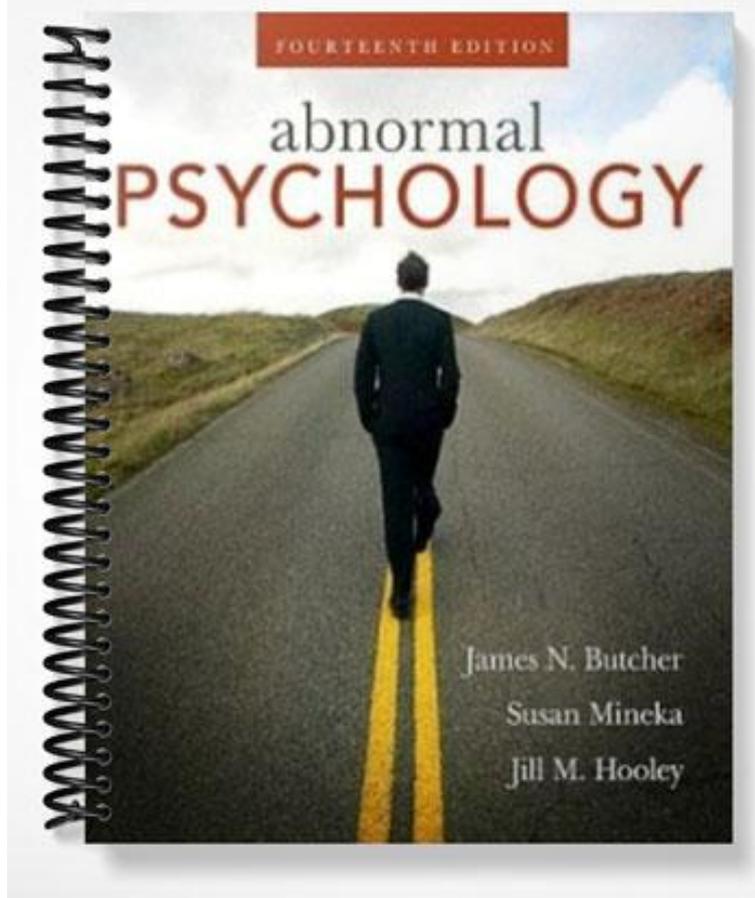
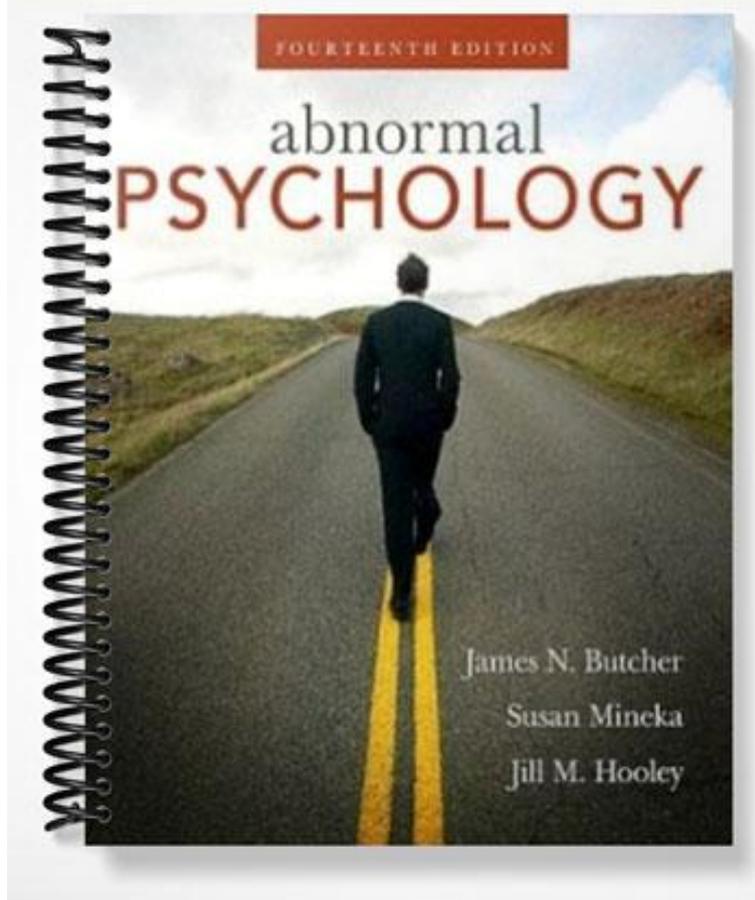


**SOLUTIONS MANUAL**



**SOLUTIONS MANUAL**



# **Instructor's Manual**

*for*

Butcher, Mineka, and Hooley

## **Abnormal Psychology**

Fourteenth Edition

*prepared by*

Martha J. Hubertz  
Florida Atlantic University

**Allyn & Bacon**

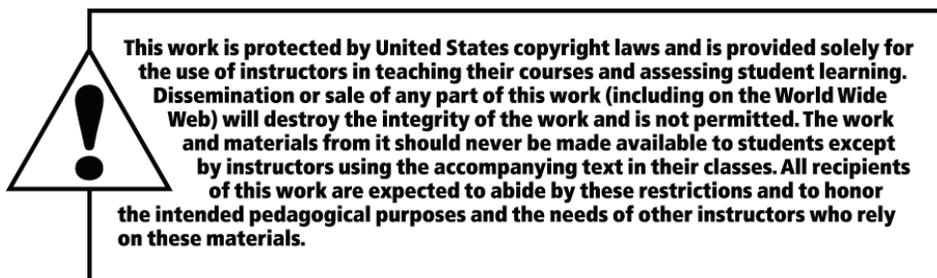
Boston Columbus Indianapolis New York San Francisco Upper Saddle River  
Amsterdam Cape Town Dubai London Madrid Milan Munich Paris Montreal Toronto  
Delhi Mexico City Sao Paulo Sydney Hong Kong Seoul Singapore Taipei Tokyo

Copyright © 2010, 2007, 2004 Pearson Education, Inc., publishing as Allyn & Bacon,  
75 Arlington Street, Suite 300, Boston, MA 02116

All rights reserved. Manufactured in the United States of America. The contents, or parts thereof, may be reproduced with *Abnormal Psychology*, Fourteenth Edition, by James N. Butcher, Susan Mineka, and Jill M. Hooley, provided such reproductions bear copyright notice, but may not be reproduced in any form for any other purpose without written permission from the copyright owner.

To obtain permission(s) to use material from this work, please submit a written request to Pearson Higher Education, Rights and Contracts Department, 501 Boylston Street, Suite 900, Boston, MA 02116, or fax your request to 617-671-3447.

10 9 8 7 6 5 4 3 2 1      13 12 11 10 09



**Allyn & Bacon**  
is an imprint of



[www.pearsonhighered.com](http://www.pearsonhighered.com)

ISBN-10: 0-205-64991-2  
ISBN-13: 978-0-205-64991-4

# Contents

Preface .....	iv
Sample Syllabus .....	viii
CHAPTER 1 Abnormal Psychology: An Overview .....	1
CHAPTER 2 Historical and Contemporary Views of Abnormal Behavior .....	22
CHAPTER 3 Causal Factors and Viewpoints .....	43
CHAPTER 4 Clinical Assessment and Diagnosis .....	64
CHAPTER 5 Stress and Physical and Mental Health .....	82
CHAPTER 6 Panic, Anxiety, and Their Disorders .....	112
CHAPTER 7 Mood Disorders and Suicide .....	134
CHAPTER 8 Somatoform and Dissociative Disorders .....	157
CHAPTER 9 Eating Disorders and Obesity .....	179
CHAPTER 10 Personality Disorders .....	195
CHAPTER 11 Substance-Related Disorders .....	214
CHAPTER 12 Sexual Variants, Abuse, and Dysfunctions .....	240
CHAPTER 13 Schizophrenia and Other Psychotic Disorders .....	261
CHAPTER 14 Cognitive Disorders .....	281
CHAPTER 15 Disorders of Childhood and Adolescence .....	297
CHAPTER 16 Therapy .....	319
CHAPTER 17 Contemporary and Legal Issues in Abnormal Psychology .....	340

# Preface

---

This *Instructor's Manual* bridges the gap between the textbook, which is designed for introductory *Abnormal Psychology* students, and the instructor, who knows the material and who instead needs help coordinating lecture presentations, activities, and assignments with the text. The *Manual* will help you focus on being a lively and engaging instructor by lightening your organizational load.

You will notice that this *Instructor's Manual* offers some extra advice to beginning *Abnormal Psychology* instructors. This extra attention is provided because newer instructors are often especially in need of efficiently organized and readily available tips for handling material in the classroom. Nevertheless, more experienced instructors will also benefit from this *Manual*. Indeed, it is hoped that there is enough new and interesting material in this *Manual* to sustain the attention of *Abnormal Psychology* instructors who are more experienced than the beginning instructors for whom it will probably be a more regular reference.

Each chapter of this *Instructor's Manual* corresponds to a chapter in the textbook. To make this *Manual* as accessible as possible, each chapter follows the same structure. Instructors who familiarize themselves with this structure will find that they can readily find exactly what they need.

## Teaching Objectives

Even though much of the *Manual* is devoted to the various means of teaching your students about *Abnormal Psychology*, it is important to keep the ends in mind as well. *Teaching Objectives* are given to provide clear goals for your various pedagogical efforts. *Teaching Objectives* articulate the ideas, concepts, findings, facts, controversies, and principles you are hoping to convey to your students. These same *Objectives* are provided to the students in their *Study Guide*, assuring that everyone is working toward the same ends!

## Chapter Overview/Summary

The *Chapter Overview* is a narrative version of the bullet-point *Summary* that is given at the end of each chapter of the textbook. Not only does it provide a refresher on major points from the chapter, it is an easy way to identify important principles, findings, and crucial issues. Reading the *Summary* is a good way to get the big picture firmly in mind before giving the chapter closer study. Some instructors find that the *Chapter Overview* can even serve as an annotated set of notes to lecture from.

## Detailed Lecture Outline

Once the big picture is appreciated, the *Detailed Lecture Outline* drills down into the specific items the chapter covers. What the *Outline* lacks in explanation, it makes up for in detail, touching as it does on most of the specifics that make up each of the broader points the chapter seeks to convey. The *Outline* also exposes the precise structure of the chapter, giving the sequencing the authors felt was most natural given the content to be covered. Of course it would

be unwise to lecture directly from this outline, not least of all because it would be impossible to cover all of it within the traditional semester- or quarter-length course! Instead, instructors are encouraged to identify the chapter points they seek to elaborate upon in the classroom, identify and highlight the location of these points in the *Outline*, and use adjacent material to contextualize this material. You might also want to keep the *Outline* handy during your lecture to prompt you about each of the pieces necessary to support the conclusions you are building toward – or at least to back-up your memory for dates and spelling!

## **Key Terms**

As is the case with any scientific field, learning *Abnormal Psychology* requires learning its technical vocabulary. To help assure that technical terms are learned, and especially to learn the technical meanings of terms having non-technical meanings, a list of *Key Terms* is provided for each chapter. Note that these same terms are listed at the end of each textbook chapter, so you can expect that your students will be interested in focusing on the same ones you are.

## **Lecture Examples / Discussion Topics**

Each chapter gives at least five different *Lecture Launchers*. These are designed to help capture the attention of your students and to get them focused on the class. They are helpful at the start of class to get everyone thinking about abnormal psychology rather than thinking about their last class, where they are going for lunch, what they will be doing that night, or what's in the news. Although they are called *Lecture Launchers*, many work well in the middle of class, which is helpful for breaking up long lectures, or even at the end of class, to encourage thinking and discussion between classes. When working with these ideas, be sure to turn off the overhead or PowerPoint projector, walk around the room, make eye contact with as many students as possible, engage quiet students, balance encouragement with challenge and persistence with tolerance for pauses. Especially early in the semester, socialize your students to your expectation of an active classroom. If they learn that you give up easily and that you will quickly revert to lecturing, they will socialize you to do so.

## **Activities / Demonstrations / Assignments**

The various *Activities / Demonstrations / Activities* are also designed to stimulate student engagement with the course. They involve group projects, personal reflections, questionnaires, light research, and other small projects that can be done in or out of class. More often than you might imagine, the best teaching can be accomplished by getting out of the way and letting students teach each other. Cooperative education has sound empirical credentials, and it makes sense to let this powerful process work for you whenever possible. Again, apparent student passivity may be a deterrent, but persistence and enthusiasm will be amply rewarded! Realize that students are probably more interested in the activity than they care to reveal in front of their peers.

## MyPsychLab Resources

Each chapter contains relevant resources from MyPsychLab. MyPsychLab is a learning and assessment tool that enables instructors to assess student performance and adapt course content—without investing additional time or resources. Students benefit from an easy-to-use site on which they can test themselves on key content, track their progress, and utilize individually tailored study plan. Instructors benefit from an easy to use resource which encourages independent learning and helps ensure students are getting the reinforcement needed to master key concepts and the scientific thinking framework for everyday life. For more information on MyPsychLab go to [www.mypsychlab.com](http://www.mypsychlab.com).

## Teaching Tips

Instructor's Manual author Martha Hubertz has developed helpful advice and suggestions for the novice instructor, and advice for all instructors of Abnormal Psychology.

## Video Resources

Allyn & Bacon makes an extensive collection of videotaped material available to *Abnormal Psychology* instructors. In particular, *Abnormal Psychology Video: ABC News and Client Interviews* is a collection of custom video segments highlighting issues related to diagnosis and treatment that is available to adopters of this text. Depending on course enrollment, Allyn & Bacon also makes available videos from the American Psychiatric Press video series and from the Annenberg/CPB “World of Abnormal Psychology” series. Contact your Allyn & Bacon representative or visit the Allyn & Bacon website ([www.ablongman.com](http://www.ablongman.com)) for details. The *Video Resources* section of each chapter of this *Manual* also lists some of the most relevant and readily-available videos available from other sources. Finally, students can be fairly good at identifying examples of psychopathology from major motion pictures (e.g., Russell Crowe in *A Beautiful Mind*, Glenn Close in *Fatal Attraction*). It is especially educational if students who bring clips to class are asked to explain in detail which symptoms their chosen clips portray. One has to be quite careful, though, not to perpetuate erroneous stereotypes or to leave students with the mistaken impression that the fictionalized depictions represent the phenomenon in its prototypic form.

## Web Links

The web is an especially tricky resource for students and instructors of *Abnormal Psychology*. On the one hand, an enormous amount of excellent information is available to those who know where to find it. On the other hand, there is an unusually large proportion of bad information as well. While it is no doubt true that there is misinformation on the web about any scholarly topic you'd care to name, psychology in general, and *Abnormal Psychology* in particular, seems especially susceptible. Therefore, web links are provided for each chapter. Some very high quality sites are given along with some especially egregious ones, each clearly indicated as such. It is probably worth mentioning that the web is also somewhat unstable, inasmuch as links seem to change fairly frequently. Therefore, if you find a dead link in this *Manual* it might be worth using a major search engine, like [Google.com](http://Google.com), to try to find it, just in case it is merely moved, not entirely abandoned.

## **Handouts**

Following the individual chapters, this *Manual* gives handouts and other materials that are freely available for photocopying and distribution to your students. These include questionnaires, short essay assignments, personal reflections, compilations of information, and other items that instructors might find useful. Most often the handouts and activities go along with items in the *Activities / Demonstrations / Assignments* section.

*Abnormal Psychology* is inherently fascinating – but you probably know that already! *Abnormal Psychology* can be a pleasure to teach. Butcher, Mineka, and Hooley have pulled an enormous amount of information together in the textbook, and the publisher has provided a useful array of ancillary materials to support you. Hopefully, this *Manual* ties it all together and lightens your load along the way.

# Sample Syllabus

---

**Instructor:** You R. Organized, Ph.D., ABPP  
109 Meehl Hall  
O: 555-7763 H: 555-4993  
[You.R.Organized.1@state.edu](mailto:You.R.Organized.1@state.edu)  
  
[www.state.edu/~YRO1](http://www.state.edu/~YRO1)

**Class Location:** 208 Chapman Hall  
**Time:** Tu Th 3:30 - 4:45  
**Credits:** 3.0 (PSY 354)  
**Office Hours:** Mon 2:45-3:45 Wed 9:00-10:30  
**TA:** Jane Doe –  
[Jane.Doe.1@state.edu](mailto:Jane.Doe.1@state.edu)

**Description:** This course covers the domain of psychopathology as it is represented in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (2000: 4<sup>th</sup> ed., Text Revision). In this course I will; a) explain the scientific bases of contemporary theories of major psychological disorders such as schizophrenia, depression, and anxiety, b) encourage empathy for people suffering from mental illness, c) inform students, as future policy-makers and citizens, about societal implications of mental disorders, d) educate about mental health treatment for students who will be future consumers and referrers to such services, e) promulgate preventive information, and f) prepare students for further graduate-level training in psychopathology.

**Required Texts:** Butcher, J.M., Mineka, S., & Hooley, J.M. (2010). *Abnormal Psychology* (14<sup>th</sup> Ed.). Boston, MA: Allyn & Bacon. (ISBN: 0-205-59495-6)  
Meyer, R.G., Chapman, K.L., & Weaver, C.M. (2009). *Case Studies in Abnormal Behavior* (8th Ed.). Boston, MA: Allyn & Bacon. (ISBN: 0-205-59416-6)

**Optional Text:** Butcher, J.M., Mineka, S., & Hooley, J.M. (2010). *Study Guide for Butcher, Mineka, & Hooley's Abnormal Psychology* (14<sup>th</sup> Ed.). Boston, MA: Allyn & Bacon. (ISBN: 0-205-64986-6)

**Exams:** There will be three exams during class time, and a final exam during Finals Week. The attached "Class Schedule" shows the dates. Each exam will have 50 multiple-choice questions that you will have 75 minutes to answer. Since the textbook is comprehensive and provides a disproportionate share of the course material, **exam content will come approximately 70% from the texts** and 30% from lecture, cases, class discussion, and film clips. Exams are not cumulative; they will cover only material assigned since the prior exam. You **will** be responsible for text material that is assigned but not covered in class. In order to reward close study of the text, some exam items will be quite difficult.

**Makeup Exams:** Essay makeup exams will be given only for *previously* approved absences or in cases of documented emergencies. They must be taken within one week of the regular exam.

**Grading:** Grades are based on the sum of the four exam scores (200 points), in-class essays (50 points), and extra credit (12 points: described separately), according to the following system. If scores are unusually low, a curve will be used with the third highest score in the class taken as the 100% value against which the remaining scores are compared, in which case extra credit points will be added *after* the curve is set. Class attendance is required, and **participation will help students on grade borderlines.**

A	93% and above	B+	87-89%	C+	77-79%	D	60-69%
A-	90-92%	B	83-86%	C	73-76%	F	59% and below
		B-	80-82%	C-	70-72%		

# CHAPTER 1: Abnormal Psychology: An Overview

## Teaching Objectives

1. Explain the authors' approach to the study of abnormal psychology.
2. Discuss common topics and issues relevant to abnormal psychology.
3. Explain why we need to classify mental disorders and the advantages and disadvantages of classification.
4. Summarize the DSM-IV definition of mental disorders illustrating several problems with this approach.
5. Identify how cultural issues can influence the definition of abnormal psychology.
6. Identify the professionals responsible for working on the mental health "team."
7. Explain the difference between the prevalence and the incidences of mental disorders.
8. Discuss the prevalence rates for mental disorders.
9. Summarize current trends in patient care including inpatient and outpatient treatment.
10. Describe the scientific inquiry process.
11. Describe the importance of hypotheses in the research process.
12. Identify the critical elements of sampling and generalization.
13. Compare and contrast observational research strategies, experimental research designs, and single-case experimental designs.
14. Illustrate how research designs allow psychologists to make statements about the efficacy of treatment.
15. Discuss the importance of animal research to understanding abnormal behavior.
16. Identify the basic principles behind the text's study of abnormal psychology.

## Chapter Overview/Summary

Encountering instances of abnormal behavior is a common experience for all of us. This is not surprising given the high prevalence of many forms of mental disorder. A precise definition of abnormality is still elusive. Even though we lack consensus on the precise definition of abnormality, there are clear elements of abnormality: suffering, maladaptiveness, deviancy, violations of society's standards, causing discomfort in others, and irrationality or unpredictability. These elements allow for the adoption of a prototype model of abnormality. Although this model is helpful, we have the additional problem of changing values and expectations in society at large.

Despite these difficulties, psychologists continue to classify mental disorders for several reasons: classification systems provide a nomenclature that allows us to structure information in a more helpful way, research on etiological factors, treatment decisions, social and political implications, and insurance reimbursement. There are also many disadvantages to classifying mental disorders: loss of information, stigma, stereotyping, and labeling.

The DSM-IV definition is atheoretical, focusing on a clinically significant behavioral or psychological syndrome or pattern that is associated with distress or disability (impairment in one or more areas of functioning), and not simply a predictable or culturally sanctioned response to a particular event. Mental disorders, then, are the product of 'dysfunctions' within the individual. As might be expected, there are many criticisms of this definition. For example, what is meant by the term "clinically significant," which determines what is culturally sanctioned, and how much impairment is necessary for a diagnosis to be made? Wakefield has proposed a definition that describes a mental disorder as a "harmful dysfunction." His approach focuses on social values in defining abnormality as well as an evolutionary model to determine what is functional, creating potential new difficulties. This current text utilizes the prototype model adopted by the DSM classification system.

Culture shapes the presentation of clinical disorders in some cases. There are also certain disorders, such as *taijin kyofusho*, that appear to be highly culture specific. DSM opts for a categorical classification system similar to that used in medicine. Disorders are regarded as discrete clinical entities, although not all clinical disorders are best considered in this way. Even though it is not without problems, the DSM provides us with a working set of criteria that help clinicians and researchers to identify and study specific and important problems that affect people's lives. Although it is far from a "finished product," knowledge of the DSM is essential to a serious study of the field.

The extent of mental disorders may be surprising. Several epidemiological studies have been conducted in recent years. The lifetime prevalence of having a DSM-IV disorder is 46.7%. In addition, there is significant comorbidity, especially among those individuals who have severe disorders. Unfortunately not all people with mental disorders receive treatment. Some may deny or minimize their problems and others try to cope with their problems on their own. Even when the problems are recognized, many delay seeking treatment or seek assistance from a primary health care provider such as a physician. Most treatment is conducted in outpatient settings and

inpatient care is typically brief and provided only for those who need more intensive care. In an ideal case, the mental health team, composed of professional and paraprofessionals, may gather information from a variety of sources, process and integrate all the available information, arrive at a consensus diagnosis, and plan the initial phase of treatment.

To avoid misconception and error, we must adopt a scientific attitude and approach to the study of abnormal behavior. This requires a focus on research and research methods, including an appreciation of the distinction between what is observable and what is hypothetical or inferred. To produce valid results, research must be done on people who are truly representative of the diagnostic groups to which they purportedly belong.

Research in abnormal psychology may be observational or experimental. Observational research studies things as they are. Experimental research involves manipulating one variable (the independent variable) and seeing what impact this has on another variable (the dependent variable). Mere correlation between variables does not allow us to conclude that there is a causal relationship between them. Simply put, correlation does not imply causation. Although most experiments involve studies of groups, single case experimental designs (e.g. ABAB designs) can also be used to make causal inferences in individual cases. Analogue studies are studies that provide an approximation to the human disorders of interest (e.g. animal research). Although generalization can be a problem, animal research in particular has been very informative.

## **MyPsychLab Resources**

The current edition offers yet more assets and resources to aid you in teaching with this text. The new edition of MyPsychLab offers many videos, activities, and even short PowerPoint-like clips to clarify points in the text. Go to [www.coursecompass.com](http://www.coursecompass.com)—you can register for access to my lab assets. Contact your book rep for the access codes for this text. Your students will also need to register using their e-mail address, Course ID, and a Student Access Code (provided with student's textbook or in a student access card/kit available from your campus bookstore). If you assign any of the simulations or activities, students will have to have access to the site. If you would like to show videos, only you will need access. Once registered and logged in, click on "Intro to Psychology Materials" then select "Intro Psych Media Materials." There are many brief video clips under "Abnormal Videos" that you may find interesting. You can also select "All Pearson Intro Psych Videos." For each section, I have included the appropriate clips so that you can show them when covering the appropriate materials.

## **Detailed Lecture Outline**

### ***Lecture Launcher 1.1: 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 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.

### ***Teaching Tip 1.1: General Tips for Students on Studying***

Teaching Abnormal poses some interesting issues as it attracts a wide variety of students. Often I'll have both freshman and seniors in the class as well as majors from all different areas. Because of this I often spend a little more time discussing the qualifications of different areas of the fields. I also spend time on studying. Many students seem to erroneously feel that they know much of the material from TV and movies and thus may not study enough.

### ***MyPsychLab Resource 1.1: Video on "It Video: More Tips for Effective Studying"***

Under the MyPsychLab assets, go to: [www.coursecompass.com](http://www.coursecompass.com) - log in. Select "Intro to Psychology Materials," then select "Intro Psych Media Materials," select "All Pearson Intro Psych Videos." Go to "it video: more tips for effective studying," a brief (under 3 minutes) video on studying habits. Also, there is an "it video: Why is cramming an ineffective study method."

## I. What Do We Mean by Abnormality?

The first discussion is about the way 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

**Handout 1.1:** Begin this discussion by having students take a few minutes to fill out handout 1.1 “Is it Abnormal?”

You then want to discuss some of their answers in relation to how difficult it is to define “abnormal” behaviors.

Both 1 and 6 involve similar behaviors but one would be far more acceptable than the other—why? Students should point out that gender may play a role, or maybe the situation or context of the behavior

Both 2 and 9 are both about persons talking to themselves. Again, the context makes all the difference

Both 3 and 7 further highlight the issue of culture and context in how we interpret behaviors. This is also a good time to discuss religion and religious behaviors (the APA steers clear of most religious behaviors because it gives rise to issues of religious freedom). Ask students what behaviors done in a religious context would seem “abnormal” outside of one.

Both 4 and 10 are in reference to hearing voices. Again, it continues the discussion above as #10 again involves a religious freedom. You can also use this one to discuss the perhaps “adaptive value” of schizophrenia. E.g., even today in a remote non-industrialized setting (for example the Amazon) if you think you are talking to god it is most likely a plus. Here in the states, not so much.

Both 5 and 8 have to do with superstitious behaviors. Ask students what superstitious behaviors they perform, or know of behaviors that others do. How different is that from some of the rituals you see in OCD?

It is important to point out to students that there are many issues to defining abnormal behavior. What’s appropriate for one gender, or in one context, or in one culture, may be profoundly “abnormal” in another.

### ***Activity 1.1: Defining Abnormality***

Students can be introduced to the numerous definitions of abnormality described in *The World around Us 1.2: The Elements of Abnormality* by trying to formulate their own definition of what is abnormal. The question “How would you define abnormal behavior?” can be used to initiate the discussion. A number of different answers will be generated, and these should be recorded on the blackboard. The instructor will have to 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.

There are several elements in a comprehensive definition of abnormality.

- A. The Elements of Abnormality
  1. Suffering: this is personally defined psychological suffering. E.g., you can’t leave your house because you need to wash your hands 1,000 times. This is one of the most important aspects according to the APA.
  2. Maladaptive behavior: any behavior that is maladaptive for the individual OR towards society. E.g., anorexia: starving oneself is maladaptive.

### ***Lecture Launcher 1.2: 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. As 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?

3. Deviancy: statistically unusual behaviors. Again, point out this is not comprehensive, e.g., depression is in no way statistically unusual.
4. Violation of the standards of society. This gets at failure to follow the conventional social and moral codes of an individual society. E.g., taking ones clothes off in public.

***Lecture Launcher 1.3: 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-III-R (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?

5. Causing social discomfort: This is related to the above violation of social norms but results in others discomfort.
  6. Irrationality and unpredictability: This is related to behavior that cannot be expected and/or behaviors that appear to be irrational. E.g., washing one’s hands 500 times.
- B. The DSM-IV Definition of Mental Disorder (See table 1.1)
1. Mental disorder as clinically significant distressing or disabling syndrome in the individual.
  2. DSM utilizes “prototype” approach.
  3. Atheoretical—causal mechanisms are not described.
  4. Rules out culturally sanctioned behaviors.
  5. DSM definition still problematic—what is “clinically significant?”
  6. Wakefield—“harmful dysfunction” as alternative to DSM definition.
    - a. Classifies “harm” in terms of social value
    - b. “Dysfunction” determined according to evolutionary theory

***Lecture Launcher 1.4: Abnormality as “Harmful Dysfunction”***

An interesting article that can be used for a brief lecture and discussion session is one by J. Wakefield published in 1998 (“Diagnosing DSM-IV: DSM-IV and the concept of disorder.” Behavior Research and Therapy, 35, 633-649). The author suggests that the DSM-IV is over inclusive of its diagnostic criteria. The DSM does not distinguish harmful conditions due to internal dysfunction from harmful conditions that are not disordered or problems in living. The author recommends a dimensional approach to diagnosing mental disorder. Students can be asked about the value of having a diagnostic system, such as the DSM-IV, that does not examine the context of the individual’s life. The events that trigger mental disorder would have a more meaningful place in the dimensional approach than in the DSM classification system. Students can be asked to discuss the events that may lead to problems in living conditions that are harmful to the individual, yet don’t cause internal dysfunction. Would there be different outcomes for the different situations? Have students list the problems of living that may cause dysfunction in life. Should a person be diagnosed with a mental disorder if experiencing these situations?

7. DSM is a work-in-progress
- C. Why Do We Need to Classify Mental Disorders?
1. Advantages—overall, you are looking at 5 main advantages:
    - a. Nomenclature helps structure information
    - b. Promotes research
    - c. Directs treatment
    - d. Delimits domain of professional expertise
    - e. Delineates insurance reimbursement

- D. What Are the Disadvantages of Classification—overall have to do with negative consequences for the individual
1. Loss of information/detail
  2. Stigmatizing

**Lecture Launcher 1.5: Stigma Progress?**

Using an overhead transparency, a PowerPoint slide, a whiteboard, or a chalkboard, write the following question, “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, or (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.

3. Stereotyping

**Activity 1.2: Stereotypes and 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. 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. This is readily accomplished by asking students to bring examples to discuss in class. 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.

4. Labeling—Classification should be of disorders not of people

**Lecture Launcher 1.6: 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 (an example from the text is 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 piercing that they have. Tally the number of students who report 0, 1, 2, 3, 4, 5 or more piercing and talk about how the acceptance of piercing has changed in the past few years in our culture.

**Teaching Tip 1.2: Students with Disabilities**

You may want to consider asking the students with disabilities office to come in and do 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. I’ve found that many students in Abnormal, more so than other classes, often self-disclose diagnoses and other personal information and this discussion may make them more sensitive to others in the class that have been “labeled” and how that in and of itself has effected them.

- E. How Does Culture Affect What Is Abnormal?
1. Culture shapes the clinical presentation of disorders

**Activity 1.3: 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.

- F. Culture-Specific Disorders
  - 1. Certain forms of psychopathology are culture-specific
    - a. *taijin kyofusho*: Japan—marked fear of giving offense
    - b. *ataque de nervios*: Caribbean—distress triggered by a stressful event
  - 2. Nevertheless, 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 to be the product of mental disorder
- II. How Common Are Mental Disorders?
  - A. Prevalence and Incidence
    - 1. Frequencies of particular disorders are of great interest to professionals
      - a. Research efforts are guided by frequencies
      - b. Allocation of treatment resources depends upon the extent of the disorder
    - 2. Epidemiology is the study of the distribution of mental disorders
    - 3. Prevalence is the number of actual, active cases in a given population during any given period of time—typically expressed as a percentage
    - 4. Point prevalence—at any instant
    - 5. One-year prevalence—during an entire year
    - 6. Lifetime prevalence—full lifespan—tends to be higher than other prevalence rates
    - 7. Incidence is a rate—specifically, the number of new cases occurring over a period of time (usually one year)

**Lecture Launcher 1.7: Rates of Incidence**

Here you may want to again discuss issue in the 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?

- B. Prevalence Estimates for Mental Disorders
  - 1. The Epidemiologic Catchment Area study: sampled citizens of five communities (Baltimore, New Haven, St. Louis, Durham, and Los Angeles)
  - 2. The National Comorbidity Survey: sampled the entire United States
  - 3. One-year prevalence—based on the replication of the National Comorbidity Survey
    - a. 18.1% anxiety disorder (see table 1.2)
    - b. 26.2% any disorder (see table 1.2)
  - 4. Lifetime prevalence of having a DSM-IV disorder: 46.7%
    - a. May be an underestimate as did not assess for eating disorders, schizophrenia, autism, or most personality disorders
    - b. Disorder with the highest lifetime prevalence—major depressive disorder (See table 1.3)
    - c. although lifetime prevalence high, remember that duration may be brief or severity may be mild
  - 5. Comorbidity especially high in people who have severe forms of mental disorders (50%) in comparison to those who have milder forms of mental disorders (7%)
- C. Treatment
  - 1. Not all people with disorders get treatment
    - a. Some deny or minimize their problems
    - b. Some fear stigma of diagnosis
    - c. Some try to cope on their own

- d. Some spontaneously recover
  - e. Some see general practitioner physicians
  - f. Even if people recognize they need help, many delay treatment
2. Inpatient and outpatient treatment
- a. Inpatient hospitalization is declining
  - b. Budget cuts
  - c. Even if hospitalized, stays tend to be shorter and people referred for additional outpatient treatment
  - d. Effective medications
  - e. Deinstitutionalization (chapters 2 and 18)

***MyPsychLab Resource 1.2: Video on “Recent Trends in Treatment”***

You may want to show a brief 2-minute video on current trends in treatment. Log into MyPsychLab select “Intro to Psychology Materials,” then select “Intro Psych Media Materials,” then click on “All Pearson Intro Psych Videos”; once in select “Recent Trends in Treatment.” You can either do this as an in class demo (if your room has a computer set up)—or as a suggested exercise.

- D. The Mental Health “Team” (The World around Us 1.2)
- 1. In both mental health clinics and hospitals, people from several fields may function as an interdisciplinary team.
  - 2. Professional
    - a. Clinical psychologist
    - b. Counseling psychologist
    - c. School psychologist
    - d. Psychiatrist
    - e. Psychoanalyst
    - f. Clinical social worker
    - g. Psychiatric nurse
    - h. Occupational therapist
    - i. Pastoral counselor
  - 3. Paraprofessional
    - a. Community mental health worker
    - b. Alcohol- or drug-abuse counselor

***Teaching Tip 1.3: Careers in Psychology***

Make a copy of The World Around Us 1.2 and review with students. You may also want to take this opportunity to briefly discuss the different graduate degree programs and also, that students should make themselves aware of the requirements for licensing in the state they wish to eventually practice. If your department has someone that regularly schedules seminars for students to review graduate programs in psychology then you may want to announce in class when the next one is.

III. Research Approaches in Abnormal Psychology

***MyPsychLab Resource 1.3: Video on “Research Methods”***

You may want to show a brief 5-minute clip on research methods in Psychology. Once logged in to MyPsychLab, select “Intro to Psychology Materials” then select “Intro Psych Media Materials,” then click on “Lillenfield, Lynn, Namy and Woolf: Psychology 1<sup>st</sup> Ed”; once in select chapter 2 “Research Methods” click “find now” and watch “Research Methods.” You can either do this as an in class demo (if your room has a computer set up)—or as an extra learning exercise for them to do on their own. There are questions throughout the clip so that you can further discuss the points being made.

- IV. Sources of Information
- A. Case Studies
- 1. Kraepelin and Bleuler described cases of schizophrenia
  - 2. Alzheimer described a case of Alzheimer’s disease
  - 3. Freud described cases of phobia and obsessive-compulsive disorder.
  - 4. However, cases may be idiosyncratic and results not generalizable

**Lecture Launcher 1.8: Issues with Case Studies:**

This is a good time to point out the problems with case studies. For example, Alex the African parrot (see clip at: [www.youtube.com/watch?v=c4gTR4tkvcM](http://www.youtube.com/watch?v=c4gTR4tkvcM)). 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 Phinneas Gage's uncontrolled emotions, Piaget's observations of his children), they can also be very wrong (e.g., Alex the 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 there are only a handful of people who have a condition on the planet, or in cases of brain damage.

- B. Self Report Data
  - 1. Self-report data may be misleading
- C. Observational Approaches
  - 1. Overt behavior
  - 2. Psychophysiological variables
  - 3. Brain imaging technology allows us to observe how the brain works
- V. Forming and Testing Hypotheses
  - 1. Careful observation can suggest interpretations requiring scientific testing
  - 2. Cases and prior data are good sources of hypotheses
  - 3. Various perspectives explain the same behavior differently
  - 4. Causal hypotheses shape treatment strategies we use

**Lecture Launcher 1.9: 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.

- A. Sampling and Generalization
  - 1. Studies that examine groups of people are valued over single cases
  - 2. May identify multiple causes for disorders
  - 3. Can generalize results to other cases
  - 4. Sampling is the careful selection of a sub-group that is representative of a larger population for close study
    - a. The more representative the sample the more able we are to generalize
    - b. Ideally, we would like to be able to use random sampling to avoid potential biases
    - c. Erroneous conclusions can emerge from faulty sampling

**Lecture Launcher 1.10: 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 are there ways to get better data.

- B. Internal and External Validity
    1. External validity is being able to generalize results beyond the current study.
    2. Internal validity is how confident you are in the current studies results.
  - C. Criterion and Comparison Groups
    1. People with the disorder are the criterion group
    2. Control groups—typically healthy people—are used for comparisons
- VI. Research Designs
- A. Studying the World as It Is: Observational Research Designs (see figure 1.4)
    1. Experimental studies of etiological factors unethical and impractical
    2. Observational research requires no manipulation of key variables
    3. Study natural groups (e.g., depressed people)
  - B. Measuring correlation
    1. A statistic that ranges from -1 to +1 with a 0 in between. Correlations of +1 or -1 means the two variables are directly related. A correlation of 0 means there is no relationship between the two variables. (see figure 1.3 for a scatterplot example). The number, denoted by  $r$ , tells the strength of the relationship between two variables.
    2. A positive correlation means the two variables hang together—as variable A goes up or down—variable B goes up or down with it. E.g., watching violent media and committing aggressive acts or smoking and lung cancer, or students who miss a lot of class tend to do poorly in class.
    3. A negative correlation indicates that as variable A goes up or down, variable B does the opposite. E.g., having a low score in golf means you are doing well, or having a lot of money decreases risk for schizophrenia.
    4. Can provide rich source of inference—may suggest hypotheses and occasionally provide crucial data that confirm or refute these hypotheses
  - C. Statistical Significance
    1.  $P < .05$  is the level of statistical significance. This indicates that there is roughly a 5% probability the correlation would happen by chance. The size of the correlation dictates how strong the correlation is.
  - D. Correlations and Causality
    1. Correlation or association of variables is not evidence of causation
      - a. A might cause B or B might cause A
      - b. A and B might both be caused by C
      - c. A and B are involved in a complex web of relationships with other variables

**MyPsychLab Resource 1.4: Simulation “Correlational Studies”**

You may want to assign students to complete one of the MyPsychLab exercises on “Correlational Studies.” Once logged in, they would select “Intro to Psychology Materials” then select “Intro Psych Media Materials,” then click on “Live Psych Simulations”; once in select the first simulation “Correlational Studies.” You can either do this as an in class demo (if your room has a computer set up)—or as an extra learning exercise for them to do on their own. There is a quiz but it would not be something you could grade off of as they can change their responses.

- E. Retrospective versus Prospective Strategies
  1. Retrospective memories can be both faulty and selective
  2. Such a strategy may increase the odds that investigators discover what they expect to discover
  3. Prospective studies often focus on high-risk populations before they develop the disorder
  4. Identification of differentiating variables

5. When hypotheses correctly predict behavior, we are much closer to establishing a causal relationship
- F. Manipulating Variables: The Experimental Method in Abnormal Psychology
  1. Scatterplots of positive, negative, and zero correlation
  2. Scientific control of all but one variable
  3. Independent variable is manipulated
  4. Dependent variable is observed for experimentally induced changes

***MyPsychLab Resource 1.5: Simulation “The Experimental Method”***

You may want to assign students to complete one of the MyPsychLab exercises on “The Experimental Method.” Once logged in, they would select “Intro to Psychology Materials” then select “Intro Psych Media Materials,” then click on “Live Psych Simulations”; once in select the first simulation “The Experimental Method.” You can either do this as an in class demo (if your room has a computer set up)—or as an extra learning exercise for them to do on their own. There is a quiz but it would not be something you could grade off of as they can change their responses.

***Handout 1.2: Research Methods: Is it an experiment or is it a correlation?***

You may want to either assign students to do this on their own and then go over it in class, or uses this in class as examples of the concepts you’ve just covered.

For each example state if the study described is an experiment or a correlation. If it is an experiment, identify the independent and dependent variables. If it is a correlation, identify if it is a positive or negative correlation.

1. Researchers are interested in whether eating disorders are related to childhood abuse. They looked at females both diagnosed with eating disorders and no diagnoses of eating disorders and compared it to self-reports of abuse in childhood. They found that females with a history of abuse were slightly more likely to develop an eating disorder than females in the general population.

Positive correlation

You again could point out the actual rate is about 25%—it is significant, but in no means does A predict B. You may want to point out that ice cream sales and violent crime are also correlated—this does not mean eating ice cream causes violence, rather that in the summer both go up.

2. Dr. Benzo is interested in developing a new anti anxiety drug with less side effects and risk of dependency than the current leading treatments. She gets one group of subjects that take her new super drug A, one group that takes a placebo, and one group that takes the currently prescribed treatment. She then measures which group has the lowest levels of anxiety.

Experiment—-independent variable: treatment type - Dependent variable—anxiety level

3. Researchers notice what they feel is a connection between an external locus of control and sustaining injuries in a tornado. They find that for people in Alabama, there is a relationship between having an external locus of control and dying in a tornado.

Positive correlation

4. Drs. Dre and Snoop are interested in the effects of smoking marijuana on memory. They predict that smoking marijuana will decrease short-term memory. They expose 100 rats to marijuana smoke three times a day, 100 rats to marijuana smoke one time a day, and 100 rats to no marijuana smoke ever. After 1 week of this condition, they teach the rats to run a maze and measure how many trials it takes each group of rats to learn the maze.

Experiment—-independent variable: exposure level to marijuana - Dependent variable—memory of maze

5. Researchers are interested in the rates of incidence of schizophrenia and socioeconomic status (SES), they compare SES and diagnoses of schizophrenia and find that as SES increases, the likelihood of being diagnosed schizophrenic decreases.

## Negative correlation

6. Researchers are interested in the efficacy of cognitive behavioral therapy (CBT) in treating depression. They give some people pharmaceuticals, some CBT, and some both. They found that patients receiving both are less depressed than either of the other two groups.

Experiment—-independent variable: treatment condition - Dependent variable—level of depression.

- G. Studying the Efficacy of Therapy
  1. Random assignment to treated or untreated group
  2. Untreated (e.g., “waiting list”) control group
  3. Ethics of withholding effective treatment may lead to an alternative research design in which two or more treatments are compared
  4. Comparative-outcome research: comparing new versus established treatment
- H. Single-Case Experimental Designs
  1. Many observations of one subject
  2. ABAB design

**Activity 1.4: 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 5 pulse rates during “treatment,” the students once again sit and record five resting pulse rates in one-minute intervals. Students could repeat the treatment phase if the instructor wished to demonstrate an ABAB designs. Once the data collection is complete, each student could draw a graph of his or her results and attempt to draw some conclusions regarding how “treatment” impacted heart rate.

- I. Animal Research
  1. Permits experimental manipulation
  2. Ethical considerations still apply
  3. “Analogue” of human conditions
  4. Findings from animal research provided impetus for learned helplessness model of depression

**Lecture Launcher 1.11: Ethics in Scientific Research**

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

You may want to show a brief 3-minute clip on “Before Informed Consent: Robert Guthrie,” discussing the Tuskegee Study, a highly unethical example of human research. Once logged in to MyPsychLab, select “Intro to Psychology Materials” then select “Intro Psych Media Materials,” then click on “All Pearson Intro Psych Videos,” then scroll down to “Before Informed Consent: Robert Guthrie.” You can either do this as an in class demo (if your room has a computer set up)—or as an extra learning exercise for them to do on their own. There are questions throughout the clip so that you can further discuss the points being made.

**Activity 1.5: 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 be sent to the library 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.

VII. The Focus of This Book

- A. A scientific approach to abnormal behavior
  - 1. Clinical picture
  - 2. Causal factors
  - 3. Treatments
- B. Openness to New Ideas
  - 1. Biological
  - 2. Psychosocial (e.g., psychological and interpersonal)
  - 3. Sociocultural (e.g., culture and subculture)
- C. Respect for the Dignity, Integrity, and Growth Potential of All Persons

VIII. Unresolved Issues: Are We All Becoming Mentally Ill? The Expanding Horizons of Mental Disorder

- A. There Is Constant Pressure to Expand DSM to Encompass More
  - 1. Economic interests of mental health professionals support expansion
  - 2. For instance, “road rage”
- B. Too Much Expansion Would Make DSM Scientifically Useless

**Key Terms**

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

**Lecture Launchers**

***Lecture Launcher 1.1: 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 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.

### ***Lecture Launcher 1.2: 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. As 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?

### ***Lecture Launcher 1.3: 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-III-R (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?

### ***Lecture Launcher 1.4: Abnormality as “Harmful Dysfunction”***

An interesting article that can be used for a brief lecture and discussion session is one by J. Wakefield published in 1998 (“Diagnosing DSM-IV: DSM-IV and the concept of disorder.” *Behavior Research and Therapy*, 35, 633-649). The author suggests that the DSM-IV is overinclusive of its diagnostic criteria. The DSM does not distinguish harmful conditions due to internal dysfunction from harmful conditions that are not disordered or problems in living. The author recommends a dimensional approach to diagnosing mental disorder. Students can be asked about the value of having a diagnostic system, such as the DSM-IV, that does not examine the context of the individual’s life. The events that trigger mental disorder would have a more meaningful place in the dimensional approach than in the DSM classification system. Students can be asked to discuss the events that may lead to problems in living conditions that are harmful to the individual, yet don’t cause internal dysfunction. Would there be different outcomes for the different situations? Have students list the problems of living that may cause dysfunction in life. Should a person be diagnosed with a mental disorder if experiencing these situations?

### ***Lecture Launcher 1.5: Stigma Progress?***

Using an overhead transparency, a PowerPoint slide, a whiteboard, or a chalkboard, write the following question, “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.

### ***Lecture Launcher 1.6: 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 (an example from the text is 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