Abnormal Psychology

Lecture 1
Abnormal psychology is the scientific study of abnormal behaviour. Use empirical method to study (description, causation, treatment). Psychopathology is just description and causation.

Abnormal is unusual or deviant behaviour that causes distress and is often unacceptable in the culture. Neither one on its own is necessary or sufficient.

Psychological abnormality is not as readily definable as physical illness. It exists on a continuum with normality. The definition of abnormal often reflects culture values and social norms.

Models of Mental Illness
- Supernatural: caused by spirits, stars, moon or past lives and treated with exorcism, prayer
- Biological: caused by internal physical problems
  - Oldest and currently most dominant model in psychiatry. Assumes that psychological disorders can be diagnosed similarly to physical illness, explained in terms of biological disease process and are best treated with medication/surgery, ECT.
  - Criticisms and limitations include:
    - Need to avoid extreme reductionism
    - Certain complex psychological phenomena may be impossible to explain at the neural/molecular level
    - Need to avoid over-extrapolation from animal research
    - Need to avoid assuming causation from treatment
    - The medical model may not be applicable to conceptualizing and diagnosing mental illness
      - Clear boundary between physical health and illness but continuity between mental health and disorder
      - Clear boundaries between different physical illnesses but psychological disorders commonly co-occur
- Psychological: caused by beliefs, perceptions, values, goals, motivation
- Sociocultural: caused by poverty, prejudice, cultural norms

Lecture 2
The integrative approach says that psychopathology is multiply determined. One-dimensional accounts of psychopathology are incomplete; consider reciprocal relations between biological, psychological, sociocultural factors (i.e. nature and nurture).

Psychological models include:
- Psychoanalytic
  - Emerges from the repression of unresolved conflict
  - Treated with insight
  - Most dominant model during first half of the 20th century
  - Id, ego, superego and stages of psychosexual development
  - Maladjustment from:
    - Unresolved conflicts resulting in anxiety, defense mechanisms
    - Critiques include lack of empirical evidence and unfalsifiability
- Behavioural
  - Due to learned responses from stimuli
    - Classical conditioning – Pavlov
    - Operant conditioning – Skinner
  - Maladjustment results from:
    - Faulty learning
  - There are many treatment applications
  - Critique: cognition important. Bandura (1974) incorporated this with his observational learning/modeling
    - Incorporated cognition to behaviourism
- Humanistic
  - Caused due to thwarted self-actualisation
  - Psychological health derived from fully functioning, self actualized persons
  - Maladjustment results from:
    - Environment imposes conditions of worth
    - Own experience, emotions, needs are blocked
    - Self-acualisation thwarted
  - Treated with empathy, unconditional positive regard
  - Critique: difficult to research (rogers pioneered treatment evaluation research)
- Cognitive
  - Due to negative core beliefs, biased thinking
- Cognitive-Behavioural Model
  - Currently the dominant model in psychology
  - What we think influences what we feel and do
  - Maladaptive behaviour results from:
Latent core negative beliefs (Aaron Beck)
- Interpretation of experiences: consistent with core negative beliefs
- Cognitive biases (overgeneralization, selective attention, etc…)
- Negative automatic thoughts

Classification Systems:
- Improve communication between researchers
  - Look for causes, test treatments
- Improve communication between health professionals
- May improve communication and understanding of mental health in the community
- May reduce social stigma
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
  - Problematic reliability
  - Inter-rater reliability: how much depression?
  - Problematic validity
  - Based on unproven theories about etiology
  - DSM-5 (2013) acknowledges limitations of categorical system, planned to introduce dimensional measures to complement diagnostic categories
    - Allows assessment of severity
    - Retained categorical system

Lecture 3
Why classify and diagnose?
- Improve communication between researchers
- Improve communication between health professionals
- May improve communication and understanding of mental health in the community
- May reduce social stigma

Classification systems:
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
  - Reliability and validity problematic
  - Major developments in classification (1980s+)
    - Major depression: 5 or more symptoms present in 2 week period for diagnosis
    - DSM-5 acknowledged limitations of categorical systems but retained it
      - It allows for assessment of severity, not just presence
- International Classification of Diseases and Health Related Problems (ICD)

Anxiety and Anxiety disorders
- Anxiety is activated in response to a perceived threat. The experience of anxiety is the same in normal and abnormal anxiety
- Three interrelated anxiety systems are:
  - Physical system. Includes:
    - Fight/flight response – sympathetic nervous system
    - Mobilises resources to deal with threat. Symptoms include sweating, heart rate increase, trembling, etc.
    - These are the classic systems of autonomic arousal
  - Cognitive system. Includes:
    - Perception of threat.
    - Attention shifts to threat. Hypervigilance (i.e. difficulty on concentrating on other tasks/things apart from threat)
  - Behavioural system. Includes:
    - Escape/avoidance
    - This may include aggression or freezing around others
- Abnormal anxiety or anxiety disorders are not qualitatively different from normal anxiety. They have the same physical, cognitive and behavioural aspects.
  - However, occurrence is excessive/inappropriate
    - i.e., anxiety occurs in the absence of objective threat and is more intense than objective level of threat
  - Typically characterised by overestimation of threat
    - i.e., probability of negative outcome overestimated, cost of negative outcome overestimated
- DSM 4 anxiety disorders are categorized according to focus of anxiety however experience of anxiety is same/similar in each. The disorders include:
  - Separation anxiety disorder
  - Specific phobias
  - Social phobia
  - Generalised anxiety disorder
  - Obsessive-Compulsive disorder
- Obsessions: intrusive thoughts or impulses
- Compulsions: ritualized behaviours to relieve the anxiety caused by the obsessions

o Posttraumatic and Acute Stress Disorders
  - Thoughts/memories of traumatic experience

o Panic disorder
  - Unexpected/spontaneous panic attacks
  - Anxiety about having another attack
    - With/without agoraphobia

o Anxiety disorder not otherwise specified
  - Anxiety disorders are highly comorbid with each other and with depression

**Lecture 4**
The diagnosis of anxiety disorders changed from DSM 4 to DSM 5.

- These changes include:
  - Trauma and Stressor related disorders
    - Reactive attachment disorder
    - Disinhibited social engagement disorder
    - Posttraumatic stress disorder
    - Acute stress disorder
    - Adjustment disorders
  - Obsessive compulsive and related disorders
    - Obsessive-compulsive disorder
    - Body dysmorphic disorder
    - Hoarding disorder
    - Trichotillomania (hair-pulling disorder)
    - Excoriation disorder (skin-picking)

- Panic attacks have also been reclassified.
  - Symptoms include:
    - Abrupt and intense fear or anxiety
    - Peaks within 10 mins
    - Classic symptoms of autonomic arousal
    - Other physical symptoms
    - Fear of dying, loss of control, going mad may cause:
      - Situationally bound or cued panic
        -Occurs in the presence or anticipation of feared stimulus
      - Situationally predisposed panic
      - Unexpected or uncued panic
  - Panic disorder
    - Unexpected/spontaneous panic attacks
    - Anxiety/worry about having another attack
    - Symptoms persist one month or more
  - Agoraphobia
    - Fear or avoidance of situations or events associated with panic
      - Avoidance of physical activity, quit job, become housebound etc…
      - 30-50% with Panic disorder also have agoraphobia
  - Social Phobia
    - A fear of social situations in which the person is exposed to unfamiliar people or to possible scrutiny
    - Exposure to feared social situation invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack
    - The person recognises that the fear is excessive or unreasonable
    - The feared situations are avoided or else are endured with intense anxiety or distress
    - Interferes significantly with the person’s normal routine, occupational functioning, or social activities, or there is a marked distress about having the phobia
  - Specific phobias
    - Fear of animals, natural environment, etc… May results from
      - Classical conditioning (Bouton)
      - May not be a complete account (Menzies & Clarke, 1995)
        - Conditioning event is not sufficient or necessary to cause phobia
      - Some stimuli are more likely to become phobic than others
        - Hammer/needle/drill relatively rare
        - Phobia fears: significant threat to survival
        - Genetic preparedness (Seigman, 1971)
          - Easier to learn
  - Generalised Anxiety Disorder
    - Excessive and uncontrollable worry
    - About wide range of outcomes

Clark’s (1988) cognitive theory of panic disorders demonstrates how a misinterpretation of sensations triggers anxiety and autonomic arousal resulting in panic.
- Physical symptoms are different from panic
  - Tension, irritability, restlessness, sleep problems
- May be associated with:
  - High trait anxiety, intolerance of uncertainty, reduced ability to tolerate distress, reduced problem solving confidence/success
  - Obsessive-Compulsive disorder
    - Obsessions: repeated, intrusive, irrational thoughts or impulses. **Cause severe anxiety**
    - Compulsions: ritualized behaviours to relieve the anxiety caused by obsessions
    - Associated with:
      - Intolerance of uncertainty, Inflated responsibility, Thought-action fusion, Magical ideation
  - Posttraumatic Stress Disorder
    - Stressor: an event in which
      - The person has experienced, witnessed, or been confronted with an event that involves actual or threatened death or serious injury, or a threat to the person’s physical integrity
      - The person’s response involved intense fear, helplessness, or horror
    - Re-experiencing
      - Intrusive images, memories, and dreams
      - Acting or feeling as if the event were recurring
      - Psychological distress, physiological arousal
    - Avoidance and numbing
      - Avoidance of reminders of the trauma
      - Pervasive numbing of general responsiveness
    - Persistently increased arousal
      - Sleep disturbance, anger, irritability, poor concentration, hypervigilance, startle
- **RISK for PTSD**
  - 50-60% of people experience traumatic events
  - PTSD prevalence: 5-11%
    - Critical to identify people who need assistance to prevent post-trauma problems
- **Risk factors**
  - Pre-trauma (i.e. coping style), trauma (i.e. meaning), and post-trauma (i.e. social support)

- **Treatment of Anxiety Disorders**
  - Cognitive Behavioural Treatment
    - Aim to reduce (biased) threat appraisal
      - How likely/bad that the event will occur
    - Cognitive techniques
      - Thought-diaries to identify automatic thoughts
      - Thought challenging
    - Behavioural techniques
      - Exposure to feared stimuli/outcomes is essential
      - Exposure to phobic object, social situation, body sensation, intrusive thought, traumatic memory

**Lecture 5**

DSM 4 also diagnoses mood disorders. These include:

- **Depressive disorders**
  - Unipolar: depressive mood/episodes only
    - Depressive episode: abnormally low mood
  - Bipolar disorders
    - Manic episode: abnormally elevated mood
      - Including 3 or more of inflated self-esteem, grandiosity, etc…
  - Extremes in normal mood
  - **Major Depressive Disorder**
    - One or more major depressive episodes including depressed mood most of the day, weight loss or gain, fatigue/loss of energy, etc… 5 or more episodes are needed in a 2-week period for diagnosis
      - Affective symptoms: Depressed mood, anhedonia
        (loss of pleasure/interest)
      - Cognitive symptoms: Indecisiveness, lack of concentration
      - Somatic symptoms: fatigue, sleep or appetite change
    - Single or recurrent depressive episode, not accounted for by other disorders.
    - Recurrent episodes are common
  - **Dysthymic disorder**
    - Persistently depressed mood that continues for at least 2 years
    - Symptoms of depression are milder than major depression
    - Symptoms can persist unchanged over long periods
    - Double depression (both MDD and dysthymia)

- **Biological theories**
  - Genetic vulnerability
Heritability: 35-60%, creates a vulnerability to mood disorders
- No evidence for specific genes
- Biological vulnerability + stress = depression

- Neurochemistry
  - Low levels of noradrenalin and/or serotonin
    - No good evidence for mechanism

- Neuroendocrine system
  - Excess cortisol in response to stress
  - Increased stress is strongly related to mood disorders

- Psychological theories
  - Cognitive vulnerability + stress = depression
    - Schema theory (Beck 1976)
      - Pre-existing negative schemas
        - Activated by stress
        - Result in information processing biases:
          - Biased attention, memory, interpretations
        - Negative thoughts become dominant in consciousness
          - Distorted view of self, world, future

    - Learned helplessness theory (Seligman, 1974)
    - Ruminative response styles (Nolen-Hoeksema, 1991)
    - Interpersonal factors (such as negative thinking)

- Biological Treatments
  - Drug treatments
    - Selective serotonergic reuptake inhibitors (SSRIs)
      - Effective in 70-80%
  - Electroconvulsive therapy (ECT)
    - Involves applying brief electrical current to the brain
    - Uncertainty as to how this works
    - Last resort: effective for severe depression (80%)

- Psychological Treatments
  - Cognitive Behavioural Therapy (CBT)
    - Addresses cognitive errors in thinking
      - Aims to develop more realistic view
        - Not positive thinking
    - Includes behavioural components
      - Behavioural activation: increase reinforcing events
      - Behavioural experiments: test beliefs
  - Outcomes comparable to drug therapy
    - Lower relapse rates than biological treatments
    - Meta-analysis: 29 vs. 60% (Gloaguen et al., 1998)

Lecture 6
Eating disorders are also listed in the DSM 4. They include:

- **EDNOS**
  - Subclinical AN or BN
  - Binge Eating disorder
  - Purging disorder
  - Night eating syndrome
  - Grazing

- **Anorexia Nervosa**
  - Refusal to maintain body weight at a minimally normal weight for age and height
    - Weight less than 85% of that expected
  - Intense fear of gaining weight or becoming fat even though underweight
  - Body image disturbance
    - Denial of seriousness of low body weight
    - Undue influence of body weight/shape on self-evaluation
  - Amenorrheoa
    - Restricting vs. binging/purging type
  - Associated features of AN include:
    - Psychological problems
      - Depressed mood, irritability, anger, etc…
      - Often associated with starvation syndrome