Week 1: Introduction to Abnormal Psychology

Abnormal Psychology

- Defining ‘abnormal’ is difficult as it is subject to what people perceive as being normal and not normal.
- Knowledge of what is abnormal thus guides intervention, funding, and support.
- Frequency (abnormal): statistical rarity.
- Norm deviation (abnormal): being, thinking, or behaving differently to everyone else.
- Risk (abnormal): behaviour that is dangerous to oneself/others.
- Distress (abnormal): personal dissatisfaction.
- Dysfunction (abnormal): when symptoms impede every day life, work, relationships, etc.
- Contemporary views are eclectic and integrative, and borrow from multiple perspectives.

The Biological Perspective

- Based on observations that mood is effected by by neurological and neurochemical changes e.g. brain injuries.
- **Abnormality** as having singular biological cause and treatment e.g. spots + fever = measles (treat with A), spots + no fever = appendicitis (treat with B).
- **Example:** balancing the four humours: blood, phlegm, yellow bile, and black bile.
- Early medical interventions had no real understanding between cause and symptoms e.g. cold baths and teeth pulling for psychosis.
- Influence structural or chemical functions.
    - Chemical: serotonin + dopamine = the big ones.
        - Medications are very common.
    - Structural: surgery , ECT, etc.
        - Reserved from extreme cases; comparatively rare.

- Medical interventions = painting with a bucket.
    - Variety of side effects to any medical intervention.

Psychological Models

The Psychodynamic Perspective

- Abnormality as arising from unresolved conflict between the id, ego, and superego e.g. anxiety: id wants to eat, ego says to diet.
- Developmental stages:
    - Oral, anal, phallic, latent, genital.
    - Abnormality as wrong stage for age.
- 'Defence' mechanisms as coping behaviours:
    - *Denial:* refusing to engage with reality.
    - *Repression:* keeping thoughts in unconsciousness.
    - Abnormality as poor defence mechanisms.
- **Psychodynamic treatment:**
    - Uncover cause of symptoms from unconsciousness and then address e.g. dream analysis, free association.
    - Obvious problems with his approach e.g. claims are unfalsifiable (can't be tested), logical issues (how can you consciously repress something into an unconscious state?), no clear line between normal and abnormal.
    - Non-evidence-based, should not be used, makes many disorders much worse (e.g. BDD; Phillips, 2005).

The Behavioural Perspective

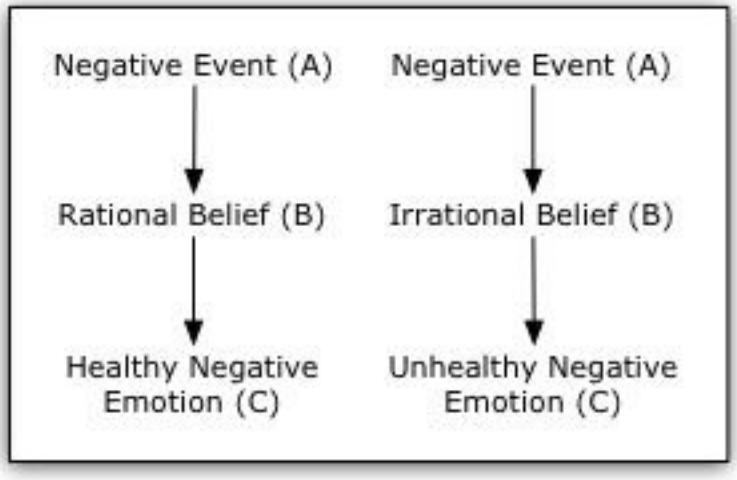
- Learning theory: classical, operant conditioning (US + UC = CR).
- Abnormality as learned behaviour, and/or lack of/disruption to rewarding behaviour.
    - Phobia: bitten by a dog, avoided ever since, thus conditioned to fear dogs.

- Depression: trained to receive hugs from girlfriend, she leaves, loss of expected reward.

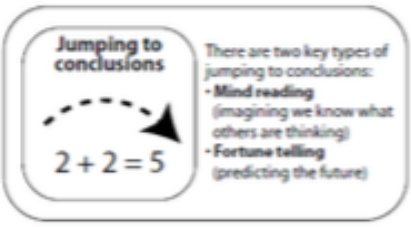
- Various applications:
  - *Token economy:* conditioning to perform behaviours using secondary reinforcers e.g. star charts, stickers, marbles in a jar.
  - *Exposure therapy:* the breakdown of existing conditioning.
- Interventions work, are easily tested and replicable, but confronting and potentially dehumanising.
  - Aversion therapy: conditioning to dislike something.
  - **Example:** being shown pictures of men while being made to vomit as a "treatment" for homosexuality (MacCulloch & Feldman, 1965).

The Cognitive Perspective

- Cognition = mediator to affect and behaviour
- Abnormality as faulty/maladaptive beliefs and thoughts.
- **ABC model:** antecedents via beliefs = consequences.



- **Cognitive treatment:**
  - Faulty condition can be process (how) or content (what), and limited only by your imagination.



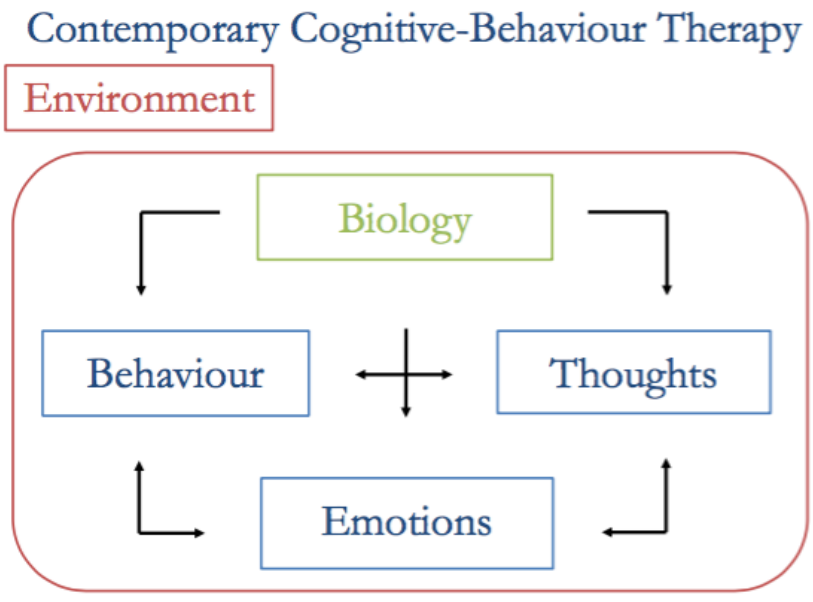
- Treatment = replace faulty cognitions with more adaptive/realistic ones e.g. cognitive restructuring, positive self-affirmation.
- Requires insight, degree of intelligence, and control.

The Humanist Perspective

- All humans are driven by an innate need for self-actualisation - requires unconditional positive regard.
- Abnormality as failure to achieve self-actualisation, and/or insufficient positive regard.
- Treatment: provide unconditional positive regard, allow the person to reach actualisation.
- Concepts are good, but they are unfalsifiable, ergo untestable.

Cognitive-Behaviours Perspectives

- Evidence-based perspectives:
  - Psychodynamic and humanistic not falsifiable (should not use).
  - Cognitive and behavioural are falsifiable (should use).
- But CT/BT are limited when employed alone.
- CBT: integrative of both - abnormality as a dysfunction in either cognition or behaviour.
- Most evidenced and supported view to date.



- Integrative CBT combines cognitive and behavioural perspectives, acknowledges influence of biological and psychosocial factors.
- Abnormality as a combination of factors which vary depending on symptoms.
    - Allows for customised understanding of the individual.
- **Example:** two different people with same symptoms but different causes.
    - Phobia: negative experience as a child.
    - Phobia: incorrect teaching from parents.

The Socio-Cultural Perspective

- The individual doesn't exist within a vacuum, and abnormality may arise from external forces e.g. family influences, cultural perspectives, socioeconomic status.
- Environmental forces clearly play a role e.g. media + eating disorders (Spettigue & Henderson, 2004).
- But reality is we're still talking about effect on an individual.
- Not all people exposed to unfair social structure develop psychological symptoms e.g. 99% of women exposed to media, only 9% develop an eating disorder.

Diagnosis And Assessment

- *Diagnostic classification:* breakdown of symptoms based on commonalities, presentation, ethology, etc.
    - **Example:** sadness vs. fear vs. obsession.
- *Diagnosis:* the labels used to describe, classify, and organise various symptom presentations.
- Diagnosis and assessment imposes communication across clinicians/areas e.g. "John has crying, lethargy, suicidal ideation, and weight loss" OR "John has major depressive disorder".
- There are many similar diagnoses with only minor differences.It is not always a straightforward process as there are many overlapping features in psychology.
- Two major nomenclatures available:

    - Diagnostic and Statistical Manual of Mental Disorders (DSM).
    - International Classification of Diseases (ICD).
    - Both offer descriptive accounts of mental health conditions.
- DSM = psych only; ICD = medical + psych.
    - Psychology generally adopts DSM-5.

The DSM-5 (APA, 2013)

- DSM-5 offers a range of 'disorders' and labels to organise these disorders.
- Variety of disorders within each label e.g. mood vs. anxiety vs. psychotic disorders.
- Mental disorders are not things, just labels that describe symptoms. They do not explain the phenomenon.
- Still, it is the best system we have.