PSYC3102 PSYCHOPATHOLOGY

Semester 1, 2018

Lectures 1 – Lecture 12

1. Introduction
2. Models of Psychopathology
3. Schizophrenia
4. Anxiety-Related Disorders
5. Mood Disorders
6. Somatic Symptom and Dissociative Disorders
7. Neurocognitive disorders
8. Sexual Dysfunction, Gender Dysphoria & Paraphilic
9. Intellectual Disability & Autism Spectrum Disorder
10. Psychological Factors & Medical Conditions
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Contents

Lecture 1: Introduction

Introduction: History, Classification, Assessment

What is Abnormal Psychology?

Scientific study of behaviour with four main objectives:

1. **Describing** evident behaviours – fulfilling criteria for a disorder
2. **Explaining** why behaviour/a disorder is evident
3. **Predicting** outcome
4. **Managing** behaviours that are considered problematic

Concepts of Abnormality

- **Relativist view.** Symptoms & causes vary across cultures
- **Absolutist view.** A disorder is caused by the **same biological factors**

How do you define abnormalitiy?

- Cultural plays a role in developmental abnormality
- Behaviour – deviantly, dangeriously or dysfunctionally abnormal?
- Behaviour cause distress or dysfunction for the individual or others?
- Duration, intensity and frequency
- Why they develop in certain people compared to others?

Elements of Abnormality

1. Personal suffering
2. Maladaptiveness
3. Irrationality and incomprehensibility
4. Unpredictability and loss of control
5. Level of emotional distress
6. Interference in daily functioning
7. Vividness and unconventionality
    a. Deviations from the norm (developmental, societal & cultural)
8. Observer discomfort
9. Violation of moral and ideal standards

Defining Abnormal Behaviour

DSM-5

- Focuses on **symptoms** and **scientific basis** for disorders
    - **Clinical presentation** – What specific symptoms cluster together?
    - **Aetiology –** What causes the disorders?
    - **Developmental stage** – Does the disorder look different for children & adults?
    - **Functional impairment** – Immediate and long term consequences
- **Mental disorders involve one or all of the following:**
    - Present distress
    - Disability (impairment in one or more areas of functioning)
    - Significant risk of suffering death, pain, disability, or an important loss of freedom

Is Mental Illness a myth?

- Thomas Szasz

    - MI = “problems in living“
    - A means of social control
- Labelling can be misused:
    - ‘Drapetomonia’
    - ‘ADHD’?
- Clinical labelling leads to stigma and discrimination.
- Middle Ground?

Distinctions	Professional Practice Requirements for Psychologists
Psychiatrist	**APS Membership** APS approved six year degree and two years’ supervised experience
Clinical Psychologist	
Psychoanalyst	**APS College of Clinical Psychologists Membership** Approved post-graduate degree in clinical psychology + two years supervised experience
Psychotherapist	
Counselling Psychologist	**Registration: Psychologists Board of Australia** Approved four year degree + two years supervised experience OR Approved four year degree and post-graduate degree.

Epidemiology

Definition: The study of the frequency & distribution of disorders within a population

- **Incidence.** Number of new cases of a disorder that appear in a population within a specific time period
- **Prevalence.** Total number of active cases in a given population during specific period of time
    - **Life-time prevalence** = proportion of population affected **at some point** during their lives
- **Comorbidity.** More than one condition

Epidemiology: Australia/QLD Statistics

- **1 in 4** suffer mental disorders during their lifetime
- Over ½ million Qlders suffer with a mental disorder that significantly interferes with their daily lives
- 1 in 4 Qlders who visit a GP do so for mental health reasons
- 100 Australians attempt suicide every day
    - 2,361 Australians committed suicide in 2010 (ABS, 2012)
    - 77% were males
    - 35-44 years highest suicide rates

History of Psychopathology

The Ancient World

- Supernatural explanations prevailed except in Greece
- Hippocrates (5th C. BC) classified mental disorders into three categories:
    1. Mania
    2. Melancholia
    3. Phrenitis (brain-fever)
- **All** forms of disease had natural causes:

- Imbalance in essential fluids
  - Blood, phlegm, yellow & black bile
  - Treatment procedures focused on restoring balance

The Middle Ages

- After fall of Roman Empire, efforts to discover natural causes virtually ceased
- Religion dominated supernatural view
- Abnormal behaviour interpreted as the work of the devil or witchcraft (exorcisms)
- Wars, peasant revolts & plagues: "evil forces"
  - Persecution of people viewed as promoting or hosting the devil
  - Many with mental disorders treated like witches

The Renaissance (14^{th} – 17^{th} centuries)

More **humane view** of the mentally ill

Critics of demonology:

- Paracelsus – Stars & planets affected the brain
- Weyer – First physician to **specialise** in the treatment of mental illness
- Search for effective treatments begun

Led to the development of asylums

- By mid-16^{th} C. asylums established (e.g., London's Bethlehem Hospital)
- 'Treatment' consisted of confinement (shackles, chains, isolation in dark cells), torturous practices (ice-cold baths, spinning in chairs, severely restricted diets) and medical treatments (bloodletting, purgatives)

19^{th} century & the Beginning of Modern Thought

Moral treatment

- American & French Revolutions Individual rights
- Humanitarian ideas characterised this age
- Reforms in the care of people with mental disorders:
  - Philippe Pinel
  - People started to improve

Pinel's Classification System (late 19^{th} century)

1. Melancholia
2. Mania
3. Mania with delirium
4. Dementia
5. Idiotism

Kraepelin and the German Classifiers (1920s)

- Kraepelin:
  1. Dementia praecox
  2. Manic depressive psychosis
- Around the same time:
  - Syphilis General paresis Search for biological causes

Somatic Treatments

TABLE 1.3
Somatic Treatments Introduced and Widely Employed in the 1920s and 1930s

Name	Procedure	Original Rationale
Fever therapy	Blood from people with malaria was injected into psychiatric patients so that they would develop a fever.	Observation that symptoms sometimes disappeared in patients who became ill with typhoid fever
Insulin coma therapy	Insulin was injected into psychiatric patients to lower the sugar content of the blood and induce a hypoglycemic state and deep coma.	Observed mental changes among some diabetic drug addicts who were treated with insulin
Lobotomy	A sharp knife was inserted through a hole that was bored in the patient's skull, severing nerve fibers connecting the frontal lobes to the rest of the brain.	Observation that the same surgical procedure with chimpanzees led to a reduction in the display of negative emotion during stress

Note: Lack of critical evaluation of these procedures is belied by the unusual honors bestowed upon their inventors. Julius Wagner-Jauregg, an Austrian psychiatrist, was awarded the Nobel Prize in 1927 for his work in developing fever therapy. Egaz Moniz, a Portuguese psychiatrist, was awarded the Nobel Prize in 1946 for introduction of the lobotomy.

- Medical model for mental disorders now particularly relies on <u>medication</u>

The Psychoanalytic Revolution

- Franz Mesmer (late 18th C): Neurologist who identified hysterical disorders and treated them with hypnosis
- **Freud**
  - Trained by Jean Charcot; Influenced by hypnosis work
- Joseph **Breuer**
  - Hypnosis **+ catharsis**
- **Freud**
  - Free association
- **"Studies in Hysteria"** (1895) Freud & Breuer marked the beginning of the psychoanalytic revolution
  1. Psychological factors affect behaviour
  2. Talking treatment more effective than harsh physical & moral treatments
  3. Behaviour influenced by thoughts, impulses & wishes we may be unaware of
  4. Non-psychotic disorders are worthy of treatment

Biopsychosocial Framework

- **Abnormal behaviour reflects a combination of:**
  1. Biological factors
  2. Psychological factors
  3. Social factors
  4. Environmental factors
- Since **each individual is unique**, no single model can fully explain the presence of abnormal behaviour
  - **Many different factors** contribute to illness as a "whole"
- Culminates in the **diathesis-stress** framework

Advances in Treatment

- **Behavioural therapies**
  - Behaviour therapy
  - Cognitive and behaviour therapy (CBT)
  - CBT + Mindfulness and acceptance therapy
- **New psychotropic drugs (30s and 40s)**

    - Many are essentially tranquilisers
    - Mostly serendipitous; Subdued people
- **Led to deinstitutionalisation (70s)**
- Out-patient psychiatric clinics: focus on management
- Community mental health centres: focus on rehabilitation

Current View

- Behaviour must always be considered within the context in which it occurs.
- To understand abnormal behaviour it is best to adopt a scientist-practitioner approach.
- A variety of theories exist surrounding the development of abnormal behaviour; however, it is best to incorporate a holistic or multidisciplinary approach to both the development of and treatment of abnormal behaviour.

Diagnosis and Classification

Symptom

- A manifestation of pathological condition. In some uses of the term it is limited to subjective complaints - also includes objective signs of pathological conditions (e.g., mood)

Syndrome

- A group of symptoms that occur together that constitute a recognisable condition.
- In DSM-5 most disorders are syndromes

Classification system

- List of conditions with a description of the symptoms characteristic of each & guidelines for assigning individuals to categories

Classification

Purposes

1. Enables clinicians to diagnose a person's problem as a disorder
2. Information retrieval
3. Facilitates research
4. Facilitates communication
5. Facilitates treatment selection (sometimes)

Problems with classification?

- Categorical vs. dimensional approach

Development of Diagnostic Nomenclature

- **18th & 19th century** - Pinel's classification system
- **20th century** - Kraepelin
- **Mid-1930s** psychiatric classification system developed by hospital superintendents
- **1941** classification system developed for soldiers from war
- **1949** Mental disorders in 6th edition of the International Classification of Diseases (ICD-6) WHO (now ICD-11)
- **1952** Diagnostic Statistical Manual of Mental Disorders, APA
    - 1968 DSM-II
    - 1980 DSM-III
    - 1987 DSM- III-R
    - 1994 DSM-IV
    - 2013 DSM-5