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)

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  – 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?)
Luposilipophobia: 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.
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