PYB 306 Exam Revision Guide

Week 1: Introduction to Psychopathology

- Defines what counts as “abnormal”, how the DSM defines a mental disorder, and how common mental disorders are

DSM-5 vs DSM-5-TR

- TR = text revision. Note: most of the change is to the supporting text, not the criteria
- They are diagnostic categorical systems – identifies categories of mental illness
- Categories group similar conditions, but where a disorder sits has changed between editions

Epidemiology

- **The study of frequency and distribution of disorders in a population** (etiology = causes or origins)
- Lifetime prevalence – USA 46%, AU 45%. Note: alcohol dependence/substance use counts as a mental disorder

Psychopathology

- Psychopathology has 3 uses:
    - Describing abnormal behaviour or functioning
    - The mental disorders (conditions, illnesses) themselves
    - The science or study of mental disorders

The DSM-5 definition of a mental disorder

- A mental disorder is a syndrome characterised by clinically significant disturbance in an individual’s cognition, emotional regulation or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental function
    - Syndrome = a cluster of symptoms
    - 3 areas can be disturbed = cognition, emotional regulation, behaviour

- 3 processes that can be dysfunctional = psychological, biological, developmental

What is abnormal behaviour? (DSM-5- view)

- Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities
- They are not:
  - An expectable or culturally sanctioned response
  - The products of social deviance or conflicts with society

Indicators of abnormality

1. Violation of social norms
2. Social discomfort
3. Irrationality/unpredictability
4. Dangerousness
5. Subjective distress or maladaptive behaviours-(unhelpful or harmful)
6. Statistical deviance = rare or unusual
7. Suffering

- No single indicator is enough as each has problems
- Mental disorders are shaped to some extent by cultural factors

Unit review check

- Psychopathology is a continuum = abnormal behaviour sits on a continuum with normal behaviour. No single indicator decides it
- Pathology is common and a major burden = lifetime prevalence is close to 50% in Australia and 46% in the USA
  - The WHO global burden of disease measures its impact
- Assessment and classification shape how we respond, they vary over time = The DSM gives a common language and enables epidemiology
  - Definitions change over time and across cultures, and threshold changes alter prevalence
- Why boundaries shift / where disorders fit = DSM categories groups similar conditions, but placement is subject to change between editions
- Understand the limits of the framework = the DSM is one of several systems, it needs to be used critically
  - DSM limitations = process criticisms (field trials, task-force composition), lowered thresholds, new disorders without a clear scientific basis,

unproven validity, reification of disorders, neuroscience not delivering, and reduced reliability

- Frame of reference: personal, medical, or other = definitions show a mind-body tension, which shapes treatments and the role of the helping professionals

Week 2: Assessment and Treatment principles

- How clinicians gather and combine info to reach a diagnosis, the main treatment paradigms, and how we know whether a treatment works

Part 1: Assessment

Purposes of Assessment

- How the assessment is framed and delivered depends on the clinician's theoretical lens
- It may include a diagnosis -> stigma is a risk -> the DSM is used for diagnosis
- Decisions should be based on clusters of information, not single facts

Diagnostic reasoning

- Diagnostic reasoning = the thinking process used to combine information into a diagnosis
- Hypothetico-deductive method = form a hypothesis and then text whether there is enough evidence for it and look for disconfirming evidence too

Methods of assessment (sources of information)

1. Clinical interview = a behavioural/observational assessment of presentation e.g., speech, appearance, emotional reactivity
    a. Gather family history/genogram
    b. Strengthens = protective factors, resources and support
2. Psychological tests = many are standardised and scores are compared with a reference group
3. Physical/medical assessment = neuroimaging, EEGs, genetic tests

Things that can distort assessment

- Biases = personal, human cognition and cultural
- Procedural/process/interpersonal factors
- "the nature of the beast" the same diagnosis can show up with different symptoms
- Accurately measuring normal behaviour

Part 2: Treatment

Definitions

- Treatment = applying techniques to relieve the symptoms of a disorder and produce better functioning
- **Psychotherapy = using psychological techniques and the therapist-client relationship to produce emotional, cognitive, and behavioural change**
- Psychotropic medications = chemical substances that affect psychological states
- More research needed on how treatments work
- Some treatments were serendipitous (accidental) discoveries, so strong research controls are needed:

Major Paradigmatic Approaches

- Biological = survival/genetic determinants, medication and non-medical treatment, bodily structures and functions
- Psychodynamic = unconscious processes, caused by early childhood, psychoanalysis treatment with focus on the unconscious mind
- Behavioural = social learning, exposure therapy, focus on observable behaviour
- Humanistic/experiential = capable of free will, determining own path, treatment = empathy, support, and acceptance
- Cognitive/CBT = maladaptive/unhelpful cognition, CBT, thought processes
- Family/couple = social processes and systems, faulty interpersonal processes, focus on role identification, communication, interactions

Comparing paradigms on four dimensions

	Biological	**Psychodynamic**	**Humanistic/experiential**	**Cognitive behavioural**
Goal	Treat the physical or brain disease process	Increases awareness of unconscious motives and defences	Increases emotional awareness e.g., reflective listening	Change contingencies – teach more adaptive cognitions and skills
Methods	Diagnostic, medications, psychosurgery, ECT	Free association, dream analysis, focus on childhood	Empathy, support, chances to explore emotions	Skills training, guided learning, behavioural rehearsal (role play),

				new cognitions, problem solving
Length	Brief	Long-term	Variable, not typically structured	Short term with booster sessions
Therapist role	Active, directional, diagnostician	Passive, non-directive	Passive, non-directive supporter	Active, directive, non-judgemental, teacher

Combined vs eclectic therapy

- **Combined = uses 2 or more treatment approaches together e.g.,** biological + psychological = biopsychosocial approach, treated through medication + psychotherapy for depression or schizophrenia
- **Eclectic therapy = selects techniques from different therapies based on the individual** e.g., interpersonal or multimodal therapy, more client-centric and common

Harmful therapies

- All treatment has the potential to harm e.g., side effects, breach of trust, loss of liberties (against own will)

Harmful psychological therapy	**What it involves**	**Potential harm**
Critical incident stress debriefing	Processing trauma too soon	Increased risk of PTSD
Scared straight	Seasoned inmates scare young people about the consequences of crime	Increased conduct problems

Does psychotherapy work?

- A landmark 1977 meta-analysis supported the effectiveness of psychotherapy
- Most research comes from North America, so it may not be generalisable
- Therapy works for many but not all people
- The average client is better off than 80% of untreated people
- 2/3 of clients improve vs only 1/3 of people who don't seek therapy
- Most improvement happens in the first six months

Knowing what works: research design issues

- How trial participants are selected, and how representative they are
- Treatment fidelity = was the treatment delivered as intended?
- Nature of trial and length of follow-up

Types of studies

- efficacy study = tests whether a treatment works under ideal, tightly controlled conditions
- effectiveness study = tests whether it works in real-world clinical settings
- pragmatic trial = designed to assess effectiveness in everyday, real-world practice
- case series = describes outcomes in a group of patients without a controlled comparison

Placebo and common factors

- Placebo = beliefs and expectations about a treatment help
- Common factors = aspects shared by all treatments that predict a positive response whatever the approach e.g., therapist attributes
- Causal inferences = hard to infer that improvement was caused by the treatment

Summary

- Each paradigm suggests different treatments; some are **controlled by certain professions** (e.g. only doctors prescribe).
- Biological, psychological and social therapies can all have **aversive or unintended effects**. Clients must be told about **known and unknown risks**.
- **Common factors matter**, but there's growing evidence for **specific therapies for specific disorders**.
- Clients should be told about the **research evidence and alternatives**.

Unit review check

- Assessment is critical; identify best practice = know the sources of information (interview, psychological tests, physical/medical assessment) and their pros and cons, reliability, validity, standardisation
    - The hypothetico-deductive method = question -> hypothesis -> prediction -> test -> conclusion

1. Identify a problem/question = what do I want to know?
2. Form a hypothesis = make a testable prediction
3. Deduce predictions = what should happen if the hypothesis is correct?
4. Test the predictions = collect data/evidence
5. Evaluate results = support, reject, or modify the hypothesis

- Treatment reflects trends in models of mental illness = each paradigm (biological, psychodynamic, behavioural, humanistic, CBT, family) implies its own cause and treatment
- How well do frameworks work? How should we evaluate treatments? = efficacy (how well something works when it is used under ideal/controlled conditions) vs effectiveness (how well something works under normal conditions)
    - Meta-analysis limitations
        - file-drawer problem = studies with non-significant or negative results are less likely to be published
        - no individual prediction = tells us about the average effect across a group
    - treatment fidelity = how closely a treatment is delivered according to the intended/protocolled treatment
    - participant representativeness
    - follow-up length
    - outcomes measured
    - success doesn't prove aetiology (the cause or origins of a disease)
- assess factors of your assessment approach; overcome cognitive and cultural biases = assessment is distorted by personal, cognitive, and cultural biases and process factors
    - counter them with testable hypotheses, standardised methods and a search for disconfirming evidence
- use results to craft a response (diagnosis, treatment plan) = diagnostic reasoning combines clusters of information into a diagnosis, then an evidence-based treatment (Nurcombe & Fitzhenry-Coor, 1987)
- putting people first: common factors (alliance, support, hope) = common factors (therapist, client and illness attributes) predict improvement whatever the approach. Clients should be informed of risks and alternatives.
- Biopsychosocial model = combined therapy (biological + psychological) is consistent with a biopsychosocial approach
- Prevention = WHO prevention strategies
    - Primary = prevent it BEFORE it happens
    - Secondary = catch it EARLY
    - Tertiary = reduce the IMPACT (treat/manage)

Week 3: Mood Disorders (Depressive & Bipolar)

- Covers depressive and bipolar disorders: how they're defined in the DSM-5, how to tell them apart, what causes them, how they're treated, and suicide prevention

Part 1: Defining mood disorders

- Mood = a pervasive and sustained emotional response
- Mood disorders are defined by mood episodes: periods when behaviour is dominated by "ups" and "downs"
- Euthymia = normal mood

Spectrum of "downs"

- Dysphoria/dysthymia: lower mood, unpleasant but not as severe
- Depression: pervasive and sustained low mood plus related behaviours and symptoms

Spectrum of "ups"

- Euphoria: intense well-being, excitement, over-confidence, over-optimism
- Hypomania: increased energy, less severe than mania
- Mania: elevated mood, inflated self-esteem and associated symptoms

Impacted domains

- Emotional = mood extremes, ups and downs
- Cognitive = effects abilities, appraisals = grandiosity and inflated self-esteem, or the depressive negative triad
- Somatic (bodily) = fatigue, energy levels, pain threshold, appetite, sleep
- Behavioural/affective = psychomotor slowing vs agitation

Depression vs normal sadness

- Depression differs from normal sadness when the mood change:
    - Is pervasive and persistent and doesn't improve
    - Affects day-to-day functioning
    - Comes with extra cognitive, somatic and behavioural signs and symptoms

How the DSM groups mood disorders

- Previously in DSM-IV mood disorders = depressive + bipolar disorders in one category
- Now DSM-5 = separate chapters for depressive disorders and bipolar disorders
- Specifiers = add details to describe a person's disorder more precisely

Depressive disorders

- Common features = a primary impairment involving sad, empty, or irritable mood, plus somatic and cognitive changes. They differ in duration, timing, severity, and presumed aetiology (cause)

DSM-5 depressive disorders

- Disruptive mood dysregulation disorder (DMDD) = new in DSM-5, children aged 6-18, chronic, severe, persistent irritability
    - Alen Francis critique = temper tantrums are now a mental disorder
- Premenstrual dysphoric disorder (PMDD) = new, a severe form of PMS
- Major depressive disorder (MDD), retained "classic" condition, 5+ of 9 symptoms over 2 weeks
- Persistent depressive disorder (PDD) = merged, chronic, milder, over years
- Depressive disorder NOS (not otherwise specified) /due to another medical condition = in other categories, diagnostic due to medical condition or substance use
- DSM-5-TR adds unspecified mood disorder
- DSM-5 removed the bereavement (loss) exclusion

Major depressive episode/disorder

Criterion A

- **Need more than 5 of these 9 symptoms over the same 2-week period and needs to include 1 and 2**

1. **Depressed mood –** most of the day, nearly every day
2. **Markedly diminished interest or pleasure** in all or almost all activities (anhedonia = loss of pleasure)
3. Significant **weight loss or gain** or appetite change
4. **Insomnia or hypersomnia**
5. **Psychomotor agitation or retardation**
6. **Fatigue** or loss of energy

7. Feelings of **worthlessness** or excessive **guilt**
8. Diminished ability to **think, or concentrate, or indecisiveness**
9. Recurrent **thoughts of death,** suicide ideation, a suicide attempt or a specific plan

- Multiple episodes = a diagnosis of MDD
- MDD differs across cultures

Bereavement

- DSM-5 removed the bereavement exclusion – MDD after loss can be diagnosed
- Allen Frances criticised this as normal grief will become MDD

Bipolar disorders

- Common feature = a primary impairment of mood with a manic or hypomanic component

DSM-5 bipolar diagnoses

- Bipolar I = at least one manic episode
    - A distinct period of changed mood lasting about a week
    - Abnormally elevated, expansive or irritable modo plus increased energy
- Bipolar II = depressive episode + hypomania
    - Same symptoms as mania, but shorter, milder and less severe, lasting at least 4 consecutive days and past depression
- Cyclothymia = chronic, fluctuating mood disturbance for 2+ years

Part 2: Causes, prevalence and care

Depressive disorders

- One of the most common forms of psychopathology
- Comorbidity with anxiety
- Episodes can recur
- Major impact = lost productivity and suicide risk
- Depression is expected to increase, with a younger age of onset, and higher rates in young people
- Cognitive vulnerability = maladaptive/unhelpful schemas give rise to low mood and then people blame themselves for thinking/feeling that way

Bipolar disorders

- Manic episodes are highly likely to recur
- Onset is younger than depression
- Precipitating factors = schedule-disrupting events e.g., disrupted sleep or routine
- Genetic contribution is especially influential in bipolar I

Treatment

Depressive disorders

- Social approaches = meaning-making, life roles
- Psychological = cognitive therapy, interpersonal therapy, CBT
- Biological approaches
- Combination
- Depressive symptoms can be treated successfully

Bipolar disorders

- Medication = mood stabilisers
- Psychotherapy = cognitive therapy, interpersonal therapy

- Choose treatment based on individual factors

Suicide and suicide prevention

Risk factors

- In Australia, suicide rates are higher in older people
- Rates are higher in ABTSI people and especially younger increased by incarceration
- Risk factors = presence of a mental disorder, decreased feelings of belonging, feeling like a burden

Intervention principles

- Population level = gun control
- Individual, emergency = crisis centres
- Individual, non-emergency = psychotherapy

Targeting high-risk groups

- Older people = build social support, meaning and contribution

Unit review check

- Definition, aetiology, epidemiology (frequency), treatment
    - Symptoms & duration = MDD – need 5/9 symptoms over 2 weeks
    - Causes = stressful life events, maladaptive schemas, less reinforcement, genetics (especially bipolar I)
    - Treatment = CBT, IPT (interpersonal psychotherapy = focuses on improving interpersonal relos and social functioning), cognitive therapy, medication (mood stabilisers for bipolar)
- Common presentations (epidemiology) = depressive disorders = among most common, mean onset 32, rising in young people
- More-vs-less-established biological bases = moderate – a genetic contribution (strongest in bipolar I) and neuroimaging findings, but psychosocial triggers matter (life events, schedule disruption)
- Little change vs radical reframing in DSM-5
    - reframed – mood disorders split into separate depressive and bipolar chapters
    - DMDD (disruptive mood dysregulation disorder for child/adolescent) and PMDD (premenstrual dysphoric disorder) = new
    - PDD (persistent depressive disorder/dysthymia) merged
    - Bereavement (loss) exclusion removed
    - MDD retained
- Why boundaries shift/thresholds = DMDD turns tantrums into a disorder, removing the bereavement exclusion medicalises grief
- Putting people first: special needs, complex situations = suicide prevention at multiple levels (population, emergency, non-emergency), adapted for older people, young adults and Indigenous Australians (culturally appropriate language)