

# Defining Abnormal Behaviour



## Learning aims

At the end of this chapter you should:

- Understand the complexity in distinguishing between abnormal and normal behaviour
- Understand the various definitions of abnormal behaviour
- Be familiar with the differences between deviance and dysfunction
- Comprehend the complexities of legal definitions and insanity.

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## INTRODUCTION

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### CASE STUDY

Matt is a 42-year-old construction worker. He has been married for 20 years, has two nearly grown children, served four years in the military and has been employed at the same construction company since he left military service. He is described as steady and reliable. Yet, there is one thing that

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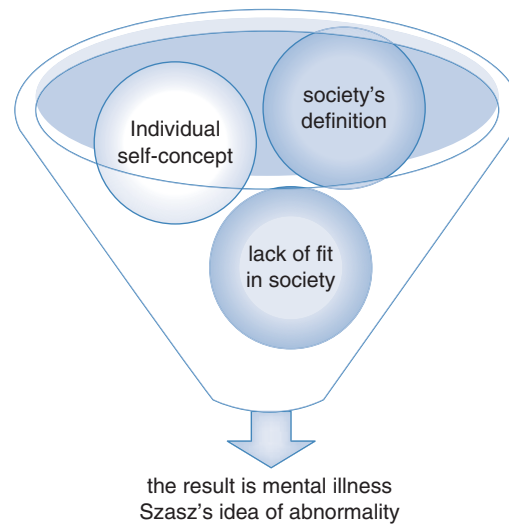
doesn't seem quite right; he carries small brass bells with him wherever he goes. He has carried these bells since he was a child and will tell people that they are for luck. The reality is that Matt carries them to keep evil spirits away. He stopped telling people his real reason for carrying bells because people were less understanding than if he just said he carried them for luck. Matt's beliefs do not interfere in his life, he has never been treated for a mental illness, and he doesn't appear to use them to control anything else in his life. His behaviour has made him the butt of jokes. He has been called harsh names; he has been physically and mentally abused by others and yet he continues to carry his bells. Time has taught him to hide them in his clothing and he has taken to sewing them in the seams of his shirts and trousers. How would you describe Matt's behaviour? Is Matt mentally ill?

### WHAT IS ABNORMAL BEHAVIOUR?

What is abnormal behaviour? How do we define what is abnormal? We can identify behaviour that is 'weird' when we see it but how do we 'define' it. The majority of us avoid what we define for ourselves as 'odd' behaviour, for example we would probably choose not to sit next to someone acting in an odd fashion or dressed in odd clothing on a bus or train. We don't like individuals who smell unclean and whenever possible stay away from them.

On the whole, we would define abnormality as being outside the parameters of what is accepted in our society. But how is this defined and what does 'normal parameters' really mean? Who decides what is abnormal vs. normal? If normal behaviour is defined by a society, what is a society?

A society is a collective of individuals who are defined by the language that is spoken, religious practices and ethnic diversity. Societies are fluid and constantly changing. What was the norm for a society one hundred years ago may not be the norm of the same society today. How an individual behaves within a group is defined by the constraints of the society. Rules and norms govern what are deemed to be normal parameters. If you lived a solitary existence, how you behaved would not be dictated by others as you would be free to do as you chose. Your behaviour would not impinge on anyone else. When an individual lives within a group, the definition of normal behaviour is usually classified by a consensus of what is considered to be normal for that group. Occasionally, certain groups of people can push the boundaries but even this has limitations. For example, many normal behaviours are classified by age ranges. A 16-year-old who chooses to dye their hair a bright lime green colour would probably not be classified as abnormal; perhaps unusual, but not extreme. We would probably agree that this behaviour is pushing the boundaries, but we would also define it as youthful behaviour and therefore acceptable. However, if a 70-year-old engages in the same behaviour, our evaluation of this individual would be outside of normal boundaries. The norms that govern behaviour at different age categories have unwritten rules that guide behaviour. Although it is certainly not illegal to dye hair any colour, at any age, certain colours would be governed by rules of what is considered age-appropriate behaviour and anyone acting outside these boundaries would probably be classified as behaving in an abnormal way. This is also complicated by the number of inappropriate behaviours. If the only behaviour that is outside of the norm, i.e. lime green hair, and



**Figure 1.1**

all other behaviours are age appropriate and considered normal, the unusual element may be classified as odd or eccentric. The single behaviour displayed with all else being normal may not be defined as abnormal, although it would probably never be considered normal. The consequence of having 'odd' hair would probably result in those individuals within the same age range ostracizing the individual until they changed their hair back to an age-appropriate colour. So, what is abnormal psychology and how do we determine that people are behaving in abnormal ways? Do we define abnormality by the number of extreme behaviours?

Efforts to define psychological abnormality typically raise as many questions as they answer. Ultimately, a society selects general criteria for defining abnormality and then utilizes that criterion to judge particular cases. Szasz (1960) believed that the entire idea of abnormality and mental illness was invalid and what society defines as abnormal are simply problems in living or finding a niche, not that something was wrong with the individual. Other researchers have believed that the concept of mental illness is used to control or change people whose unusual patterns of functioning upset or threaten the social order (Sarbin & Mancuso, 1980; Scheff, 1966).

These viewpoints may seem extreme and hardly anyone would argue that the pressures of being successful and attaining one's goals in society do not contribute to stress and dysfunctional behaviour, but how do we define this contribution and more importantly, what can we do to change the pattern?

Perhaps it is important to look at how the past has defined abnormal behaviour. History has provided us with examples of behaviour that has been defined as abnormal for that society and that time and place. It may be important in our search for meaning to begin with earlier examples of what was defined as abnormal to help us understand how we classify abnormal behaviour today.

## HISTORICAL PERSPECTIVES OF ABNORMAL BEHAVIOUR

Ancient societies believed that events and people were controlled by the supernatural and when individuals in the community acted outside of what was considered 'normal' they were then placed at the mercy of evil spirits that could cause affliction, inhabit their bodies or cause terrible events to happen to family members. History is filled with stories of individuals who intentionally exchanged their souls in order to obtain wealth and power. Therefore, ancient societies looked for physical evidence of evil and found it in anything that deviated from the norm (Millon, 2004). Physically and mentally abnormalities were proof of demonic possession. Individuals were generally held to be responsible for their own ailments or had committed some act to place family members in danger.

The treatments used by many early societies in order to purge the person from evil generally involved extreme physical measures in order to make the corporeal manifestation of the demon unpleasant and allow the evil spirit to leave the body. Unfortunately the extreme physical 'treatment' often proved fatal but nevertheless was considered a success as it kept the rest of the community safe from harm (Porter, 2002).

The idea that evil spirits were responsible continued for thousands of years, until Hippocrates, a Greek physician, began to change the way illness was perceived. Hippocrates believed that imbalances and disorders were not the result of evil spirits and instead were problems within the brain and body. He relied on observations and explanations which would be the beginning of the scientific method. Hippocrates greatly influenced medicine by shifting the ideology from corporeal to tangible. He correctly assumed that the most important area of the body was the brain and that it was central to intellectual activity and abnormal behaviour was as a direct result of disease. Hippocrates introduced the theory of heredity and environmental factors into the concept of mental illness and developed more compassionate treatments which subjected individuals to less cruel and violent methods (Porter, 2002).

Hippocrates was also the first to classify abnormal behaviour into three distinct categories; mania, melancholia and phrenitis, giving each detailed clinical descriptions. Others would follow the direction that Hippocrates proposed. Plato continued the belief that abnormal behaviours occurred as a result of brain and body dysfunction and would insist that these individuals should be cared for by their families and not punished for their behaviour. Galen made major contributions with his scientific examination of the central nervous system and how this contributed to abnormal behaviour (Porter, 2002).

Just as mankind appeared to be striding forward, they took a gigantic step backward with the rise of Christianity. Religious dogma reinstated the ancient ideas that abnormal behaviour was the result of supernatural contact; however instead of random, unnamed evil spirits the culprit was the devil. Scientific attempts to understand, classify and explain became less important than accepting disease and dysfunction as a manifestation of God's will.

The influence of Christianity did not promote science and instead actively discouraged it. Physicians were no longer allowed to conduct scientific experiments to determine the cause of death. Anyone who challenged Christian doctrine was denounced as a heretic and condemned. Initially, those who continued the teachings of Hippocrates and Plato were denounced and when

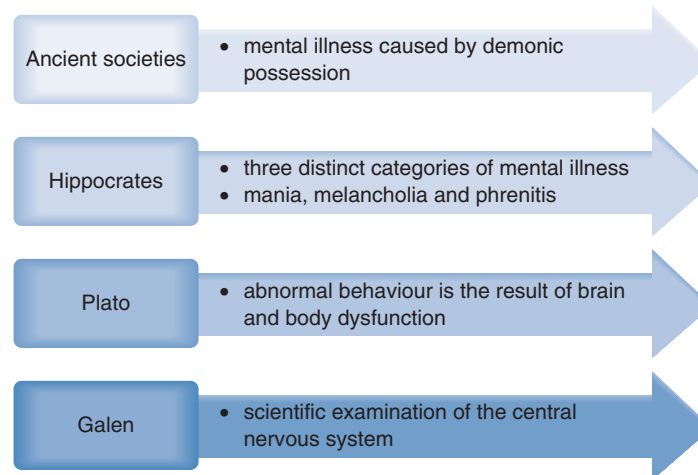


Figure 1.2

this proved an ineffective deterrent they were executed by the church and all their papers and books were seized and burned. Scientific thought was in conflict with church doctrine and religious leaders found it abhorrent to mutilate the dead when clearly the death was at God's will (Porter, 2002).

Illness, whether physical or mental, was now seen as punishment for sin. The sick person was guilty by the hand of God for wrongdoing and relief could only come from repentance. The treatment of individuals at this time was imbalanced; some individuals were treated with compassion while others were subjected to cruel punishments designed to elicit confessions. The downward decline of positive treatment continued and individuals displaying abnormal behaviour, mental and physical illnesses were subject to prayers, curses, flogging, starvation and immersion in hot water. Church leaders deemed what was abnormal behaviour and corrected the inconsistencies (Foucault, 2006).

During the fifteenth and sixteenth centuries religious leaders were constantly battling social and religious reforms. In an effort to quash protests which threatened the Church's power, the Church claimed that these insurrections were the acts of the devil and began to actively endorse demonic possession and witches (Eghigian, 2010).

In 1484 Pope Innocent VIII issued a decree calling on the clergy to identify and exterminate anyone thought to be in league with the devil. This resulted in the publication of the *malleus maleficarum* (the witches' hammer). The document acted to confirm the existence of witches and also outlined various ways of detecting them (Alexander & Selesnick, 1966).

An individual displaying any behaviour that was deemed to be abnormal in any way was suspected of witchcraft. It is probable that anyone with any type of mental illness would certainly have been condemned as being a witch. Individuals behaving outside of traditional norms were seen by the Church as being undesirable or uncooperative and were tortured in order to obtain confessions, with thousands of individuals being burned alive and mutilated in the name of the Church (Alexander & Selesnick, 1966).

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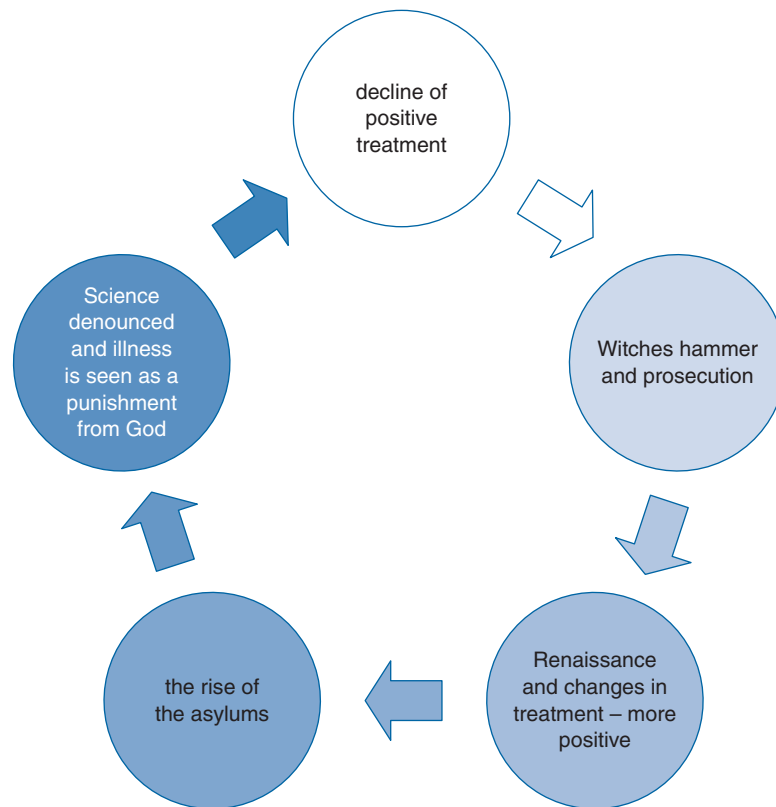
A change in attitudes came with the Renaissance period, which is defined as the fourteenth through sixteenth century. This saw a resurgence of rational and scientific inquiry which led to great advances in the sciences. The humanistic movement also originated during this time frame and emphasized human welfare and the worth and uniqueness of the individual. The Renaissance period allowed individuals to understand that acting outside of norms would not lead to total anarchy, rather it led to a period of prosperity and growth. These changes in attitude of allowing individuals the freedom to express themselves slightly outside of the norm leads us to the next element of defining abnormality (Bewley, 2008).

Previously held explanations of mental illness began to lose support and favour and in 1563 a German physician named Johann Weyer published a book which challenged the foundation of witchcraft and alleged that many of the people who had been tortured, imprisoned and burned as witches were instead mentally disturbed. Although the practices of cruelty toward the mentally ill had somewhat subsided, the ideology was still very much active and present. Weyer's book was immediately banned by both church and state and the author was emotionally and physically punished for speaking out against the long held belief of witchcraft and demonology (Bewley, 2008).

However, instead of stifling the information, many began to believe and eventually the beliefs stated by Weyer became the forerunner of the humanitarian perspective towards the mentally ill. The care of people with mental illnesses began to improve and instead of the inhuman treatment of punishment, abandonment and death, people were kept at home and cared for by family members with the help of their friends and neighbours and the financial support of the local parish. During this period, all across Europe religious shrines were devoted to the humane treatment of people with mental disorders (Van Walsum, 2004; Airing, 1975).

The mid-sixteenth century continued to bring positive changes to the care of the mentally ill. Private homes and small communities could only help a small number of mentally ill individuals. Large cities had difficulty housing all the individuals who needed this type of care. The idea of the state providing accommodation and care began with converting hospitals and monasteries into asylums where the insane were to be sheltered from a hostile world, kept from harming themselves or others and given help and treatment. As these began to fill, the government began to build special hospitals specifically designated for the care of the mentally disturbed, many of which were built in secluded areas and surrounded by high walls with locked gates. These hospitals, now called asylums, quickly became overcrowded and what began with good intentions for treatment and care became filthy conditions where the patients began to be physically restrained rather than receiving treatment. Patients became inmates and they were locked in boxes or crates, chained to walls and floors, given bare sustenance, beaten and mistreated, with many dying of starvation and physical illness. The Bethlem Royal Hospital in London (also called Bedlam) became one of these infamous places and was well known for its inhumane treatment of patients. It housed people in such deplorable states and was in such a state of chaos that it became a public spectacle and members of the general public would pay to stare at the various patients chained and locked in their cells, and laugh at their antics. It became so well known that the name entered the English language and is used to describe chaos and confusion. Gradually the general public began to see the mentally ill as a menace and security became more important than treatment (Arnold, 2009).

The reform movement of the eighteenth and nineteenth centuries came about with the influence of two men, Philippe Pinel and William Tuke. Pinel was a physician in France and had been placed

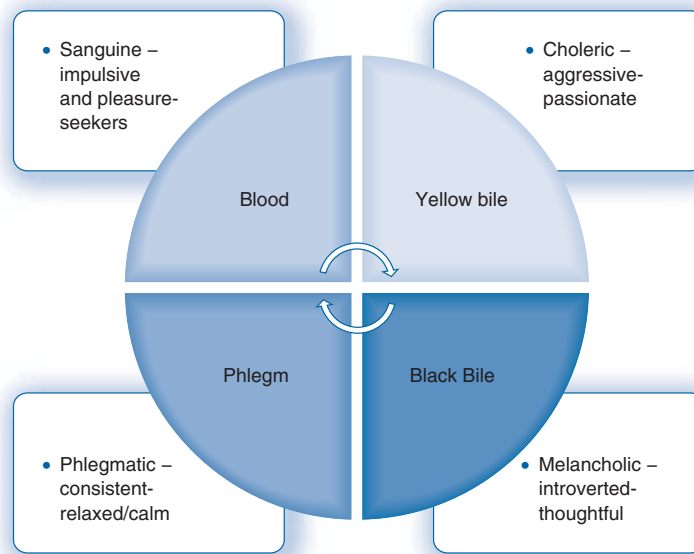


**Figure 1.3**

in charge of a hospital for insane men. He changed the hospital practices to include humane treatment, moral guidance and respectful techniques which were termed the ‘moral treatment movement’. Pinel ordered that patients be released from chains and confinement and encouraged to exercise outdoors. Patients were treated with kindness and respect, which appeared to foster their recovery and improve behaviour. Tuke also changed the way individuals were treated; he abhorred the inhumane practices of confining individuals in crowded, cramped cells, often chained to walls or the floor. He established a retreat at York where patients worked, prayed and talked about their problems (Arnold, 2009; Borthwick et al., 2001).

While physical treatment was improving for many individuals, the mental factors that were believed to be at the heart of mental illness were being investigated. Two distinct schools of thought emerged: the biological viewpoint and the psychological viewpoint. The biological viewpoint was headed by Emil Kraepelin who believed that mental illness was a result of biological factors. Kraepelin would later be considered to be the father of the classification system otherwise known as the Diagnostic and Statistical Manual of Mental Disorders (DSM). The second school of thought was led by Josef Breuer and Sigmund Freud and became the

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**Figure 1.4** The four humours and associated temperaments – kept in balance, allowed the person to be physically as well as mentally healthy

psychological perspective. This ideology held that psychological processes were the reason for mental illness (Kent, 2003).

The early 1900s saw a reversal of the moral treatment movement. Several factors were responsible; severe money and staffing shortages, decline in recovery rates, and a new wave of prejudice and fear from the public (Bockoven, 1963). Quickly public mental hospitals were back to providing custodial care and became filled to over-capacity. With the overcrowding came poor treatment and abuse of the patients. Although many mental health reforms had been passed and hospitals attempted to put humane practices into place, the sheer numbers of individuals with mental illness often made these practices unrealistic. Additionally the humane practices were not sufficient for all cases (those that were dangerous or endangered others) and clearly something more was needed. Psychological treatment was available but was generally only accessible to individuals who had the means to pay for this type of intervention. Individuals who could not afford psychological therapies and private care were relegated to the public mental hospitals (Kent, 2003).

In 1949 the Australian psychiatrist John Cade reported on the success of giving lithium to long-term hospitalized manic patients that calmed them enough for them to be released. In 1950 the drug thiorazine was synthesized, which was extremely effective in the treatment of psychotic patients. It has been claimed that this drug alone has been responsible for the single greatest advances in the twentieth century (Andreasen, 1984; Lickey & Gordon, 1991). Suddenly long-term hospitalized patients were able to be released. A new class of drug, the psychotropic medications came in three



basic classes. The first category were antipsychotic drugs, to correct disordered thinking and hallucinations, the second were antidepressant drugs to lift the moods of those individuals who were depressed and the third class were anti-anxiety drugs to reduce tension and worry (Sweet, Rozensky & Tovian, 1991).

Many of the patients who were provided with these drugs dramatically improved and were able to be discharged from hospital care. The new drugs created a different system of caring for the mentally ill and a phase of deinstitutionalization occurred. Patients were now being discharged into community care and outpatient care, which solved many of the overcrowding problems at mental institutions. They in turn were able to begin implementing many of the principles that had begun with Pinel and his moral treatment movement, as well as provide psychological therapies that had only once been accessible to the wealthy (Barham, 1997).

In spite of the new drug therapies and deinstitutionalization, many believed that the inhumane physical practices of the past that consisted of chaining individuals who were suffering from mental illnesses to beds, walls and chairs have only been replaced by chaining their minds. Although the new drug therapies appeared to be a significant improvement, the side effects that accompany the drug therapy are considerable (Breggin, 2001). It is not uncommon for individuals to exchange damaged minds for damaged bodies in the form of lowered life expectancy, extrapyramidal effects on motor control, lowered white blood cell count, tardive dyskinesia, sexual dysfunction and tardive psychosis. These have a potential for permanent chemical dependence leading to psychosis that can be even more debilitating than before the drug was administered (Keshavan, 2004).

## EVALUATION IN CONTEXT

Abnormal behaviour must be evaluated in its context. All behaviour must be evaluated in terms of its time frame, social norms and rules that govern behaviour. We have expectations of how people should behave at public places. For example our expectation at a train station is that people should be orderly, fairly well dressed, clean and to wait patiently for the departure or arrival of their train. Anyone whose behaviour is outside of these norms becomes suspect. We would avoid dirty, unkempt individuals who push and shove and yell, in loud obnoxious tones.

However at a three-day outdoor music festival someone in a three piece suit would be totally out of place; the norm for this venue is grimy, dirty and dishevelled. In fact many people at these festivals wear mud caked all over their bodies as if they are badges of honour. Generally, the more outrageous the behaviour, the more the surrounding people find this to be entertaining. Individuals who push and shove and yell in loud obnoxious tones are welcomed and cheered. However, even this venue has limits; it is considered outside the norm to attack other people or to cause bodily harm to others. At what point does amusing behaviour become abnormal? It is difficult to describe in detail where the line is drawn – but generally those of us living in a society can readily identify when the behaviour becomes extreme and unwanted. Abnormal behaviour must always be evaluated with regard to a specific time frame, social norms and expectations of behaviour for that venue/place and it must be judged against what is ‘normal behaviour’ and normal expectations.

## GENDER

Our gender plays a major role in our perceptions and how we define ourselves. Being male or female affects the way our parents raise us, our role in life, the way other people respond to us and the way we are treated by society. It has historically also been used to determine normal and abnormal behaviour. Gender defines the range of behaviour that is considered appropriate and permissible and generally the range is narrower for women than for males. Women who do not conform to the current defined roles of femininity are more likely to be labelled as mentally ill (Scheff, 1966). Until relatively recently it was widely accepted that the only desirable roles for a woman were those of wife and mother and that a woman's entire life should revolve around these roles. Even today in the UK archaic remnants of masculine/feminine social definitions continue to exist, e.g. if a woman hasn't married before the age of 25 she is deemed a spinster by the UK Registrar's Office. In comparison, there are no offensive terms for an unmarried man of any age.

Traditional roles form the basis for social behaviour. If we as a society determine that there are certain traditional roles for a group of people, anyone acting outside of these roles would be behaving in abnormal ways. We continue to be influenced by traditional roles that determine that certain types of jobs and careers are preferable to others. A female wanting to work in non-traditional roles is no longer considered abnormal but she is still far from the norm. For example, a female plumber may have a difficult time securing jobs independently as many would feel that only a male plumber would provide good service.

In the past 30 years women were denied opportunities to many different types of professions such as: accountancy, engineering, politics, medical and legal careers although this is slowly changing and women are being trained and securing jobs in these professions. Unfortunately these changes did not occur without a great deal of discord and women were forced to fight for their rights. Many became pioneers and had to break down barriers in order to overcome gender discrimination.

Various studies have documented how boys and girls are socialized into traditional sex roles. Witt (1997) found that children learn at a very young age what the difference in gender means and through a variety of activities, opportunities and positive and negative reinforcement, experience the process of gender role socialization. Santrock (1994) found that as children develop they internalize the process of gender roles and these become firmly entrenched and part of a child's self-concept. Rubin, Provenzano and Luria (1974) found that parents have different expectations of sons and daughters as early as 24 hours after birth. Further studies have documented that a child internalizes the parental messages regarding gender at a very early age and their defined self-identity and self-concepts of gender come from parents (Lauer & Lauer, 1994; Santrock & Warshak, 1979; Kaplan, 1991). Hoffman (1977) found that reasons given by women for preferring a son over a daughter were to please their husbands, carry on the family name and to be a companion for their husband. Reasons for wanting a daughter included having a companion for themselves and to have fun dressing a girl and doing her hair.

Stereotyping is defined as attaching an usually unfavourable and inaccurate perception to a group of people. Stereotypes often make it easier to justify unequal treatment of the stereotyped person or group. Among the traditional stereotypes of women is the belief that they are naturally passive, domestic and weak. However unrealistic and inaccurate these stereotypes may be, many

individuals in society believe them to be true. One of the unfortunate effects of stereotyping is that even people who are victimized by these labels tend to believe that they are true. They become self-fulfilling prophecies, i.e., if a woman believes that being a car mechanic is an occupation that women are incapable of doing because they are not strong enough, she will not take her car to a female car mechanic, believing her to be incapable, nor will she consider the idea of becoming a car mechanic herself or encourage female children to consider that occupation. Goldberg (1972) found that women value professional work that they think was done by a man more highly than the same work if they think it was done by a woman. Horner (1970) found that many women were motivated to avoid success, fearing that the more ambitious and successful they became, the less feminine they would be.

The norms of a society are an important source of prejudice and discrimination. Anyone outside of these norms will subject themselves to a variety of conforming social pressures and when these do not work, can be labelled as abnormal and even insane. If an entire society believes that women are less valuable, more mentally unstable, emotional and weak, these definitions will be accepted by most members as being accurate.

In early civilization women were equal partners and revered as the bringers of life and fertility (Eisler, 1988). This ideology began to change with the origin of the patriarchal structure most associated with warfare (Brown & Harris, 1978). With warfare, invasions and destruction became the norm and male dominance and enslavement of women became common. Engels (1983) further stated that the changing status of women also came with the beginning of private ownership of land that coincided with warfare. Society moved from a transient state to a static phase where land ownership, social class and patrilineal inheritance became important. As a result of these changes, women have been dominated by men in every aspect of their lives including reproductive rights and sexual freedom.

Chastity and fidelity became important societal virtues and in order for men to ensure that women remained 'pure' and that they retained control they designed chastity belts. These devices first appeared in Europe in the fifteenth century and were used until the late 1800s, first by fathers and then by husbands. They enabled men to have complete sexual and reproductive control which included the prevention of masturbation. The most important role for a woman to have was as wife and mother. Any woman who chose a life outside of these roles was considered abnormal. Working-class women were expected to work until they had children. These women tended to have more children than upper- and middle-class wives. In the middle of the nineteenth century, the average married woman gave birth to six children. Over 35 percent of all married women had eight or more children. It wasn't until the early 1900s that women began advocating for changes in reproductive rights.

Marie Stopes in 1918 wrote a guide for women concerning contraception which caused turmoil with the leaders of the Church of England and the Pope, who believed that the use of birth control was wrong and condemned all forms of contraception. Again, the idea that a woman should be allowed to choose outside of the traditional roles and deny her husband children was considered abnormal behaviour and anyone participating in this behaviour was reprimanded by society as well as the religious organization they were associated with.

The first pharmaceutical form of birth control became available in 1957 and for the first time in history women gained control of their reproductive rights as they no longer were required to have

the cooperation of men to prevent pregnancy. They could privately engage in safe and relatively effective methods of birth control without the express permission of a man. Women could now engage in sexual freedom that had previously only been the right of males.

Although women had gained access to their reproductive rights and sexual liberty, the expectations of what is allowed concerning chastity and fidelity continue to be firmly held and what is allowed continues to be a factor in defining abnormal behaviour. Boys are allowed to be sexually active while girls are socialized away from sexual behaviour. When girls behave outside of socialized norms they are often considered to be abnormal and their behaviour is negatively labelled.

Women and men are still considered different and treated differently by social institutions, including the government and its legal system. The range of social norms and values reflects different standards of behaviour for men and women. Women and men are also shaped by the culture in which they are raised, so that most adults are socialized for the roles their culture has prescribed for them. Change threatens individual identity and the society that governs behaviour and norms.

The ideology of male superiority has been perpetuated in religious documents, school textbooks, the media and science. Great men of science such as Aristotle asserted that males were by nature superior and in charge of ruling, whereas women were inferior and required domination. Freud described man as the prototype of humanity and regarded females as incomplete and having a weakened superego (Doherty, 1973). In fact the majority of Freud's patients were women. Men have dominated every component of society and defined women's roles and although this is slowly changing there are elements that continue, as it is difficult to overcome a long history of traditions.

How do these differences in gender relate to psychopathology? The history of abnormal psychology and women has been a picture of mistreatment, cruelty, and at times violence. Women have been subject to long-term institutionalization at the hands of male family members and husbands as a method of control and retribution when they refused to conform to traditional roles (Roth & Lerner, 1974). Women were lobotomized in higher numbers than their male counterparts, again at the behest of male family members and husbands who felt that their nonconformity with social roles was mental illness (Jasper, 1995).

Psychologists and psychiatrists who have been predominantly male have also held stereotypical beliefs about women. In the nineteenth century women were viewed by these professions as prone, by their biological nature, to hysteria and insanity; often just being female was a proof of a disease (Bleier, 1984). Early psychological theories have been written by mostly Euro-American men and have not addressed any of the issues that pertain to women. Research conducted in psychotherapy has found that many therapists continue to foster traditional sex roles and can be biased in their evaluations of their women patients (Hare-Mustin, 1983).

The net effect of these biases is to reinforce traditional roles in women patients and to identify women who do not fit the traditional principles as maladjusted or ill. Brown and Harris 1978 found that the psychiatric influence has been such that any problem is seen as individually based rather than socially determined. As a result many women who have felt miserable and unhappy as housewives have defined themselves as being responsible or inadequate rather than recognizing that in many cases they are victims of social situations which have been the cause of their problems.

In spite of the changes that have occurred in providing women with access to health and better employment practices, the mental health establishments are slow to change. Diagnoses and treatments have continued to be used to control and victimize women. Issues include the sexist use of

psychoanalytic concepts and psychiatric diagnoses, the misuse of medication, and sexual misconduct in therapy (Geller, 1995).

Differences in gender have been noted in the literature concerning depression and anxiety (Culbertson, 1997). What accounts for the higher rates of depression and anxiety in comparison to their male counterparts? Many believe that the higher levels of depression and anxiety are a direct result of women being subject to the impact of social forces that they have to endure; the sale of young girls for marriage or prostitution, restriction of liberty and education for women and the considerable control that males exercise on the lives of women in many patriarchal societies around the world (Locke, 1992; McGoldrick, Pearce & Giordano, 1982).

Women's individual differences in the field of abnormal psychology have gone relatively unaddressed. Many researchers believe there is a need to provide a meaningful context for sociocultural understanding, attending to women's individual differences within and across cultural groups, and to the forces of gender socialization and the impact on identity and self-esteem (Jordan, 1991; Steele, 1997).

## MULTICULTURAL PERSPECTIVES

Early research supported the idea of a cultural universality that defined abnormal behaviour. In other words, there was a well defined idea of what were normal patterns of behaviour that existed in spite of the differences in culture and these patterns were world wide. For example, if schizophrenia was a universal disorder that appeared in all cultures and societies the processes would be more similar than dissimilar and the disorder would be similar in origin, process and manifestation. Additional research in this area found that the idea of cultural universality in patterns of abnormal behaviour did not exist (Draguns, 1997). If lifestyles, culture and world views affect how we behave overall it would logically follow that it affects the expression and determination of abnormal behaviour. Therefore the importance of culture and diversity cannot be denied in the manifestation of abnormal behaviour which may or may not lead to a mental disorder. Statistics indicate that mental illness appears in greater numbers in cultures that place emphasis on monetary success. How does this factor into third-world nations? Does mental illness exist in smaller numbers because it goes undiagnosed or is it a factor of culture? We return to the discussion of what is normal. What can be outside of the realm of normal behaviour without being judged abnormal? What specifically is the relationship between cultural norms, values and attitudes and the manifestations of abnormal behaviour? How does an individual move from being abnormal to being mentally ill?

All behaviours, whether normal or abnormal, begin from a cultural context. Culture plays a major role in our understanding of human behaviour. But what is culture? Culture is defined as 'shared learned behaviour which is transmitted from one generation to another for purposes of individual and societal growth, adjustment and adaptation' (Marsella & Kameoka, 1989). Culture is not synonymous with a race or ethnic group. Race and/or ethnic groups are surrounded by their own cultural context within the greater society as a whole. The cultural context may be similar or completely different. Individuals may completely embrace their cultural heritage or disregard it completely. Culture can be a powerful determinant of world views and it can affect how we define normal and abnormal behaviours as well as how we treat mental disorders within a defined culture.

**Table 1.1** Examples of culture-bound syndromes as defined by the DSM

<b>Amok</b>	Malaysia	Mad uncontrollable rage
<b>Brain fag</b>	West Africa	Mental exhaustion – vague somatic symptoms, depression
<b>Dhat syndrome</b>	India	Anxiety and hypochondriacal concerns associated with semen
<b>Ghost sickness</b>	Native Americans/ North America	Sickness attributed to contact with the dead or dying
<b>Latah</b>	Indonesia	Trance-like reflex where the victim engages in repetitive speech or movements
<b>Shenkui</b>	Chinese	Unresolved anger which disturbs the balance of the five bodily elements
<b>hwabyeong</b>	Korean	
<b>Evil eye</b>	Mediterranean	A look that brings ill health and general bad luck that is cast from a person with unnatural powers
<b>Susto</b>	Central America	Lifelong damage resulting from a severe or frightful experience
<b>Taijin kyofusho</b>	Japan	A form of social anxiety and fear of interpersonal relations
<b>zaar</b>	Ethiopia	Possession of an individual by a spirit

(Adapted from the American Psychiatric Association, 2012)

The concept of cultural relativism originates from an anthropological tradition and emphasizes the belief that lifestyles, cultural values and world views affect the expression and determination of abnormal behaviour. What is universal in human behaviour that is also relevant to understanding abnormal behaviour? Can it be outside the realm of normal behaviour without being abnormal? Our definition is still problematic. If behaviour is common and is embraced by a community of people, can it still be defined as abnormal? For example, binge drinking, defined by an excessive use of alcohol within a short time frame, is a common theme among 16–30-year-olds in the UK. Often this type of behaviour clashes with outside cultures when British youth decide to go abroad and continue with this behaviour in other countries. Evidence shows that this type of behaviour is having serious effects on the health and welfare of an entire generation of people (Crabbe, Harris & Koob, 2011). Although the individuals taking part do not recognize it as deviant, distressing, dysfunctional and even dangerous, a large number are becoming alcohol dependent, which will eventually interfere with their personal life as well as cause lifelong health problems. Would we consider this abnormal behaviour? Would we consider this a mental disorder?

## ABNORMAL AS DEFINED AS DEVIATION FROM IDEAL MENTAL HEALTH

The concept of ideal mental health was proposed as a criterion of normality by humanistic psychologists Carl Rogers and Abraham Maslow in the 1950s. Deviations from the ideal are taken to

indicate varying degrees of abnormality. Maslow (1946) believed that an individual's life goal was self-actualization, which he described as a desire for self-fulfilment. Many psychoanalytically oriented psychologists have used the concept of consciousness and balance as criteria for abnormality. Humanistic and personal-centred psychologists have proposed aspects of maturity, competence, autonomy and resistance to stress. Utilizing these constructs as the only criterion for defining normality/abnormality leads to a number of problems. The first is which goal or idea should be used and who determines what this will be? The answer to this question depends on the particular frame of reference or values embraced, but again this causes problems in defining abnormal behaviour because there is a large degree of variability. Second, most of these goals/ideas are vague and lack clarity and precision. If resistance to stress is the goal, are the only mentally healthy individuals those who can either resist or adapt to stress? What types of stress? What about environments that produce stress. A war zone would easily be classified as a stressful environment as the people living in the area would be afraid for their lives. What about an individual who lives on a farm in Yorkshire? Are these environments comparable? Would we categorize the person living in a war zone as abnormal because they have an inability to cope with the stresses associated with their environment?

Another well accepted definition of abnormal behaviour is an individual who has lost or distorts their reality. This definition is not comprehensive and does not even cover the above example of stress. Albee (1959) defined a mental disorder as an unusually persistent pattern of behaviour over which the individual has little or no voluntary control; it differentiates them from others; it incapacitates them and interferes with normal participation in life.

Efficiency has also been used as a definition of abnormal behaviour. Decreased efficiency is associated with the more serious aspect of abnormal behaviour, i.e. mental illness. But again efficiency is too broad a concept. Efficiency would discriminate among sensory-perceptual anomalies, motor anomalies and thought disorders but not other, lesser types of mental illnesses.

## CRITERIA OF NORMALITY AND MENTAL HEALTH

Consensus regarding positive mental health is far from unanimous. Some identify the mentally ill as anyone who seeks psychological care; at the other end of the spectrum are those who view the mentally ill as those who hallucinate, lose or distort contact with reality, or have suicidal ideation (Bentall, 2003).

The criterion for positive mental health is the absence of mental illness. Evaluation of actions as sick, or normal, or extraordinary in a positive sense often depends on accepted social conventions. When normality is used as a criterion for mental health then it is usually defined either as statistical frequency or normality in terms of the way a person ought to behave (Bartlett, 2011).

Mental health or normality is virtually impossible to define. We generally think of normal people as average or those individuals who do not deviate from what is considered normal in their social living groups. Rosenhan (1973) conducted an experiment in normality and mental health. He had five men and three women disguise the fact that they were normal and claim that they were hallucinating so that they could be admitted as mental patients. Once they were admitted, they behaved as their usual normal selves. Rather than the authorities seeing these pseudo patients as the healthy people they were, they continued to perceive them in terms of their diagnosis at the

**Table 1.2** An operational point of view in defining mental illness

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1	Exposure to psychiatric treatment
2	Labelled mentally ill by psychiatric diagnosis
3	The individual sensing abnormality seeking assistance
4	Identified as mentally ill by psychological testing
5	Dysfunctional behaviour
6	Dangerous to self or others
7	The absence of positive mental health

---

time of admission. The only individuals who could identify them as normals were the in-patients. This experiment was somewhat embarrassing, as individuals who were in charge of mental health facilities believed that they had the training and experience to recognize mental illness, when in fact this experiment cast a shadow of doubt upon the way we classify mental illness and the fact that trained professionals could not distinguish mentally ill individuals from the mentally well.

## MEDICAL DEFINITION

A medical classification of abnormal behaviour describes the characterization by the presence of specific symptoms that define abnormality. Certain symptoms are the basis of determining whether an individual is experiencing an underlying disorder. There are two basic variations of the medical definition that can be distinguished as either organically based or psychologically based. The organic based definition characterizes a group of disorders that have a biological foundation. Many abnormal behaviours are known to have a biological foundation and the medical classifications are sufficient to clearly identify these disorders. The second variation of the medical definition of abnormal behaviours is more difficult to define in terms of parameters. The psychological element to mental disorders without the presence of a biological determinant can be difficult to classify. These disorders are referred to as functional disorders. Examples of psychological symptoms that can be underlying a mental illness are mood, attitudes and traits. Symptoms such as delusions, hallucinations and depression would be signs of a mental disease (Kutchins & Kirk, 2003).

The medical classification of defining abnormal behaviour is that it departs from the norm and harms the affected individual. This definition does allow for the various criteria and perspectives concerning mental illness as well as implying that there is no specific designation from normal to abnormal but is based solely on harm. A mental disorder under this classification implies recognizable pattern behaviour (Kutchins & Kirk, 2003).

One of the major problems with the medical definition of abnormal behaviour is that mental illness differs from physical disease and the medical approach is difficult to apply. Many mental



illnesses cannot be detected in the early stages and often appear difficult to distinguish from normal behaviour. Often the precipitating cause is difficult to identify and the identification and etiology are often debated. In addition, the classification is defined by the presence of symptoms as the sole basis for identifying abnormality. Physiological disorders can be easily detected; fever, swelling, skin rashes are symptomatic of many physical disorders and can be measured and evaluated. A change in mood cannot be evaluated so easily. Another significant difference in the two types of medical classification is that the psychological categorization is also related to the reactions of others and is relative to social norms and desired behaviours (Kutchins & Kirk, 2003). Many social factors can contribute to abnormal behaviour with the individual struggling to cope before they are diagnosed with a mental illness. It is only when the individual becomes harmful to themselves or others that the abnormal behaviours shift to mental illness.

A further complexity in the medical definition of functional disorders is the designation of what symptoms are related to which disorders. Currently, there is a commonly used system of psychiatric classification describing a wide range of psychological disorders that is often utilized to overcome the complexity of determining psychological dysfunction. This system is published as a manual by the American Psychiatric Association and is referred to as the Diagnostic and Statistical Manual (Kutchins & Kirk, 2003).

Guidelines based on research and clinical practice have been collected and documented to provide a basis for what constitutes mental disorders, normal and abnormal psychological development and psychological dysfunction. Although this classification system appears to be a reliable way to classify mental disorders, the reality is much more complicated. If we were to take one of the cultural based disorders such as Ghost sickness, the classification system would quickly evaluate the individual as having some type of psychotic disorder. When culture is taken into consideration this classification would be inadequate; clearly the classification has some significant drawbacks.

## CLASSIFICATION OF ABNORMAL BEHAVIOURS

Why is it important to classify abnormal behaviour? Without a systematic structure each abnormal behaviour would have to be evaluated as a separate and distinct element, a decision would have to be reached whether or not the behaviour is abnormal and then whether it is problematic. Without a classification system patterns could not be established, treatment could not be standardized and researchers would not understand each other's categories. Classification systems allow decisions to be made in terms of the treatment and progression of the illness.

### DSM-IV-R

The first classification system was developed in the nineteenth century by Emil Kraepelin. He developed a comprehensive model of classifications based on his clinical observations and focused his system on distinctive features, or symptoms associated with abnormal behaviour patterns. His classification systems established the groundwork for future systems that are in

**Table 1.3** Purpose of diagnosis

- 
- |   |  |
|---|--|
| 1 | To organize clinical information that is concise, coherent and retrievable |
| 2 | Communication among professions  |
| 3 | Prediction of clinical course  |
| 4 | Selection of appropriate treatment   |
- 

use today. The diagnostic and statistical manual of mental disorders published by the American Psychiatric Association (DSM) is descriptive, not explanatory, and describes diagnostic features of abnormal behaviours. Utilizing the DSM classification system, the clinician arrives at a diagnosis by matching the individual's behaviour with the criteria that define particular patterns of abnormal behaviour. Abnormal patterns of behaviours are classified as mental disorders and involve emotional distress, impaired functioning or behaviour that places people at risk of personal suffering, pain, disability or death. The DSM system helps to sort out various categories of disorders, to identify the disorder most suitable to describe the condition of the individual (Reigier, Narrow & Kupfler, 2010).

### Statistical definition of abnormal behaviour

A statistical definition of abnormal behaviour is based upon the concept of the relative frequency of behaviours in a population. Abnormality could be defined as those behaviours that are relatively infrequent or are atypical of the population. A statistical definition would provide a definition based on behaviours that are numerically rare. Utilizing a statistical definition of abnormality we can classify most behaviours within a distribution. The majority of the 'normal' population would fall into the middle ranges of a bell-shaped curve. As one moves away from the middle range in either direction they could be classified as being statistically more extreme and therefore abnormal (Helzer & Hudziak, 2002). There are several problems with defining abnormality in this way. If we go back to our previous example of binge drinking, just because more people are engaging in a behaviour that might be dangerous or dysfunctional does not make it normal. However, under this definition, the behaviour would be classified as normal because a large number of individuals participate, therefore individuals in the specified age ranges who do not binge drink would be classified as abnormal.

Within the statistical definition there are many examples where extremes are useful. Unusual abilities or talents would be classified as abnormal under this definition but we would not consider a gifted musician as abnormal. If a specific dimension were agreed upon as relevant in determining abnormal behaviour, there might be a problem in deciding whether extremely high or low scores, or both, were to be included in the notion of abnormality. Also for social behaviours only one side of the extreme may be relevant for abnormality, i.e. depressed mood. Further, this definition does not provide a useful category in deciding whether an individual is impaired or mentally ill. The statistical definition oversimplifies the nature of abnormal behaviour. Abnormal behaviour is not a matter of one dimension. There may be several dimensions that need to be included such as: how the

individual functions socially, the manner in which the problem is manifested and how an individual meets obligations and expectations of others. As a final problem, the statistical definition implies that being average is desirable or healthy and while society functions on the basis of normality and social conformity, it also restricts the freedom and individualism of people living in a community. There is also the issue of defining standards.

Standards for acceptable performance vary markedly as a function of socioeconomic standing, cultural and ethnic relationships, race, sex, age and various other demographic variables. One problem is that they fail to take into account differences in place, community standards and cultural values. If deviations from the majority are considered abnormal, then many ethnic and racial minorities that show strong subcultural differences from the majority will be classified as abnormal. When we use a statistical definition, the dominant or most powerful group generally determines what constitutes normality and abnormality. How does one evaluate such personality traits as assertiveness and dependence in terms of statistical criteria? People who strike out in new directions – artistically, politically or intellectually – may be seen as candidates for psychotherapy simply because they do not conform to normative behaviour. Our example of lime green hair would fall into this definition of ‘least frequently’ as there does not appear to be a huge number of people who choose this colour. So under our definition we would classify this behaviour as abnormal – but would you consider someone with this hair colour to be dysfunctional? Definitions based on statistical deviation may at first seem sufficient, but they actually present many problems.

### Social definition

A social definition defines abnormal behaviour within the view of conformity. Individuals in society follow norms and widely accepted standards of behaviour. Conformity to these standards defines normal behaviour whereas deviation from these standards defines abnormal behaviour. Behaviours that violate social norms are likely to be those labelled as abnormal. The social definition recognizes that behaviours viewed outside of social parameters as dangerous, disruptive or merely beyond comprehension are likely to be singled out as deviant. Individuals who violate role expectations are

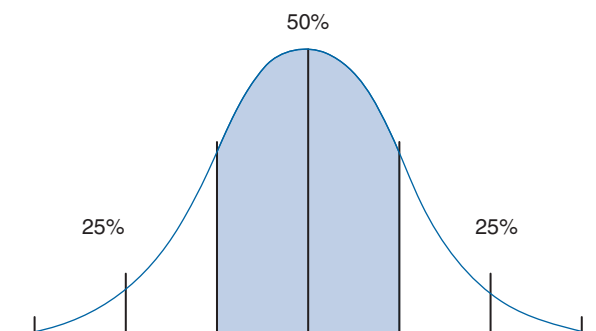


Figure 1.5

likely to be labelled as deviant or mentally ill. The social definition acknowledges the importance of the community that defines when a member is behaving in a socially unacceptable way (Bowers, 2000). Those who identify an individual as behaving abnormally play a major role in defining and detecting deviant behaviour. The social definition of abnormality generally begins with someone being bothered by the behaviour as violating the standard rules of conformity. Abnormal behaviour is not described as disturbed but disturbing to someone other than the individual participating in the behaviour. The identification of deviant behaviour and mental illness involves others who interact with the individual whose behaviour is considered deviant. The behaviour is then socially defined in terms of the particular relative standards for behaviours and expectations of those with whom the individual interacts. These standards are not absolute, but vary according to the social reference group to which the individual belongs. A social definition of abnormal behaviour is whatever society says is a mental illness or psychological impairment. Unacceptable behaviours are defined by people in everyday life who decide what is sufficiently deviant to single out as mental illness (Horwitz, 2004).

There are a few problems with the social definition of abnormality. First, it does not meet the characteristics of many mental health professionals who believe that mental illness is more than a violation of social norms. The social definition does describe an important element of abnormality as there is a social component present in many individuals with disturbed behaviour. For example individuals who are actively hallucinating can be frightening to others, as they interact with people and objects that only they can see, even though the interactions may be harmless. If this person lived outside of a community, there would be no one to define the disturbance.

Thomas Szasz (2004), a noted psychiatrist and social critic of the scientific foundations of modern psychopathology, believes that mental illness is a myth and is a creation by society to use, control and change behaviour. According to Szasz, people may suffer from problems in adjusting to the complicated struggle with living in society and not from mental illness. His argument stems from three beliefs: behaviour is labelled abnormal because it is different not wrong; abnormal behaviour is a reflection of something wrong in society and not the individual; and individuals are labelled mentally ill because their behaviours violate the social order. Szasz further asserted that the concept of mental illness is dangerous and is used as a form of social control by those in power. His critics have dismissed his ideology and state that mental illness is not simply a factor of social definition with the new scientific methodologies and techniques as confirmation.

## ADAPTIVE AND MALADAPTIVE BEHAVIOUR

Another element of social definition and abnormal behaviour is adaptation. Adaptation is defined as a dynamic process between the attributes of an individual and their environment (Horwitz, 2004). Our environments are constantly changing requiring individuals to modify how they respond and react. Two elements that must be kept in balance are our personal characteristics (skills, education, attitudes, physical condition) and the confronting situations (divorce, physical illness, failures). Maladaptive behaviour implies that the individual is not coping with the changes that they are required to make. For some individuals the stress causes abnormal behaviour. For example an

individual who is made redundant will have to make many changes: they may have to significantly cut their expenditures; their relationships may suffer; they may have to make alternative living arrangements. The stress of all these changes may cause the individual to participate in abnormal behaviour such as a reliance on alcohol as a maladaptive coping strategy.

## DEVIANCE VS. DYSFUNCTION

Another way of evaluating abnormal behaviour is to look at the element of deviancy. Deviancy is a sociological term for individuals who violate the norms of society (Dijker & Koomen, 2007). The violation can be informal like dress and appearance or formal, like the rules that govern motoring. An individual can be deviant but not necessarily dysfunctional. So how do we distinguish deviant behaviour from dysfunctional behaviour? Both are considered undesirable and both are abnormal.

In an attempt to distinguish abnormal behaviour and functional/dysfunctional behaviour, psychologists often categorize abnormal behaviour into four groups: deviance, distress, dysfunction and danger (Blackburn, 1995). Patterns of psychological abnormality can then be examined to determine whether the behaviour is functional or dysfunctional. Individuals can have one or more of the categories. Deviant is defined as different, extreme, unusual, perhaps even bizarre; distressing as unpleasant and upsetting to the person; dysfunctional as interfering with the person's ability to conduct daily activities in a constructive way; and dangerous as causing physical or mental harm to themselves or others.

The criterion of deviance is subjective and depends on an individual being judged by society as acting outside of standard rules and norms. Certain sexual behaviours, delinquency and homicide are examples of acts that our society considers deviant and abnormal. But social norms are far from static and behavioural standards cannot be considered absolute, so other types of behaviours that may be considered deviant today may not be considered deviant in the future. Changes in our attitudes towards tattooing and body piercing provide an example of modifications in our society towards this type of previously deviant behaviour. In the 1940s and 1950s, outside of ethnic groups, the military and deviant biker clubs, very few males were tattooed and women were almost never tattooed. To have a tattoo for a female generally branded that person as deviant, undesirable and a woman of disrepute. Today tattooing and piercing are commonplace among men and women of all ages. Body art has become so widespread and ordinary that a tattoo no longer carries any stigma or indicates membership in any type of group.

## DISTRESS

Unusual functioning does not necessarily qualify as abnormal. According to many clinical theorists, behaviour, ideas, or emotions usually have to cause distress before they can be labelled abnormal (Blackburn, 1996). Individuals who suffer mental distress often seek help to alleviate their discomfort. Many physical reactions stem from a strong psychological component; fatigue, nausea, pain

and heart palpitations can all be indications of psychological distress. Discomfort can also be manifested in extreme or prolonged emotional reactions, of which anxiety and depression are the most prevalent and common. It can be normal for an individual to feel depressed after suffering a loss or a disappointment, but if the reaction is so intense, exaggerated and prolonged that it interferes with the person's capacity to function adequately, it is likely to be considered abnormal (Busfield, 2011).

## DYSFUNCTION

Abnormal behaviour tends to be dysfunctional; that is, it interferes with daily functioning. It so distracts or confuses people that they cannot care for themselves properly, take part in ordinary social interactions, or work productively. Dysfunction in an individual's biological, mental and emotional states is often manifested in role performance. One way to assess dysfunction is to compare an individual's performance with the requirements of a role. In everyday life, people are expected to fulfil various roles and responsibilities. Emotional problems sometimes interfere with the performance of these roles, and the resulting role dysfunction may be used as an indicator of abnormality (Busfield, 2011).

Another related way to assess dysfunction is to compare the individual's performance with his or her potential. Psychological testing is one way of measuring an individual's capability and then making a comparison with current functioning.

## DANGER

The critical element in determining abnormal behaviour is the factor of dangerousness. When an individual becomes dangerous to themselves or others and their behaviour is consistently careless, hostile and hazardous, abnormal behaviour is generally quickly brought to the attention of professionals. As a result of violating social norms and endangering the general public an individual will be promptly upgraded from abnormal to mentally ill (Blackburn, 1997). Mental health professionals are often called on to determine whether an individual is dangerous, and more than likely will be part of a legal proceeding to assess whether the individual should be incarcerated in order to protect the public as well as the individual. Predicting violent behaviour is very difficult and often professionals will err on the side of caution rather than take a risk of misjudging the situation and causing harm to the individual or members of society. Past violent behaviour is generally a predictor of future violence. However, not all past violent behaviour may be reported or known at the time an assessment is conducted. All these elements must be equally considered as the consequences for incorrectly predicting extreme violence are severe. It is often easier to piece together the facts after the individual has committed an act of violence. The majority of individuals displaying aggressive abnormal behaviour never act on them. Another issue is the lack of agreement over what types of behaviour are violent or dangerous. Acts of violence such as murder, rape and assault are easy to identify but other types of violence are less ominous such as destroying property, verbal abuse and receiving ASBOS. It is also thought that less violent behaviours can lead to more serious types of

offences. So pushing and shoving at a pub could lead to a violent, possibly lethal physical assault. In addition, violence tends to be situation-specific; a person in a structured environment may be less likely to commit a violent act in a structured environment than in their own home. Another component that must be considered with the determination of abnormal behaviour and dangerousness is substance abuse. The potential for violence and dangerousness is increased when a person is under the influence of drugs and/or alcohol.

## LEGAL DEFINITIONS

A legal definition of abnormal behaviour is used by the courts as a basis for their verdicts and is generally of limited use outside of the judicial system. The definition of abnormal behaviour develops out of a need to determine mental disease and whether an individual should be held responsible for an illegal act. The definition of abnormal behaviour will vary depending on the purpose of the decision and whether there is evidence of psychological impairment. This definition is different from the other types we have discussed because it is used for the sole purpose of giving a judgment after an individual has committed an offence against society. Often the issue of guilt or innocence is in little doubt; instead the court system must make a decision whether the person is to be held accountable for their actions. A legal definition of abnormal behaviour is not based on understanding or clarification, rather it seeks to define the boundaries of justice and society (Blackburn, 1997).

Legal definitions do not help to define abnormal behaviour or mental illness and instead reflect the norms and rules of a society on a case-by-case basis. Legal definitions are used in making practical decisions and their sole purpose is to determine whether an individual is responsible for their behaviour and how long they should be incarcerated either in prison or a mental institution. Legal definitions of abnormal behaviour are concerned with whether the judgment is appropriate given the mental stability or instability in direct relation to the crime committed. Legal definitions do not change the way a community or society define mental illness or abnormal behaviour and instead often reinforce the idea that individuals who behave outside the norm are dangerous to society. Legal definitions are directional; they first determine whether the abnormal behaviour is symptomatic of a mental illness and then determine personal responsibility. Ultimately the court system will decide the fate of the individual who has committed a crime, how that individual will be treated with respect to their mental status and what is best for the protection of society (Kapardis, 2002). For example, the crown prosecution will decide whether an individual is able to stand trial, whether they are capable of participating in their defence and if found guilty, whether they should be incarcerated in prison or go to a mental institution for treatment.

Legal decisions in the determination of mental illness and personal responsibility are very complex. Relatives and friends may be called to court to provide evidence of the person's behaviour and mental status previous to the offence. Individuals in contact with the person in question may also provide evidence of what they witnessed, before, during and after the offence in an attempt to determine the presence or absence of mental illness. Professional judgements are solicited for the defence of the individual as well as the prosecution. Expert testimony can be influential when there is a subjective evaluation of the individual's competence and behaviour patterns. However,

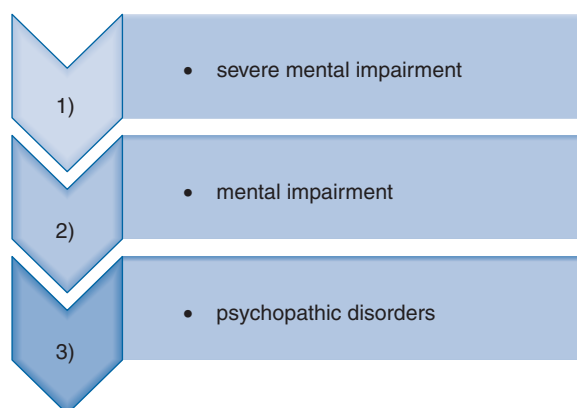
professional judgement can be inconsistent and often brings the ideology of abnormal behaviour and mental illness into question. It is not unusual for experts within a given discipline to make opposing claims. The differences in opinions that arise in legal situations often reveal that clarity in behaviour and mental illness are difficult to decide (Kapardis, 2002).

Where does the boundary lie between abnormal behaviour and mental illness? If the legal definition is only concerned with individual responsibility the presence of abnormal behaviour may be all that is necessary to determine that the individual is not competent and responsible. Abnormal behaviour is judged in terms of degrees and is constantly changing dependent upon the many elements and phases of the judicial system. Decisions are generally made by a small group of individuals and not the society as a whole.

The legal definition in the UK for mental incompetence is arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of the mind. The judicial system does not have a specific definition of abnormal behaviour or mental illness. Instead the court system advocates that the criteria should be what an ordinary sensitive person would decide on a case-by-case basis and the decisive factor should be personal responsibility.

The Mental Health Act in the UK does define three forms of mental disorder:

- 1 Severe mental impairment, a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.
- 2 Mental impairment, a state of arrested or incomplete development of mind (not amounting to a severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.
- 3 Psychopathic disorders: a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned (Mental Health Act, 1983).



**Figure 1.6** Abnormal behaviour and insanity



## ABNORMAL BEHAVIOUR AND INSANITY

The major definition of criminal responsibility in the UK was developed from the 1843 trial of Daniel M’Naghten, who shot and killed Edward Drummond in the belief that Drummond was the prime minister of England. M’Nagten was acquitted by a reason of insanity and committed to a mental institution where he spent the rest of his life. His acquittal on the murder charge caused great concern throughout the UK as it was felt that the insanity plea was a way of escaping punishment. This case eventually led to the creation of the M’Nagten rule that states that in order for an individual to be judged insane and not held personally responsible they must be (a) mentally impaired to such a degree that they are incapable of understanding the wrongfulness of their behaviour and (b) unable to conform their behaviour to the law. Before 1843 there was no generally accepted legal definition of insanity and the M’Nagten rule provided guidelines.

The guidelines specify that mental disease may not be defined solely in terms of repeated criminal behaviour and they combine two themes in defining criminal responsibility (Mental Health Act, 1983). These guidelines still leave the judicial system with a highly complex structure in deciding whether or not an individual was truly unable to resist an impulse or merely choose not to do so.

## INTEGRATED DEFINITIONS

Various definitions of abnormal behaviour serve different functions and convey different implications. All the definitions that have been discussed have significant limitations. It is imperative that the definition of abnormal behaviour include many factors such as value systems, culture, gender, age, context and societal norms. It is clear that a single perspective may not be appropriate for an accurate definition of abnormal behaviour.

Strupp and Hadley (1977) proposed a three-part method for defining normality and abnormality. They identified three aspects that are useful in the evaluation of an individual’s mental health: (1) the individual in question, (2) the society of the individual, and (3) the mental health professional. Each element operates from a different perspective, using different criteria and when combined could provide a three-dimensional evaluation of behaviour that would encompass a multidimensional view.

## CONCLUSION

If we returned to our case study and applied the various definitions, the statistical definition would certainly place Matt’s behaviour in the abnormal range – it would be fairly uncommon for many middle-aged men to carry around brass bells to ward off evil spirits. In terms of making an evaluation from a medical definition Matt would not fit the criteria; his past indicates that he has never had any type of breakdown, and although he is using the bells to ward off evil spirits he seems to be able to cope and be very successful, so a health professional might feel that the behaviour is ‘odd’ but

it is not dysfunctional. If we evaluated Matt's behaviour from a sociological perspective we would probably judge him to be abnormal, as the rules of behaviour for a middle-aged man would probably not include 'bell behaviour' – although if we added an element of culture, Matt's behaviour might not be as odd as we originally thought. In conclusion if we looked at Matt's behaviour from an integrated perspective we would probably conclude that although it is a bit odd, we would judge Matt to be normal.

## Summary

This chapter focused on defining abnormal behaviour from a variety of perspectives. The discussion involved various elements such as deviance, dangerousness, dysfunction and maladaptive patterns of behaviour. The norms and rules of society were also discussed in terms of evaluating abnormal behaviour. A broad framework based on the various theoretical principles for evaluating normal and abnormal functioning was examined.

## Key terms

**Bell-shaped curve** – in probability theory, is a continuous distribution where random variables tend to cluster around a single mean value

**Conformity** – the act of matching attitudes, beliefs and behaviours to a society

**Cultural relativism** – the belief that lifestyles, cultural values and world views affect the expression and determination of abnormal behaviour

**Culture** – shared learned behaviour which is transmitted from one generation to another for purposes

of individual and societal growth, adjustment and adaptation

**Self-actualization** – the final level of psychological development when all basic and mental needs are fulfilled

**Social norm** – the rules that a group and/or community use for values, beliefs attitudes and behaviours

**Society** – a collective of individuals defined by the language that is spoken, religious practices and ethnic diversity

## Study guide

- 1 Evaluate the differences between the legal definition of mental illness and the social element of abnormal behaviour.
- 2 Research the DSM classification system and the historical changes that have occurred as the norms of society have changed.
- 3 Investigate the Mental Health Act (1983) and how this applies to psychologists
- 4 Explore the role of the mental health professional in the determination of violent behaviour.

### Case study in focus

Discuss the various ways we would classify our case study of Matt. How would this be defined statistically? Could we define Matt's behaviour in social terms? How could Matt's behaviour be adaptive and therefore functional? What about the elements of deviance vs. dysfunction?

### Personal development

Investigate how society has used the term 'abnormal' to label and ostracize groups of individuals throughout history and how this term has been used to the detriment of individuals and our groups.

### Suggested reading

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