History & Diagnosis of Psychopathology:

Normality & Abnormality:

⇒ Historically, mental health became a concern when it *threatened public order.* Early approaches to treatment were largely focused on maintaining the safety of the public. Early treatments were 'moral' failings or 'physical problems'.

⇒ **De-institutionalization** occurred around the 1950's in two stages:
Stage 1 - where new treatments led to an open-door policy, allowing individuals to be treated on an outpatient basis.
Stage 2 – asylums began to close, and treatment shifted to the community.

→ The majority of treatments now occur via general practitioner (~40%)

How is normality defined?

→ Being like the majority, autonomous functioning, accurate reality perception, regulated moods & adequate interpersonal relationships.

How is abnormality defined?

→ Statistical infrequency, norm violation, personal distress & disability/dysfunction.

Why are mental disorders considered to be fuzzy?

→ Comorbidity between disorders is common, and there are many ways to meet criteria for disorders.

What is a mental disorder (according to the *DSM-5*)?

⇒ A clinically significant disturbance in an individual's cognition, emotional regulation or behaviour, usually associated with significant distress or disability in social, occupational or other important activities.

⇒ An expectable or culturally approved response to a common stressor or loss (such as the death of a loved one) is <u>not</u> a mental disorder.

⇒ The episode must not be attributable to a substance or medical condition, and must not be better explained by another psychiatric condition.

⇒ Mental disorders are *constructs* (ideas).

→ Diagnosis must be made by a clinician

→ The DSM recommends using the *WHO Disability Assessment Schedule* to assess distress and functional impairment.

Why diagnose or classify psychopathology?:

⇒ **Facilitate communication:** among clinicians, between science & practice.

⇒ **Facilitate care:** identification of treatment & prevention of mental disorders, description of experience, possible etiology & prognosis.

⇒ **Research:** test treatment efficacy, and understand etiology.

⇒ **Education:** teach psychopathology.
⇒ **Information management:** measure & pay for care (allows for reimbursement etc).

The case against diagnosis/classification:
⇒ **Leads to bias or restricted thinking** – diagnostic boundaries are rarely distinct, and diagnoses change over time (e.g. PTSD, multiple personality disorder).
⇒ **Are associated with jargon** – jargon may mask what is actually being discussed.
⇒ **Inhibit research** – if we only study conditions meeting specific criteria, we may miss the bigger picture (e.g. Research domain criteria (RDoC)).
⇒ **Can be stigmatising and have personal implications**

→ **Thomas Szasz** contends that mental disorder is a myth – that emotional distress, family and personal turmoil are *not* societal constructions. Kendler (2016) also suggests that few cases of mental disorder appear to be entirely socially constructed.

Terminology:
⇒ **Signs:** objective findings observed by a clinician (e.g. tachycardia, pressured speech, poor eye contact).
⇒ **Symptoms:** subjective complaints reported by a patient (e.g. low mood, anxiety, paranoia).
⇒ **Syndrome:** a collection of signs, symptoms & events that occur in a particular pattern, that indicate the existence of a disorder (e.g. bipolar disorder, depression).
⇒ **Disorder:** a syndrome which can be discriminated from other syndromes. To be labelled a disorder means there is a distinct course to the syndrome, and the age & gender characteristics of the disorder have been described. In some cases, prognosis may also be known.
⇒ **Disease:** for a disorder to be labelled a disease, there has to be indications of abnormal physiological processes or structural abnormalities (e.g. Parkinson's disease).

Assessment of psychopathology:
→ Pen & paper tests (e.g. BDI)
→ Clinical interviews (e.g. SCID)
→ Behavioural assessment (e.g. AX-CPT)
→ Activity diaries
→ Psychological tests (e.g. MMPI)
→ Medical tests (e.g. MRI)
→ Psychophysiological tests
→ Neuropsychological tests (e.g. WAIS)

▪ *Context* is important

Anti-psychiatry movement:
→ 1960s (*Thomas Szasz et al*.): psychiatric practice was considered repressive & controlling.
→ *Foucalt* argued that treatment was largely about forcing individuals to conform.
→ *Thomas Szasz* believed that psychiatric treatment was a means by which to punish deviance from societal or moral norms. He further argued that diagnoses were not meaningful & used to justify inappropriate treatments.
→ Many advocates of the movement argue that *sociocultural* factors (shifts within subsections of society that are undesired by others) are a major determinant of problems.

What is normal functioning?
→ *Marquand et al. (2019)* proposed that mental disorders can be viewed using a normative model (subject level statistics), with statistically significant deviation from the norm indicating impairment.

Primary approaches to classification of mental disorder:
1. Categorical: divides psychological disorders into categories based on criteria sets with defining features (e.g. Diagnostic Statistical Manual of Mental Disorders (DSM)).
2. Dimensional: aspects of psychopathology are quantified on a scale (e.g. Hierarchical taxonomy of psychopathology (HiTOP)).
3. Hybrid: a hypothetical combination of categorical & dimensional (e.g. MMPI-2).

Dimensional vs Categorical Classification:
Categorical:
→ Better clinical & administrative utility – clinicians are often required to make dichotomous decisions (e.g. to obtain treatment funding), clinical resources are often limited.
→ Facilitates easier communication.

Dimensional:
→ Closely model the lack of sharp boundaries between disorders, between disorders & normality.
→ Have greater capacity to detect change, facilitate monitoring.
→ Can develop treatment-relevant symptom targets – not simply aiming at the resolution of the disorder (most treatments actually target symptoms, not disorders).

Distress & functional impairment:
⇒ Recommended to be measured using the World Health Organization Disability Assessment Schedule v2.0
⇒ Measures understanding & communication, mobility, self-care, getting along with others, life activities, societal participation.

Models to understanding mental disorders:

HiTOP model (Hierarchical taxonomy of psychopathology):

⇒ Uses different hierarchical levels to understand the disorder and how it relates to other disorders.

⇒ Hypothesises that latent processes are common to a range of emotional disorders and associated symptoms.

⇒ Focuses on treating the things underlying the disorder (e.g. spectra such as internalizing) as opposed to the signs and symptoms of the mental disorder.

⇒ Acknowledges that disorders have similar components, maladaptive traits, signs and symptoms & that disorders are interrelated representations of similar issues

Behaviours in this model:

▪ Internalising: self-soothing or self-punishment (the stuff going on inside the person's head)

▪ Externalising: how the person reacts with others and the world.

Research domain criteria model (RDoC):

→ Posits that disorders arise as a feature of dysfunctional domains that have emerged in development.

→ Focuses on studying groups of mental disorders together as domains, as opposed to individual disorders in isolation.

→ The domains include negative valence (feeling down/negative emotions), positive valence (experiencing positive emotions/happiness), cognitive systems (memory/solving mental problems), systems for social process (interactions with others etc), arousal/regulatory systems (how your body regulates its arousal), sensorimotor (brain-body monitoring as you engage in movements).

→ For example, negative valence is common across several disorders (depression, schizophrenia etc.). Focusing on that particular problem (negative valance) can help us to treat individual problems via treating the problem as a whole.

→ Creates data-driven categories based on integrated data (e.g. polygenetic risk score, inflammatory markers) and symptom-based categories (e.g. major depressive disorder, mild depression).

→ Takes heterogenous diagnostic categories and finds common dimensions and subgroups.

Freudian paradigm:

→ The unconscious has a huge influence on what we do in our day-to-day life.

→ Only once we become aware of our unconscious motivations (via psychoanalysis) can individuals choose less maladaptive & more adaptive behaviour.

Behavioural paradigm:

→ Goal of behavioural interventions is to interrupt and/or change stimulus-response associations (e.g. classical conditioning, operant conditioning).