Lecture 1: Definitions, models, normality, abnormality, & diagnosis

Normality vs. Abnormality

- Factors
    - Statistical infrequency attributed to cultural norms – consider IQ, physical strengths (uncommon – abnormal; common – normal)
    - Norm violation – consider tattoos (violates – abnormal; non-violating – normal)
    - Personal distress – consider usual emotions
    - Disability/dysfunction (behavioural, emotional, cognitive)
    - Unexpectedness

Psychopathology

- Definition
    - Study of nature, causes and development of abnormal behaviour, thoughts and feelings
    - Describe behaviour, thoughts or feelings indicating a mental illness, even if they do not constitute a formal diagnosis
- Considerations
    - Clinical description
    - Causation (Aetiology)
    - Treatment and outcome
- Function of diagnosis/classification
    - Assists communication
    - Provides information about individual's experience, cause, treatment, prognosis
    - Collects and communicates health statistics and research
- Criticism against diagnosis/classification
    - Bias or restrict thinking
    - Associated with jargon
    - Inhibit research
    - Stigmatising
    - Assumption that emotional distress and gamily and personal turmoil are diseases
    - Question "boundaries of madness" (R. Bentall)
    - View of church of scientology

Terminology: Descriptive psychopathology

- Presenting problem
- Clinical picture/clinical description
- Prevalence, incidence
- Age of onset
- Acute onset, insidious onset
- Course (episodic, recurrent chronic, time-limited)
- Prognosis
- Signs: objective findings observed by a clinician

    - Tachycardia (rapid heartbeat rate)
    - Accelerated speech
    - Poor eye contact
- Symptoms: subjective complaints reported by a patient
    - Low mood
    - Derealisation
    - Paranoia
- Syndrome: signs, symptoms and events that occur in a particular pattern and indicate the existence of a disorder
    - Bipolar disorder
    - Obsessive compulsive disorder
    - Schizophrenia
- Disorder: a syndrome that can be discriminated from other syndromes; distinct course to syndrome, described age and gender characteristics, may know prognosis
- Disease: indications of abnormal physiological processes or structural abnormalities
    - Multi-intact dementia

Classification

- Categorical: divided based on criteria sets with defining features
- Dimensional: quantified on a scale
- Prototypical approach: identifies essential characteristics of a disorder and optional non-essential characteristics

Categorical vs. Dimensional

- Categorical
    - Better clinical and administrative utility
    - Easier communication
- Dimensional
    - Lack boundaries between disorders and abnormality
    - Greater capacity to detect change and facilitate monitoring
    - Can develop treatment0relevant symptom targets (not aiming at resolution of disorders but symptoms)

Classification systems

- Caveat re diagnosis
    - DSM diagnoses are “constructs” (not proven entities)
        - Diabetes: proven entity with known biological causes
        - Schizophrenia: defined by proposed criteria and incomplete understanding of cause
    - Impairment is crucial in making a diagnosis
    - Limitations of categorical approach
    - Use of clinical judgement
    - Ethnic/Cultural considerations
    - Classifications describe diseases, not people

Models of mental illness/psychopathology

- Biological Paradigm
    - Genetics

    - Structural brain damage
    - Discorded physiology (eg. inflammation processes and depression)
    - Neurochemistry
    - Other (eg. viruses, season of birth and schizophrenia)
- Cognitive and social learning models
    - Social and developmental factors
    - Learned behaviour
        - Bandura's social learning theory
        - Operant behaviour
        - Classical conditioning
        - Cognitive model
    - Psychoanalytic paradigm
        - Structure (eg. Id, ego, superego)
        - Stages of psychosexual development (eg. oral, anal, phallic, and latency stages)
        - Defence mechanisms (eg. projection, splitting and denial)
    - Stress-vulnerability models
        - Resilience (family environment, temperament, self-esteem, temperament, previous experience with stressors)
            - Ability to adapt to stress and adversity
            - ABC model: individual's interpretation of an event that results in emotional and behavioural responses
    - Biopsychosocial models
        - Biological factors (normal biology, disease processes, genetic influences)
        - Psychological factors (thoughts, feelings, perceptions)
        - Social/Environmental factors (culture, ethnicity, social environment)
    - Clinical staging model
        - Mental disorders develop over time with worsening severity
        - Aims to define various stages of development of disorder
        - Preventive focus (stop emergence of first episode of disorder)
        - If prevention is not possible, then prevent progression to later stage, prevent worsening and poor prognosis
        - Aims to use more universal conventions (less cost, harmful, intense)
        - Stages
            - 0 – increased risk of psychotic disorder (no symptoms)
            - 1a – mild or non-specific symptoms (includes neurocognitive deficits of psychotic disorder, mild functional change or decline)
            - 1b – ultra high risk moderate but sub-threshold symptoms (includes moderate neurocognitive changes and functional decline)
            - 2 – full threshold disorder with moderate symptoms; first episode of psychotic disorder (includes neurocognitive deficits and functional decline)
            - 3a – incomplete remission from first episode of care