally, this was taken as evidence of how important labels and expectations affect interpretations of people's behavior. However, it is worth envisioning a control group of pseudo-patients who report equally severe physical symptoms to physicians. Indeed, people with some kinds of somatoform disorder (Chapter 8) succeed in getting fairly dramatic treatments, including surgery, in the absence of genuine organic pathology. It is also worth noting that many pseudo-patients were diagnosed with atypical subtypes of schizophrenia, suggesting that the hospital staff recognized that there was something quite different about these patients. The Rosenhan study also raises questions about securing informed consent from research participants, draining precious treatment resources, and how long it is reasonable to observe an apparently recovered psychotic person to ensure that relapse is not imminent. These, and other design, ethical, and statistical matters, many of which were published in a subsequent issue of *Science* (1973, vol. 180, pp. 1116–1122), qualify the interpretation of this classic report substantially.

Sampling Issues in Abnormal Psychology
Discuss with students where the data in this area comes from. Is it from Intro to Psych students like data in Social? Is it from schools and education data clearinghouses like Developmental? Here you are generally looking at what sample? Who's included? Who's excluded? By getting students to think about where the data comes from and if it excludes many people, students should be able to think about how good is the data in this area and if there are ways to get better data.

Ethics in Scientific Research
This is a great time to discuss the ethical treatment of subjects, both human and animal. Point out to students that drug studies, for example, involve both humans and animals. Regardless of the long-term pay off, the cost to a subject can be high; where should the line be drawn?

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ACTIVITY

Creating a Survey
Have students create a 15-item survey/questionnaire to assess depression or anxiety symptoms in adolescents. Then have students discuss which questions can provide insight as to whether a symptom is chronic or acute. Also ask students to include questions that might provide information about the etiology of the disorder. Finally, discuss any questions that might cause ethical concerns.

Learning Objective 1.6: Describe three different approaches used to gather information about mental disorders.

LECTURE SUGGESTION

Issues with Case Studies
This is a good time to point out the problems with case studies. For example, Alex the African parrot. Despite many attempts, researchers have never replicated these results. Keep in mind, although case studies can be dead on (e.g., early descriptions of schizophrenia, the role of the amygdale in Phineas Gage's uncontrolled emotions, Piaget's observations of his children), they can also be very wrong (e.g., Alex the African parrot, some of Freud's assumptions based on his case studies). Also, remind students that although there are significant limitations to case studies, many times it is the only way, for example, when only a handful of people have a condition, or in cases of brain damage.

ACTIVITY

Pros and Cons of Research Approaches
After discussing the three approaches to gathering information—case study, self-report, and observation—have students discuss the pros and cons of each one. Then have students conduct research to find studies illustrating each type of approach. Either individually or in groups, students can conduct online research to browse recent issues of *Journal of Abnormal Psychology, Journal of Consulting and Clinical Psychology, Archives of General Psychiatry*, and *American Journal of Psychiatry* to find at least one article of interest.

Learning Objective 1.7: Explain why a control (or comparison group) is necessary to adequately test a hypothesis.

LECTURE SUGGESTION

The Importance of a Control Group
Discuss the many different types of control in the experimental method. Discuss the advantages and disadvantages of a placebo-group (active) control versus a passive control group study. Also

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discuss the advantages and disadvantages of repeated designs, such as ABAB, versus comparing two independent groups. Factors to discuss might include time, attrition, cost, and control of confounding variables.

ACTIVITY

Different Methods of Control
Have students design a study examining the effectiveness of a psychotherapy treatment method for anxiety. How many groups should they compare? Will they use an active or a passive control group? Then have them design a study examining the effectiveness of a medical treatment for anxiety. How many groups should they compare? Will they use an active or a passive control group? Is there a difference in the way they would design control groups for medication studies compared to psychotherapy studies?

Learning Objective 1.8: Discuss why correlational research designs are valuable, even though they cannot be used to make causal inferences.

LECTURE SUGGESTION

Correlation Is Not Causation
Students often assume that a correlation can be interpreted as a causal relationship. Provide examples of alternative explanations for strong correlations. For example, you can discuss the strong positive correlation between ice cream sales and drowning deaths to discuss the third variable bias. Or you can discuss the direction problem in the relationship between self-esteem and achievement.

ACTIVITY

Journal Browsing
Students can gain a greater appreciation for scientific approaches to the study of abnormal psychology by perusing current issues of some of the more rigorous journals in the field. Either individually or in groups, students can conduct online research to browse recent issues of *Journal of Abnormal Psychology, Journal of Consulting and Clinical Psychology, Archives of General Psychiatry,* and *American Journal of Psychiatry* to find at least one article of interest. They can then be asked to present this article to the class, summarizing its purpose and main findings. It can also be instructive to ask that students make some general classifications of the research design. Is the selected study correlational or experimental? Retrospective or prospective? What diagnosis is under consideration? Does the article address etiology, descriptive psychopathology, or treatment? Is there a control group? A historical perspective can be encouraged by randomly assigning students to study articles from various decades

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Learning Objective 1.9: Explain the key features of an experimental design.

LECTURE SUGGESTION

The Experimental Design

Manipulation and control are key features of the experimental design. Using a concrete example, such as a clinical drug trial study for depression, discuss and identify the independent and dependent variables in the study. Have students help with the manipulation process by forming the comparison groups for the independent variable. Discuss the importance of placebo groups and of having an active, rather than passive, control group. Finally, emphasize the significance of random assignment in eliminating confounding variables.

ACTIVITY

Single-Case Experimental Design
James Carr and John Austin (1997) developed a demonstration of single-case experimental design that can easily be used in a classroom setting. Students are instructed on how to take their own pulse rate and record these data for five, 1-minute intervals. This constitutes baseline. The treatment phase then begins by asking students to stand up and do jumping jacks for 20 seconds. The students then sit and take their pulse rate again for one minute. Students repeat the treatment phase four additional times. Following the collection of the five pulse rates during "treatment," the students once again sit and record five resting pulse rates in 1-minute intervals. Students could repeat the treatment phase if the instructor wishes to demonstrate an ABAB design. Once the data is collected, each student could draw a graph of his or her results and attempt to draw some conclusions regarding how "treatment" impacted heart rate.

Revel Videos

What Does It Mean to Have a Mental Disorder?

Case Studies

Self-Report Data

Correlational and Experimental Research Designs

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