

Chapter 2 Assessment, Classification, and Treatment of Abnormal Behaviour

Chapter Overview:

Methods of Assessment

The Clinical Interview

The most widely used method of assessment, the clinical interview, involves the use of a set of questions designed to elicit relevant information from people seeking treatment. Clinicians generally use a structured interview, which consists of a fairly standard series of questions to gather a wide range of information concerning presenting problems or complaints, present circumstances, and history.

Psychological Tests

Psychological tests are structured methods of assessment that are used to evaluate reasonably stable traits such as intelligence and personality.

Intelligence Tests

Tests of intelligence, like the Stanford-Binet and the Wechsler scales, are used for various purposes in clinical assessment, including determining evidence of mental retardation or cognitive impairment, and assessing strengths and weaknesses. Intelligence is expressed in the form of an intelligence quotient (IQ).

Personality Tests

Self-report personality inventories, like the MMPI, use structured items to measure various personality traits, such as anxiety, depression, and masculinity-femininity. These tests are considered objective in the sense that they make use of a limited range of possible responses to items and an empirical, or objective, method of test construction.

Projective personality tests such as the Rorschach and TAT, ask subjects to interpret ambiguous stimuli in the belief that their answers may shed light on the unconscious processes. Concerns persist about the validity of these tests, however.

Neuropsychological Assessment

Methods of neuropsychological assessment help determine organic bases for impaired behaviour and psychological functioning. For example, the Luria Nebraska Test Battery is a sophisticated batteries of tests measuring various perceptual, intellectual, and motor skills and performance.

Behavioural Assessment

In behavioural assessment, test responses are taken as samples of behaviour rather than as signs of underlying traits or dispositions. The behavioural examiner may conduct a functional assessment, which relates the problem behaviour to its antecedents and consequences. Methods of behavioural assessment include behavioural interviewing, self-monitoring, use of analogue or contrived measures, direct observation, and behavioural rating scales.

Cognitive Assessment

Cognitive assessment focuses on the measurement of thoughts, beliefs, and attitudes in order to help identify distorted thinking patterns. Specific methods of assessment include the use of a thought record or diary and the use of rating scales such as the Automatic Thoughts Questionnaire (ATQ).

Physiological Measurement

Measures of physiological function include heart rate, blood pressure, galvanic skin response (GSR), muscle tension, and brain wave activity. Brain-imaging techniques such as EEG, CAT scans, PET scans, MRI, fMRI, BEAM, and MEG probe the inner workings and structures of the brain.

Classification of Abnormal Behaviour

The Diagnostic and Statistical Manual of Mental Disorders (DSM), is the most widely accepted diagnostic system, now in its fourth edition. Another widely used system is the International Classification of Diseases (ICD) published by the World Health Organization. Now, in its tenth edition, and with Canadian enhancements and modifications, the system is known as the ICD-10-CA, which has been adopted as the Canadian standard for coding, reporting, and tracking health information.

The DSM uses specific diagnostic criteria to group patterns of abnormal behaviours that share common clinical features and a multiaxial system of evaluation. Strengths of the DSM include its use of specified diagnostic criteria and a multiaxial system to provide a comprehensive picture of the person's functioning. Weaknesses include questions about reliability and validity, and about the medical model framework.

Methods of Treatment

Psychotherapy involves a systematic interaction between therapists and clients that incorporates psychological principles to help clients overcome abnormal behaviour, solve problems in living, or develop as individuals. The various approaches to psychotherapy employ theory-based specific treatment factors and nonspecific factors such as the quality of the therapeutic relationship and the installation of hope.

Biological Therapies

Biological approaches include drug therapy, electroconvulsive shock therapy (Ed), and psychosurgery. Minor tranquilizers such as Valium may relieve short-term anxiety but do not directly help people solve their problems. Neuroleptics help relieve flagrant psychotic features, but regular use of most antipsychotic drugs has been associated with a risk of disabling side effects. Antidepressants have been shown to be effective in treating depressive disorders, and lithium has been shown to be effective in treating bipolar disorder. ECT is often associated with dramatic relief from severe depression, but questions remain about side effects. Psychosurgery is conducted only rarely because of adverse consequences. Deep brain stimulation involves implanting electrodes within the part of the brain that affects mood.

Psychodynamic Therapies

Psychodynamic therapies originated with psychoanalysis, the approach to treatment developed by Freud. Psychoanalysts use techniques such as free association and dream analysis to help people gain insight into their unconscious conflicts and work them through in the light of their adult personalities. More recent psychoanalytic therapies are generally briefer and less intensive.

Behaviour Therapy

Behaviour therapy applies principles of learning to help people make adaptive behavioural changes. Behaviour therapy techniques include systematic desensitization, gradual exposure, modeling, aversive conditioning, operant conditioning approaches, social skills training, and self-control techniques.

Humanistic-Existential Therapies

Humanistic approaches focus on the client's subjective, conscious experience in the here and now. Rogers's person-centered therapy helps people increase their awareness and acceptance of inner feelings that had met with social condemnation and been disowned. The effective person-centered therapist possesses the qualities of unconditional positive regard, empathic understanding, genuineness and congruence.

Cognitive-Behavioural Therapies

Cognitive therapies focus on modifying the maladaptive cognitions that are believed to underlie emotional problems and self-defeating behaviour. Ellis's rational-emotive therapy focuses on disputing the irrational beliefs that occasion emotional distress and substituting adaptive behaviour for maladaptive behaviour. Beck's cognitive therapy focuses on helping clients identify, challenge, and replace distorted cognitions, such as tendencies to magnify negative events and minimize personal accomplishments. Meichenbaum's cognitive-behavioural therapy attempts to integrate behavioural principles and

cognitive techniques in a way that reduces or eliminates problematic behaviours and changes dysfunctional thoughts and cognitions.

Eclectic Therapy

Eclectic therapists make use of multiple models of psychotherapy. In technical eclecticism, therapists use techniques from different approaches without necessarily adopting the theoretical models on which they were based. In integrative eclecticism, therapists attempt to synthesize and integrate diverse theoretical models.

Group, Family, and Marital Therapy

Group therapy has several advantages over individual treatment, such as reduced costs, opportunities for shared learning experiences and mutual support, and increased utilization of scarce therapist resources. The particular approach to group therapy depends on the orientation of the therapist.

Family therapists work with conflicted families to help them resolve their differences. Family therapists focus on clarifying family communications, resolving role conflicts, guarding against scapegoating individual members, and helping members develop greater autonomy. Marital therapists focus on helping couples improve their communications and resolve their differences.

Computer-Assisted Therapy

Computer-based interventions and therapy come in all forms, from online cognitive-behavioural therapy with a live therapist using a video-chat service to self-guided behaviour therapy for children with anxiety. Computer-based interventions for various disorders have the potential to dramatically expand and alter the landscape of treatment.

Does Psychotherapy Work?

Psychotherapy researchers have generated encouraging evidence of the effectiveness of psychotherapy. Although there are few well-designed head-to-head comparative treatment studies, the results of meta-analyses of research studies that compare psychotherapy with control groups support the efficacy of various approaches to psychotherapy.

Multicultural Issues in Psychotherapy

Therapists need to take cultural factors into account in determining the appropriateness of Western forms of psychotherapy for different cultural groups. Some groups may, for example, have different views of the importance of the autonomy of the individual, or may place more value on spiritual than psychotherapeutic interventions.

Abnormal Psychology and Society

Psychiatric Commitment and Patient's Rights

The legal process by which people are placed in psychiatric institutions against their will is called psychiatric or civil commitment. Psychiatric commitment is intended to provide treatment to people who are deemed to suffer from mental disorders and to pose a threat to themselves or others. Legal or criminal commitment, by comparison, involves the placement of a person in a psychiatric institution for treatment who has been acquitted of a crime by reason of insanity. In voluntary hospitalization, people voluntarily seek treatment in a psychiatric facility, and can leave of their own accord, unless a court rules otherwise.

Predicting Dangerousness

Although people must be judged dangerous to be placed involuntarily in a psychiatric facility, mental health professionals have not demonstrated any special ability to predict dangerousness

Mental Illness and Criminal Responsibility

The Insanity Defence

Three court cases established legal precedents for the insanity defence. In 1834, a court in Ohio applied a principle of irresistible impulse as the basis of an insanity defense. The M'Naughten rule, based on a case in England in 1843, treated the failure to appreciate the wrongfulness of one's action as the basis of legal insanity. People who are criminally committed may be hospitalized for an indefinite period of time, with their eventual release dependent on a determination of their mental status.

Competency to Stand Trial

People who are accused of crimes but are incapable of understanding the charges against them or assisting in their own defence can be found incompetent to stand trial and remanded to a psychiatric facility.

The Duty to Warn

Although information disclosed by a client to a therapist generally carries a right to confidentiality, the California Tarasoff ruling held that therapists have a duty or obligation to warn third parties of threats made against them by their clients.

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Students Should Be Able to:

1. Discuss sociocultural and ethnic factors in the assessment of abnormal behaviour.
2. Describe different types of interviewing techniques, explaining their strengths and weaknesses.
3. Describe the features of tests of intelligence and personality.
4. Describe the use of psychological tests in the assessment of neuropsychological functioning.
5. Discuss the advantages and limitations of behavioural assessment, and describe the following behavioural techniques: the behavioural interview, self-monitoring, use of contrived measures, direct observation, and behavioural rating scales.
6. Discuss cognitive methods of assessment.
7. Discuss the use of physiological measurement in assessment, including the use of brain-imaging techniques.
8. Discuss historical origins of modern diagnostic systems and the development of the DSM system.
9. Describe the features of the DSM system and evaluate its strengths and weaknesses.
10. Identify and describe various culture-bound syndromes.
11. Describe the legal procedures for psychiatric commitment and the safeguards to prevent abuses of psychiatric commitment.
12. Discuss the controversy concerning psychiatric commitment.
13. Discuss the problem faced by psychologists and other professionals who are given the task of attempting to predict dangerousness.
14. Discuss the legal basis of the right to treatment and right to refuse treatment.
15. Discuss landmark cases that establish the legal precedents for the insanity plea.
16. Distinguish between the “not-guilty-by-reason-of-insanity” verdict and the “guilty but mentally ill” verdict.

17. Distinguish between the insanity plea and the principle of competency to stand trial.

18. Discuss the “duty to warn” obligation for therapists and describe the landmark case on which it is based.

Lecture and Discussion Suggestions:

1. Psychological assessment. Essentially, assessment is the process of collecting and processing information from a client as a basis for determining the person’s problems as well as the goals and strategies used in treatment. Ideally, this involves a variety of measures that will lead to a balanced assessment of the individual. In actual practice, however, clinicians tend to be highly selective in their choice of methods, depending partly on the particular client and her or his problem. For instance, when a client expresses paranoid ideas, the clinician might include the MMPI-2 to identify specific patterns of abnormality. In another instance, when a client is intensely fearful of mingling with others in public places, the clinician may want to do a functional or behavioural analysis of the phobic behaviour, identifying the conditions in which this behaviour occurs. Finally, a psychological assessment should include the client’s overall strengths and weaknesses, not simply what’s wrong with the person.

2. Clinical versus statistical prediction. Can machines do better at making accurate diagnoses? In this research area clinical judgment is pitted against statistical formulas—the same set of psychological test scores about patients is given to clinicians to think about, and is also plugged into statistical prediction formulas. Since the early 1950s, studies have shown that the formulas do at least as well as the clinicians. In fact, in recent research statistical techniques have actually been found to predict how the clinicians reach their decisions. It is possible to read this research and reach three general conclusions:

- A. Clinicians rarely do better than statistical formulas.
- B. The formulas in many cases are more accurate than the clinicians.
- C. Clinicians should be replaced by the statistical formulas.

Needless to say, such conclusions have not sat well with clinicians. The clinicians have argued that there is more to understanding a client than just his or her test scores—formulas cannot make behaviour observations.

A more moderate conclusion is that while some clinical tasks can clearly be automated, it is probably best in most cases to combine clinical and statistical methods. Statistics are not a replacement for a clinician, but a tool the clinician can use.

Murphy, K. R., & Davidshofer, C. O. (1994). *Psychological Testing: Principles and Applications*, 3rd Ed. Englewood Cliffs, N. J.: Prentice-Hall.

3. The clinical interview. This continues to be the oldest and most widely-used method of assessment for good reasons. First, a face-to-face setting allows clients to describe their presenting complaints in their own words. Second, the clinician may observe a variety of nonverbal behaviours, which also provide clues as to the client's personality and problems. And third, the interviewer may orient the interview to the person rather than vice versa. At the same time, a major disadvantage of the interview is that the data may be distorted by the particular questions asked as well as the interviewer's personal and cultural biases.

Furthermore, each clinician may interpret the same data in different ways. Therefore, it is often advisable to supplement the clinical interview with personal and family data, as well as other methods of assessment, such as standardized personality tests.

4. Classifying abnormal behaviours. Have students discuss the pros and cons of classifying abnormal behaviours. You might point out the advantages of the DSM-IV over earlier approaches, especially the shift away from the psychodynamic assumptions of causality to a more descriptive and cause-neutral approach. Yet critics point out that any system of classification greatly restricts the amount of information included about the person, overlooks the individual's uniqueness, and results in social stigmas. You might begin this discussion by simply asking "Why do we need a system for classifying abnormal behaviours?" and move the discussion from there to the various pros and cons of such a system.

5. Intelligence tests. Ask students for their opinions about intelligence tests, including their usefulness and limitations. Because of the controversy surrounding intelligence testing, clinicians now use these tests more selectively, preferably along with other measures. Intelligence tests may be useful in a number of ways, including the high correlation between measures of intelligence and standardized achievement test scores. Yet, such tests also may be culturally biased and might be misinterpreted, especially in the case of individuals from culturally diverse or disadvantaged backgrounds.

6. Personality tests. Discuss the usefulness of personality tests from the client's perspective. Ask volunteers to share their experiences in getting results of a personality or career inventory. A common misunderstanding of career inventories such as the Strong-Campbell Interest Inventory (SCII) is that this instrument tells us which careers we should choose. But in reality, the results indicate which clusters of careers tend to be most compatible with our interests, and thus those in which we are most likely to persist, but not the ones that we should choose.

7. On Being Sane in Insane Places. Rosenhan's article, On Being Sane in Insane Places (Science, 1973, 179, pp. 250-258) is engaging for students to read and can be counted on to provide material for classroom discussion. Replies to the article (Science, 1973, 180, pp. 1116-1122) are also particularly valuable to

assign, as they present a wide variety of viewpoints on the study. A few questions such as: Was Rosenhan setting up the psychiatrists? Is insanity in the eye of the beholder? What are the effects of the label “insane?” Can medicine detect liars? There should be sufficient information to sustain discussion on that controversial piece of research.

8. Personality tests and job screening. A somewhat disturbing trend that appears to be increasing in recent years is the tendency of companies to use personality tests, such as the MMPI in their applicant screening process for new hires. Ask students to discuss the pros and cons of using personality tests in this situation. In discussing the cons, you might point out that tests like the MMPI were not really designed to be administered on a massive scale to a “normal” population and might pose a significant problem of “false positives” when used this way. Also, there is the related issue of personnel departments not always having employees who are properly trained to interpret the subtleties that are often involved in understanding the meaning of the scores provided by many of these tests. Should these tests be used in these situations to begin with? What are the dangers in having tests like these administered and interpreted by employees with often minimal training in the meaning of the scores?

9. Distinguish between a psychological disorder and an illness. A common misunderstanding of the DSM system of assessment stems from our greater familiarity with the medical model, in which symptoms are necessarily linked with causes in the course of diagnosing and treating an illness. However, in the DSM-IV, abnormal behaviours are viewed as signs of mental disorders, which are clinically significant clusters of features that may be identified and treated without necessarily knowing the underlying causes. In fact, for most mental disorders, the etiology is unknown. Thus, the DSM-IV is a theoretical with regard to etiology or causal factors, except in regard to those disorders for which this is well established, as in many of the cognitive disorders with organic origins. The major justification for this approach is that the inclusion of etiological theories would be an obstacle for the use of the manual by clinicians of varying theoretical orientations, including psychologists. Also, it would not be possible to present all the reasonable theoretical orientations.

10. The disadvantages of the DSM approach. As your text notes, not everyone has been happy with the multiaxial approach and the philosophy introduced with the DSM-III in 1980. One such critic has been George Valliant, who found five problems with this DSM approach:

- A. The DSM ignores other cultures and is too anchored in American ideas.
- B. The DSM ignores the fact that most diagnoses reflect dimensions and not categories. He states “pregnancy is a black-and-white diagnosis, schizophrenia is not.”

- C. DSM pays too much attention to surface phenomena and too little attention to the longitudinal course of problems.
- D. DSM does not pay enough attention to the underlying psychological causes of problems.
- E. DSM sacrifices validity for the sake of reliability. Valiant likens the DSM's emphasis on being objective to drafting all seven footers for pro basketball—it is a very reliable method, but ignores the more crucial skill of ball handling.

In particular, you might discuss with the class Valiant's second objection. Many others have criticized DSM for pigeon-holing people into categories when many problems and behaviours are on a continuum. Ask the class how they would design DSM-V?

Valliant, G. E. (1984). The disadvantages of DSM-III outweigh its advantages. *American Journal of Psychiatry*, 141, 542-545.

11. The fundamental attribution error. Social scientists tend to regard human behaviour as resulting from the interaction between the individual's dispositional tendencies (intentions, traits, etc.) and his or her situational influences or immediate environment. However, when it comes to explaining behaviour, social scientists are well aware of the biases in the way we interpret behaviour, depending mainly on whether it's our own or someone else's behaviour. According to the fundamental attribution error, we tend to overemphasize personal, or dispositional, causes in accounting for other people's behaviour, but underemphasize these causes for our own behaviour. Expressed differently, we readily excuse our behaviour because of unfavorable circumstances, while jumping to unwarranted conclusions about other people's motives in similar behaviours and circumstances. Thus, when speaking about ourselves, we use words that denote our actions and reactions to a situation, such as "I get angry when" and "I become violent when." But when talking about someone else, we generally use words that describe that person's traits or personality, such as "He has such a bad temper" or "She is a violent person" (McGuire and McGuire, Journal of Personality and Social Psychology, 1986, 51, pp. 1135-1143). The risk of the fundamental attribution error occurs when jury members must decide whether an act of violence such as an assault or shooting was malicious (due to dispositional factors) or in self-defense (situational influences).

12. The impact of malpractice litigation. The exorbitant rise in insurance rates in the 1980s and 1990s and the increased frequency of malpractice cases brought against professionals have had a mixed impact on mental health care. On the one hand, these changes have alerted mental-health professionals to become more conscientious about making risk assessments in their clients, to balance confidentiality with the need to warn, and to assure continuation of care. All these changes are in the best interest of the client as well as the professional.

However, malpractice litigation has also spurred various negative, defensive practices among professionals. For instance, some professionals tend to engage in excessive risk-avoidance, such as refusing to treat clients who are viewed as potentially violent. Or they may avoid asking questions that could yield information about the likelihood of violent behaviours. While certain defensive practices may protect professionals against litigation, as well as further rises in insurance rates, they are not in the best interests of clients.

13. Mutual-help groups. Today, more than 12 million people participate in an estimated 500,000 mutual-help or self-help groups—groups whose members share a common problem and meet regularly to share their concerns without the guidance of professionals. Although these groups often have multiple functions, such as fostering self-help and lobbying for reform, most have the same underlying purpose, namely, to provide practical help as well as social support in dealing with a problem common to all members. A major assumption is that no one understands you or may help you better than someone who has the same problems, whether its alcoholism, obesity, or bereavement. In an atmosphere that is friendly and compassionate, new members soon realize that participation is voluntary with no strings attached. There is usually an unwritten code of confidentiality within the group. Even when there is a specified path to recovery, as in the various “anonymous” groups, members can proceed at their own pace. Groups that deal with addictive behaviours or emotional disorders often use a “buddy” system so that new members can count on a familiar person for encouragement and support. In an atmosphere of acceptance and mutual support, members can communicate more openly, view their problems more objectively, and find more effective coping strategies.

14. Predicting violence. Discuss the problems of predicting violence. Because incidents of violence in the community by mentally ill persons tend to get a high degree of media coverage, there tends to be an impression that people who are mentally ill are much more violent than others. Students might be interested to know that people with abnormal behaviours without prior history of violent behaviour are no more likely than the general population to engage in violence. What pressures are therapists under and what factors do they have to consider when they attempt to make predictions about potential violent behaviour from a patient being considered for release into the community?

15. The insanity plea. Discuss the insanity plea. How do students feel about a person accused of a vicious crime being declared “not guilty by reason of insanity?” What are the pros and cons of the alternative “guilty but mentally ill” verdict? What would be the pros and cons of scrapping the insanity defence entirely?

Do students feel that most people accused of crimes get off on the insanity defence? They don't! Only a small percentage of criminals use the defence, and only a small percentage of them use the defence successfully. Do students feel that people who are found not guilty by reason of insanity spend less time in

confinement than those found guilty of the same crime? Again, they don't! The average person found not guilty by reason of insanity spends more time in a mental hospital than the person found guilty of the same crime spends in prison (when parole, probation, and early release programs are taken into account).

In discussing this, you might consider that recently one state legislature passed a bill requiring that psychiatrists and psychologists giving testimony in court cases wear a tall conical hat and wave a "magic" wand during their testimony. Fortunately the bill was vetoed by the governor. What do actions like this say about the public's perception of the "expertise" of psychologists and psychiatrists giving "expert" testimony in court? How has the insanity plea contributed to these perceptions?

Student Activities:

1. Reflective listening. Instruct students to pair up in dyads. One person is to select a concern or problem he or she feels comfortable sharing. Then the person is to share this problem with his or her partner for about five minutes or so. The partner is to listen with empathy, giving only nonjudgmental feedback, without adding to or analyzing what is being expressed. Then have the partners switch roles. After the dyads have completed their role playing, ask the participants how it feels to be listened to. How does active or reflective listening differ from everyday conversation? It's been said that social conversation is often a competitive exercise in which the first person to throw a breath is declared the listener. But we might add---a reluctant, frustrated listener, who doesn't listen at all, but merely awaits his or her turn to speak.

2. Selecting a therapist. Ask students how they would go about selecting a therapist for themselves. You might have students share their suggestions orally or jot them down and then share them. In selecting a therapist, psychiatrist J. Ingram Walker (Everybody's Guide to Emotional Well-Being, Harbor Publishing, 1982) suggests that we consider two key questions: (1) Is the therapist professionally trained and certified or licensed? (2) Do I feel comfortable with this person? Ordinarily people must be qualified to list themselves as a psychologist, psychiatrist, or social worker in the telephone book. Also, professionals usually display their state license or other certificates in a prominent place in their offices. But you also want to know whether you'll feel comfortable talking to the therapist. Does this person really listen to you? Is he or she warm or empathic without being condescending? Once you've selected a therapist, in the initial session it's appropriate to discuss such matters as the person's approach to therapy, the length of treatment, and the fees.

3. Locating therapists. Assign students to prepare a list of therapists in your area, with regard to degrees, areas of specialization, forms of treatment, and other factors. They might call some therapists for such information, consult a local

mental health association, check the Internet, and consult phone book listings as ways of gathering this information. They can compare availability of the many types of treatment discussed in this chapter.

4. Design an outcome study. Break the class into groups and give them the task of designing a research study to evaluate a psychotherapy technique. They are to consider therapist and technique variables, control groups, measures of outcome, and follow-ups. Let the group report their designs and use this to discuss some of the complexities of research the text authors describe.

5. Self-help resources. Not everyone goes to a therapist for help. Millions of Americans turn to self-help sections in their libraries and bookstores. Have students collect examples of various self-help manuals, guides, and books. Ask them to critically evaluate these with regard to evidence presented for their effectiveness.

6. The MMPI-2. Ask students to jot down their true or false responses to the following statements: "I never read the comics," "I am an important person," "I usually get nervous before an important exam." Then ask how many students answered "true" to the statement "I am an important person." Originally, this item was designed as a measure of self-importance and grandiosity in the earlier versions of the MMPI, with fewer than 1 out of 10 respondents in a normal sample endorsing it over 50 years ago. However, the connotations of this statement have changed with the times, especially due to social changes and the human potential movement of the past two decades. Today, 5 out of 10 males and 7 out of 10 females endorse this statement. As a result, people's responses to such test items were reexamined in the re-standardization project that produced the revised MMPI or MMPI-2.

7. Projective techniques. Get students' responses to a TAT card or some ambiguous scene in a magazine involving one or more people. Then display the picture and ask students to write a paragraph or so in response to the following questions: What are the people in this picture doing? What are they saying to each other? And how do you think this situation will turn out? Now ask volunteers to share their responses. You'll usually find that responses vary considerably from one person to another, illustrating how each of us tends to project our own motives and feelings into the figures shown. You might point out that it is the common themes in a person's responses to a series of pictures that provide important clues to his or her personality, not simply the responses to a given picture.

8. Designing an assessment program. Break students into groups. Then tell them that they have been chosen to design an assessment program for a community mental health center. Students can discuss the types of problems they are most likely to encounter in this setting and discuss the sort of assessment instruments they might make available to their clinicians. They might also discuss how they would evaluate the reliability and validity of the diagnoses made by their

clinicians. Finally, students can discuss which assessment techniques appear to be best suited to particular presenting problems, such as family issues, school and learning problems, substance abuse disorders, etc. When students have completed their plans, have each group present its assessment program, explaining why they made the decisions they made.

9. Rorschach demonstration. Most students are interested in seeing the Rorschach cards and trying their hand at answering and interpreting them. A demonstration might accompany a lecture on the influence of psychological perspectives on Rorschach interpretation. Show several cards to the class and ask students “What might this be?” and have them write down their associations. This exercise alone exposes students to the discomfort of responding to an ambiguous stimulus, as many will ask for more structure (Can I look at the card upside-down? Can I give more than one answer? Am I supposed to look at the whole thing?).

As in standard Rorschach administration, follow with an inquiry: “What makes it look like that to you?” and, again, have students write down their explanations. When students have written their answers down, then you might have them share their answers (voluntarily) with the class and discuss with them some aspects of how the test is scored, as well as the way different psychological perspectives would view a given response to a Rorschach card.

10. Role play an interview. Find a student volunteer to be interviewed by you in front of the class. The interview does not need to inquire about pathology, but might include questions of interests, hobbies, career aspirations, and so on. Assign half of the class to record the subject’s nonverbal behaviours—eye contact, posture, tone of voice, gestures, smiles and frowns, etc. Have the other half of the class do the same thing for the interviewer. After about 10 minutes of interview, have the class present and discuss their observations. Look for evidence of reliable recordings across students. Compare and contrast nonverbal behaviours of the subject and the interviewer.

11. Construct an anxiety test. This can be done either as an in-class activity or as an extra assignment. Have the students play test-developer for a new test of anxiety. First they must define what they want to measure, then select a format, and then generate test items. Have them field test the resultant anxiety test on each other. They can then discuss the problems with the test from both the test-developer and test-taker point of view. You might have them do a reliability study by administering their test, waiting a couple of days, and administering it again. There are many discussion issues that will arise as students tackle this assignment.

12. Collect “pop-psych” tests. It is interesting to have students search for self-tests in various magazines and other popular media. Have them collect examples of these tests, and then use the examples to discuss issues such as reliability and validity.

13. Interviews of homeless people. Since many homeless people suffer from mental illness and would have been institutionalized 30 years ago, they are a population suitable for discussion in this unit. Have several members of the class go to a local shelter and interview some homeless people (with the shelter's permission, of course). You might ask several volunteers to do this and to report their impressions to the class. Or you could invite someone who works with homeless people to speak to your class. Either way, one of the aims of this exercise is to help students gain a realistic understanding of the homeless and of homelessness. Hopefully, you may dispel some of the stereotypes about the homeless, such as they are all deadbeats who are too lazy to work. At the same time, it would be interesting to discover what proportion of your sample of homeless people are either former mental patients or might have been hospitalized involuntarily under the less stringent standards of earlier eras.

14. Patients' rights. The purpose of this exercise is to determine how knowledgeable students are about mental patients' rights. You might make up a true-false quiz on patients' rights. Then ask for several volunteers to administer this quiz to a sample of students who are not taking abnormal psychology, and report their findings to the class. In order to guard against the "set" response, in which respondents might detect that all the items are true and thus "see through" the test, you might intersperse several "filler" items which are false. Some suggested filler items are:

- A. All patients have the right to at least one weekend home leave each month if they should desire it.
- B. Patients may not refuse to perform work which is done for the maintenance of the hospital facility if they are physically and mentally capable of performing the work.
- C. Patients have the absolute right to choose their own therapists.

15. Locating community resources. Have students look in your community or area for resources beyond the traditional mental health delivery system: paraprofessionals, support groups, rescue missions, outreach agencies, and so on. Their task is to identify some of the kinds of helpers discussed in this chapter.

16. The role of the police. Encourage students to interview police officers, or have a police officer speak to your class about the police role in the mental health system. See what your students can learn about the types of behaviour problems police officers encounter. The police are a key resource in the community in helping to identify people with mental disorders, and often in physically transporting them to the proper treatment facilities. How do police officers deal with psychotic behaviour, abusive situations, and so on? Perhaps an officer can speak to the class about the police role in the mental health system.

17. Commitment laws. Have students investigate the procedures in your area for involuntary commitment. In many places the county attorney's office can be a good place to begin. How often are people involuntarily committed? Should a family wish to undertake this step for a member, exactly how would they go about it?

Potential online discussion questions:

1. Neurotransmitters:

Controlling brain chemistry (neurotransmitter levels), is the best approach to treating mental disorders. Discuss.

2. Cognitive-behavioral treatment:

Cognitive-behavioral treatment is the best approach in treating people suffering with mental disorders. Discuss.

3. Mandatory treatment:

If a qualified mental health professional knows that treatment will make a person's life better they should be able to force treatment regardless of the patient's desires. Discuss.

Online resources:

CPA Code of Ethics

<http://www.cpa.ca/aboutcpa/committees/ethics/codeofethics/>

Visit this page to read the Canadian Psychological Association's code of ethics for psychologists.

Mental Health Info Source

www.cmellc.com/topics

This is a mental health education website. It contains access to e-journals and information on a wide range of mental disorders.

Mental Help Net

www.mentalhelp.net

This site has articles and descriptions of psychological disorders. It also provides links to assessment tools and other mental health resources and services.

Psychiatry Online

www.priory.com/psych.htm

This site provides an international forum for psychiatry and has links to the latest articles, papers, and journals.

The Section on Clinical Psychology of the Canadian Psychological Association

<http://www.cpa.ca/aboutcpa/cpassections/clinicalpsychology/>

This Canadian Psychological Association site is home to the Section on Clinical

Psychology. It is a central source for information about the clinical psychology profession in Canada.

Statistics Canada—Mental Health and the Criminal Justice system

www.statcan.gc.ca/pub/85-561-m/2009016/section-a-eng.htm

Information is provided here on mental health and the Canadian criminal justice system, including statistics.

Video Resources:

Prentice-Hall Videos

ABC News/PH-Library #2: Psychotherapy Under Scrutiny (Night Line, 4/27/92)
Psychotherapist-patient relationships are discussed in light of the case of a Boston psychotherapist and her patient who killed himself.

Assessment and Diagnosis of Childhood Psychopathology, 26 min. colour (Penn State Univ.). Provides an overview of standard psychiatric assessment.

The Assessment/Therapy Connection, 29 min. colour (Research Press). Arnold Lazarus makes a multi-modal assessment of a 45-year-old depressed woman.

Behavioural Interviewing with Couples, 14 min. colour (Research Press).
Demonstrates the six basic stages of an initial marriage counseling interview.

DSM-III-R Training Guide, 60 min. colour (Brunner/Mazel). Although it does not reflect the changes from the DSM-III-R to the DSM-IV, it still provides a useful practice for assessment. Presents 5 vignettes for practice assessment.

Intelligence: A Complex Concept, 28 min. colour (MGHF). Examines a variety of intelligence tests and discusses the problems that confront the effort to provide measures of intelligence.

Personality, 30 min. colour (CRM/McGraw-Hill). A college student volunteers for a thorough assessment by a clinical psychologist. Includes self-views, views of parents and others, and the use of intelligence and projective tests.

Simulated Psychiatric Patient Interview, 90 min. 6 cassettes, colour (UCLA School of Medicine). Shows methods used in interviewing patients with schizophrenia, organic brain syndrome, and phobias.

Unconscious Motives, 40 min. (IU). Shows how psychological tests and interview techniques are able to uncover a situation implanted in the “unconscious” of two subjects through hypnosis.

What Is Normal? 30 min. colour (Insight Media). Experts discuss classifying behaviour according to the DSM-II-R.

Commitment Evaluation, 20 min. colour (IU). Shows a patient being evaluated for commitment to a psychiatric hospital, with a discussion of the issues involved.

Crime anti Insanity, 52 min. colour (Films, Inc.). Explores the issue of releasing patients from mental hospitals when they are deemed to be no longer dangerous.

Involuntary Hospitalization of the Psychiatric Patient: Should It Be Abolished? 29 min. black and white, made in 1969 (NMAC). Dr. Thomas Szasz debates this issue with Dr. Masserman.

Mental Retardation and the Law, 22 min. black and white (Michigan Media). Three films that present case vignettes raising pertinent issues in the areas of civil rights, psychological testing, and institutional commitment.

These People, 28 min. colour (Horizon House Institute). Depicts citizens' reactions to the release of patients from a nearby state mental hospital.

Titticut Follies, 85 mm, colour (Grove Press). Describes patients' reactions to their treatment at a prison for the criminally insane.

Internet Resources:

1. Assessment-psychometrics is an e-mail group dealing with the use and evaluation of psychological tests, including discussion of instruments.

SEND E-MAIL TO: listserv@netcom.com

IN THE BODY OF THE MESSAGE TYPE: subscribe assessment-psychometrics

MMPL is a group devoted exclusively to the MMPI and MMPI-2. If interested in joining, e-mail your credentials to Robert H. Reiner, Ph.D.:
Reiner@acfcluster.nyu.edu

2. Forensic-psych. This is a forum to discuss criminal and civil forensic psychiatry/psychology including treatment issues, trial issues, disability insurance, and ethics. This forum is limited for use to mental health and behavioural science professionals, professional-oriented students, and special others only after user authentication via fax or e-mail. To subscribe:

SEND MAIL TO: listserv@netcom.com

IN THE MESSAGE TYPE: subscribe forensic-psych