EXAM REVISION – ABNORMAL PSYCHOLOGY

WEEK 1: Historical Overview

- Defining: The DSM assigns **mental disorder** with various characteristics – personal distress, disability (impairment in functioning), violation of social norms, and **harmful dysfunction** (value judgement that a behaviour is harmful).
- History of Psychopathy:
  - ***Early demonology***: **Demonology** refers to the doctrine that an evil being can dwell in a person and control their body, leading to **exorcism**.
  - ***Early biological explanations***: Began separating medicine from religion/superstition; belief in disordered thinking/behaviour associated with brain pathology; mania, melancholia, and phrenitis balanced by 4 humours.
  - ***The dark ages***: Monasteries replaced physicians as healers, supernatural beliefs returned. Lunacy trials began to determine mental health, leading to hospitalisation.
  - ***Development of asylums***: **Asylums** housed those with psychological disorders; medical treatments crude and painful; Pinel advocated for humane treatment, but this was saved for the upper class; the **moral treatment** approach began to take hold but was abandoned again.
- The Evolution of Contemporary Thought:
  - ***Biological approaches***: A major medical success was the elucidation of the nature of syphilis (causal link between infection, brain damage and psychopathology). Galton coined *nature* and *nurture* to talk about genetic differences, and created the eugenics movement. A climate of experimentation and radical interventions was created (**electroconvulsive therapy** – from inducing seizures to reducing depressive symptoms; *prefrontal lobotomy* – destroying tracts connecting frontal lobes to rest of the brain).
  - ***Psychological approaches***: Mesmer believed **hysteria** (physical incapacities with no physical cause) was caused by distribution of a universal magnetic fluid, leading to first forms of **hypnotism**; Charcot believed it was a problem with the nervous system, but was persuaded and helped with hypnosis. Breuer introduced the **cathartic method** (reliving earlier trauma and releasing emotional tension by expressing forgotten thoughts). **Psychoanalytic theory** – psychopathology results from **unconscious** conflicts with the individual; the **psyche** consists of **id**, **ego** and **superego**; **defence mechanisms** are a strategy the ego uses to protect against anxiety; **psychotherapy** attempts to understand early childhood experiences, the nature of key relationships, and current relationship patterns (free association, interpretation, analysis of transference). Jung (**analytical psychology**) hypothesised a **collective unconscious** consisting of archetypes. Adler (**individual psychology**) regarded people as tied to society as fulfilment in doing good things (social good).
  - ***Behaviourism***: **Classical conditioning**. The **law of effect** states that behaviour that is followed by a satisfying consequence leads to repetition, and unpleasant consequences leads to discouragement. Modelling. Behaviour therapy applies procedures based on operant/classical conditioning (**systematic desensitisation** – deep muscle relaxation, gradual exposure).
- Diagnosis and Assessment:
  - ***Reliability***: **Reliability** refers to consistency of measurement; **interrater reliability**; **test-retest reliability**; **alternate-forms reliability**; **internal consistency reliability**.

- ***Validity***: **Validity** is related to whether a measure measures what it purports to; **content validity**; **criterion validity** (predictive, concurrent); **construct validity**.
- ***Changes in DSM-5***: Removal of the multiaxial system; organising diagnoses by causes; enhanced sensitivity to developmental nature; new diagnoses; combining diagnoses; ethnic and cultural considerations.

- Psychological Assessment:
  - ***Clinical interviews***: A **clinical interview** pays attention to the ways in which questions are responded to. A **structured interview** has questions set out in a prescribed fashion (Structured Clinical Interview/SCID).
  - ***Specific***: **Psychological tests** further structure the process of assessment. **Personality inventories** are self-reports that indicate habitual tendencies. Behavioural self-monitoring – self-monitoring; **ecological momentary assessment** (real time data collected when prompted).
- Neurobiological Assessment:
  - ***Imaging***: CT/MRI – structure; PET – function and some structure; fMRI – structure and function.
  - ***Neurotransmitter***: post-mortem analysis of neurotransmitters and receptors; assays of **metabolites**.
  - ***Neuropsychological assessment***: Behavioural tests to assess abilities.

WEEK 2: Indigenous and Multi-Cultural Mental Health

- Culture: Culture mediates how we see and experience the world. **Ethnocentrism** refers to making judgements about another culture according to the values/standards of one's own culture, leading to rigid/irrational generalisation and assumptions of inferiority. Solutions to address 'abnormal' are cultural practices, and "Indigenous/immigrant health" cannot exist unless defined in Western terms.
- Mental Health: PTSD seems to be the most common mental disorder suffered, and reactions can look difference in different cultural groups. Issues – onus on individual, pathologizes suffering, category fallacy (symptoms have different cultural meanings), no consideration of collective experience, masks social/moral imperatives. Personality disorder is also common, but there are issues in diagnosing "atypical behaviour". **Malignant grief** is the process of irresolvable, collective and cumulative grief that affects Aboriginal individuals and communities, causing them to lose function and ultimately leading to death. Substance abuse also figure predominately as a background factor to mental illness.
    - ***Reinforcing factors***: Collective sense of self, intimate connection with all aspects of life, importance of kinship and social roles, and spiritual beliefs. Anxiety is low for these reasons.
- Health: **Susto** – culturally specific ways of expressing particular concerns/stress, often with somatic symptoms; **khyal cap** (wind attack) – symptoms similar and atypical to panic attack.
- Explanatory Models of Illness: The **explanatory model** elicits the layperson/patients' view of the cause of condition, timing of symptom onset, pathological processes, history of malady, and appropriate treatments. Symptoms → appropriate healer and diagnosis → probable cause/treatment → success → continuation of symptoms leads to review and new treatments.

WEEK 3: Eating Disorders and Body Image

- Clinical Description:
  - **Anorexia nervosa**: 3 diagnostic criteria – restriction of behaviours that promote healthy weight, intense fear of weight gain, and distorted body image (amenorrhea used to be required). Severity ratings are based on BMI. Subtypes - **restricting** (limiting food intake) and **binge-eating purging** (regular engagement of these actions). Onset typically early/mid adolescence, often after an episode of dieting an occurrence of a life stress. *Prognosis* – 50-70% recover (6-7 years, relapses common initially); higher death rates. **Egosyntonic** refers to wanting the disorder.
  - **Bulimia nervosa**: episodes of rapid consumption (under 2 hours; loss of control) followed by compensatory behaviour to prevent weight gain; once a week for 3 months; often doesn't end in weight loss; *severity rating* depends on number of compensatory behaviours in a week (1-3 mild, 14+ extreme). Onset typically late adolescence or early adulthood; 90% women. *Prognosis* – 70% recovery.
  - **Binge eating disorder**: recurrent binges (once per week, 3 months), lack of control during episode, along with 3+ other characteristics (rapid eating, eating alone, until uncomfortably full or when not hungry, guilt/disgust); lack of weight loss and absence of compensatory behaviours; *severity ratings* – number binges per week (1-3 mild, 14+ extreme); *prognosis* – 25-82% recover.
- Aetiology:
  - ***Genetic factors***: Bulimia – 42% attributable to genetic factors, 58% to unique environmental factors. AN – a number of single nucleotide polymorphisms.
  - ***Neurobiological factors***: The **hypothalamus** is the key brain centre for regulating hunger and eating; **endogenous opioids** are produced by the body to reduce pain sensations, enhance mood, and suppress appetite (released during starvation and exercise), and may become positive reinforcers; *serotonin* promotes satiety, binges may result from deficit, food restrictions may result from interference; *dopamine* linked to rewarding aspects of food and motivation, with restrained eaters more sensitive to food cues (signalling salience).
  - ***Psychodynamic***: Disturbed parent-child relationship; failure to develop sense of self due to conflicting mother-daughter relationship.
  - ***Environmental***: Early menarche; maternal stress during pregnancy; premature birth.
  - ***Cognitive behavioural factors***: AN – emphasis on fear of fatness/body-image as motivation factors, and behaviours that achieve thinness negative reinforce (reduce anxiety) and positive reinforce (positive comments); **low positive emotion differentiation** refers to not being able to distinguish between emotional states well. BN/BED – purging temporarily reduces anxiety but lowers self-esteem, leading to inevitable cycle; may function as means of regulating negative affect, but actually introduces more negative emotions after binge.
  - ***Sociocultural factors***: The ideal for women is a thinner body, and for men is muscle mass. Appearance-related website exposure is related to body surveillance, etc.
  - ***Gender influences***: **Objectification theory** (ideal vs cultural self).
- Treatment: Antidepressants decrease compensatory behaviours, depression, distorted eating view (AN low response rate). AN – two-tiered process of immediate hospitalisation and operant conditioning; can combine family therapy and lunch meetings. BN – CBT challenges perception of thin and cognitive dissonance, and teaches assertiveness.