PSYC 30014
Psychopathology in Everyday Life

CONTENT

Lecture 1: Introduction to Psychopathology

A. Definitions

1. **What is 'normal'?**
   a. Being typical/ majority?
   b. Autonomous functioning?
   c. Accurate reality perception? – experience generally agreed upon
   d. Regulated mood? – in control of emotion
   e. Adequate interpersonal relationships?
2. **What is 'abnormal'?**
   a. Statistical infrequency – don't occur very frequent
   b. Norm violation – behavior that is contrast to a norm at a given culture at a given time
      i. Emphasizing being 'in' – shouldn't have to conform/fit it
      ii. Context should change, but not the person
   c. Personal distress
      i. Are there some states of psychopathology that aren't related to distress?
         - E.g. Mania in bipolar disorder, substance dependency → do not feel distressed, feel good and in control
   d. Disability/dysfunction
      i. 'Drapetomania' = behaviour indicating a 'pathological' desire to escape slavery → 'abnormal' to want to escape since these slaves have food and shelter
   e. Problematic to define normality/abnormality by only one of these aspects → Need to consider most/all
3. **What is 'psychopathology'?**
   a. A descriptive term used to describe behaviour, thoughts (cognition), feelings, and experiences, which are indicative of mental illness, even if they do not constitute a formal diagnosis (clinical description)
      i. Even if it is not severe/ frequent enough to meet criteria to warrant a formal diagnosis
   b. The study (e.g. PSYC30017) of the nature, causes and development of abnormal behaviour, thoughts, feelings and experiences.
   c. For clinicians, considerations of psychopathology cover three aspects:
      i. Clinical Description
      ii. Causation (Aetiology) – Contextualize how it has been developed
      iii. Treatment and Outcome
4. **What is a 'Mental Disorder'?**
   a. DSM-5:
      i. "clinically significant disturbance in an individual's cognition, emotion regulation or behaviour…usually associated with significant distress or disability in social, occupational or other important activities"
         - clinically significant: severe and frequent enough to impact on the person
         - usually, NOT always
      ii. "an expectable or culturally approved response to a common stressor or loss, such as the death of a love one, is not a mental disorder."
         - Depressive disorder VS. grief
5. **Why should we classify psychopathology (diagnosis classification e.g. DSM-5)?**
   a. Communication – among clinicians/students, between science and practice
   b. Clinical – facilitate identification of treatment, and prevention of mental disorders, descriptive of experience, possible etiology and prognosis.
   c. Research – test treatment efficacy and understand etiology
   d. Education – teach psychopathology
   e. Information Management – measure and pay for care
      i. DSM-5 gives us a common language to speak
      ii. budget per case → Distribute funds effectively
6. **Why shouldn't we classify psychopathology?**
   a. Bias or restricted thinking – Diagnostic boundaries are not always distinct and diagnoses may change over time
      i. Need time to develop trust and familiarity to disclose information and understanding that is enough to diagnose psychopathology
      ii. Disorder itself change overtime e.g. psychoses and eating disorders → restrict your thinking about patient
   b. Associated with in-group jargon – Are clinicians in fact talking about the same construct?
      i. Jargon can influence this to more or less an extent
   c. Inhibit research – Fuzzy diagnostic boundaries and external validity of pigeon hole research.
      i. A lot of in terms of symptomatology (co-occurrence of symptoms of more than one disorder) e.g. depression shows symptoms schizophrenia

d. Stigmatising and implications for the self – How does this affect existing experience?
    i. Risk of stigma – not necessary the specific label
    ii. Implication of perceiving a diagnosis for patients – what they will be able to do for the rest of their life
e. Some institutions and people contend that mental disorder is a myth
    i. i.e Scientology, Thomas Szasz: perpetuated by big pharma to support the industry of psycho/pharmaceutical industry
    ii. General thesis: Psychology and psychiatry rely on the assumption that emotional distress, and family and personal turmoil are diseases is an unproven hypothesis that is actively promoted by drug companies, among others.
f. Question "boundaries of madness"
    i. i.e. R. Bentall
    ii. Boundary between disorder and no-disorder is not clear cut
    iii. Better ways to think of pathology than diagnosis/classification perspective

B. Terminology

1. Presenting problem
    a. All the problems described when someone comes to see you (clinician)
2. Clinical picture or clinical description
    a. What clinician would work out based on their observation and what the person says collectively, taking it all in context in terms of diagnostic formulation and etiological formulation (case formulation)
3. Prevalence
    a. Proportion of population with a disorder
    b. Epidemiology data: all compare male and female → perpetuate the historical binary experience and conception of gender; gender is not just binary construct but multi-dimensional
4. Incidence
    a. New cases over a time period
    b. a given time period – ~1 year generally
5. Age of onset
    a. Age when symptoms first start for a person
6. Acute onset
    a. When the onset of symptoms of disorder happens very quickly
7. Insidious onset
    a. onset of symptoms happens over time
8. Course – episodic, recurrent, chronic, time-limited
    a. Course = how the disorder manifests overtime for a person
    b. Episodic course = periods of wellness and illness overtime
    c. Recurrent/ chronic course = more treatment-resistant, unrelenting
9. Prognosis
    a. Prediction of what will happen to the person as regards of mental health recovery
10. **Signs**
    a. Objective findings OBSERVED by a clinician
    b. E.g. behaviour, Tachycardia, accelerated speech, poor eye contact
11. **Symptoms**
    a. Subjective complaints EXPERIENCED / REPORTED by a patient
    b. Feelings, thoughts
    c. E.g. Low mood, derealisation, paranoia
12. **Syndrome**:
    a. Signs, symptoms and events that occur together in a systematic pattern that indicates the existence of the CONSTRUCT OF A DISORDER
    b. E.g. Bipolar disorder, Schizophrenia
13. **Disorder**
    a. A syndrome which can be discriminated from other syndromes. according to a characteristic pattern of presentation
    b. To be labelled a disorder = there is a distinct course to the syndrome and the age and gender characteristics of the disorder have been described. In some cases, prognosis may also be known.
14. **Disease**
    a. For a disorder to be labelled a disease, there has to be indications of abnormal physiological processes or structural abnormalities i.e. unknown physiological cause
    b. E.g. multi-infarct dementia.

C. Method to Study Psychopathology

1. Assessment of psychopathology **(Context is important)**
    a. Pen and paper tests
    b. Clinical interviews
        i. The more structured i.e. script-like the interview is, the more reliable the diagnosis will be
    c. Behavioural assessment
    d. Activity Diaries
    e. Psychological tests, e.g. MMPI
    f. Medical tests
    g. Psychophysiological tests
    h. Neuropsychological tests

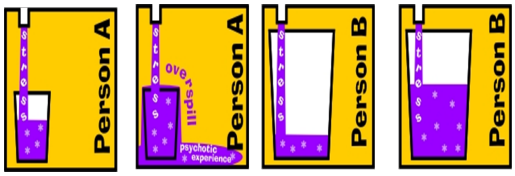
D. Classification Systems of Psychopathology

1. Two primary approaches to classification of mental disorder

    a. Categorical:
        i. Divides psychological disorders into categories based on criteria sets with defining features
        ii. Advantages
            - Better clinical and administrative utility - clinicians are often required to make dichotomous decisions
            - Decision to facilitate treatment
            - Easier communication
    b. Dimensional:
        i. Aspects of psychopathology are quantified on a scale i.e. Continuum
        ii. Advantages
            - Give a lot more information than categorical system → contextualization
            - Closely model lack of sharp boundaries between disorders and normality
            - Greater capacity to detect change, facilitate monitoring
            - Can develop treatment-relevant symptom targets- not simply aiming at resolution of disorder
                - Most treatments actually target symptoms, not disorders
                - DSM-5 is the first step towards including dimensional conceptualization of psychopathology
2. Historical Development of classification systems
    a. 1856-1926: Emil Kraepelin released *Psychiatry: A textbook*
        i. first classification of psychopathology → provided criteria based on clinical observation
        ii. Described dementia praecox, manic depressive illness, and paranoia
            - Dementia praecox = schizophrenia
        iii. Described 10 subtypes of dementia praecox - each reflecting different symptom profiles (Catatonia, hebephrenic etc.)
    b. 1948: WHO added mental disorders to ICD-6
    c. 1952: APA published first edition of DSM
        i. Rooted in psychodynamic theory
        ii. Psychotic Disorders and Neurotic Disorders
    d. 1968: DSM-II
    e. 1969: ICD-8
    f. 1980: DSM-III
        i. Atheoretical approach
        ii. Criteria became more (very) specific, structured, narrow
        iii. Multiaxial system developed
        iv. DSM III onwards: Evidence-based; focus on clinical practice; diagnosis classification is based on the presenting problems VS DSM & DSM II: theoretical focused; what might have given rise to the experience
    g. 1987: DSM-III-R
    h. 1994: DSM-IV
    i. 2000: DSM-IV-TR (Text revision)
        i. 5 subtypes of schizophrenia
    j. 2013: DSM5
        i. Banned subtypes of schizophrenia because it wasn't reliable and didn't have good utility (reliability and validity of schizophrenia)
3. DSM diagnoses are "constructs" as they are inferred, not proven, entities
    a. Diabetes: proven disease entity with a known biological cause
    b. Schizophrenia: defined by proposed criteria and incomplete understanding of cause

E. Models of Psychopathology

1. Biological Paradigm
    a. Genetics
    b. Structural brain damage
    c. Disordered physiology e.g. inflammation processes and depression
    d. Neurochemistry
    e. Functional connectivity impairments: e.g. schizophrenia.
2. Learning Models
    a. Social and developmental factors
    b. Learned behaviour
        i. Bandura's social learning theory
        ii. Operant behaviour
        iii. Classical conditioning models
        iv. Cognitive models of varying degrees of complexity and depth
3. Psychoanalytic Paradigm
    a. Structure: E.g. Id, ego and superego
    b. Stages of psychosexual development: E.g. oral, anal, phallic, and latency stages
    c. Subconscious defence mechanisms: E.g. projection, splitting, denial
4. Stress-diathesis models



    a. Diathesis + Stress → experience psychopathology
        i. Diathesis: we all have a more or less degree of vulnerability for psychopathology (often in terms of personality)
        ii. Stress: Commonly life events, and not just negative ones
            - The number/magnitude of life stress that could give rise to psychopathology, is relative to the amount of vulnerability that you have
    b. Resilience: an associated important factor
        i. Balance the scale
        ii. Well-being
5. Cognitive Models

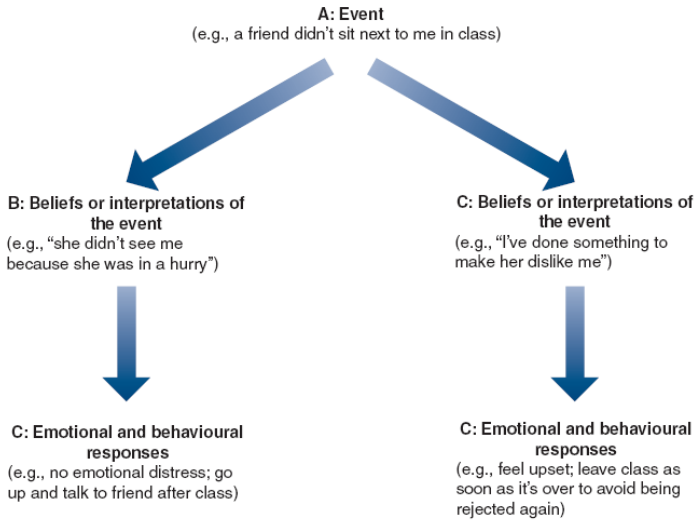


Figure 1 **According to the ABC Model, it is the individual's interpretation of an event (rather than the event itself) that results in emotional and behavioural responses. As a result, different interpretations of the same event can result in different emotional and behavioural responses.**

    a.
    b. ABC Model: How we feel is based on what we think about things that happened – adaptively / maladaptively
6. Biopsychosocial Models
    a. Embedded as the core approach – How most clinicians would approach psychopathology
    b. Understand mental disorder integrates a range of factors:
        i. Biological: normal biology, disease processes and genetic influences
        ii. Psychological: thoughts, feelings and perceptions
        iii. Social/Environmental: culture, ethnicity, social environment

F. Models of Dimensional Approaches to Mental Disorder

1. Clinical Staging Model (McGorry, et al. 2006)
    a. Development of Model
        i. Adopted from cancer staging (stages reflecting disease – here disorder – progression)
        ii. Based on observations in schizophrenia
    b. Aims
        i. Define various stages of the development of disorder
            - Think in Continuum based way but still have discrete sections along that continuum that comment upon the development of the disorder
        ii. Facilitate early identification of disorder and intervention
            - In most cases, mental disorders develop over time with worsening severity
            - Preventive focus: central goal is to stop emergence of first episode of disorder
            - If complete prevention is not possible, then the aim is to prevent progression to later stage, prevent worsening and poor prognosis
        iii. Use more universal interventions that are less costly, less harmful and less intense at earliest stages
            - E.g. psycho-social intervention – relatively low intensity
    c. Stages
        i. **0** = increased risk of psychotic disorder but no symptoms currently
        ii. **1a** = Mild or non-specific symptoms, including neurocognitive deficits of psychotic disorder; mild functional change or decline
        iii. **1b** = Ultra high risk moderate but sub-threshold symptoms, with moderate neurocognitive changes and functional decline to 'caseness' (GAF <70)
        iv. **2** = First episode of psychotic disorder: full threshold disorder with moderate symptoms, neurocognitive deficits and functional decline (GAF 30-50)
        v. **3a** = Incomplete remission from first episode of care (could be linked or fast tracked to Stage 4)
        vi. **3b** = Recurrence or relapse of psychotic disorder, which stabilises with treatment at a level of GAF, residual symptoms, or neurocognition below the best level achieved following remission from first episode
        vii. **3c** = Multiple relapses, provided worsening in clinical event and impact of illness is objectively present
2. Transdiagnostic Model
    a. Recognition of SHARED aetiological and maintenance factors
        i. A move away from notion that each type of mental illness is associated with ONE unique underlying cognitive and potentially neurological factors
        ii. Thinking about symptoms themselves rather than psychopathology as a disorder where symptoms are clung together
    b. May account for high levels of comorbidity between disorders
        i. Need to account for why this symptom occurs across various disorders
        ii. E.g. anxiety and depressive disorders
    c. May provide an explanation why diagnostic specific therapies not effective for all sufferers
        i. E.g. repetitive negative thoughts → anxiety/depression;
        ii. E.g. perfectionism → depression, anxiety, and eating disorder