Week #1 – Classification & Diagnosis

3 Categories in the Conceptualisation of Abnormality

Psychological Dysfunction: Refers to a breakdown in cognitive, emotional or behavioural functioning. Knowing where to draw the line between normal/ abnormal dysfunction can be difficult, so these problems are often considered to be on a continuum or dimensions rather than categories of present or absent. This is why, having dysfunction alone is not enough to meet the criteria for a psychological disorder.
Distress or Impairment: The behaviour must be associated with distress to be classified. This alone is not enough for diagnosis, furthermore there are some conditions where suffering/ distress are absent.
Atypical or Not Culturally Expected: Violating social norms or deviating from the average.

Common definition of Psychological Disorders:

Behavioral, psychological, or biological dysfunctions that are unexpected in their cultural context and associated with present distress and impairment in functioning, or increased risk of suffering, death, pain, or impairment.
+It is never easy to decide what represents dysfunction, and some scholars have argued that health professionals will never be able to satisfactory define disease or disorder.

The Scientist-Practitioner Approach to Psychology

The most important development in the recent history of psychopathology. The adoption on scientific methods to learn more about the nature of psychological disorders, their causes and their treatment. Psychologists may function as a scientist-practitioner in one or more of three ways..
1. Keep up with the latest scientific diagnostic and treatment procedures
2.Evaluate their own assessments or treatment procedures to see whether they work.
3. Conduct research, often in clinics or hospitals that produce new information about disorders and their treatment.

Clinical Descriptions

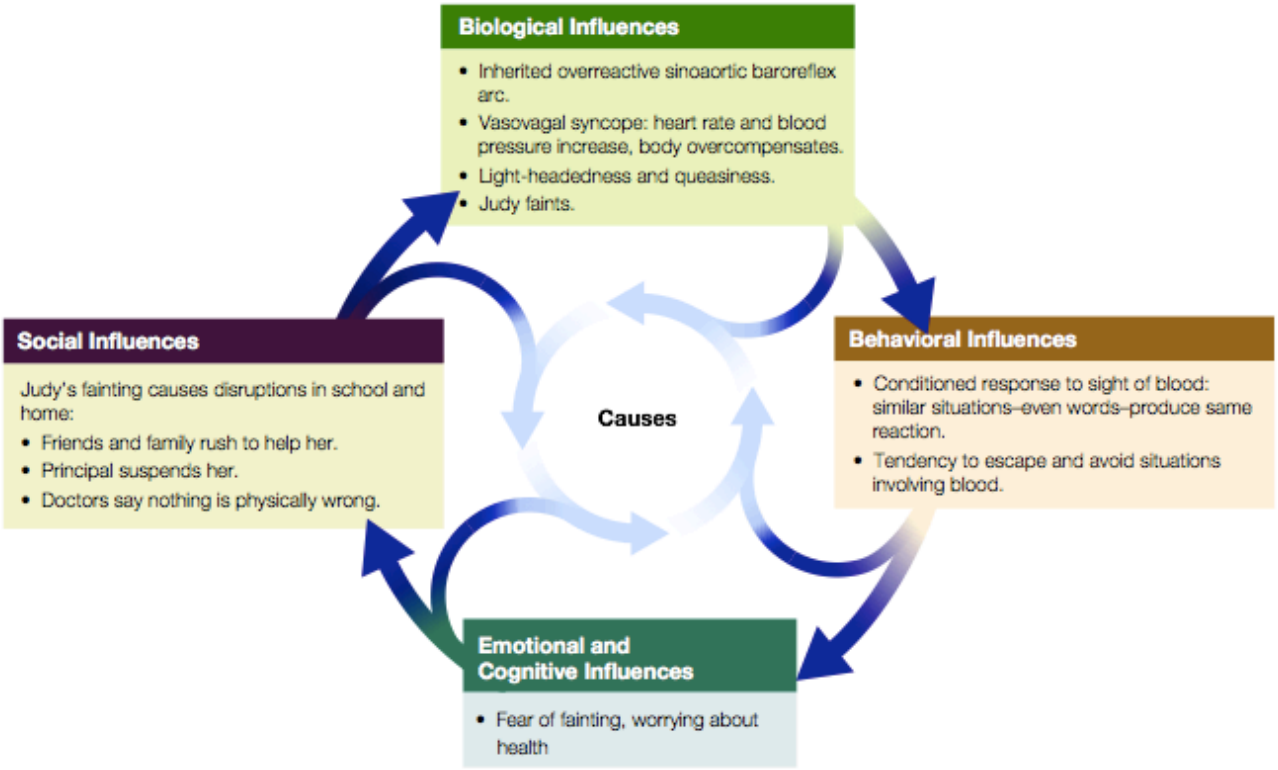
+In hospitals or clinics we say that a patient 'presents' with a problem or we discuss the 'presenting problem'
+ Describing the person's presenting problem is the first step in determining her clinical description
+ Prevalence: How many people in the population as a whole have the disorder
+ Incidence: How many new cases occur during a given period.
+ Prognosis: The anticipated course of a disorder, so we might say "the prognosis is good" or "the prognosis is guarded".

One Dimensional models of Psychopathology

Says that psychopathology is caused a physical abnormality or by conditioning, which attempts to trace the origins of behaviour to a single cause. We still

encounter this form of thinking, however most scientists and clinicians believe that behaviours are a result of multiple influences.
+ Ignores critical information

Multidimensional Model of Psychopathology
Causes of disorders are eclectic and integrative, because any one component of the system inevitable affects the other components, forming a complex network.



Genes
Long molecules of deoxyribonucleic acid (DNA) at various locations on chromosomes, within the cell nucleus.
Genes and Behaviour
Best estimates attribute about half of our enduring personality traits and cognitive abilities to genetic influence. Twin studies determined that during adulthood, genetic factors were responsible for stability in cognitive abilities, whereas environmental factors were responsible for any changes. It has also become clear that adverse life events such as a chaotic childhood can overwhelm genetic influence. Evidence suggests that genetic factors make some contribution to all disorders but account for less than half of the explanation.
Genes and the Environment
Eric Kandel suggested that the very genetic structure of cells may change as a result of learning if genes that were inactive or dormant interact with the environment in such a way that they become active. Competing ideas suggest that the brains plasticity is subject to continual change in response to the environment, even at the level of genetic structure.
The Diathesis-Stress Model: Individuals inherit tendencies to express certain traits or behaviours, which may then be activated under conditions of stress. Each inherited tendency is a *diathesis*, which means a condition that makes

Week 7 – Schizophrenia and Other Psychotic Disorders

History of diagnosis of Schizophrenia

Kraepelin

- Gives what stands today as the most enduring description and categorization of schizophrenia
- Combined several symptoms of what were previously referred to as insanity that usually reflected separate and distinct disorders: catatonia (immobility and excited agitation), hebephrenia (silly and immature emotionality), and paranoia (delusions of grandeur or persecution)
- Included all these symptoms under the Latin term dementia praecox
- People with dementia praecox: distinguished dementia praecox with manic depression.
- Different age of onset and a poor outcome (which was different to manic depression), and included symptoms such as hallucinations, delusions, negativism, and stereotyped behaviour

Bleuler

- Introduced the term schizophrenia
- Belief that underlying all the unusual behaviours shown by people with the disorder was associative splitting of the basic functions of personality
- Believed that a difficulty keeping a consistent train of thought characteristic of people experiencing the disorder lead to the many and diverse symptoms they displayed
- Thus, inability to keep a consistent train of though was the universal underlying problem

Major Clinical Symptoms of Schizophrenia

- Psychotic behaviour: used to characterize many unusual behaviours, and usually involves delusions (irrational beliefs) and or hallucinations (sensory experiences in the absence of external events)
- Can affect all the functions we rely on each day
- Schizophrenia spectrum disorder – different variants included within this spectrum, currently used by the DSM5
- DSM5 includes schizophrenia, as well as other related psychotic disorders that fall under this heading, including schizophreniform, schizoaffective, delusional and brief psychotic disorders, as well as a personality disorder (schizotypal personality disorder) is included under the umbrella category of schizophrenia spectrum disorders
- Positive symptoms – generally refer to symptoms around distorted reality
- Negative symptoms – deficits in normal behaviour in areas such as speech, blunted affect, and motivation
- Disorganized symptoms – include things such as rambling speech, erratic behaviour, and inappropriate affect
- A diagnosis requires that two or more positive, negative and/or disorganized symptoms be present for at least 1 month, with at least one of these symptoms including delusions, hallucinations, or disorganized speech

- The DSM5 further includes a dimensional assessment which rates the severity

Positive Symptoms

- Include the more obvious signs of psychosis
- Delusions
    - Disorder of thought content – or a delusion
    - Delusions of persecution – that others are 'out to get them'
    - Other delusions include Capgras syndrome – where the person beliefs someone they know has been replaced by a double
    - Cotards syndrome – belief that they are dead
    - Motivational view of delusions – would look at these beliefs as attempts to deal with and relieve anxiety and stress
    - A deficit view of delusion – sees these beliefs as resulting from brain dysfunction that creates these disordered cognitions or perceptions
- Hallucinations
    - The experience of sensory events without any input from the surrounding environment
    - Hallucinations can involve any of the senses
    - Auditory hallucinations – most common experience of hallucinations
    - Auditory hallucinations appear to be related to metacognition (or thinking about thinking)
    - People who experience hallucinations appear to have intrusive thoughts, but they believe they are coming from somewhere or someone else. They then worry about having these thoughts and engage in meta worry, which has been linked to increased anxiety and depressive symptoms for those suffering from hallucinations
    - The part of the brain most active in hallucinations was Broca's area, which is known to be involved in speech production, rather than language comprehension
    - This then supports the metacognition theory
    - A further possible explanation is poor emotional prosody comprehension, which is an aspect of our spoken language that communicates meaning and emotion
    - Suggests that emotional prosody is deficient in persons with auditory verbal hallucinations when interpreting inner voices

Negative Symptoms

- Usually indicate the absence or insufficiency of normal behaviour which often includes apathy, poverty of thought or speech and emotional and social withdrawal
    - Avolition – inability to initiate and persist in activities. Show little interest in performing even the most basic day to day functions, including those associated with personal hygiene
    - Alogia – refers to the relative absence of speech. Believed to reflect a negative thought disorder, where patients may have trouble finding the right words to formulate their thoughts. Further, it may
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Week 11 – Cultural Approaches to Psychopathology

Relevance of the cultural perspective

Culture – the values, norms, and similarities between a group of people that bring them together

- Cultural factors: language, dialects, parts of country the person may be from (how this impacts their wellbeing), resources, traditions, values they have in leading life (hospitality), religion (forced/choice), everyday engagements
- All of these help us in making an etiology specific for the person
- Need to look at how the person describes the condition
- Looking for all these factors to manage diagnosis

Essentialness of 'cultural lens'

- Must recognize that Australia is a multicultural society
- Many different languages spoken, with different cultures
- Impacts of cultural background on wellbeing
- Currently use a western model in etiology of psychology
- Must recognize this may not be efficient
- Need to be gathering more data regarding culture
- May miss out on information if we are not using such data

When/how culture should influence assessment and diagnosis

- Always think about culture when speaking to the client
- Must also always be using evidence based findings in assessment and intervention in relation to which methods work for a particular person
- Everyone's culture could influence their behavior and pathology – including western cultures
- Culture however should not be exclusively used for diagnosis
- Expressions of symptoms may be similar across all cultural groups

Differences in assessment and diagnosis on culture

- How culture may exacerbate a certain disorder
- Triggers of psychopathology – violence in media on aggressive behavior in children and adolescents
- Higher/lower levels of severity, depending on help-seeking behavior. Certain cultural factors may infringe on a person's ability to seek help (ostracism)
- People who are more likely to seek help – level of severity reduced
- Agents in the expression of clinical symptoms – some cultures may be less likely to present symptoms, making it more hidden
- Decisive factors in intervention

DSM-5 culturally relevant diagnosis

The DSM5 has a limited use of culture

- There is no specific information on the extent to which cultural background influenced pathology
- Some information in the DSM5 – however it is still limited. Still a lack of specific information