PSYC3018: ABNORMAL PSYCHOLOGY

INTRODUCTION TO ABNORMAL PSYCHOLOGY

WHAT IS ABNORMAL PSYCHOLOGY?

Abnormal psychology is the scientific study of 'abnormal behaviour'. It aims to develop a **description**, possible **causation**, **maintaining** factors, and **treatment** of psychological disorders using **empirical** methods.

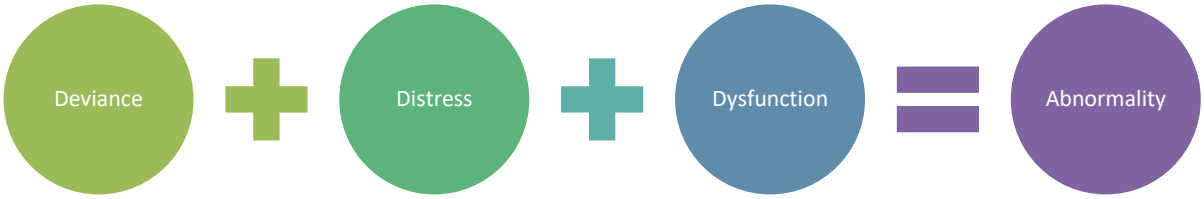
WHAT IS ABNORMAL?

Historically

Mental illness used to be equated with insanity. In the past, some behaviours which are now recognised as mental illnesses were seen as everyday issues.

Today

Our sense of abnormality comes from our understanding of what is normal in society. Something is abnormal if it fulfils the **three Ds**:



Today we have 400+ categories of mental disorders in the DSM/ICD, each containing descriptions of **symptom clusters**.

MENTAL ILLNESS AS DEFINED BY THE DSM

A mental illness is…

- A clinically significant behavioural or psychological pattern
- Associated with distress
- Not merely an expected and culturally sanctioned response to an event
- Currently considered to be a manifestation of dysfunction
- Currently listed in the DSM or ICD!

PREVALENCE OF MENTAL DISORDERS

PREVALENCE

Prevalence – the **proportion** of the population that **has** a diagnosable disorder within a **specified time period**. This can be looked at in terms of:

- **Point-prevalence** i.e. right now
- **One-year prevalence**
- **Lifetime prevalence**

There are many factors which may influence someone's ability to seek or receive treatment and for this reason it is hard to determine the actual prevalence of mental disorders. In psychiatric epidemiology large representative samples are used in an attempt to estimate prevalence.

INCIDENCE

Incidence – the **proportion** of healthy individuals that **will develop** the disorder within a **specific time period**.

CLASSIFICATION AND DIAGNOSIS

MEDICAL MODEL

In this model it is assumed that:

- Illness is qualitatively different from health
- Different illnesses are distinguishable from one another and occur independently with specific causes and treatments

Finding a specific cause and treatment is the ultimate goal of this model. As a result, illnesses are classified based on hypothesised **cause** e.g. hysteria (previously thought to be caused by a wandering uterus), lunacy (said to be caused by the moon), masturbatory insanity (…self-explanatory!)…these were often wrong.

Certain scientific advancements like the **germ theory of disease, Broca + Wernicke's brain areas** etc. supported biological causation and consequently the medical model and the development of psychiatry in the 1850s. It was thought that if physical illnesses had a biological cause why couldn't mental illnesses be caused by infections, toxins, brain damage, or hereditary too? From this resulted many painful treatments where the 'infected area' was removed.

PSYCHOANALYTIC MODEL

In the 1850s-1950s **Freud** and other psychoanalysts revolutionised the concept of mental illness, suggesting that there was **no clear division between normal and abnormal**. This saw an increase in clients with milder conditions and the inclusion of other conditions like anxiety and depression as mental illnesses.

DEVELOPMENT OF THE DSM

EARLY DSM

DSM-I (1952) and DSM-II (1968) were strongly influenced by **psychoanalytic theory**. These have low inter-rater reliability, problematic validity and unproven theories.

DSM-III AND BEYOND

DSM-5 (2013) currently reflects the **medical model**. Emil **Kraepelin** is often referred to as the father of psychiatric classification by encouraging the **listing of symptoms** (based on measurement, observation, reports) rather than making theoretical assumptions about the cause of an illness. This improved reliability as clear criteria for diagnosis was created.

It is becoming apparent that a **dimensional approach** may be more appropriate than the current categorical approach to understanding mental disorders.

ANXIETY AND RELATED DISORDERS

WHAT'S CURRENTLY LISTED IN THE DSM?

Anxiety disorders in the DSM are ordered by their average age of onset…

- **Separation anxiety disorder** – being away from the primary caregiver
- **Selective mutism** – lack of speech in social interactions
- **Specific phobia** – animal, natural environment, blood-injection-injury, situational
- **Social phobia / Social anxiety disorder** – fear of negative evaluation
- **Panic disorder** – spontaneous panic attacks, anxiety about having another attack
- **Agoraphobia** – fear of being outside the home, in crowded, small, or open spaces, standing in line
- **Generalized anxiety disorder** – excessive and uncontrollable worry about a range of outcomes

CHANGES FROM DSM-IV TO DSM-5

Additions	Removals
Selective mutism Agoraphobia as able to occur separately from panic disorder	PTSD and OCD were given their own chapters with other similar disorders

GENERALIZED ANXIETY DISORDER

WHAT IS IT?

First introduced in DSM-III-R, GAD is defined as **excessive, uncontrollable worry about a variety of events**. The worrying is not irrational but is disproportionate to the situation.

- Occurs more days than not for > 6 months
- Not explained by a normal situation
- Requires at least 3/6 of the following symptoms: restlessness, fatigue, difficulty concentrating, irritability, muscle tension, sleep disturbance
    - **Somatic symptoms** are more commonly experienced in GAD rather than autonomic arousal

GAD VS. NORMAL WORRY

'Normal worry' occurs in response to a **perceived future threat** which is usually physical or social. Normal worry tends to be comprised of more **verbal thoughts** rather than imagery. This type of worry has positive aspects such as motivation, problem solving, avoiding negative outcomes, distraction. Attempts to control worry usually involve **problem solving, distraction or social support**.

THEORIES OF CAUSATION

Problem solving theories

- Worrying involves **problem solving** events. In pathological worrying this process is **thwarted**.
  - Biased threat perception → more worries
  - Tendency to negatively evaluate solutions
  - Difficulty choosing a solution

Metacognitive theory

- Suggests there are **two types of worry**; worry and metaworry.
  - Worry – normal threat perception, positive beliefs about worry, worrying used to cope with threat and problem solve
  - Metaworry – negative beliefs about worry, ineffective thought control strategies, increased anxiety/worry until it is excessive and uncontrollable

Intolerance of uncertainty theory

- Perhaps GAD sufferers believe that **uncertainty is a bad thing** which will cause frustration and stress.
  - Worrying is used to reduce anxiety with the aim to reduce uncertainty to zero
  - Pre-occupation with details

Experiential avoidance

- Perhaps excessive worry is associated with **fear of anxiety** and the **intolerance of distress**.
  - Worriers avoid internal experiences
  - Attempts to predict negative/uncomfortable affect – difficulties in tolerating and regulating emotion

Avoidance theory

- Worrying contains more verbal thought than imagery. GAD patients are more inclined to **worry using imagery**.
  - Imagery is much more anxiety arousing
  - Switching from imagery to words reduces anxiety
  - Worry is a form of cognitive avoidance, it interferes with emotional processing and maintains fear structures

TREATMENT

- Reflecting on biased threat perception – looking at probability and cost judgements
- Structured problem-solving training
- Exposure to vivid images of feared event – emotional regulation training
- Challenging beliefs about worry

Treatment effects are modest, about 50% of patients have improved at follow-up.

OBSESSIVE-COMPULSIVE DISORDERS

WHAT'S CURRENTLY LISTED IN THE DSM?

All disorders in this section involve **repetitive** behaviours/mental acts. They are **highly comorbid** with each other and are often present in first degree relatives as well (genetic role).

- **Obsessive-Compulsive disorder (OCD)**
- **Body dysmorphic disorder**
- **Hoarding disorder**
- **Excoriation disorder**
- **Trichotillomania**

OCD

Obsession – recurrent and persistent thoughts, urges or images that are unwanted and cause distress

Compulsion – repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession, aimed at reducing/preventing anxiety

DSM-5 CRITERIA

To qualify for OCD a person must be experiencing obsession, compulsions or both. These behaviours must be **time-consuming** or cause significant distress or dysfunction.

Individuals may vary in their level of **insight** into the problematic nature of their behaviours, better insight = better treatment outcome. OCD may be **tic-related**.

COMMON COMPULSIONS

The content of OCD symptoms usually falls under **four categories** although a patient may experience obsessions from more than one category.

Cleaning	Harm	Forbidden or taboo thoughts	Symmetry
•Obsession with contamination •Cleaning compulsions	•Fear of harming onself or others •Checking compulsions	•Agressive, sexual, religious obsessions •And related compulsions	•Obsessions with symmetry •Repeating, ordering, and counting compulsions

PREVALENCE

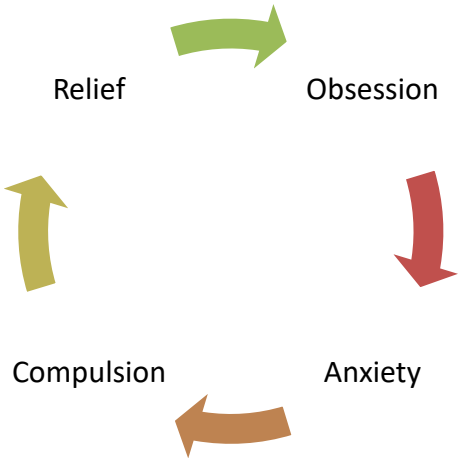
Mean age of onset for OCD is **19.5 years**, but can be very early on. Lifetime prevalence of 2.3%, more common in women. OCD is **chronic if untreated**, it is unlikely the individual will get better by themselves. OCD is often **comorbid** – high levels of comorbidity with anxiety, depression and bipolar.

<u>Causation: the cognitive model</u>

Whilst obsessions are not uncommon people with OCD respond to the obsessive thoughts differently or **misinterpret** them, sometimes perceiving the **thought as an intention** (harm compulsion). Attempts to supress thoughts leads to **thought checking** which actually creates the thoughts making matters worse.

OCD is associated with certain cognitive factors:

- Intolerance of uncertainty
- Inflated responsibility
- Thought-action fusion
- Magical ideation (in extreme OCD)



<u>Maintenance</u>

OCD is maintained by **operant reinforcement**; compulsions are **negatively reinforced** through anxiety reduction forming a self-feeding maintenance cycle.

TREATMENT

Treatment for OCD is similar to anxiety:

- Medications – antidepressants, serotonin reuptake inhibitors
- CBT
    - Challenging beliefs about intrusive thoughts and compulsions
- Behavioural experiments
- Exposure + response prevention (ERP)
    - Exposure to obsession but prevent compulsion from being carried out
    - An opportunity to learn that there are no negative consequences if the compulsion is not performed

HOARDING DISORDER

Hoarding disorder is characterised by a **difficulty parting with possessions** regardless of their value. It stems from a **perceived need to save the items**. As a result, hoarding disorder patients accumulate many items that clutter living areas and comprise their use.

The hoarding must cause significant distress or impairment and cannot be better attributed to another medical condition.

<u>Prevalence and treatment</u>

- 2-6% lifetime prevalence
- Starts early and usually worsens with age
- Treatment is not really known yet…

BODY DYSMORPHIC DISORDER

Body dysmorphic disorder involves a **preoccupation with perceived defects** in physical appearance – that are **not observable to others**. i.e. the person sees a body feature(s) as exaggerated or worse than they are – this is different to normal appearance concerns!