**UNIT 6: ABNORMAL BEHAVIOUR AND THE LAW**

**INTRODUCTION**

Once again welcome to unit 6 of abnormal behaviour and the law. The unit will start by giving definition of abnormal behaviour then proceed to discuss other relevant sections of the subject. The unit is divided into two sections as follows?

Section 1: Definition of abnormal behaviour

Section 2: Models of abnormal behaviour

**Unit Objectives**

by the end of this unit, you should be able to

1. Define Abnormal behaviour
2. Discuss the models of abnormal behaviour

**SECTION ONE: DEFINITION OF ABNORMAL BEHAVIOR**

* 1. Section Outline
  2. Section Introduction.
  3. Section Objectives.
  4. Definition of Abnormal Behavior
  5. Section summary
  6. **Section Introduction**

Welcome to section one of unit 6. In this section you will go through the definition of abnormal behavior and begin to understand the complexity of judging what is abnormal and normal. Abnormality (or dysfunctional behavior), in the vivid sense of something deviating from the normal or differing from the typical (such as an [aberration](http://en.wiktionary.org/wiki/aberration)), is a subjectively defined behavioral characteristic, assigned to those with rare or dysfunctional conditions. Defining who is normal or abnormal is a contentious issue in [abnormal psychology](http://en.wikipedia.org/wiki/Abnormal_psychology).

**1.2 Section Objectives**

By the end of this section you should be able to:

1. Discuss abnormal behaviors’ definitions
   1. **Definition of Abnormal behaviour**

Abnormal behavior may be defined using various categories.

***1.3.1 Statistical abnormality -***A behavior may be judged abnormal if it is statistically unusual in a particular population. One criterion for "abnormality" that may appear to apply in the case of abnormal behavior is **statistical infrequency**. This has an obvious flaw — the extremely intelligent, are just as abnormal as their opposites. Therefore, individual abnormal behaviors are considered statistically unusual, as well as undesirable. The presence of some form of abnormal behavior is not unusual. About one quarter of people in the United States, for example, are believed to meet criteria for a mental disorder in any given year.[1]Mental disorders, by definition, involve unusual or statistically abnormal behaviors.

***1.3.2* *Violation of socially-accepted standards*** -  An abnormal behavior might be defined as one that goes against common or majority or presumed standards of behavior. For example, one might be judged abnormal in one's failure to behave as recommended by one's family, church, employer, community, culture, or subculture. Another criterion is [morality](http://en.wikipedia.org/wiki/Morality). This presents many difficulties, because it would be impossible to agree on a single set of morals for the purposes of diagnosis.

***1.3.3 Theoretical approaches -*** Theories approach abnormality by starting with a theory of personality development, If normal development can be defined, then abnormality is defined by the failure to develop in this way. For example, if adults normally arrive at a moral stage that prohibits killing other people, and someone does not arrive at this stage, that person might be called abnormal.

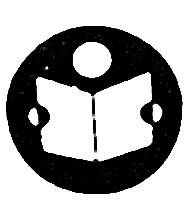
***1.3.4 Subjective abnormality -***Abnormal behavior can be defined by a person's feeling of abnormality, including feelings of anxiety, strangeness, depression, losing touch with reality, or any other sensation recognized and labeled by an individual as out of the ordinary. A more discerning criterion is [distress](http://en.wikipedia.org/wiki/Suffering). A person who is displaying a great deal of depression, anxiety, unhappiness, etc. would be thought of as exhibiting abnormal behavior because their own behavior distresses them. Unfortunately, many people are not aware of their own mental state, and while they may benefit from help, they feel no compulsion to receive it.

***1.3.5 Biological injury*** - Abnormal behavior can be defined or equated with abnormal biological processes such as disease or injury. Examples of such abnormalities are brain tumors, strokes, heart disease, diabetes, epilepsy, and genetic disorders.

Another criterion that has been suggested is that abnormal behavior violates the standards of society. When people do not follow the conventional social and moral rules of their society, the behavior is considered abnormal. However, the magnitude of the violation and how commonly it is violated by others must be taken into consideration.

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***1.3.6 Culture -*** The first of these criterion being *culture*; what may be seen as normal in one culture, may be seen as abnormal in another. The second criterion being the *situation & context* one is placed in; for example, going to the toilet is a normal human act, but going in the middle of a supermarket would be seen as highly abnormal, i.e., defecating or urinating in public is illegal as a misdemeanor act of indecent public conduct. The third criterion is *age*; a child at the age of three could get away with taking off its clothing in public, but not a man at the age of twenty. The fourth criterion is gender: a male responding with behavior normally reacted to as female, and vice versa, is retaliated against, not just corrected. The fifth criterion is historical context; standards of normal behavior change in some societies, sometimes very rapidly.

**1.4 Section Summary**

Abnormal behaviour is one of those concepts that is not easy to define. The line between what is normal and what is abnormal is not always clear-cut and easy to specify. Nonetheless, the following definition specifies several criteria that can help us think about what abnormal behaviour is. Abnormal behaviour is behaviour that is deviant, maladaptive, or personally distressful. There are three criteria in this definition of s of these criteria needs to be met for the classification of abnormal behaviour, but two or three may be present.

So what can we say is abnormal or unacceptable behavior? If you behave abnormally then this could be anything that is or could be viewed as being: irregular, non-standard, uncharacteristic, unusual, strange, anomalous, odd or peculiar, intolerable, unsuitable, unwelcome, unwarranted, unprovoked, or unjustified.

**SECTION TWO: MODELS OF ABNORMAL BEHAVIOR**

2.0 Section Outline

2.1 Section Introduction

2.2 Section Objectives

2.3 Contents of the subject

2.4 Section Summary.

**2.1 SECTION INTRODUCTION**

Welcome to section two of unit six: There are a number of historical and contempo­rary views or models of abnormal behavior. They include the demonological, medical, social-learning, and cognitive models. The organic and psy­choanalytic models are offshoots of the medical model.

**2.2 section objectives**

By the end of this section you should be able to:

1. Define abnormal behaviour.

2. Discus the models of abnormal behaviour

**2.3 CONTENT OF THE SUBJECT**

***2.3.1 The Demonological Model -*** Throughout human history, the demonological model has been the most widely believed model for explaining abnormal behavior. During the Middle Ages and during the early days of Ameri­can civilization along the rocky coast of Massachu­setts, the demonological model was in full sway. It was generally believed that abnormal behavior was a sign of possession by agents or spirits of the Devil. Possession could stem from retribution, or God having the Devil possess your soul as punish­ment for your sins. Wild agitation and confusion were attributed to retribution. Possession was also believed to result from deals with the Devil in which people (“witches”) traded their souls for earthly power or wealth. Witches were held re­sponsible for unfortunate events, ranging from a neighbor’s infertility to a poor crop.

In either case you were in for it. An exorcist, whose function was to persuade those spirits to find better pickings elsewhere, might pray at your side and wave a cross at you. If the spirits didn’t call it quits, you might be beaten or flogged. If your behavior was still unseemly, there were other remedies, like the rack, which have powerful influ­ences on behavior.

In 1484 Pope Innocent VIII ordered that witches be put to death. At least 200,000 accused witches were killed over the next two centuries. Europe was no place to practice strange ways. The goings-on at Salem were trivial by comparison.

There were ingenious “diagnostic” tests to fer­ret out possession. One was dunking the suspect under water. Failure to drown was interpreted as support by the Devil - in other words, possession. Then you were in real trouble.

***2.3.2 The Medical Model:* Organic and Psychoanalytic Versions**

According to the medical model, abnormal behav­ior reflects an underlying illness, not evil spirits. The organic model and the psychoanalytic model are offshoots of the medical model.

**2.3.2.1- Medical Model: Organic Version** in 1883 Emil Kraepelin published a textbook of psychiatry in which he defined the medical model. Kraepelin argued that there were specific forms of abnormal behavior, which within the medical model are often called mental illnesses. (See Table 9.1 for a list of many of the commonly used terms concerning abnormal behavior that reflect the widespread influence of the medical model.) Each mental ill­ness had specific origins, which he assumed were physiological. The assumption that biochemical or physiological problems underlie mental illness is the heart of the organic model.

Kraepelin argued that each mental illness, just like each physical illness, was typified by its own cluster of symptoms, or syndrome. Each mental illness had a specific outcome, or course, and would presumably respond to a characteristic form of treatment, or therapy.

Contemporary supporters of the organic model point to various sources of evidence. For one thing, a number of mental disorders run in families and might therefore be transmitted from generation to generation by DNA. For another, imbalances in neurotransmitters and other chem­icals produce behavioral effects like those found in disorders such as severe depression and schizo­phrenia, as we shall see later.

According to the organic model, treatment re­quires biological expertise and involves controlling or curing the underlying organic problem. The biological therapies discussed in Chapter 10 are largely based on the organic model.

**2.3.2.2 - Medical Model: Psychoanalytic Version**

Sigmund Freud’s psychoanalytic model argues that abnormal behavior is symptomatic of unconscious conflict of childhood origins -an underlying psy­chological rather than biological disorder. The abnormal behavior (or “symptoms”) often reflect difficulty in repressing primitive sexual and ag­gressive impulses.

Within Freudian theory, neurotic behavior and anxiety stem from the leakage of primitive im­pulses. Anxiety represents the impulse itself and fear of what might happen if the impulse were acted on. In the case of psychosis, impulses are assumed to have broken through, so that behavior falls under the control of the id rather than the ego or superego. According to psychoanalytic the­ory, treatment (other than a sort of “Band-Aid” therapy) requires resolving the unconscious con­flicts that underlie the abnormal behavior.

The medical model is a major advance over demonology. It led to the view that mentally ill people should be treated by qualified professionals rather than be punished. Compassion replaced hatred, fear, and persecution.

But there are problems with the medical model. For instance, the model suggests that the mentally ill, like the physically ill, may not be re­sponsible for their problems and limitations. In the past, this view often led to hospitalization and sus­pension of responsibility (as in work and mainte­nance of a family life). Thus removed from the real world, the coping ability of the mentally ill often declined further. But today most adherents of the medical model encourage patients to remain in the community and maintain as much respon­sibility as they can.

**2.3.3. - The Social-Learning Model**

From a social-learning point of view, abnormal be­havior is not necessarily symptomatic of anything. Rather, the abnormal behavior is itself the prob­lem. To a large degree, abnormal behavior is be­lieved to be acquired in the same way normal be­haviors are acquired -for example, through conditioning and observational learning. Why, then, do some people show abnormal behavior?

One reason is found in situational variables; that is, their learning or reinforcement histories might differ from those of most of us. But differences in person variables such as competencies, encoding strategies, self-efficacy expectations, and self-regulatory systems might also make the difference.

A person who lacks social skills might never have had the chance to observe skillful models. Or it might be that a minority subculture reinforced behaviors that are not approved by the majority. Punishment for early exploratory behavior, or childhood sexual activity, might lead to adult anx­ieties over independence or sexuality. Inconsistent discipline (haphazard rewarding of desirable be­havior and unreliable punishing of misbehavior) might lead to antisocial behavior. Children whose parents ignore or abuse them might come to pay more attention to their fantasies than to the outer world, leading to schizophrenic withdrawal and in­ability to distinguish reality from fantasy. Deficits in competencies, encoding strategies, and self- regulatory systems might heighten schizophrenic problems. Since social-learning theorists do not be­lieve that behavior problems necessarily reflect or­ganic or unconscious problems, they often try to change or modify them directly, as with behavior therapy (see Chapter 10).

**2.3.4 The Cognitive Model**

Cognitive theorists focus on the cognitive events - such as thoughts, expectations, and attitudes -that accompany and in some cases underlie abnormal behavior.

One cognitive approach to understanding ab­normal behavior involves information processing. As noted in earlier chapters, information-process­ing theorists compare the processes of the mind to those of the computer and think in terms of cycles of input (based on perception), storage, retrieval, manipulation, and output of information. They view abnormal behavior patterns as disturbances in the cycle. Disturbances might be caused by the blocking or distortion of input or by faulty storage, retrieval, or manipulation of information. Any of these can lead to lack of output or distorted output (e.g., bizarre behavior). Schizophrenic individuals, for example, frequently jump from topic to topic in a disorganized fashion, which information- processing theorists might explain as problems in manipulation of information.

Other cognitive theorists (Albert Ellis, 1977, 1987, is one) view anxiety problems as stemming from irrational beliefs and attitudes, such as per­fectionism and overwhelming desire for social ap­proval. Aaron Beck attributes many cases of depression to “cognitive errors,” such as self-de­valuation, interpretation of events in a negative light, and general pessimism (Beck et al., 1979). Some cognitive psychologists, as we shall see, attribute many cases of depression to cognitions to the effect that one is helpless to change things for the better.

Social-learning theorists such as Albert Ban­dura (1986) and Walter Mischel (1986) straddle the border between the behavioral and the cogni­tive. As noted, they place primary importance on encoding strategies, self-regulatory systems, and expectancies in explaining and predicting behav­ior. For example, expectancies that we will not be able to carry out our plans (low “self-efficacy ex­pectations”) sap motivation and lead to feelings of hopelessness -two aspects of depression (Ban­dura, 1982).

Many psychologists look to more than one model to explain and treat abnormal behavior. They are considered eclectic. For example, many social-learning theorists believe that some abnor­mal behavior patterns stem from biochemical fac­tors or the interaction of biochemistry and learn­ing. They are open to combining behavior therapy with drugs to treat problems such as schizophrenia and bipolar disorder. A psychoanalyst might also be eclectic. He or she might believe that schizo­phrenic disorganization reflects control of the per­sonality by the id and argue that only long-term psychotherapy can help the ego achieve suprem­acy. But the psychoanalyst might still be willing to use drugs to calm agitation on a temporary basis.

Now let us consider the major categories of abnormal behavior, as compiled in the third edi­tion (revised version) of the Diagnostic and Statistical

Manual of the Mental Disorders (DSM –III-R) by the American Psychiatric Association (1987). We shall refer to the DSM-III-R because it is the most widely used classification system in the United States. However, psychologists criticize the DSM-III-R on many grounds, such as adhering too strongly to the medical model. So our use of it is intended as a convenience, not an endorsement. In future years psychologists might publish their own system for classifying abnormal behavior patterns.

**Unit 6 Review Questions**

1. Behavior may be judged abnormal by the following EXCEPT?
2. Statistical abnormality
3. Violation of socially accepted standards
4. Theoretical
5. Lingual diversion
6. Subjective abnormality
7. Brain tumors, strokes etc help to define behavior abnormality in the category of
8. Subjective abnormality
9. Theoretical approach
10. Violation of standards
11. Biological injury
12. Brain maladaptivity
13. Criterion commonly referenced as maladaptivity
14. If a person is behaving in ways counter-productive to their own wellbeing
15. When a person does not follow the conventional social and moral rules of their society
16. When statistically rare behaviours are called abnormal
17. There is failure to function
18. Where all definitions of abnormality are used to determine whether an individual behaviour is abnormal
19. Medical model of behaviour pioneers are people like?
20. Albert Ellis
21. Emil Kraeplein
22. Pope Innocent VIII
23. Albert Bandura
24. Walter Mischel

**Answers**

1. a
2. d
3. a
4. b

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