PYB306: Psychopathology

Semester 2, 2024

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Week 1: Welcome & Introduction

Readings

Chapter 1 – Overview and research

Defining abnormal psychology

There is no universal definition of abnormal psychological behaviour, but there are some **indicators**:

Subjective distress

Maladaptive behaviour

Statistical deviance

Violation of social norms

Social discomfort

Irrationality/unpredictable

Dangerous

The DSM-V

> *"A mental disorder is defined as a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning."*

Chapter 2 – Earliest views of abnormality

Religion

Earliest perspectives often claimed abnormal behaviour to be a result of the **'possession'** of some kind of demon or god. This could be treated via exorcism.

It could also be seen as a **withdrawal from God's protection** and therefore the person was abandoned to evil.

Hippocrates

Believed that mental disorders were the work of the human body.

Emphasised the role of **heredity and predisposition**.

Three categories – mania, melancholia, and phrenitis.

People were thought to have one of four personalities: **sanguine (active, optimistic), phlegmatic (calm, relaxed), choleric (agitated, irritable), melancholic (pensive, thoughtful).**

Did, however, believe that hysteria was limited to women and was caused by the uterus, and said marriage was the best remedy.

Philosophical conceptualisations

Believed people suffering from disorders could not be held responsible for criminal acts and so should not be punished like a normal person.

Stated that both **individual differences and sociocultural influences** would impact a person's thinking and behaviour.

Mental disorders were in part divinely caused.

Early Chinese conceptualisations

Natural rather than supernatural causes for illnesses. **Positive and negative forces** are supposed to **balance**, but when there is an imbalance there is illness.

Saw that stress and mental illness caused organ issues.

Middle Ages

First mental hospital was founded in Baghdad in 792.

Unlike in the Middle East, most other mental illness treatment was left to the clergy.

Renaissance

Believed the moon had a supernatural power over the brain.

Witchcraft ideas were circulating.

Towards the end of the Renaissance, there were religious figures who were arguing that **mental disorders are no different to physical illnesses** and should be treated by health professionals and scientists.

Asylums

First started appearing in the 1500s, as a refuge for those struggling with mental illness. Stigma. Abuse and inhumane conditions

Pinel and Tuke

Pinel was in charge of a Paris hospital, and **removed chains from patients with mental illness, treating them with kindness** as an experiment. It was very successful (duh). Tuke did a similar thing in the UK, and eventually got nurse support on the hospital grounds where there had been abuse previously. These ideas spread around the world pretty quickly to other British colonies.

They started focusing on Moral Management – treatment focusing on the patient's social, individual and occupational needs.

Dorothea Dix carried out a campaign to challenge the inhumane treatment of people with mental illness, called the **Mental Hygiene Movement**. Wanted to change the focus to the physical wellbeing of hospitalised patients and raised money to do so.

19th and 20th centuries

Stopped the use of the straitjacket.

Mental hospitals continued to grow.

Medications like mood stabilisers and antipsychotics were introduced.

Deinstitutionalisation – significant reduction in state and country mental hospital populations in the US. Seen as more humane to treat people with mental illness in their own community.

Chapter 3 – Causal factors and viewpoints

If X is shown to occur before Y then we infer that X is a **risk factor** for Y. If X can be changed over time, it is a **variable risk factor** for Y. If not, it is a **fixed marker** for outcome Y. If a change in X leads to a change in Y then it is a **causal risk factor**. If not, it is a variable marker of outcome Y.

Necessary cause – a characteristic that must exist for the disorder to occur.

Sufficient cause – a condition that guarantees the occurrence of a disorder.

Contributory cause – increases the probability of a disorder developing but is neither necessary nor sufficient for it to occur.

Distal risk factors – occurring relatively early in life that do not show their effects for years.

Proximal risk factors – occur shortly before the occurrence of symptoms.

Reinforcing contributory cause – condition that tends to maintain maladaptive behaviour.

Causal pattern – when there is more than one causal factor involved.

Many mental health disorders are believed to develop when someone has a preexisting vulnerability for that disorder experiences a major stressor. These are often called diathesis-

stress models. Protective factors decrease the likelihood of negative outcomes among those at risk. Protective factors usually lead to resilience – the ability to adapt successfully to even very difficult circumstances.

The biopsychosocial viewpoint acknowledges that biological, psychological and social factors all interact and play a role in psychopathology and treatment.

Biological factors:

Genetic vulnerabilities – vulnerabilities for mental disorders are usually **polygenic**.

Brain dysfunction and neural plasticity

Neurotransmitter and hormonal abnormalities in the brain or other parts of the nervous system – can be issues with neurotransmitter production/release, how they are deactivated or brought back in. **Norepinephrine, dopamine, serotonin, glutamate, gamma aminobutyric acid (GABA). HPA axis** issues with hormone production and release.

Temperament – the general responsiveness to ways of **self-regulation**, tendency to withdraw.

Psychological factors:

Psychodynamic – using the **unconscious elements** a person (id, ego, superego), anxiety defense mechanisms (projection etc.), psychosexual stages of development.

Object-relations theory, interpersonal perspective, **attachment theory**.

Behavioural factors:

Classical and operant **conditioning**.

Generalisation and discrimination. One person who responds to all similar stimuli or when they learn to distinguish between similar stimuli and respond accordingly.

Observational learning.

Cognitive-behavioural factors:

Reinforcement, self-efficacy.

How thoughts and information processing can become distorted and lead to maladaptive emotions and behaviour (**schemas**).

Attributions and their relationship to behaviour.

Social factors:

Early deprivation or trauma – institutionalisation, neglect and abuse in the home, separation

Parenting styles – links to their parents' psychopathology but also any marital discord/divorce.

Low socioeconomic status – unemployment.

Maladaptive peer relationships – bullying, popularity vs. rejection.

Prejudice and discrimination – race, gender, ethnicity etc.

Cultural factors:

What is considered normal vs abnormal?

Prevalence of disorders in different areas.

Different concepts of distress.

Lecture

About the DSM-5

A 70-year history, where expanding on the previous editions and having a few ‘text-revision’ copies.

Section I: introduction and organisational view of the text, revisions, field tries, and the reviews of the text.

Section II: text on conditions, diagnostic criteria, codes.

Section III: assessment measures, cultural formulations, glossary and other conditions that might need further study before being in the main text.

DSM-5-TR: update the text based on reviews of it (gender dysphoria) and of emerging literature, there was an addition of the grief category and some other diagnostic entities.

Imperfections:

Process criticisms (trials and the composition of the task force)

The lowering of diagnostic thresholds

The introduction of new disorders without a clear scientific basis.

Failure to test/demonstrate validity of diagnostic categories.

Reification of disorders.

Failure to deliver on the promise of neuroscience.

Reduced ‘reliability’ of many diagnoses.

There is also the ICD-11 and the USNIMH Research Domains Criteria.

Defining psychopathology

The term to describe abnormal behaviour/functioning. It is the manifestation of mental disorders/conditions/illnesses. It implies that psychologists and students should function as scientist-practitioners.

There are 7 possible indicators of psychopathology

Subjective distress – reported feelings of discomfort or struggle, feeling unwell and wanting help.

Maladaptiveness – not able to achieve goals.

Dangerousness – causing harm to themselves or others.

Irrational or unpredictable – random changes to behaviour that are not described by any pattern/trigger.

Social discomfort – how others perceive the person's behaviour.

Violation of social norms – whether the behaviour aligns with the general patterns of their social world.

Statistical deviance – rare behaviours.

There are some challenges for using these indicators. For example, subjective distress may be brought about through insight, understanding and self-awareness – people might think that nothing is wrong, and they don't require help. Some people need adjustments to perform daily tasks. When exploring statistical rarity, how rare should it actually be? Is it necessarily deviant if it just rare? Are common behaviours not harmful just because they're common? Social and cultural values often are very different in how they define abnormal behaviour and how these abnormal behaviours are responded to.

Another view is that psychopathology arises from 'harmful' dysfunction, but this also relies on different definitions of what is harmful. It is often framed as not being able to perform in their natural/normal function which causes harm to the person considering the culture in which they live.