

Abnormal Psychology

Defining Abnormality

- Statistical Approach
 - abnormality = infrequency – but this is not sufficient on its own
- Valuative Approach
 - abnormality = “social deviance” – unacceptable or doesn’t conform to social standards in context
- Practical Approach
 - abnormality = disruptive thoughts/behavior severe enough to interfere with long-term functioning – maladaptive, probably causing personal distress

Perspectives on Psychology

- biological
- behavioral
- psychodynamic
- humanistic
- cognitive
- evolutionary
- sociocultural

Perspectives on Depression

- **biological**
Serotonin Hypothesis for depression, supported by effectiveness of SSRI anti-depressants (like Prozac); Kirsch and colleagues have questioned this, claiming SSRIs are about as effective as placebos – very controversial claim
- **behavioral**
Learned Helplessness theory of depression – emotional, motivational, and cognitive deficits in dogs and humans experiencing unavoidable aversive events (shocks for dogs; life experiences for humans)
- **cognitive**
Beck's view of depression as based in distorted beliefs that can be challenged and corrected in "Cognitive (later Cognitive-Behavioral) Therapy"

Practical Approach

- CONTENT of behavior & thinking
 - what it DOES
 - causes discomfort
 - appears bizarre
 - is dysfunctional – interferes with daily life
- CONTEXT of behavior
 - when and where it OCCURS
 - inappropriate for situation
 - inappropriate for cultural context

Diagnosing vs. Labeling

- American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (2013)
 - APA's DSM-5 for short
 - NOT "American PSYCHOLOGICAL Association" (the usual "APA" in Psychology!)
- Pros: allows standardization of diagnoses; tracking of similarly categorized cases for research
- Cons: labeling
 - societal "blaming" of disorder
 - stigmatizing of the mentally ill

Anxiety Disorders

- defining anxiety
 - apprehension, dread, uneasiness
 - unfocused (vs. FEAR which is focused on a particular object or event)
 - “normal” anxiety
 - facilitates functioning in easy, skilled tasks
 - inhibits functioning in complex, unskilled tasks

Anxiety Disorders

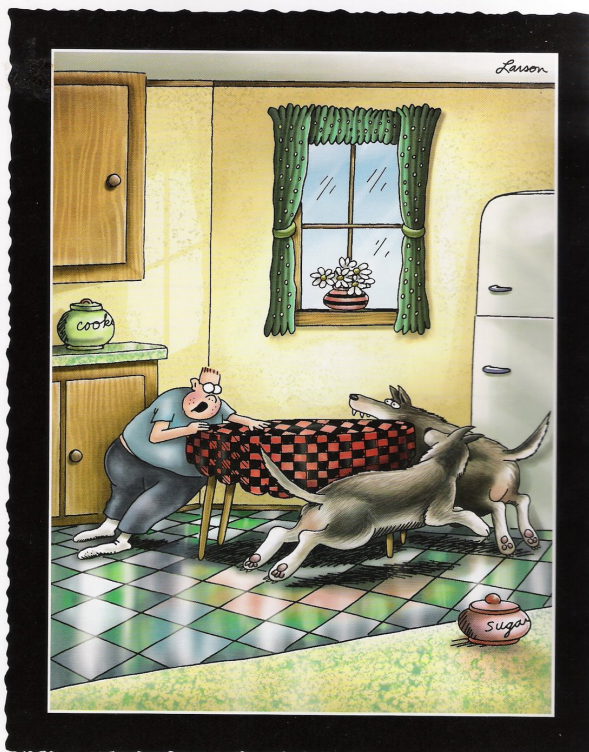
- Disorders
 - when anxiety becomes intense, long-lasting, disruptive
 - Generalized Anxiety Disorder
 - Panic Disorder
 - Phobias
 - specific phobia
 - agoraphobia
 - social phobia / Social Anxiety Disorder
 - Obsessive-Compulsive Disorder
 - recurrent thoughts vs. ritualistic behaviors
 - Post-Traumatic Stress Disorder

Anxiety Disorders

- Phobias as learned
 - e.g., Watson and Little Albert – bad experiment though, shouldn't be so famous
 - phobias as classically conditioned fear: fear-inducing US causes fear UR, non-frightening CS is associated with US and then produces fear CR
 - extinction doesn't happen, because 1) phobic person avoids the thing and 2) exposure to it may cause intense fear response, strengthening phobia
 - treat w behavior therapy: systematic desensitization
 - 1) teach relaxation response, incompatible with fear or anxiety response;
 - 2) create hierarchy of phobic stimuli; 3) pair increasingly fearful stimuli w relaxation till fear is gone, even for most frightening stimulus (e.g. actual spider on arm)

Anxiety Disorders

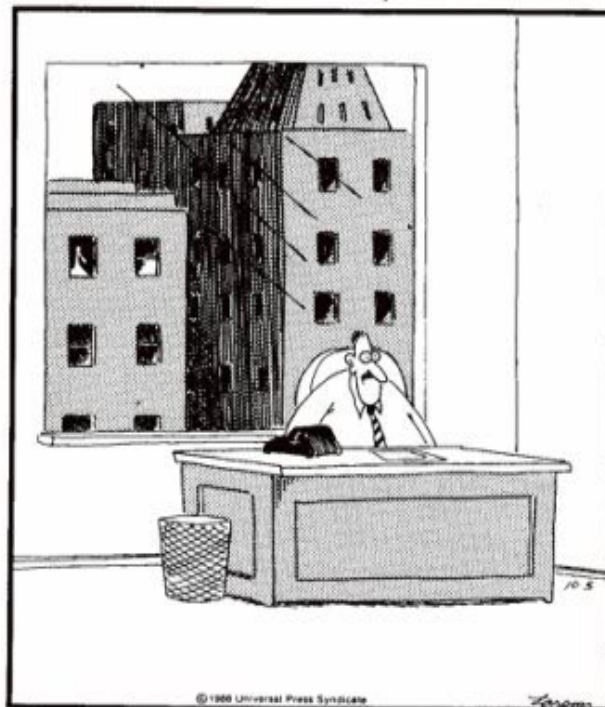
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 - treat w behavior therapy: systematic desensitization
 - people shown photos of spiders / snakes vs. flowers / mushrooms paired w shock: form fear of the photos – but extinction takes longer for spiders / snakes (evolution? social learning?)



Luposliphobia: The fear of being pursued by timber wolves around a kitchen table while wearing socks on a newly waxed floor.

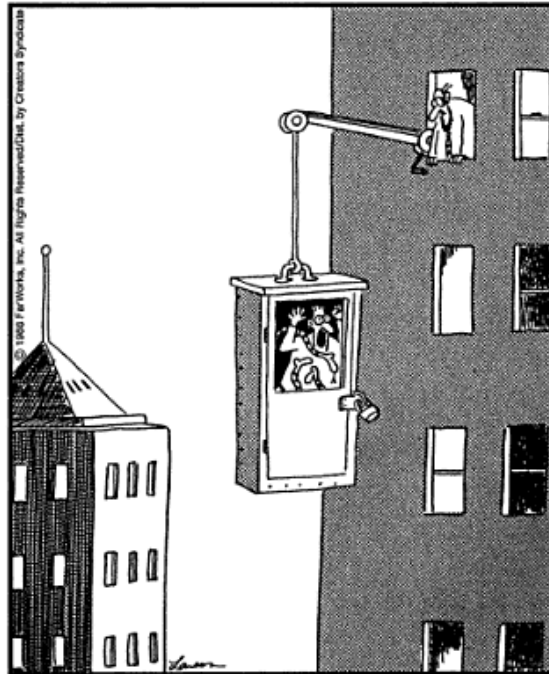
THE FAR SIDE

By GARY LARSON



Anatidaephobia: The fear that somewhere, somehow, a duck is watching you.

THE FAR SIDE® BY GARY LARSON



Professor Gallagher and his controversial technique of simultaneously confronting the fear of heights, snakes, and the dark.

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Dissociative Disorders

- disruption in consciousness, memory, or identity
- Dissociative Amnesia:
identity 1 -> identity ?
- Dissociative Fugue
identity 1 -> identity 2
- Dissociative Identity Disorder:
identity 1 -> identities 1, 2, 3, ...

Somatic Symptom Disorders

- psychological problem that takes somatic (physical body) form
- Disorders
 - Conversion disorder
 - “functional neurological disorder” if no stressor
 - organically impossible
 - “la belle indifference” – patient isn’t bothered
 - SSD with pain features
- controversial

Mood Disorders

- extreme moods for at least 2 weeks
- Depressive Disorders
 - Major depressive - not just sadness
 - worthlessness, weight loss/gain, sleep change, difficulty concentrating; delusions; suicidal
 - adult incidence rate of 30%
 - women twice as likely to be diagnosed
 - Persistent depressive (dysthymia) – less intense, longer lasting
- Bipolar Disorder (formerly manic-depression)

Mood Disorders

Depression: Learned Helplessness view

- humans show deficits like dogs exposed to uncontrollable unpredictable shock
- put in situation where they can avoid shock by jumping over barrier in box
- they don't do it: deficits are 1) motivational (no trying, just accept it), emotional (whining, crying, sullen, nonreactive), 3) cognitive (may accidentally jump and avoid, but no learning from that)

Personality Disorders

- long-term, inflexible “life styles” that cause problems
- Cluster A (odd, bizarre, eccentric)
 - Paranoid PD, Schizoid PD, Schizotypal PD
- Cluster B (dramatic, erratic)
 - Antisocial PD, Borderline PD, Narcissistic PD, Histrionic PD
- Cluster C (anxious, fearful)
 - Avoidant PD, Dependent PD, Obsessive-Compulsive PD

Personality Disorders

- **anti-social personality disorder**
 - failure to conform to social norms, obey laws
 - deceitful, lying, impulsive, irritable, aggressive
 - physically violent; disregard for the safety self or others
 - irresponsibility, inconsistent work behavior, not paying bills
 - no remorse or guilt, indifference to others' pain, rationalizing hurting others
 - less stressed by aversive situations including punishment
 - related to criminality, but not necessarily criminal - can be successful
- think about what IS social

Personality Disorders

- **borderline personality disorder**
 - originally “on the borderline” between neurosis (distress without delusions or hallucinations) and psychosis
 - now focus is on instability of emotions, relationships, and identity
 - self-destructive impulsive behavior, feelings of emptiness
 - extreme shifts between seeing others as good or bad
 - self-harm, suicidal behavior, drinking and drug use, other maladaptive behaviors
 - more women, more young, more low SES
 - cause: possibly childhood abuse or other stressor combined with genetic component (diathesis-stress)

Schizophrenia

- “split mind”, but not MPD / DID
- affects around 0.5-1% of *any* population
- begins in late adolescence / early adulthood
- pattern of serious symptoms involving severely disturbed thinking, emotion, perception, and behavior

Schizophrenia symptoms

- thought disorders
 - incoherent forms
 - neologisms
 - loose associations, clang associations
 - word salad
 - disorders in content: delusions
 - of persecution
 - of grandeur
 - thought broadcasting
 - thought blocking
 - thought insertion

Schizophrenia symptoms

- disorders of perception & attention
 - problems with selective attention
 - feeling detached from world
 - hallucinations
 - sensations w/o external stimuli to produce them
- disorders of affect
 - flat or blunted affect
 - inappropriate affect

Schizophrenia symptoms

- disorders of movement
 - agitated movement
 - catatonia
- other characteristics
 - decreased motivation
 - decreased social skills
 - decreased personal hygiene
 - decreased day-to-day functioning

Schizophrenia causes

- formerly thought due to bad child-rearing by cold parents - discredited
- organic – genetic heritable component, various neurotransmitters regulation, pre-frontal cortex smaller, larger ventricles (fluid-filled spaces between brain tissue areas)
- controllable through medication (to varying extents)

Causes of Mental Illness

- Demonological & Supernatural Models
 - until Hippocrates 4th century BC: deviancy cause by demons or gods
 - Middle Ages: deviancy encouraged if viewed as result of devotion to God, but if not...
 - heretics/disbelievers burned at stake for their deviancy
 - still prevalent in some non-western cultures
 - though belief in demonic possession as cause of mental illness is somewhat popular in US as well

Causes of Mental Illness

- Medical Model
 - 4th century BC: Hippocrates (Greek physician) attributed deviancy to physical disease
 - post-Middle Ages: asylums devoted to medical care of mentally ill
 - horrible conditions, little medical care offered
 - developed into Biological Model
 - 1850s: large state mental hospitals