Introduction to Abnormal Psychology

Definition

Scientific study of abnormal behaviour by examining its **description** (classification, diagnosis), **causation** (bio-psycho-social), **maintenance** (what sustains disorder), **treatment** (effectiveness).

This differs slightly from psychopathology which studies only description and causation/maintenance.

Abnormal

It is usually based on three interacting continuous (with normality) criteria.

1. **Deviance from social norm**
    a. Depends on culture
    b. Can be positive such as exceptional academic abilities
2. **Causes distress**
    a. Most of the times but not always. E.g. bipolar disorder causes patient to be in a constant state of euphoria
    b. Normal distress is clearly not abnormal
3. **Maladaptive behaviour** i.e. their ability to adapt has been compromised. E.g. substance abuse disorders

Models of Mental Illness

This includes supernatural, biological/medical, psychological, social-cultural (caused by poverty, prejudice, cultural norms).

Biological Model – Oldest and Most Dominant (DSM)

This model asserts that abnormal behaviour:

- Can be explained in terms of biological disease process including structural brain abnormalities (schizophrenia) and neurochemical imbalances (depression – serotonin)
- Can be diagnosed similarly to physical illnesses
- Are best treated with medication, surgery, ECT (electroconvulsive therapy)

Historically, mental illness was synonymous with madness and was seen through gross distortion of reality and bizarre thoughts, affect and behaviour. In 19-20th century, biological model began to take root as some mental illnesses were found to have physical causes such as germs.

The model does have **limitations** including:

- Can be reductionist in that complex psychological phenomenon cannot simply be explained at the neural/molecular level
- Dependence and extrapolation from animal research
- Sometimes assumes causation from treatment i.e. 'hormone replacement worked for depression therefore the illness is the result of serotonin deficiency'

- May not be applicable in conceptualising and diagnosing mental illnesses since:
    - mental health and illness is not distinctive from each other
    - mental illnesses can co-occur

Psychological Model

Psychoanalytic – Freud (early 20th century)

Causation

- Psychic conflict between id, ego, superego. Proposes unresolved conflicts → anxiety → defence mechanisms (reaction formation etc.) → symptoms
- Fixation in psychosexual stages

Critiques

- Lack of evidence
- Unfalsifiable. E.g. you want to kill your friend. If you do, then you prove that unresolved conflict has lead to abnormal behaviour. If you don't, then you are unconsciously suppressing your urges

Treatment

- Insight therapies – involves verbal interactions intended to enhance clients' self-knowledge and thus promote healthful changes in personality and behaviour

Humanistic – Rogers, Maslow

Causation

- environment imposes conditions of worth
- own experience, emotions, needs are blocked
- self-actualisation thwarted

Critiques

- Difficult to research

Treatment

- Empathy
- Unconditional positive regard

Behavioural – Pavlov, Skinner

Causation

- Faulty learning through classical or operant conditioning

Treatment

- New learning

Critiques

- Does not account for cognitive processes of human beings
    - Bandura's observational learning

Cognitive Behavioural (what we think influences what we do) – Aaron, Beck

Causation

- latent core negative beliefs
    - interpretation of experiences so to be consistent with core negative beliefs i.e. "they only help me to ruin me in some way"
    - cognitive biases – overgeneralisation, selective attention, catastrophising, personalising, magnification, mistaking feelings for facts etc.
    - negative automatic thoughts

Treatment

- Demonstrating instances that don't fit with subject's negative core beliefs

Classification Systems - DSM

DSM is first published in 1952 and it's currently on its 4th edition. WHO also publishes the International Classification of Diseases and Health Relation Problems (ICD), which has included mental disorders since 1948.

DSM I and II (1968) are strongly influenced by psychoanalytic theory. E.g. it describes depression as '…associated with a feeling of guilt for past failures or deeds. The degree of the reaction in such cases is dependent upon the intensity of patient's ambivalent feeling towards his loss…'. This is clearly hard to test.

DSM III (1980), IV (1994), IV-TR (text revision, 2000) contain no theoretical assumptions about causation. They rely on empirical description of symptoms obtained through:

- Patient report, direct observation, measurement
- No assumptions about the unconscious
- Clear, explicit criteria and decision rules so more reliable

The problem still remain regarding its validity i.e. if you only have 4 of the required 5 factors for depression, does that mean you don't have depression at all, so DSM is still rather reductionist.

DSM V (2013) – introduces dimensionality making it more valid. It also allows for assessment of severity as opposed to only presence of disorder.

Anxiety

Anxiety is in fact an evolutionary advantage in that it is safer to perceive an unknown object to be harmful than to safe. However excess anxiety is problematic.