1 - INTRODUCTION TO ABNORMAL PSYCHOLOGY

Intro: lecture pod 1

Abnormal psychology examines mental health, broadly described as “psychopathology,” a term increasingly preferred ove “abnormal psychology” due to concerns about stigma. The field aligns closely with clinical psychology, focusing on treatme approaches like CBT and acceptance and commitment therapy. Historically, mental health research categorized condition such as hysteria and delusions as “abnormal” starting in 1888. However, recent perspectives emphasize that conditions lil anxiety (affecting 1 in 4) and depression (affecting 1 in 5) are prevalent and thus “normal” within society.

The Journal of Abnormal Psychology, originally published in *1888*, was renamed in *2022* to the **Journal of Psychopathology and Clinical Science** to reflect the commonality and diversity of psychiatric conditions and move awa from "abnormal" as a descriptor.

Models of mental health: lecture pod 2

Biological Model: Mental illness may be due to **genetic** or **biological factors**, such as hormonal changes or stress-relat cortisol dysfunction. Treatments include medication, **Electroconvulsive therapy** (ECT), and **Transcranial magnetic stimulation** (TMS), with emerging therapies like **3,4-methylenedioxymethamphetamine (MDMA)-assisted Psychotherapy,** otherwise known as **MDMA-assisted treatment**(the use of prescribed doses of MDMA as an adjunct to psychotherapy sessions**).**

The life-course perspective emphasises how **age-related hormonal events** (e.g., puberty, pregnancy) impact psychological health.

Psychological Models

Psychodynamic	Rooted in **Freud’s** theory, where mental distress arises from conflicts between the **id, ego**, and **superego.** Treatments include **talk therapy** to address unconscious defence mechanisms like repression. A. **ID**(Primal Instincts)**: basic urges, needs, and desires** B. **EGO**(Rationality)**: decision-making component, conscious awareness** C. **SUPEREGO**(Inner voice)**: existential, future, moralistic goals**
Behavioural	This model explains distress as **learned responses**, treated through conditioning-based techniques like **exposure therapy**. Examples include **token economies** for reinforcing **positive behaviour** or **desensitisation** for phobias.
Cognitive	Suggests that faulty thinking leads to distress. **Cognitive Behavioral Therapy (CBT)** works by restructuring negative beliefs and includes the **ABC model**, where thoughts (**Beliefs**) lea to emotional (**Consequences**) following an event.
Humanistic	Emphasises **self-actualisation** and the importance of **unconditional positive regard.** Treatment includes approaches like **client-centred therapy**, which supports personal growth
Mindfulness and "Third-Wave" Therapies	This includes **ACT, DBT**, and **mindfulness-based CBT.** These focus less on changing thoughts and more on how individuals relate to their **experiences**, addressing the distress caused by **avoidance** or **resistance to symptoms.**

Socio-Cultural Perspective: This perspective acknowledges the influence of **family, culture, and socioeconomic statu** It emphasizes the **biopsychosocial model**, where mental health is a product of **biological**, **psychological**, and **social factors**. The WHO's report on mental health highlights how **structural** and **community** factors shape mental health *(Wor Health Organization, 2022).*

MODULE 2 - ASSESSMENT AND DIAGNOSIS

Diagnosis: Purpose and Process

The primary purpose of diagnosing mental health conditions is to guide effective treatment, enable targeted research, and support healthcare administration. Diagnostic manuals provide the framework for this, primarily the **DSM-5-TR** (Diagnostic and Statistical Manual of Mental Disorders, 5th edition, Text Revision) and the **ICD-11** (International Classification of Diseases). While **DSM-5-TR** is widely used in Australia for clinical psychology, the **ICD-11** remains prevalent globally, especially in coding for health statistics.

Key Concepts:

1. **Criteria-Based Classification**: Diagnosis relies on meeting specific criteria to categorize symptoms and inform treatment.
2. **Differences and Similarities**: While DSM and ICD share many diagnoses, they diverge in certain conditions, e.g. complex PTSD, which is recognized in ICD-11 but not DSM-5.
3. **Historical Development**: The DSM originated post-World War II, initially designed for inpatients with severe conditions and later expanding to outpatient scenarios. With each edition, the DSM has moved closer to the ICD in terms of criteria standardization.

Lecture Pod Reference: Diagnosis Overview and Systems

Benefits and Limitations of Diagnosis

Diagnoses are beneficial for directing research, guiding treatment, and providing patients with a structured understanding their conditions. However, diagnostic systems also have considerable limitations:

1. **Stigmatization and Labeling**: Diagnosis can result in stigma, especially in culturally sensitive contexts where men health labels may lead to discrimination.
2. **Diagnostic Accuracy**: Most diagnoses rely on self-report and informant reporting, introducing subjectivity that can lead to misdiagnosis.
3. **Categorical vs. Dimensional Models**: DSM's categorical model (e.g., Obsessive-Compulsive Disorder as a distin diagnosis) contrasts with dimensional approaches like those used in Autism Spectrum Disorder, where symptoms placed on a continuum.

The **DSM** is primarily a categorical tool but has increasingly included dimensional elements in recent editions, emphasisin symptom severity. This structure allows for clear categories but can omit nuances, such as individuals with symptoms that not fully meet the criteria but still experience significant distress.

Lecture Pod Reference: Limitations of DSM and Diagnostic Approaches

Transdiagnostic Approaches

A recent development in mental health diagnosis is **transdiagnostic approaches**, which assess symptom patterns that c across multiple disorders. This approach recognises that certain mental health symptoms (e.g., emotional regulation) underlie various conditions rather than being unique to one diagnosis.

Examples of Transdiagnostic Approach:

- **Depression and Anxiety**: These conditions often co-occur, suggesting that addressing their shared symptoms, lik emotional regulation, could improve treatment outcomes.

MODULE 4 - MOOD DISORDERS

Mood Disorders Overview

Lecture Pod Reference: "Abnormal Module 4" and "Treatments"

- Mood disorders encompass depressive and bipolar disorders, which differ significantly in symptomatology and genetic basis. Although previously grouped, **DSM-5** now separates these categories to acknowledge the clinical ar genetic distinctions. In contrast, **ICD-11** still combines them under *"Mood Disorders,"* reflecting ongoing debate.

Depressive Disorders

Key Subtypes and Diagnostic Criteria (Lecture Pods: "Depressive Disorders" and "Treatments")

Major Depressive Disorder (MDD)	Characterised by at least five symptoms like depressed mood, loss of interest, weight changes, and suicidal thoughts, present nearly every day for at least two weeks
Persistent Depressive Disorder (Dysthymia)	A long-lasting depressed mood. Symptoms are less severe but persist for at least two years, affecting daily functioning.
Premenstrual Dysphoric Disorder	Specific to the menstrual cycle, involving intense mood swings, irritability, and physical symptoms before menstruation. Introduced in DSM-5, it reflects 20 years of research on the impact on women's mental health
Disruptive Mood Dysregulation Disorder (DMDD)	Designed for children up to 18, marked by chronic irritability rather than episodic mania, contrasting with childhood bipolar misdiagnoses.

Severity Specifiers: **Mild**, **moderate**, **and severe**, with possible features like anxious distress, psychotic episodes, and seasonal onset.

Cultural Considerations: Different cultural groups experience depression variably. For Indigenous Australians, factors lik trauma and cultural loss contribute uniquely to depressive presentations

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Bipolar and Related Disorders

Overview (Lecture Pod: "Bipolar Disorder")

1. **Bipolar I Disorder**: Defined by manic episodes, potentially with preceding depressive episodes.
2. **Bipolar II Disorder**: Includes hypomanic and major depressive episodes but excludes full manic episodes.
3. **Cyclothymic Disorder**: A chronic, less severe variant with hypomanic and depressive symptoms over at least two years.

Manic Episode Diagnostic Criteria: It involves **elevated mood, increased energy, grandiosity, reduced need for slee and impulsivity over a one-week period**, impacting daily life. **Hypomania** shares these symptoms but with a lesser impa on functioning.