

## Definitions of Abnormality

### Statistical Infrequency

When an individual has a less common characteristic in the population. For example IQ as determined by normal distribution is where someone has an extremely high or low score

#### Evaluation:

1. Real life application – clinicians use this when they are making a diagnosis
2. Unusual characteristics can be positive for example high IQ
3. Not everyone would benefit from a label. Just because you have a low IQ does not mean you are mentally ill. The label would lead to negative effects

### Deviation from Social Norms

This is a behaviour that is different from the accepted standards in a population (the norm), they are specific to the culture we are – a behaviour is abnormal if it differs from what is acceptable in that culture. Antisocial personality disorder (psychopaths) would fit this definition as they lack important pro social standards as they do not behave ethically.

#### Evaluation:

1. This explanation is culturally relative as it depends on the culture you live in whether you get a diagnosis or not. Hearing voices for example could be considered normal in some cultures. Homosexuality is still considered abnormal in others. Norms change over time.
2. Can lead to human rights abuses and issue with social control
3. It would not be the only criteria that would be used to make a diagnosis. There would be other factors

## Definitions of Abnormality

### Failure to Function Adequately

When someone is unable to cope with ordinary demands of day to day life, e.g. basic hygiene, nutrition, having good relationships. Rosenhan & Seligman (1989) no eye contact, personal space, showing distress, irrational behaviour or dangerous.

#### Evaluation:

1. Takes the patients perspective (their subjective experience)
2. It could be just deviation from social norms as it is subjective. Not having a job might be seen as a FFA but it is about personal choice and freedom
3. Subjective judgements – the psychiatrist has to make a judgement using the global assessment of functioning scale which means it relies on one person to make that decision

### Deviation from Ideal Mental Health

When someone does not meet the criteria for good mental health. Jahoda (1958): no distress, being rational, self-actualisation, coping with stress, realistic view of world, good self-esteem, being independent, being able to work and enjoy leisure

#### Evaluation:

1. Its comprehensive – covers most of the reasons people seek help
2. Cultural relativism – it is very specific to culture. European and American culture (individualist)
3. Sets high standards that might be impossible to achieve

## Phobias: Explanation

### Clinical Characteristics

**Emotional:** anxiety, and emotional responses are unreasonable – they are excessive; **Behavioural:** panic, avoidance and endurance; **Cognitive:** selective attention to the phobic stimulus, irrational beliefs and cognitive distortions

### Explanation for Phobias

**Classical Conditioning:** The phobia is acquired through classical conditioning as the person associates the NS (the phobic object / event), with the UCS (bad experience) which leads to an UCR (fear). Eventually the CS produces the CR (fear).

**Operant Conditioning:** The person avoids the phobic stimulus / event and this then reinforces the phobia. This is negative reinforcement. The effect of this is positively reinforcing as the person feels relief as they don't have to confront the source of their fear

#### Evaluation:

1. **Watson & Raynor (1920)** study of Little Albert who was conditioned to be fearful of the white rat.
2. **Seligman (1971)** suggested that we are biological prepared to be fearful of certain things such as snakes and spiders as this would have been beneficial from an evolutionary view.
3. Practical Application – treatments such as SD and flooding which have been developed from this approach
4. Phobias don't always follow trauma
5. There are some cognitive components to fear

## Phobias: Treatment

### Systematic Desensitisation

This involves three elements: **construction of a fear hierarchy** (most fearful to least fearful); **relaxation training (may use drugs too in adults to promote relaxation)**; **gradual exposure**. The client cannot move on up the hierarchy unless they are fully relaxed as it might make them worse

#### Evaluation:

1. **Gilroy (2003)** found that it was effective for a spider phobia. 42 patients had 3 45-min sessions and were found to be less fearful 33 months later
2. Can be used for a diverse range of patients
3. It is acceptable to patients – patients prefer this as it is not as traumatic as the alternative flooding (less ethical issues)

### Flooding

The person is exposed to their phobic stimulus all at once - no gradual build up. It brings about extinction (classical conditioning) where the CS no longer brings about the CR

#### Evaluation:

1. It is cost-effective as it is quicker (**Ougrin, 2011**)
2. It can't be used with some types of phobia – e.g social phobias
3. The treatment is traumatic and therefore there are ethical issues

## Depression

### Clinical Characteristics

**Emotional:** lowered mood, anger and lowered self-esteem; **Behavioural:** Changes in activity levels, lethargy or agitation; disruption to sleeping and eating; aggression and self-harm; **Cognitive:** poor concentration, dwelling on the negative and absolutist thinking

### Explanation for Depression

**Beck** – negative triad proposes we have a negative view of self, future and world. It is the faulty cognitions we have that make us depressed, though creating a cognitive vulnerability: Faulty information processing which develops through experience; negative self-schema; and the negative triad

### Evaluation:

1. **Grazioli & Terry (2000)** assessed 65 pregnant women and found that those who had a cognitive vulnerability were more likely to suffer post-natal depression

### 2. Practical application of CBT

3. Doesn't explain all depression, e.g. depression that has a biological basis

**Ellis ABC Model** – Depression arises from irrational thought. There is an activating event, a belief, and then the consequence.

### Evaluation:

1. Not all depression arises from an activating event. It only explains reactive depression
2. Practical application of CBT
3. It doesn't explain why some people are more vulnerable or the anger seen in some cases of depression

### Treatment of Depression

**CBT – works by identifying the irrational thought and then challenging it**

**Beck's CBT** – Beck argues that the patient is like a scientist, who challenges the thoughts as scientist would test a hypothesis. The aim is to prove the thought / statement as incorrect. They are set homework to record events where people have been nice to them to challenge the thoughts

**Ellis's Rational Emotive Behaviour Therapy (REBT)** – this extends his model of ABC to include the disputing of the irrational thoughts by vigorous arguments. Empirical arguments – is there any evidence. Logical arguments - does it follow from the facts.

**Behavioural Activation** is used with both therapies as the therapist encourages the client to reengage in the activities they used to enjoy.

### Evaluation:

1. March (2007) found that CBT was 81% effective, drugs 81% effective, and combined 86% effective
2. CBT does not work for severe cases as client has to be motivated and engaged
3. The therapist-client relationship is important to success
4. Some patients want to explore their past and it is not effective for them as it is present and future oriented
5. It emphasises cognition which may not be the cause – ignores the circumstances the patient is living in which may be the cause

## OCD

### Clinical Characteristics

**Emotional:** anxiety and distress, depression, guilt and disgust; **Behavioural:** Compulsions which are repetitive (e.g. hand washing), compulsions reduce anxiety (e.g. hand washing because of fear of germs), avoidance; **Cognitive:** obsessive thoughts, strategies to deal with the obsessions (e.g. praying or meditating), and insight into anxiety

### Explanation for OCD

#### Genetic:

**Lewis (1936)** in OCD patients 37% had parents with OCD & 21% had siblings

**Candidate genes** – These genes are important in the regulation of serotonin, e.g., 5HT1-D beta (SERT gene)

**Polygenic** - Taylor (2013) said that OCD was polygenic, and found 230 genes, some which link to serotonin and dopamine

Different types of OCD might have different types of genetic variations

#### Evaluation:

1. **Nestadt (2010)** review of studies found that 68% of MZ twins and 31% of DZ linked to OCD

2. Not all genes have been identified as there are so many

3. **Cromer (2007)** found that over half OCD patients had a traumatic incident that could be linked to the OCD – therefore environmental component

#### Neural:

**Serotonin levels** – as this links to mood. Low levels.

Brain areas that link to decision-making- e.g. the frontal lobes and also the parahippocampal gyrus which links to processing unpleasant emotions

#### Evaluation:

1. There is supporting evidence as antidepressants work

2. It is not clear what neural mechanisms are involved

3. The link is correlational and therefore we cannot assume causation

### Treatment of OCD

**SSRIs** – stops the reuptake of serotonin and the breakdown and reabsorption

**Tricyclics** (older form of SSRIs) & SNRIs (work on other neurotransmitters such as noradrenaline)

#### Evaluation:

1. **Soomro (2009)** reviewed 17 studies and found that SSRI's work better than a placebo, but even better when combined with CBT

2. Drugs are cost-effective and non-disruptive

3. Drugs have side effects

4. Some cases of OCD follow trauma – therefore not biological in origin

5. Drugs are sponsored by drug companies and the research might be unreliable