Introduction 1
Classification of Mental Disorders 2
Reliability and Validity 8
Anxiety and its Disorders 12
Tutorial 23
Obsessive-Compulsive Disorder 25
Cognitive behavioural therapy - introduction 28
Bipolar Disorders 30
Intro Personality Disorders 34
Personality 37
Depression 40
Intelligence: History and Assessment 45
Intelligence: test bias and cultural bias 48
Improving intelligence: assessing the evidence 52
Psychological therapies for adults 54
Eating disorders 60
Posttraumatic stress disorder 66
Schizophrenia I: Symptoms and causes 70
Schizophrenia II: causes and treatments 76
Dementia 81
Childhood disorders 89
ABC Analysis 92
Reinforcement and punishment 93
Childhood disorders 2 94
Psychopathy - Tut 99
Childhood disorders 3 100
Lifespan psychopathy 105

Introduction

What is abnormal? Are psychological traits measurable?

- When does a personality trait become a mental disorder?
    - Shyness vs social phobia
    - Statistical deviance
- Are all mental disorders simply extremes of normal behaviour?
    - If so, what is the normal equivalent of this belief?
        - First person account of schizophrenia
- Does developmental stage matter?
    - E.g. temper tantrums - normal in second year of life but statistically deviant for a four-year old
- Is what is abnormal socially determined?
    - E.g. Fang people of Cameroon believe in witches - this is normal to believe

- Is psychopathology entirely socially determined?
- What role does culture play in abnormal behaviour?
    - Amok
- Is all suffering pathological?
    - E.g. bereavement, relationship breakup, PTSD - responses that are typical or culturally acceptable
    - Reflect suffering but are normative and not disorders
- Do all mental disorders involve suffering?
    - E.g. mania, depression
- Abnormal beliefs do not equal unrealistic beliefs?
    - E.g. depressive realism (Alloy and Abramson 1979):
        - Participants pressed a button or didn't, light turned on or didn't
        - Healthy participants overestimated their control over the light, depressed people were accurate

Classification of Mental Disorders

What are mental disorders?

- PTSD; borderline personality disorder; depression; anorexia; panic disorder; phobia; social anxiety; somatic symptom disorder; OCD; generalised anxiety disorder; Narcissistic personality disorder

Why should we care about mental disorders

- Share of population with mental health and substance use disorders 2017 and annual percentages of years of life lost and disabled that are attributable to mental health and substance use disorders - show that Australia and New Zealand are of the highest

What is classification

- Classification is 'the act or process of dividing things into groups according to their type'
- Thus, assigning things to these groups based on their shared attributes
- Mental disorders, however, are classified by symptoms that meet specific 'diagnostic criteria'

How to classify mental disorders

- Most medical disorders are classified by results of biological testing
- Mental disorders are classified by observable behaviours (signs) and self-reported feelings and thoughts (symptoms)
- Recall 'hysteria'?
    - Consisted of many symptoms, which we may now know are distinct mental disorders

Emil Kraepelin (1856-1926)

- German psychiatrist
- Grandfather of classification of mental disorders
- Published the *Compendium der Psychiatrie* in 1883
    - Defined 15 categories of mental disorders based on patterns of symptoms
- Most famous for the 'Krapeliniandichotomy':
    - Dementia praecox (schizophrenia) vs manic depression

Why should mental disorders be classified at all?

- Debatable, but some good reasons:
    - Provides a common vocabulary across psychologists, psychiatrists, GPs, social workers, governments, etc

        - Provides a guide for treatment
        - Can be used in legal setting
- Disadvantages:
    - Stigma
    - Changes self-concept (e.g. being abnormal)
    - Insurance problems

How to classify

- The categorical approach
    - Puts people into a specific group
    - Based on meeting criteria or not meeting criteria
        - Yes or no
    - Based on DM-V or ICD-11 criteria
- The dimensional approach
    - We differ along a continuum
    - How much rather than either/or
- The transdiagnostic approach
    - The latest development

How do clinicians classify mental disorders (in practice)

- Diagnostic and Statistical Manual of Mental Disorders (5th edition; DM-5)
- Diagnostic categories
    - 22 diagnostic categories in DSM-5
        - Including anxiety disorders, obsessive-compulsive and related disorders, depressive D Trauma- and Stressor-Related Disorders, Schizophrenia Spectrum Disorders, etc
- Disorders
    - E.g. the 'Anxiety Disorders' category consists of:
        - Specific phobia, social anxiety disorder, panic disorder, generalised anxiety disorder, etc
- Subtypes
    - E.g. specific phobia consists of the following subtypes: animal, natural, environment, blood-injury-injection, situational, other
- Classification changes over time
    - E.g. 5 schizophrenia subtypes in DSM-IV-TR (paranoid, disorganised, catatonic, undifferentiated and residual), removed from DSM-5

DSM Criteria for Major Depressive Disorders

1. Depressed mood most of the day, for more days than not.
2. Diminished interest or pleasure in all or most activities.
3. Significant unintentional weight loss or gain, or changes in appetite.
4. Insomnia or hypersomnia (sleeping too much).
5. Psychomotor agitation or retardation (noticed by others).
6. Fatigue or loss of energy.
7. Feelings of worthlessness or excessive guilt.
8. Diminished ability to think, concentrate, or indecisiveness.
9. Recurrent thoughts of death, suicidal ideation, or a suicide attempt.

Other depression criteria

- Must cause functional impairment
- Must not be due to substance use or medical condition (e.g. thyroid dysfunction)
- Not due to other mental disorders e.g. schizophrenia
- Must be present for 2 weeks
- Never had a manic or hypomanic episode

How common are DSM disorders?

1. Major depressive disorder (more females than males)
2. Alcohol abuse
3. Specific phobia
4. Social anxiety disorder
5. Drug abuse
6. Post-traumatic stress disorder
7. Generalised anxiety disorder
8. Panic disorder
9. Obsessive-compulsive disorder
10. Dysthymia

Limitations of the categorical approach

- Arbitrary cutoff thresholds (e.g. 5 versus 4 symptoms)
- Including a disorder in the DSM or ICD makes people believe that the disorder is real
    - A real category, different from others
- Ignores overlap between disorders when in reality there can be high comorbidity
- People classified with the same disorder may have few symptoms in common
- Poor reliability for some disorders
- Developed in the Western context (WEIRD countries)
- The line between normal and abnormal is not so clean cut as the categorical approaches would have you believe

If it's not in the DSM or ICD, is it not a disorder?

- Proposed for further study:
    - Attenuated psychosis syndrome
    - Depressive Episodes With Short-duration Hypomania
    - Persistent Complex Bereavement Disorder
    - Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure
    - Suicidal Behavior Disorder
    - Nonsuicidal Self-injury
    - Caffeine Use Disorder
    - Internet Gaming Disorder

Limitations to the categorical approach:

- Internet gaming disorder (proposed for next DSM):
    - Functional impairment
    - Preoccupation with gaming
    - Withdrawal symptoms (sadness, anxiety, irritability)