Lecture 1: What is Abnormal?

- Abnormal psychology: scientific study of **abnormal behaviour (emotion, motivation)**, especially of mental disorders
- Mental disorders from an abnormal perspective are just a subclass of abnormality
    - There are a lot of abnormal behaviours that do not necessarily constitute a mental disorder
    - e.g., constantly eating leads to obesity, but obesity is not an abnormal disorder

The Empirical Method

- RANDOMISED CONTROL TESTS
- **Description** – classification, diagnosis
    - In order to treat a disorder, we need to know that the thing we are talking about is actually an entity/construct
    - This ensures that we have accurate definitions – can describe what we are talking about
    - Diagnosis = observing a set of behaviours
        - How do we know that it is abnormal?
    - Descriptions allow specific behaviours to be "captured" and "encompassed"
    - Allows homogeneity within symptom clusters
    - e.g., "pathological independence"
    - Descriptions and diagnoses change based on what is the normal doctrine at the time as well as societal influences of what is currently considered normal
        - PROBLEM – understanding diagnoses – what is the CAUSE of the symptoms we are describing

- **Causation** – biological, psychological and sociocultural
    - Why does a disorder present for individuals?
    - Never a single causal factor, an interaction of factors

- **Maintenance** – why is a problem continuing?
    - Maintenance informs treatment

- **Treatment** – what is effective? Does this make some people get better but not others?
    - Clinicians ONLY treatments derived from empirical methods
    - It is important to have a clear taxonomy of disorders so that they can be treated
    - We can identity and understand that there is a typical symptomatology and a typical cause that a disorder follows
    - Effectiveness – what treatment works?
    - Mechanisms – what PART of the treatment accounts for someone getting better? – high specificity

- Not all psychological phenomena can be reliably tested in a RCT - does not mean that these areas are less valued

What is Abnormal Psychology?

- The distinction between abnormality and normality is inherently difficult to make
- A spectrum
- Three D's determine the location of the behaviour on the spectrum
- Abnormal Behaviour
    - **Deviance**: behaviour is considered abnormal if it is negatively evaluated by society
    - **Distress** – has it caused clinically significant distress to the individual? – Negative emotional experience
        - **Allows a self**-definition of distress – removed societal subjectivity
        - **Limited as distress not always experienced e.g., manic bipolar episode**
    - **Dysfunction** – does this behaviour get in the way of "normal" functioning
- Problems with 3 D's
    - Not one of them is necessary and sufficient in itself – need to consider them ALL SIMULTAENOUSLY to define abnormality
    - They are all closely linked to social norms
    - Expectations can change over time
    - It depends on the current doctrine at the time
- There is no clear universally accepted definition of abnormal behaviour
    - Classing abnormality is controversial
        - Shouldn't be talking about "abnormality" – should be talking about "neurodiversity"
        - Labelling mental illnesses is stigmatising and isolating and exclusive
    - Mental disorders are a subclass within abnormal side
        - Not all abnormal behaviours are a mental disorder e.g., disordered eating leading to obesity

What is 'Mental Disorder'?

- Conceptions have changes over time – constantly EVOLVING
- **Historically (100 years ago)** – *not that long ago, have really progressed*
    - Mental illness = "madness, insanity"
    - Doctors believed that there was only one mental illness - insanity was a **binary**: either sane or insane
    - **Insane**
        - Gross distortion of external reality (hallucinations, delusions)
        - Disorganised speech, affect or behaviour (confusion, memory loss)
        - These symptoms are similar to today's diagnoses of psychosis, schizophrenia, and dementia
    - The symptoms that would be deemed as "insanity" were very severe and has a serious presentation
        - Highlights that the idea of a mental disorder was only being based off a VERY small number of individuals (very few presented with the required severity to be classed as insane)
        - Limited understanding of mental disorders
        - Mental disorders were not viewed as a range
    - Were treated by "mad doctors" or "alienists" in mental asylums – more like jails than hospitals, inhumane
        - Today we treated by psychiatrists in an inpatient mental hospital (today we treat in inpatient mental hospitals)
    - Most of the things we recognise now as mental illnesses were not recognised back then– anxiety, sadness, ED - didn't "count"
        - If people were living with these issues they might talk to family, friends or priests
        - Go to a sanatorium – to "calm their nerves"

Classification Systems of Mental Disorders

- No longer a dichotomy between sanity and insanity
- Describe **symptom clusters** – each symptom cluster is unique and distinct from other disorders
- Proliferation of the number of disorders: 400+ categories of 'mental disorders'
- Proliferation of the number of trained professionals who can treat these disorders
    - Gone from a small number of people who could treat insanity
    - Now treated by psychiatrists, clinical psychologists, psychologists, social workers, counsellors
    - Often disorders require a multidisciplinary team including: GP, occupational therapists, nutritionists
- Now a large number of people treated by a large number of skilled professionals - many different options

Diagnostic and Statistical Manual of Mental Disorders (DSM)	International Classification of Diseases and Health Related Problems (ICD)
▪ American Psychiatric Association ▪ 1st edition: 1952 ▪ DSM-5 is current (2013) ▪ Used by the English-speaking world	▪ World Health Organisation ▪ Mental disorders added in 1948 ▪ ICD-10 is current (1990) ▪ Used in Europe

- **The common doctrine at the time ignorantly influences how we classify and diagnose specific mental disorders throughout the DSM's**
    - **DSM 1 and 2: Psychoanalytic influence – Freud**
    - **DSM 3 – 5: Biomedical approach**
- **We mirror prevailing the doctrine in the time**

- **Diagnosis** and **classification** are definitely a **work in process**
    - "Bibles" of psychology are NOT the same – shows that we are still trying to understand what constitutes certain mental illnesses
    - There is enough international overlap to allow clinicians to be talking about the same thing
    - The different categories between the DSM-5 and the ICD-10 indicate that we are still trying to figure out descriptions for mental disorders
- As we gain more empirical evidence to understand these disorders we can better describe and "capture them"
- Individuals might have been labelled with a different diagnosis – people with a cluster of symptoms may have been captured by a different diagnostic category which perhaps did not "fit" their symptoms – these individuals would not have responded to treatment