# PSYC251 – THE PSYCHOLOGY OF ABNORMALITY

- **What is psychology of abnormality?**
  - Examines unusual patterns of behaviour, emotion and thought
  - interested in understanding the development of disorders
  - characteristics/symptoms of these disorders
  - prevalence (how common they are in population etc.) and diagnostic criteria (DSM-5)
  - co-morbidity – how often disorders co-occur together, e.g. anxiety and depression
  - motivation and maintaining factors – what's making someone continue behaviours even though its causing harm
  - the lived experience = living with mental illness, looking at things from their perspective
- **Assessments**
  - measuring severity, symptoms and features
  - mini mental state exam
  - beck depression inventory
- **Treatments**
  - psychological;
  - CBT, Systematic family therapy, Dialectical behaviour therapy, Interpersonal psychotherapy
  - Pharmacological (medication)
- **Myths**
  - people with mental illness are dangerous
  - mental illness is uncommon
  - only certain types of people experience mental illness
  - you can't recover from mental illness
  - medication is the only option
- **Empathy** – Recognising and sharing the emotions of another person. Really trying to feel what it's like from the clients perspective
  **VS**
  **Sympathy** – Feeling of care or concern for a person
- **Defining abnormality**
  - defined as the behavioural, emotional, or cognitive dysfunctions that are unexpected in the cultural context and associated with personal distress or substantial impairment in functioning – DSM5
- **What does it mean to be abnormal?**
- Mental disorders involved abnormal behaviours but having abnormal behaviours does not always mean mental disorder
- BEHAVIOUR = what we see, more to it than that (cognitions, emotions, subjective distress)
- Quantifying abnormality so you don't misinterpret 'different' people as abnormal
- STATISTICALLY abnormal is something is that uncommon

- **Abnormal laypersons view**
  - may define abnormal according to cultural and social norm violation
  - behaviour that seems out of place
  - CULTURAL RELATIVISM = abnormal in one society, strength in another
  - TEMPORAL RELATIVISM = abnormal at one time, normal at another
  - SITUATIONAL RELATIVISM = norms that adjust according to circumstances
- **Maladaptive behaviour**
  - dysfunctional
  - non-productive
  - can be maladaptive to SELF and SOCIETY
- **Personal distress view**
  - the individual might say that abnormality is defined by the experience of psychological pain.
  - they may think abnormal = 'I am extremely upset by my thought and/or behaviours'
  - this is called a SUBJECTIVE DISTRESS definition
  - distress can be normal e.g. grief
  - distress can be absent in some disorders e.g. manic phase in bipolar
- **Impairment/disability**
  - impairment = inability to 'do' things
  - impairment may be a small part of life e.g. fear of riding a bus
  - people can adapt to impairments
  - sometimes not obvious
- **The four D's**
  - DISTRESS (from point of individual)

  anxious, depressed, feelings of guilt etc
  - DEVIANCE (point of view from culture)

  bizarre behaviour, threatening, troublesome and unpredictable
  - DYSFUNCTIONAL BEHAVIOUR (individual)

  do they have an impairment and stops the ability to function adequately in everyday life
  - DANGEROUS (culture)

  danger to themselves, others or society. Risk of suicide, impaired decision making, hurting others
  - they place a role in defining abnormal behaviour but not one factor is sufficient for all abnormal behaviour, to see how extreme the behaviours are…
- **Level of disturbance (severity)**
  - BIZARRENESS = how extreme is the behaviour
  - DURATION = how long has the symptoms persisted
  - SOCIAL FUNCTIONING = extent of effect on social functioning
- **What is diagnosis?**
  - in mental health, a diagnosis doesn't always indicate the cause and nature of the issue
  - it's often just a short hand way of referring to behaviours/beliefs/emotions that commonly occur

- **DSM-5**
  - defines mental disorders
  - lists all recognised mental disorders and their diagnostic criteria
- In order to treat a client effectively, a diagnosis is not enough. A full narrative of how the issue arose and is being maintained in a MUST before treatment. When formulating a case…
- **The 4P Formulation Format**

1. PREDISPOSING FACTORS → 2. PRECIPITATING FACTORS → PROBLEM OR ISSUE

3. PERPETUATING FACTORS

4. PROTECTIVE FACTORS

  - the Presenting problem (maybe the 5th p) is the reason the client came to therapy but may not necessarily be the most serious problem

EXAMPLE

- Sarah freaked out at a concert, breathing quickly, heart pounding, thought she was going to pass out (panic attack). Not physiological, Now she has begun to avoid other crowded places

1. Temperament, genetics and modelling
2. What triggered the problem? Crowds, excitement, things in the present not the past
3. Behavioural avoidance "if I go to the shops, I'll get a panic attack"
   Cognitive errors – catastrophic thinking
4. Acceptance, Early detection, Commitment to treatment

## ATTACHMENT

- **What is attachment**
  - An enduring emotional bond characterised by a tendency to seek and maintain proximity to a specific figure, particularly when under stress
  - a need to have bonds with other people
  - it is a biological necessity
  - continues throughout life
  - it is not optional, it's part of our programming and has evolutionary significance
  - first two years are critical
- **Origins of attachment theory**
  - **Developmental psychology**
  - **Ethology** (study of animal behaviour)
  - **Psychodynamic theory** (Freud, Bowlby, Ainsworth)
- **JOHN BOWLBY**
  - started off studying deprived and homeless children in post war Europe
  - found that children between 6-30 months old form emotional attachments to caregivers
  - the emotional attachments shown in their preference for the familiar people, a secure base and seeking proximity to caregivers
  - abrupt separation of a toddler from a caregiver interferes with attachment, possible long term negative impacts on emotional and cognitive life
  - attachments contributes to emotional and personality development

- **MARY AINSWORTH**
  - experiments with children 1-2-year-old
  - measuring individual differences in attachment
  - used to determine the nature of attachment behaviours
  - ATTACHMENT STYLES;
  Secure
  Insecure-Ambivalent
  Insecure-Avoidant
  Disorganised (or disoriented attachment)
- **Adult attachments**
  - attachment patterns as a child roughly correspond to adult attachments
  - **BARTHOLOMEW & HOROWITZ**
  - Model of self
  - Model of others
  - Adult attachment styles;
  Secure (positive on self, positive on others)
  Preoccupied (negative on self, positive on others)
  Dismissive-Avoidant (positive model of self, negative of others)
  Fearful-Avoidant (negative model of self, negative of others)
- **Attachment in clinical settings**
  - influences all four P's of formulation
  Predisposing, Precipitating, Perpetuating, Protective
  - influences the working alliance = the relationship between client and therapist
  - people with negative attachment styles may take longer to establish rapport with

## MODELS OF CLINICAL PSYCHOLOGY

**Major models**

- each model has their own strengths and weaknesses
- not one model can account for every mental disorder
- be Integrative NOT eclectic

- Behavioural
- focus on specific presenting symptoms
- how to unlearn problematic behaviours
- e.g. exposure therapy, aversion therapy

- Cognitive and Cognitive Behavioural
- crucially emphasise the role of thoughts
- thoughts play a huge role in influencing our behaviours and emotions
- e.g. Cognitive behavioural therapy (CBT) & Acceptance and Commitment Therapy (ACT)

- Humanistic-Experimental
- people have freedom, so they have responsibility for the actions they take in life
- helps patients find meaning and fulfilment
- therapists role is more of a facilitator to help the patient grow
- e.g. client-centred therapy (Carl Rogers) & Motivational Interviewing

- Systems – Couples and Families