ABNORMAL PSYCHOLOGY

WEEK 1 LECTURE 1: INTRODUCTION

- Mental disorder implies abnormal behaviour that is not only statistically rare, unacceptable to society, causes distress and/or is maladaptive, but that it also stems from an underlying dysfunction or illness.
    - Abnormal behaviour is not necessarily a mental disorder
- For a behaviour resulting from an internal dysfunction to qualify as a mental disorder it needs an additional value component: it needs to be causing harm to the individual.
- DSM-5 have given an importance to culture in a way that previous editions have not- because of the influence of culture the whole concept of mental illness is invalid.
- Even if there is agreement on the concept of abnormality it is often applied inconsistently.
    - There are problems of definition and application
    - Abnormality is not black or white- there is a continuum.
- In order to constitute an abnormal behaviour, a behaviour needs to be one or more of the following:
    1. Statistical rarity- deviate from the average
    2. Deviant- different, extreme, unusual, socially unacceptable
    3. Distress- unpleasant and upsetting
    4. Dysfunction or maladaptive- causes interference with life- often incorporated in diagnostic criteria for the various mental disorders.
    5. Danger- poses risk of harm to self or others.

DIFFERENT WAYS TO UNDERSTAND ABNORMAL PSYCHOLOGY:

- Subjective interpretation- listen to what the person reports, their experiences and behaviour and match with diagnostic criteria.
- Objective tests- depends on scores on tests.

CULTURAL FORMULATION INTERVIEW

- A set of 16 questions which clinicians use to assess impact of culture on an individual's clinical representation.
- Includes experience of membership in diverse social groups- not only person's ethnic culture but also faith and occupational culture.
- Considers aspects of background that affect perspective e.g. migration, language, sexual orientation.
- Takes into account the influence of family friends and community on a person's illness and experience.

IMPORTANT TERMS:

- **PREVALENCE:** how many people in a population have the condition
- **INCIDENCE:** how many cases occur in a given period of time.
- **SEX RATIO:** percentage of men to women with disorder
- **COURSE OF CONDITION:** chronic v episodic v time limited

- **ONSET:** acute v insidious. Age of onset.
- **PROGNOSIS:** Anticipated course of disorder
- **ETIOLOGY:** study of origins.

HISTORICAL DEVELOPMENT OF NOTION OF ABNORMAL BEHAVIOUR:

1. Super-natural
    - In the stone ages
    - Possible causes: demons, ghosts and evil spirits; moon and stars affect mental health; mental illness as punishment from god; imbalance of yin and yang.

2. Biological
    - Mental illness explained by physical causes
    - Ancient Egypt- used hysteria to explain illness in women
    - Hippocrates conceptualised mental illness as a brain or hereditary disease.
    - Prior to 20th century- mental illness was equated with insanity and people were treated in mental asylums often by non-medically trained individuals.
    - Believed insanity to be a single disease that progressed from one major symptoms to another over time.
    - Many doctors believed that all mental disturbances would eventually be identified as having a biological origin, in the form of some bacterial or viral infection, contact with toxic agents or structural brain abnormalities.

3. Psychological
    - Mental illness explained by psychological processes (manner in which people interpret the environment, their conscious or unconscious beliefs and motivations, or their learning history)
    - Approach we are most concerned about today

CURRENT PSYCHOLOGICAL MODELS OF ABNORMALITY:

MODEL	**CAUSE**	**GOAL OF THERAPY**	**TREATMENT**	**CRITICISM**
PHYSIOLOGICAL	Genetics, damage to brain, altered neurochemistry	Remove source	Drugs, ECT, diet and exercise.	Reductionist -possibility of relapse when terminating drugs
PSYCHODYNAMIC	Unconscious processes- people adopt strategies to avoid anxiety e.g. repression, denial,	Making the unconscious conscious through psychoanalysis e.g. recalling	Interpretation of unconscious clues via free association, dream analysis, analysis of	Exclusion of environmental and cultural factors.

	projection, reaction formation.	emotional trauma	resistance in therapy, analysis of transference.	
COGNITIVE BEHAVIOURAL	Faulty learning and aberrant thought patterns- Possible interpretations of event lead to different emotional and behavioural responses. Individuals adopt cognitive distortions.	Change thinking and behaviour- those that are not working for the patient.	Classical, operant conditioning, modelling. Identifying and challenging irrational and maladaptive thoughts.	Focus on cognitions and behaviour at the expense of emotion. Emphasis on present rather than past.
HUMANISTIC	Incongruence or discrepancy between self-image and experience or behaviour.	Humans choosing and searching for meaning- self-actualisation.	Approach therapeutic relationship with unconditional positive regard (rogers), motivation for behaviour is meeting needs (Maslow), gestalt techniques (perls).	How to explain deviant behaviour.
SOCIO-CULTURAL & SYSTEMIC	Focus on the whole rather than the parts. Individual in relationship with others. Discord between parts of system.	To change to a more functional system with more diversity.	Working with internal system (holistic approaches), & external system e.g. family to develop more adaptive interactions.	

- Depending on disorder some models and treatment paradigms seem to have better success.