PSY3032 Abnormal Psychology – READING NOTES

Week 1

Chapter 1: Introduction and Historical Overview

Psychopathology: field concerned with nature, development, treatment of mental disorders

Challenge = remain objective

Stigma: destructive beliefs/attitudes ascribed to groups considered different – 4 characteristics

1. Distinguishing label applied
2. Label linked to deviant or undesirable attributes by society
3. People with label seen as different – contributes to 'us vs. them'
4. People with label are discriminated against

Defining Mental Disorder (MD)

- Disorder occurs within the indv
- Involves clinically significant difficulties in thinking, feeling, behaving
- Involves dysfunction in processes that support mental functioning
- Not a culturally specific reaction to an event
- Not primarily a result of social deviance or conflict with society

4 Characteristics of Mental Disorder Definition

1. Disability
2. Distress
3. Violation of social norms
4. Dysfunction

MDs usually determined based on presence of several characteristics

History of Psychopathology

Early Demonology

- Demonology = doctrine that an evil being/spirit can dwell in a person and control their mind/body
- Demonological thinking in early Chinese, Egyptians, Babylonians, Greeks, Hebrews
- Belief that odd behaviour was caused by possession led to treatment by **exorcism** – ritualistic casting out of evil spirits

Early Biological Explanations

- Hippocrates separated medicine from religion, magic, superstition – rejected Greek belief that gods sent mental disturbances as punishment + insisted on natural causes
- Hippocrates regarded the brain as the organ of consciousness, intellectual life, emotion
- Believed that disordered thinking/behaviour were indications of brain pathology

Hippocrates classified mental disorders into 3 categories

1) **Mania**
2) **Melancholia**
3) **Phrenitis (brain fever)**

➔ HP believed normal brain functioning depended on balance of 4 humours/fluids – blood, black bile, yellow bile, phlegm
➔ Imbalance = disorders
➔ Phlegm = sluggish, dull
➔ Black bile = melancholia
➔ Yellow bile = irritability, anxiousness
➔ Blood = changeable temperament

The Dark Ages and Demonology

- Death of Galen (physician of classical era) as beginning of dark ages in western European medicine + investigation of MDs
- Greek + Roman civilisation crumbled, Church gained influence
- Christian monasteries replaced physicians as healers + authorities on MD – monks cared for sick
- Mentally ill indvs roamed countryside, getting worse
- Return to belief in supernatural causes of MD

Persecution of Witches

- 13th century - in response to social unrest, famines, plagues – witchcraft seen as heresy + denial of God
- Manual *Malleus Maleficarum (witches hammer)* to guide witch hunts
- People accused of being witches were probably mentally ill

- Confessions obtained during torture

Lunacy Trials
- Municipal authorities supplemented activities of the Church – ie the care of mentally ill indvs
- People hospitalised were not described as being possessed
- Lunacy trials to determine a person's MH were held in England
- Trials conducted to protect people with mental illness, judgement of insanity allowed the Crown to become a guardian of the lunatic's escape
- Strange behaviour usually attributed to physical injury/illness or emotional shock

Development of Asylums
- 15th century – leprosariums converted to asylums – refuges for the confinement and care of people with MI

Bethlehem and Other Early Asylums
- Priory of St. Mary of Bethlehem founded in 1243 – housed people with MI, conditions were SHIT
- Lunatics Tower – Vienna 1784 – patients could be observed by passers-by
- Medical treatments were crude/painful

Pinel's Reforms
- Philippe Pinel – primary figure in movement for humanitarian treatment of indvs in asylums
- Pinel changed the way things were run at La Bicetre – believed patients were human beings, should be approached with compassion + understanding
- BUT – Pinel reserved the more humanitarian treatment for the upper classes – patients of lower classes still subjected to terror/control

Moral Treatment
- Therapeutic regimen, introduced by Pinel during French Revolution
- Mentally ill patients were released from their restraints and were treated with compassion/dignity rather than contempt/denigration
- Moral treatment abandoned in late 19th century

<u>The Evolution of Contemporary Thought</u>

Biological Approaches

General Paresis + Syphilis
- ➔ Louis Pasteur – proposed germ theory of disease – that disease is caused by infection by minute organisms
- ➔ Theory demonstrated relation b/w syphilis and general paresis
- ➔ 1905 - causal link established between infection, destruction of brain areas, and a form of psychopathology (general paresis)

Genetics
- Francis Galton – originator of genetic research with twins, attributed man behavioural characteristics to heredity
- Coined terms nature + nurture
- Galton also created eugenics movement in 1883 –eliminate undesirable characteristics from population by restricting ability of certain indvs to have children (via enforced sterilisation)
- Courts in USA had laws prohibiting people with MI from marrying, forced sterilisation

Biological Treatments
- ➔ Warehousing of patients, shortage of professional staff – created climate that encouraged experimentation with radical interventions
- ➔ Early 1930s – inducing coma with large doses of insulin
- ➔ Early 20th century – electroconvulsive shock therapy (ECT) created by Cerletti + Bini - given to people with SCZ + depression in hospitals
- ➔ 1935 – Moniz introduced prefrontal lobotomy – procedure that destroys tracts connecting the frontal lobes to other brain areas

Psychological Treatments

Mesmer and Charcot
- Mesmer believed hysteria was caused by a distribution of a universal magnetic fluid in the body
- Felt that one person could influence fluid of another person to bring change in behaviour
- Mesmer regarded as an early-practitioner of hypnosis
- Charcot – also studied hysterical states – believed hysteria was a problem with the nervous system + had a biological cause
- Charcot also used hypnotism

Breuer and the Cathartic Method
- ❖ Breuer found that relief of a particular symptoms lasted longer if under hypnosis – indv was able to recall event + express emotion
- ❖ Relieving earlier emotional trauma + releasing emotional tension by expressing previously forgotten thoughts = CATHARSIS

Freud and Psychoanalysis
- Freud – human behaviour is determined by forces inaccessible to awareness
- Psychoanalytic theory – psychopathology results from unconscious conflicts in the indv

Structure of the Mind (Psyche)
1. **Id – repository of energy needed to run psyche – basic urges for food, affection, sex – biological (energy = libido) – unconscious**

- Id operates on pleasure principle – seeks immediate gratification + release of tension
- Fantasy used to relieve tension

2. Ego – deals with reality – conscious

- Ego operates on reality principle – mediates demands of reality + id's demands for immediate gratification

3. **Superego – person's conscience – arises from ego**

- Superego operates on moral principle

Defence Mechanisms: strategy used by ego to protect itself from anxiety

Defence Mechanism	Definition
Repression	Keeping unacceptable impulses/wishes from conscious awareness
Denial	Not accepting a painful reality into conscious awareness
Projection	Attributing to someone else one's own unacceptable thoughts/feelings
Displacement	Redirecting emotional responses from their real target to someone else
Reaction formation	Converting an unacceptable feeling into its opposite
Regression	Retreating to the behavioural patterns of an earlier stage of stage of development
Rationalisation	Offering acceptable reasons for an unacceptable action/attitude
Sublimation	Converting unacceptable aggressive/sexual impulses into socially valued behaviours

Psychoanalytic Therapy

- Goal of therapist = understand the person's early-childhood experiences, nature of key relationships, patterns in current relationships
- Therapist listening for core emotional + relationship themes
- Techniques:
- **Free Association:** patient voices whatever comes to mind
- **Transference:** refers to patient responses to analyst that reflect attitudes/ways of behaving toward important people in patient's past
- Rather than reflecting actual aspects of the analyst-patient relationship
- **Interpretation:** analyst points out meanings of certain patient behaviours – defence mechanisms are the focus

Neo-Freudian Psychodynamic Perspectives

Carl Jung and Analytical Psychology

- Jung hypothesised – in addition to personal unconscious (Freud) there is a collective unconscious – common to all people
- Collective unconscious consists of archetypes – basic categories all humans use in conceptualising the world
- Each of us has masculine + feminine traits, spiritual urges are like id urges
- Personality characteristics – extraversion vs. introversion

The Rise of Behaviourism

Behaviourism: focuses on observable behaviour rather than on consciousness or mental functioning

Classical Conditioning

- Neutral stimulus repeatedly paired with unconditioned stimulus (UCS) that naturally elicits a certain desired response (unconditioned response, UCR)
- After repeated trials – neutral stimulus becomes a conditioned stimulus (CS) and evokes the same response – now called the conditioned response (CR)
- **Extinction:** when CS is not followed by UCS = fewer CRs – CR gradually disappears

Operant Conditioning

- Thorndike studied effects of consequences on behaviour
- **Law of Effect:** behaviour followed by satisfying consequences will be repeated, behaviour followed by unpleasant consequences will be discouraged
- Skinner – introduced operant conditioning – 2 types of reinforcement
- **Positive reinforcement =** strengths a response by presenting a pleasant event
- **Negative reinforcement =** also strengthens a response BUT does so by removing an aversive event

Modelling: learning through observation of others, occurs in absence of reinforcement

Behaviour Therapy

- Applies procedures based on classical + operant conditioning to alter clinical problems
- Aka behaviour modification
- **Systematic Desensitisation -** 2 components
  1. Deep muscle relaxation
  2. Gradual response to a list of feared situations – starts with those that arouse minimal anxiety, progresses to most frightening
- Operant techniques used to extinguish undesirable behaviour – eg childhood problems

Cognitive Therapy

- Cognitive therapy emphasises that how people construe themselves and the world is a determinant of psychological disorders
- Patients become aware of maladaptive thoughts
- **Rational-Emotive Behaviour Therapy (REBT):** idea that sustained emotional reactions are caused by internal sentences that people repeat to themselves
- These self-statements can be irrational

Chapter 3: Diagnosis and Assessment

Diagnosis: allows clinician to describe base rates, causes, treatment – enables clinicians to communicate with one another

- To make a diagnosis – variety of assessment procedures used
- Begins with clinical interview

Cornerstones of Diagnosis and Assessment

Reliability and validity are the cornerstones of any diagnostic or assessment procedure

Reliability: refers to consistency of measurement – eg a ruler

Inter-rater Reliability: degree to which 2 independent observers agree on what they have observed

Test-Retest Reliability: extent to which people being observed twice or taking the same test twice, receive similar scores (6 month interval)

- Used when underlying variable being measured won't change

Alternate-Form Reliability: extent to which scores on the two forms of the test are consistent

Internal Consistency Reliability: assesses whether the items on a test are related to one another

Validity: related to whether something measures what it is supposed to measure

Validity is related to reliability – unreliable measures have shit validity – NO VALIDITY WITHOUT RELIABILITY

- But reliability doesn't guarantee validity

Content Validity: whether a measure adequately samples the domain of interest

Criterion Validity: evaluated by determining whether a measure is associated in an expected way with some other measure (the criterion)

Concurrent Validity: resulting validity when both variables are measured at the same point in time

Predictive Validity: ability of the measure to predict some other variable that is measured at some point in the future

Construct Validity: evaluated by consulting data from multiple sources (compared to criterion validity, where a test is evaluated against just one other piece of data)

- Relevant when we want to interpret a test as a measure of some characteristic/construct that is not observed overtly
- Construct = inferred attribute – eg anxiousness
- Construct validity is central to diagnostic categories – eg in the DSM

Classification and Diagnosis

The DSM-5

- Has been revised 5 times since 1952
- DSM-IV-TR (2000) – provided a summary of new research findings on prevalence rates, course, aetiology (cause) but no changes to diagnostic criteria

2 major innovations introduced by DSM-III retained by each edition since:

1. **Specific diagnostic criteria -** symptoms for a given diagnosis – spelled out precisely, clinical symptoms defined in a glossary
2. **Characteristics of each diagnosis are described more extensively –** each disorder has a description of essential features, associated features, lab findings, results from physical exams

Multiaxial Classification System: DSM-IV-TR has 5 axes – requires judgements on each of the fives axes, forces clinician to consider more info

Five DSM-IV Axes

- **Axis I:** Clinical disorders, other conditions that may be focus of clinical attention
- **Axis II:** personality disorders and mental retardation
- **Axis III:** general medication conditions
- **Axis IV:** psychosocial and environmental problems
- **Axis V:** global assessment of functioning

Removal of Multiaxial System

- Multiaxial system from DSM-IV has been removed from DSM-5
- First 3 axes = psychiatric and medical diagnoses

- Psychosocial and environmental problems = psychosocial and contextual factors
- Global assessment of functioning = disability
- Changed to be more similar to those used by the international community in the WHO International Classification of Diseases (ICD)

Organising Diagnoses by Cause

- DSM-5 defines diagnoses on the basis of symptoms
- Our knowledge base is not strong enough to organise diagnoses around aetiology
- No lab tests, neurobiological markers, genetic indicators to use in diagnosis
- DSM-5 – chapters reflect patterns of comorbidity + shared aetiology

Ethnic and Cultural Considerations in Diagnoses

DSM-IV-TR enhanced cultural sensitivity in 3 ways

(1) Providing a general framework for evaluating role of culture/ethnicity
(2) Describing cultural factors for each disorder
(3) Listing culture-bound symptoms in an appendix

DSM-5 – culture-bound syndromes relabelled as cultural concepts of distress

- DSM-5 also includes cultural formation interview – 16 questions

- In general framework – clinicians are cautioned not to diagnose symptoms unless they're atypical + problematic within a person's culture
- People vary in degree to which they identify with a culture

Criticisms of the DSM

1. **Too Many Diagnoses**
    - DSM-5 contains more than 300 different diagnoses
    - May be too many distinctions based on small differences in symptoms
    - Comorbidity is the NORM rather than the EXCEPTION
    - Of the people who meet criteria for one disorder – 45% meet criteria for another
    - Many risk factors trigger more than one disorder

2. **Categorical Classification vs. Dimensional Classification**
    - DSM-IV-TR = **categorical** classification (do they have it or not, doesn't consider continuity between normal + abnormal behaviour)
    - Categorical system forces clinician to define one threshold as 'diagnosable' – popular because cut-offs provide guidance
    - Categorical diagnoses foster false impression of discontinuity
    - **Dimensional –** systems describe the degree of an entity that is present
    - DSM-5 has categorical approach, dimensional approach to personality disorders

3. **Reliability of DSM in Practice**
    - Increased explicitness of DSM criteria has improved reliability
    - But reliability in everyday use may be lower

4. **Validity of Diagnostic Categories**
    - Diagnoses have construct validity is they help make accurate predictions
    - Certain categories have less validity than others

<u>Psychological Assessment</u>

Clinical Interviews

- Interviewer pays greater attention to how person answers/doesn't answer questions – different from a casual conversation
- Clinicians must establish rapport + obtain trust
- Clinicians can empathise with clients to draw them out – eg make an accurate summary of what client has been saying
- Structured or unstructured

Structured Interview: questions are set out in a prescribed fashion for the interviewer – eg Structured Clinical Interview (SCID) for Axis 1 of DSM-IV

Psychological Tests – structure process of assessment – 2 types

1. Personality tests
2. Intelligence tests

Self-Report Personality Inventories

- Personality inventory – person completes self-report questionnaire indicating which statements apply to them

- Statistical norms established via standardisation
- Minnesota Multiphasic Personality Inventory developed 1943, revised 1989

Projective Personality Tests

- ➔ Projective test – ambiguous stimuli presented to person – eg inkblots, drawings
- ➔ Assumption = because the stimulus is unstructured/ambiguous, the person's responses will be determined by unconscious processes and true attitudes, motivations, behaviour will be revealed (aka projective hypothesis)
- ➔ Use of projective tests assumes that respondent is unable/unwilling to express their true feelings

Thematic Apperception Test (TAT)

- ➔ Black and white pictures shown, asked to tell a story about each
- ➔ Few reliable scoring methods
- ➔ Norms based on small + limited sample
- ➔ Limited construct validity

Rorschach Inkblot Test

- ➔ Shown 10 inkblots, asked what the inkblots look like
- ➔ Exner Scoring System used to score the Rorschach – concentrates on the perceptual + cognitive patterns in responses
- ➔ Responses viewed as a sample of how client perceptually/cognitively organises real-life situations

Intelligence Tests: aka IQ tests, assess current mental ability

- IQ tests based on assumption that a sample of current intellectual functioning can predict how well indv will perform in school
- Most common = Weschler Adult Intelligence Scale (WAIS-IV), Weschler Intelligence Scale for Children (WISC-IV), WPPSI-III, and the Stanford-Binet 5
- IQ tests are standardised

IQ tests tap several functions believed to constitute intelligence

1. Language skills
2. Abstract thinking
3. Nonverbal reasoning
4. Visual-spatial skills
5. Attention and concentration
6. Speed of processing

Scores are standardised so that 100 is the mean and 15 or 16 is the standard deviation

- 65% of gen. pop. receives scores between 85 and 115
- 2.5% below 70 or above 130

Behavioural and Cognitive Assessment

Direct Observation

- Formal behavioural observation – observer divides the sequence of behaviour into parts that make sense within a learning framework
- Including things like antecedents and consequences of particular behaviours
- Cognitive behavioural clinician's way of conceptualising a situation implies a way to try changing it

Self-Observation

- Self-monitoring – used to collect data about moods, stressful experiences, coping behaviours, thoughts
- Methods for EMA range from diary-keeping at specific times to supplying smartphones that signal when to report and input directly into the phone
- Behaviour can be altered by the fact it's being self-monitored
- **Reactivity –** where behaviour changes because it's being observed
- Desirable behaviour increases + undesirable behaviour decreases when self-monitored

<u>Neurobiological Assessment</u>

Brain Imaging

1. **CT or CAT Scan**
    - Computerised axial tomography
    - Helps assess brain structural abnormalities (also can image other body parts)
    - Moving beam of X-rays passes into a horizontal cross-section of the brain – scans through 360 degrees
    - X-ray detector measures amount of radioactivity that penetrates – detects differences in tissue density
    - Compute constructs a 2D image of the cross-section with contrasts
    - Images can show enlargement of ventricles, locations of tumours + clots

2. **MRI**
    - Superior to CT because it produces higher quality pictures + doesn't rely on radiation
    - Person placed in large magnet, causes hydrogen atoms in body to move
    - When magnetic force is turned off – atoms return to their original positions + produce an electromagnetic signal
    - Signals read by computer which creates pictures of brain tissue - Structural images

3. **fMRI**
    - Allows measurement both brain structure and function
    - Takes MRI pictures so quickly that metabolic changes can be measured – provides picture of brain at work, not just structure
    - fMRI measures blood flow in the brain – called the **BOLD signal** – blood oxygenation level dependent
    - As neurons fire – blood flow increases to that area
    - Blood flow in a particular region is a proxy for neural activity there

4. **PET Scan**
    - More expensive + invasive – not used much anymore
    - Measures structure and function – measurement of structure is not as precise as MRI or fMRI
    - Substance used by the brain is labelled with a short-lived radioactive isotope + injected into bloodstream
    - Radioactive molecules of substance emit a particle **(positron)** – which collides with an electron
    - Light particles shoot from the skull and are detected by the scanner
    - Computer analyses millions of these recordings to create a picture of the functioning brain
    - Images are in colour – fuzzy spots of lighter/warmer colours = areas where metabolic rates for the substance are higher

Current neuroimaging studies in psychopathology are trying to identify dysfunctional brain areas AND deficits in ways different brain areas communicate with one another = **FUNCTIONAL CONNECTIVITY ANALYSIS**

- Functional connectivity analysis aims to identify how different brain areas are connected

Neurotransmitter Assessment

- ➔ Method of NT assessment = analysing the metabolites of NTs that have been broken down by enzymes
- ➔ **Metabolite:** an acid, produced when an NT is deactivated
- ➔ By-products of the breakdown of NTs (eg norepinephrine, dopamine, serotonin) are found in urine, blood serum, cerebrospinal fluid (CSF)
- ➔ Metabolite of dopamine = homovanillic acid
- ➔ Metabolite of serotonin = 5-hydroxyindoleacetic acid
- ➔ High level of a particular metabolite = high level of a NT, vice-versa

Problem with metabolite studies: they are correlational – causation cannot be determined

Neuropsychological Assessment

- ➔ Neurologist – specialises in problems that affect the nervous system – eg stroke, muscular dystrophy, AZD
- ➔ Neuropsychologist – studies how dysfunctions of the brain affect the way we think, feel, behave
- ➔ Neuropsychological tests – use in conjunction with brain imaging to detect brain dysfunction + pinpoint areas of behaviour impacted by problems in the brain

Halstead-Reitan Test Battery

1. Tactile Performance Test-Time
2. Tactile Performance Test-Memory
3. Speech Sounds Perception Test

- Battery is valid for detecting behaviour changes linked to brain dysfunction from tumours, stroke, head injury

Luria-Nebraska Battery – 269 items divided into 11 sections testing broad range of things

- Can be administered in 2 ½ hours, scored in a reliable way
- Advantage of LN – one can control for educational level so that a less educated person will not receive a lower scores b/c of limited education

Psychophysical Assessment

- ➔ Psychophysiology – concerned with bodily changes associated with psychological events
- ➔ Measures like heart rate, tension in muscles, blood flow in body parts
- ➔ Assessments not sensitive to be used for diagnosis but can provide info about reactivity, comparison b/w indvs
- ➔ **Electrocardiogram (EKG) –** measures heart rate
- ➔ **Electrodermal Responding** – skin conductance, sweat-gland activity boosts electrical conductance of the skin
- ➔ **EEG –** record electrical activity in underlying brain area

<u>Cultural and Ethnic Diversity and Assessment</u>

Cultural Bias

- Measures developed for one culture/ethnic group may not be reliable/valid with different cultural groups
- Tests have been translated but translation doesn't ensure the meaning of the words is the same
- Working with translators, testing with native speakers can combat this – used with MMPI-2
- Bias can exist in tests
- DSM-5s emphasis on cultural factors can sensitize clinicians – first step

Strategies for Avoiding Cultural Bias in Assessment

- Graduate training programs used to minimise negative effects of cultural bias
    1. Students learn about basic issues in assessment – eg reliability, validity
    2. Students become informed about specific ways a culture may impact assessment – not rely on stereotypes
    3. Students consider culture may not impact assessment in every case

- Assessment procedures can be modified to ensure person understands task requirements
- Examiner may need to make extra effort to establish rapport for best performance
- Clinicians should be tentative about drawing conclusions about patients from different cultures – make hypos only

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Week 2 – PDFs

Is the degree of demoralization found among refugee and migrant populations a social-political problem or a psychological one? – Briggs et al

Findings support the view that social and cultural issues play a role in understanding the degree of psychological distress among culturally diverse clients

Introduction

- People coming from non-English speaking cultures don't understand the concept of mental ill health - or they associate it with the more severe disorders that require psychiatric intervention
- Combination of being faced with the realities of migration alongside social isolation from extended family and friends can result in individuals feeling a sense of alienation and failure
- Can lead to existential distress depression and/or, demoralization
- **Demoralization** = a change in morale spanning a spectrum of mental attitudes from disheartenment (mild loss of confidence) through despondency (starting to give up) and to actually having given up
- A demoralized person, while unable to look forward with pleasant anticipation, may laugh and enjoy the present moment, but feels helpless, incompetent and inhibited in action by not knowing what to do

Discussion

- Successful resettlement requires adaptation and if expectations are not met, an individual can become very distressed, disheartened and demoralized
- Denial of employment can have negative impacts on mental wellbeing
- The extent that an interpreter is not required - enhances an individual's ability to gain employment
- Unemployment is associated with financial strain + loss of self-esteem and restriction of social contact
- It has functions other than providing income - it provides purpose to life, defines status and identity and enables individuals to establish relationships with others
- The more one interacts with the groups in the larger society, the faster one acquires skills to manage everyday life
- For those out of work, the result is a decline in psychological well-being + delay in adaptation

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If the land's sick, we're sick: The impact of prolonged drought on the social and emotional well-being of Aboriginal communities in rural New South Wales – Rigby et al

Introduction

- Connectedness to healthy land is essential for Aboriginal health and well-being
- Drought-related loss of private and public sector employment opportunities,10 particularly for Aboriginal people

***What is already known on this subject*:**

• Aboriginal people live with endemic, historically based, whole person, whole community disadvantage and yet have retained formidable resilience.
• Active caring for land is associated with wide-ranging benefits for Aboriginal health and well-being.
• Prolonged drought undermines individual, family and community well-being; communities need integrated social and well-being services to meet its challenges.

Results

1. Impacts on culture

- *Harm to traditional family structure, culture and place*
- Many participants stated that there was damage to tradition and culture associated with climate change-related impacts on the land
- *Bringing shame to culture*
- Some participants stated that drought-related impacts on communities were affecting social and emotional well-being and lowering self-esteem by promoting antisocial behaviour
- Increased use of alcohol was thought to have led to a rise in aggression, violence and conflicts within communities

2. Sociodemographic and economic impacts

- *Skewing of the population profile*
- With continuing drought, it was reported that increasing numbers of working-age people were moving to regional centres or staying longer in bigger cities
- *Loss of livelihood and participation*
- Drought has compromised employment opportunities with a differentially severe effect on Aboriginal people
- These losses have been associated with a decrease in people's ability to buy basic items, such as food, or gifts for special occasions
- *Aggravation of existing socioeconomic disadvantage*
- These included lack of (culturally appropriate) housing, overcrowding and reduced attention to home maintenance

Discussion

Drought was affecting Aboriginal well-being in six related ways:

1. Damaging traditional culture
2. Skewing the population profile in smaller centres
3. Exacerbating underlying grief and trauma
4. Undermining livelihoods and participation
5. Aggravating socioeconomic disadvantage
6. Creating a context for behaviour that brings shame to culture

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Australia's Aboriginal Population and Mental Health – Parker

AUSTRALIAN ABORIGINAL CULTURE AND "MENTAL HEALTH"

In terms of "mental health," traditional Aboriginal culture had a number of strong reinforcing factors

- Aboriginal sense of self was seen in a collective sense - connected to all aspects of life, community, spirituality, culture and country.
- The culture provided for everyone through sharing rules - kinship of prime importance, defining social roles.
- Aboriginal people given a sense of meaning through their connection to country and their Dreaming
- Spiritual beliefs offered guidance and comfort and offered a sense of connectivity and belonging despite distress, death and loss

THE EXPERIENCE OF MENTAL ILLNESS IN TRADITIONAL ABORIGINAL CULTURE

Mood Disorder

- People affected by mood disturbance suffered vegetative disturbance and restriction of emotional response
- Also - affected population often projected feelings of unworthiness and guilt on to others, were more aggressive and had more physical or "somatic" symptoms
- Cawte (1987) described features of "atypical depression" → "suicide fit" in the context of alcohol withdrawal where a person developed a significant degree of anxiety following an intense encounter with a relative.
- The affected person would away to seek a private place - may attempt to harm themselves
- Cawte also noted depression precipitated by a person being "shamed" or being fearful that they were subject to sorcery or "payback"

Psychosis

- Pintubi language had words to describe someone suffering from schizophrenia as having "closed ears" or "living in a world of their own."

Anxiety

- Anxiety disorders appeared to be a rare phenomenon in traditional Aboriginal society with low community prevalence rates of about 1%
- Number of protective factors
- Relieved stress by ascribing significant adverse personal events (eg unexpected death of someone), to sorcery which was satisfying to individuals and the community and carried great "local conviction."
- Occasional reports of the experience of significant anxiety in Aboriginal people

Personality Disorder

- Qualifying issues in the diagnosis of personality disorder when the assessor is from a different culture from the person being assessed.
- There are people who exhibit atypical (for themselves) behavioural responses to certain environmental stimuli.
- Responses disappear when the stimuli are removed
- A diagnostic dilemma occurs when adverse environmental stimuli are prolonged and behavioural responses are fixed

The Destruction of Aboriginal Culture and the Emergence of an Epidemic of Mental Illness

- British colonisation had negative impacts – introduction of diseases, removal of land which caused psychological/spiritual stress
- Also herding of Aboriginal people into reserves and settlements, destroying lifestyle and leading to marginalisation and poverty
- **Welfare Colonialism -** where Aboriginals rely heavily on provision of public sector resources - have replaced traditional methods of Aboriginal governance
- Continuing racism against Aboriginal people within Australian community has a continuing negative effect
- Higher rates of heart disease, renal disease, diabetes in abbos

Malignant Grief

- → Phenomenon of "Malignant Grief" being the end result of persistent stress experienced in Aboriginal communities.
- → Malignant grief is a process of irresolvable, collective and cumulative grief that affects Aboriginal individuals and communities.
- → The grief causes individuals and communities to lose function, become progressively worse and ultimately leads to death.
- → The grief has invasive properties, spreading throughout the body
- → Many of Australia's Aboriginal people eventually die of this grief

Stolen Generations

- → Members of the Stolen Generation were more likely to live in households where there were problems related to alcohol abuse and gambling.
- → Less likely to have a trusting relationship and were more likely to have been arrested for offenses.
- → Members more likely to have had contact with Mental Health Services.
- → Children of members of the Stolen Generation had much higher rates of emotional/behavioural difficulties and high rates of substance abuse

Substance Abuse

- → Aboriginal people who consume alcohol are more likely to do so at harmful levels
- → The community at risk concept = that young people become socialized to the way alcohol is used in the culture + to the manner in which its effects are manifest behaviourally and socially

- ➔ The "lifestyle at risk" relates to a regular pattern of heavy consumption of alcohol by an individual
- ➔ Aboriginal men admitted to hospital with mental disorders due to psychoactive substance abuse 4.5 times more than non-Aboriginals
- ➔ Aboriginal women have 3.3 times the expected rate of mental disorders due to psychoactive substance abuse

SUICIDE IN ABORIGINAL POPULATIONS

- Suicide in Aboriginal communities is unevenly distributed with different communities contributing to excess mortality with overlapping "waves" of suicide
- Community at risk and individual at risk issues related to excessive and problematic alcohol consumption
- suicide often being a public event where the body is viewed by others
- Factors that may impact on suicide in Aboriginal youth such as prolonged grief, racism and alienation, social disadvantage, life stressors
- Association between self-harm behavior in Aboriginal people and later suicide

THE ASSESSMENT OF ABORIGINAL PEOPLE PRESENTING WITH MENTAL ILLNESS

Unsafe cultural practice: any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual

Culturally safe practice: effective clinical practice for a person from another culture

- Serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions

Barriers to clinical practice in Aboriginal communities:

- differing belief systems regarding illness
- Potential perceived inefficiency of health systems and the disempowerment of Aboriginal patients
- Poor compliance issues and overwhelming high burden of disease

Symptoms of mental illness need to be understood within a specific cultural context - use of Aboriginal mental health workers can assist

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The Social and Cultural Context of Immigration and Stress – Vasey & Manderson

Explanatory Models of Illness - Highlight how local perceptions of the aetiology of illness shape its management, accommodation, healing practices,

- Mental health problems take meaning from the diverse social worlds and economic circumstances of indvs + their communities
- Ideas about stress influence how people understand the experience
- Also shape when/how/from who they seek care

Migration

- Resettlement is stressful
- Stress is compounded by:
  - Poor command of the language
  - Need to accept welfare/support
  - Accept lower positions in employment
  - Isolation from the mainstream society
  - Absence of local ethnic communities
  - Diminished social circle of friends and family
- Immigrant groups often have low SES – leads to increase in health problems + high rates of chronic illness, difficulties accessing health care, difficulties communicating with doctors
- Limited access to health + welfare services is reflected in social disadvantage + poorer standard of living
- Low levels of social capita ass. with increased vulnerability + anxiety

Partial nature of relocation – some people retain aspects of their previous identity + attempt to recreate them in a home away from home → PROCESS KNOWN AS HOMING

Health Status and Stress

- Migration often coincides with reproduction times – needs of new immigrants + new parents converge
- Risk of antenatal and postnatal depression
- Added stressors for new mothers whose own mother/support are absent
- Feminisation of migration – women often arrive in a country without their children/families – women themselves experience separation anxiety, sorrow
- Many pressures on migrant women – eg look after the household, care for aging parents back home,
- Migrant children expected to do well in school + take advantage of new opportunities – may lack resources (eg desk, computer)
- Children may experience racism, bullying – can lead to stress + depression – reflected in violence, misuse of alcohol, drugs
- Older immigrants at greater risk of poor health, stress, depression

Culturally Appropriate Responses

- ➔ Access to health services can be enhanced through cultural competence – so appropriate healthcare is provided for immigrants
- ➔ Familiarity with different belief systems, poor understanding, economic barriers to accessing health care is beneficial

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Week 3

Chapter 13: Disorders of Childhood

<u>Classification and Diagnosis of Childhood Disorders</u>

Developmental Psychopathology: field that focuses on the disorders of childhood within the context of life-span development

- Enables identification of behaviours considered appropriate at one stage + disturbed at another

Childhood disorders divided into 2 domains – externalising and internalising disorders

Externalising Disorders: characterised by outward-directed behaviours – aggressiveness, noncompliance, overactivity, impulsiveness

- Category includes ADHD, conduct disorder, oppositional defiant disorder (ODD)

Internalising Disorders: characterised by inward-focused experiences and behaviours – depression, social withdrawal, anxiety

- Category includes childhood anxiety, mood disorders

Children + adolescents may exhibit symptoms from both domains

- ➔ Across cultures – externalising behaviours are found more in boys – internalising more in girls (esp. in adolescence)
- ➔ In cultures that disapprove of aggression – more internalising behaviours (eg Buddhism, Thailand)
- ➔ Cultural sanctions against acting aggressively keep behaviours from developing unlike in the USA

<u>Attention-Deficit Hyperactivity Disorder (ADHD)</u>

Disorder in children marked by difficulties in focusing on the task at hand, inappropriate fidgeting, antisocial behaviour and excessive non-goal directed behaviour

Clinical Descriptions, Prevalence, Prognosis

- When behaviours are extreme for a particular developmental period, persistent across situations, linked to impairments in functioning – diagnosis of ADHD
- ADHD diagnosis NOT for children who are active, slightly distractible
- ADHD children have difficulty controlling their activity in situations that call for sitting still – eg school
- Difficulty getting along with peers, establishing friendships – eg b/c their behaviour is aggressive/intrusive
- Often miss social cues, overestimate their ability to navigate social situations

'Vicious Cycles' – poor social skills, aggressive behaviour, overestimation of one's social abilities – predicted decline in follow-ups

- ADHD children can know what the socially correct action is but be unable to translate the knowledge into appropriate behaviour in real social interactions
- Often rejected quickly by peers