Dysfunctional Behaviour

This area of psychology is concerned with the understanding and treatment of dysfunctional behaviours. It investigates the issues of identifying individuals with dysfunctional behaviour and the strategies related to changing such behaviour. Anxiety disorders, schizophrenia and affective disorders are three examples of dysfunctional behaviours that have received attention from psychologists and psychiatrists.

How do you help someone with a psychological disorder? The answer depends on the causes of the disorder.

Potential causes of psychological disorders include:
- Genetic or biological factors,
- Psychological conflicts,
- Societies' demands or structures.

The perspectives differ regarding how best to treat the disorders, but disorders may be due to combinations of these factors and therefore, there may be no one “correct” perspective.

- Describe and evaluate different concepts and models of dysfunctional behaviour
- Describe and evaluate approaches to treatments for dysfunctional behaviour.
- Discuss the diagnosis and classification of dysfunctional behaviour.
- Analyze the aetiology (causes) and treatment of dysfunctional behaviours.
- Describe and evaluate relevant theories and empirical studies related to the psychology of dysfunction.
- Explain how cultural, ethical, gender, and methodological considerations affect the interpretation of dysfunctional behaviour.

<table>
<thead>
<tr>
<th>A- Concepts, models and theories</th>
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</table>
| **Concepts** of “normality” and “abnormality” | - Limitations in (1) definitions of “normality” and “abnormality”; of “dysfunctional”  
- (2) Historical and cultural considerations in the concepts of “normality” and “abnormality” (HANDOUT) |
| **Models and theories** of dysfunctional behaviour, including basic assumptions | - (3) Medical models and the concept of “mental illness”  
- Psychological Models: (3) Psychodynamic, (4) Behavioural, (5) Cognitive, (6) Humanistic theories of dysfunctional behaviour  
- Social and environmental theories, such as the (7) Diathesis-Stress model |

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<th>B- Treatments</th>
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| **Approaches** to treatment | - Biological treatments, such as psychosurgery, electroconvulsive therapy and drug treatments  
- Directive psychological therapies, such as those based on the behavioural, psychodynamic and cognitive perspectives  
- Non-directive psychological therapies, such as those based on the humanistic perspective |
| **Evaluation** of treatment | - Elective approach  
- Effectiveness of treatment in helping people with dysfunctional behaviours  
- Ethical considerations |

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<th>C- Diagnosis and classificatory systems</th>
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| **Classificatory systems and diagnosis** | - Purpose and functions of diagnosis  
- Usefulness of classificatory systems  
- Gender, cultural and ethical considerations in the diagnostic process |
| **Description and etiologies** of specific dysfunctional behaviours (See disorders) | - Disorders such as:  
- Anxiety disorders  
- Schizophrenia  
- Affective disorders |
1) DEFINITIONS

**Abnormality**: Deviation from the norm or standard

There are 4 **approaches** that address the issue of what is the “norm” and what constitutes deviating from it.

### Evaluation

All approaches to define the norm need to be evaluated in relation to:

#### The concept of culture

- Must not be nomothetic BUT idiographic! (Not assume that everyone is the same!)
- Must not have a rigid definition of behaviour
  - **Alpha-bias**: Suggests that a culture is better; exenterates the differences between cultures
  - **Beta-bias**: belittles the differences between cultures
    - Need to find the middle of Alpha and Beta bias – try not to have either!
  - **Amic (go, live within a culture, gather info from within it)**
  - **Etic (study from the far, looking from outside)**

#### Biased opinions

- Researcher are usually (90%!): educated, white, middle-class American men – end up with Alpha or Beta – bias (either aware that they are from that culture or not)
- Participants are usually 19-24 year-olds undergraduates who are being studied under lab-conditions (and who are probably being paid)
- OR Participants are psychological ill: self reports: what they say is biased (they over- or under-exaggerate)

#### Classification systems

- Diagnosis is different in different cultures (e.g. if a video of behaviour is shown, 80% of Americans would diagnose them as to have dysfunctional behaviour whereas only 20% of Britons would do so)
- People from Japan have less dysfunctional behaviour – could be because the doctors don’t diagnose it, because it is not acceptable, because they don’t go to the doctor...

### Approaches

#### 1. Statistical Infrequency

Any behaviour that is statistically infrequent is classed as abnormal. Normal = mean average; any behaviour that are more than 2 St. Dev. away from the norm are considered abnormal.

- e.g. Schizophrenia: suffered by 1% of the population; Anxiety (Spielberger's anxiety inventory scale; the mean score = 40, only 2% of the population are above 55)

- No cultural bias – still normal distribution just with different mean
- Being a genius is rare but desirable!
- Some mental states are becoming statistically more common – but should they be regarded as normal? (e.g. depression, anxiety)
- Statistics depend on accurate reporting from doctors! – data might be flawed (social desirability bias, cultural differences, diagnosis...)
- Females are more likely to go to the doctor than males
- Some ethnic groups don’t seek the doctor for mental health, only for physical problems (e.g. Asians; so they appear not to suffer from depression. In china the stigma is too great so not many are diagnosed as depressed) – might be not accepted in their culture
2. Deviation from social norms

Society sets up rules for behaviour based on moral standards and thereby becomes social norms. Those who deviate from that (who violate the rules) are classified as abnormal.

But society views change over time. E.g. homosexuality was a criminal act until the 1960s, in America it was a “mental disorder” until 1973.

Many behaviours, although criminal, are committed by large numbers of people. So, using the statistical criterion it is normal behaviour but using social norms, abnormal!

- CULTURAL DIFFERENCES
  - America – insanity is sometimes used to detain political dissidence (anticommunism), e.g. Mandela was called insane
  - Japan – use it as a threat to maintain strong work ethic (mental illness is shameful, threaten with “lumi-bins” = overcrowded places where they are then put in. E.g., ex-mental-ill people aren’t allowed to work as cooks... so this is why they don’t report mental illness!
  - In western cultures, a mental disorder doesn’t necessarily mean deviant behaviour, usually can’t be used as criminal defence (You can’t say “I was depressed, that’s why I raped her!”) – only in severe cases (mass murders) it has been used
  - UK – differences in mental health in different ethnic groups, e.g. black African immigrants are between 2-7 times more likely to develop schizophrenia than white immigrants (much higher than in their own country)
  - Definition of “normal” is flawed (based on white people) – biased aspect!

- CONTEXT
  - what we expect to see vs. what is unexpected (e.g. flashing on football field is okay but not in the street)
  - looks at behaviour in (cultural) context
    - behaviour has to be judged on context it is found in; what is expected/normal behaviour in this context (cultural relativism: thinking about behaviour relative to the culture someone comes from, e.g. Irish people sit next to someone in the bus)
  - It’s the behaviour that is abnormal, not the person (assumption) – less stigma associated with behaviour!
  - Flexible definition; can change over time (temporal validity)
  - Context → some behaviour is sometimes okay (flexibility; e.g. nude at nude beach is okay but not in town)
  - Can be used to stigmatise and oppress groups who have different ways of behaving and beliefs
  - Deviating from social norms isn’t necessarily a bad thing (women were supposed to look pretty – then they wanted jobs etc: deviated from the norm) → sometimes it’s a good thing, otherwise nothing would change!

3. Deviation from Ideal mental health

Abnormality can be defined as a person who doesn’t have a “happy”-existence. Believe, that there’s an “ideal mental health”

Jahoda (1958). Humanist, first suggested that we should look at mental health rather than mental illness. He identified 6 major criteria. If these are deviated from, then the person concerned is likely to suffer or be vulnerable to a mental disorder. So the more of the criteria are present, the more vulnerable is the person for mental unhealthy (look for LACK of normal things)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Explanation</th>
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<tbody>
<tr>
<td><strong>Self attitudes</strong></td>
<td>• positive attitude towards oneself</td>
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<tr>
<td>self-respect • self-confidence • self-relevance • self-acceptance</td>
<td>• should accept strengths and weaknesses and view oneself realistically</td>
</tr>
<tr>
<td></td>
<td>(need to know who you are)</td>
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<tr>
<td><strong>Self Actualization</strong></td>
<td>• you should strive to fulfil your potential, i.e. intellectual, artistic, athletic potential</td>
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<td></td>
<td>• BUT in some cultures the future is planned for you → not everyone</td>
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<td></td>
<td>has the chance to do so (have to fulfil someone else’s ideals (e.g. forced</td>
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<td>marriage, take over business...)</td>
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</tbody>
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Resistance to stress
- ability to tolerate anxiety without disintegrating: all about developing coping-strategies
- BUT many people argue they perform better when they are stressed!

Autonomy
a person is reliant on their inner resources → make decisions with internal locus of control based on yourself, not others (what is right for you – a bit egoistic)

Perception of reality
seeing the world realistically (not opti- or pessimistically; being a realist!)

Environmental adaption
being flexible and adjusting to change

- Few would be mentally healthy on this criteria
- Many of this criteria are difficult to measure (self-reporting methods = biased)
- Ethnocentric → Western criteria → individual rather than collectionist
- Ignores external factors

4. Failure to function adequately
People who can’t cope with the demands of everyday-life (e.g. getting up/dressed... for e.g. someone who is depressed)

Features of abnormality

| Suffering | • preset of it is abnormal (except for grief) • BUT there are people who can kill and not feel rumours (psychopaths) |
| Maladaptiveness | • if behaviour prevents you from achieving life-goals → maladapted and you’re abnormal (e.g. anorexia: not eating prevents you from reaching potential) • BUT may have lack of knowledge (not maladaptive) |
| Vividness and unconventional behaviour | • If you behave different to others → abnormal • BUT suffrages don’t conform (e.g. swig themselves for human rights) |
| Unpredictability | • if behaviour is uncontrolled • BUT if you’re drunk you can behave like that, too! |
| Irrationality | • not clear why a person behaves in a certain way • BUT may be the observer lacking knowledge (e.g. person runs around because of bee) |
| Observer discomfort | if the behaviour causes observer’s discomfort (cultural differences; e.g. naked people – normal in some ethnic groups) |
| Violation of moral standards | • inappropriate (sexual) behaviour in public (e.g. masturbating in public) • BUT “normal” people also do it to some extent (e.g. excitement of sex in public) |

+ it’s right to be classified as psychological ill when your behaviour interferes with your daily functioning (construct validity = makes sense that it’s an accurate way of measuring)
+ those who are closest to you – or yourself – should decide whether you are ill (know context!)

- have to bear things in mind:
  - normal show abnormal behaviour
    o context. during exam time may not function adequately
    o hunger-strikes (protesting): choose to suffer to make their point
  - abnormal show normal behaviour
    o function perfectly in normal life but then, e.g. eat people

- Suffering is part of human life, everyone copes in different ways. How can we decide when suffering becomes abnormal?
- The person may not think their behaviour is a problem (e.g. not getting dressed) (but act 1983: allows people to be detained without their will!)
- Social class issue: the higher the social class, the less like to have a mental disorder
  o Social drift hypothesis: explains why mental illness are more common in lower classes
    - when mental ill you can’t hold job etc, so slip down social class (“social drift”) (kids then stay in lower class → “inherit” e.g. schizophrenia)
2) Culture and abnormality

Culture and influence in diagnosis + treatment of mental disorders

Sub-cultural differences: ethnicity, social class, gender

- Culture bound syndromes

  - Neurasthenia

  Very common mental illness in China
  - High prevalence of the disorder in China OR
  - Related to diagnostic procedures?
  - Many of its symptoms would meet the criteria for a combination of mood + anxiety disorder in the western world (classification system disorders DSM used in western world)
  - APA recognised culture-bound syndromes: included separate listing in the appendix of DSM

Although many of these “exotic” conditions occur frequently, as long as they're limited to other cultures, they won’t be admitted into western classification

- Depression

Appears to be absent in Asian cultures
  - Asians live with extended family = social support; might tend to sort it out with family
  - Doctors report, depression is equally common BUT Asians consult doctor only for physical

  NOT psychological problems (emotional distress) (might seek doctor for physical symptoms of depression though: tiredness, sleep and appetite disturbances...)

  \[ \text{socio-cultural differences} \] may reflect statistical likelihood of seeking professional help for emotional states

  **Leff**: Cultures vary in terms of their differentiation and communication of emotional terminology \( \rightarrow \) how they experience and express depression

  **Marsella**: Depression takes a primarily affective form in individualistic cultures (in some cultures feelings of loneliness dominate whereas in other symptoms such as headaches \( \rightarrow \) depressive symptom patterns differ across cultures because of \textit{cultural variation in sources} of stress and for coping with it!

  - Somatization

Bodily complaints as expression of psychological distress. In Chinese philosophy, the coexistence of psychological symptoms with physical symptoms is consonant. Somatization is universal but the Western psychologists just focus more on the psychological manifestations of illness.

  Problems with studies using diagnostic data: figures based on hospital admission! Low admission rates of some ethnic groups may reflect cultural beliefs about mental health (e.g. in India, mentally ill people are looked down on. China: mental illness carries great stigma)

- Culture bias in mental health

Research shows significant differences in the prevalence rates for mental disorder btw. ethnic/cultural groups in Britain. E.g. 2-7* more African immigrants diagnosed with schizophrenia than whites (however, only found in Britain in for less severe disorders, less admission rates than for whites)

- Cultural stereotyping British psychiatry

Stereotyped ideas about race are inherent in British psychiatry (e.g. believe that blacks can’t use help and are thus not suitable for open hospitals – are detained in secure hospitals. E.g. in hospital-detained psychotic patients in Birmingham, 2/3 Africans, 1/3 whites and Asians)
Culture “blindness” in diagnosis

Assumption that behaviours of white population are normative, any deviation by other ethnic group reveals racial or cultural pathology. Conversely, if a member of a minority ethnic group has some symptoms similar to white patient, they are assumed to have the same disorder which may not be the case (e.g. within culture/ethnic group it might be normal to see/hear a deceased relative during the bereavement period – under DSM criteria behaviour might be misdiagnosed as symptom of psychotic disorder).

Cross-Cultural Assessment

Leff: ethnocentric bias of procedures (e.g. PSE – Present State Examination, used in diagnosis of schizophrenia)

Rwandan study of depression

(Child Behaviour Checklist) US children tend to exhibit higher levels of under-controlled behaviours (acting out) and lower level of over-controlled behaviours (internalizing) compared to children of collectivist cultures

Importance of examining culturally sanctioned systems of healing and their influence on human behaviour

Evaluation of bilingual patients should be done in both languages – patients may use their second language as form of resistance to avoid intense emotional responses

Treatment of Abnormal Behaviour

E.g. in Malaysia, religion has been incorporated into psychotherapy (makes psychotherapy culturally relevant)

E.g. problems with group therapy in Arab Cultures: Problems to view group as therapeutic not as social activity, strict gender roles, tribal status

Indigenous healing: encompasses therapeutic beliefs and practices that are rooted within a given culture. Study of IH in 16 non-Western countries identified commonalities amongst indigenous practices: heavy reliance on family and community networks, incorporation of traditional, spiritual and religious beliefs as part of treatment, use of shamans

Naikan Therapy: Process of continuous meditation based on structured instruction in self-observation and self-reflection. Patients practise mediation from morning until evening, Interviews every 90 minutes to discuss progress for 5 minutes. Patients have to examine themselves, have to meditate on several aspects of their relationships (what other people have done for them, what they have done for others, how they cause difficulties for others)

Community psychologists go beyond traditional focus of responding to person’s distress on individual level to include analysis of mental health at community level. Community-based treatment to complement traditional psychotherapy: Identification of naturally occurring resources in community to promote healing, enhancement of coping strategies to respond effectively to stressful events, development of collaborative culturally grounded community interventions that involve community members in solving own problems

Testimonial therapy

Deactivating “networks of fear” in the psyche. Theories: consider collective traumatisation to be at least as significant as individual traumatisation.

→ Creation of an oral history archive to collect, study, disseminate memories: gives meaning and purpose to experience (reconsider previous attitudes concerning ethnic identity, forgiveness, violence and consider how experience affected their feel about their lives today = ENTRY INTO MEANING)
Models and Theories of Dysfunctional Behaviour

Models are simply attempts to explain what causes certain types of behaviour, so Model = Explanation of Causes!

The main Models are
- Biological
- Psychological: Psychodynamic, Cognitive, Humanistic, Behavioural
- Social and Environmental theories – Diathesis Stress Model

Each is a unique way of thinking about mental disorders; therefore, they have different implication treatment.
Evaluate in terms of sample of people used, ethics, repeatability, validity and reliability

3) Biological (Medical) Model

- The human is a fine-tuned machine composed of many genetically determined biological parts that must work correctly together to promote proper behaviour.
- If there is some type of imbalance in the system (e.g. too much of a certain neurotransmitter, or not enough of another), that imbalance may result in maladaptive behaviour.
- Thus, according to this view (and like the psychodynamic view) the symptoms themselves are not the real problem; the imbalance is the real problem.

- This approach has dominated thinking for the last 200 years
- The area of biological psychology focuses on the relationship between biology, behaviour and mental processes

- **Assumptions**
  1. Genetic factors
     We believe that psychological disorders can be passed from generation to generation, e.g. depression
  2. Biochemistry: Neurotransmitters
     Having too high or too low chemicals leads to psychological disorders - usually in the brain. E.g. schizophrenia and dopamine hypothesis (levels of dopamine are too high)
     1. Infection (General paresis)
        Bacteria and viruses can lead to psychological disorders, e.g. syphilis
     2. Neuroanatomy (Brain damage)
        If there’s an area of the brain which is too big/small or damaged, e.g. anorexia = part of hypothalamus is too big, schizophrenia = ventricles in the brain are too big

- Treatment
  Biological therapists use physical and chemical methods to help people overcome their psychological problems. There are three major kinds of biological treatments,
  1) Drug therapy,
  2) Electroconvulsive therapy (ECT),
  3) Psychosurgery
1. Drug Therapy (Chemotherapy)

The widespread use of this kind of therapy dates back to the 1950s, when researchers discovered some psychotropic drugs act primarily on the brain and can help to alleviate symptoms of mental disorders. Drugs are now widely used and have revolutionised the treatment of some disorders – chemicals allow people to live a normal life, they give them a manageable state. It's about dealing with the symptoms – not cause – so that you get into a state where you are able to deal with the cause. Drugs have reduced the need for psychologists.

Communication between neurons involves the release of neurotransmitters. Various drugs can affect production or release of neurotransmitters. So drugs can alter perceptions, thoughts and behaviours controlled by neurotransmitters.

Drugs typically affect transmission in the nervous system (neurotransmitters such as dopamine, serotonin, noradrenaline, GABA…) and the outcome is to increase or decrease the levels of available neurotransmitters. This can have calming or energising effects on different kinds of behaviour.

Three major groups of psychoactive drugs used:

a) Anti-anxiety drugs (depressants, minor tranquillizers, e.g. benzodiazepines) - CALMS

Initially, anxious people were given sleeping pills (barbiturates) but after some high-profile overdoses, now depressants, which are much safer, are used.

Anti-anxiety drugs are designed to treat every-day anxiety disorder (but not psychotic symptoms) like phobias, anxiety disorders, panic attacks. They may also be helpful with stress-related disorders and with reactive depression, as well as helping people who are undergoing withdrawal from alcohol and drug addiction.

The most widely prescribed drugs in the USA are the group of anti-anxiety drugs called benzodiazepines, e.g. valium and Librium. They enhance the action of GABA which generally suppresses activity in the CNS, so nervous activity in the brain stem, limbic system and ANS is reduced. Hence, they reduce anxiety. However, they are addictive and have been over- and misused and are not a long-term solution for anxiety.

+ **Cheap**
- **Don’t cure cause, only symptoms** – short-term solution only, not long term (sometimes good though) – less effective after long use; but effective
- **Side effects:** lethargy, addiction, increased tolerance, withdrawal symptoms
- **Overdose** can lead to death, especially if combined with alcohol, as the drugs are toxic
### b) Antidepressant drugs - EXCITE

They stimulate the production and inhibit the destruction of noradrenalin (neurotransmitter) so they help to lift the spirits of those who are depressed (it's the opposite of GABA; it increases everything; stimulates brain activity).

They can be divided into 3 major groups according to the way in which they achieve their effects; the outcome in all cases is **enhancement of the action of one or more neurotransmitters**.

1. **Monoamine oxidase inhibitors (MAOI)**
   - Were the first Antidepressant drugs to be discovered in the 50s.
   - They inhibit the enzyme that normally breaks down the neurotransmitters noradrenalin and serotonin; so MAOIs **increase the levels of these neurotransmitters** in the nervous system.
   - 50% success rate
   - Useful for **phobias** but only used when other anti-depressants are **ineffective** and depression if caused by biological trigger (not caused by environment, e.g. death)
   - Least used because they have more serious side effects such as high blood pressure, liver damage, even death (or otherwise hallucinations, migraine…) if mixed with cheese, red wine, chocolate…

2. **Tricyclics (TCA)**
   - They prevent noradrenalin and serotonin (neurotransmitters) from being re-uptaken after use, in effect also increasing the level of neurotransmitters in the synaptic gap.
   - e.g. Prozac: introduced 1987; 1999 37 Million people world wide were taking it (0.5% of world population). 1996 in AM 35 000 children were prescribed Prozac – over prescribed! Cultural differences!
   - 65% success rate (depression)
   - Side effects: **dizziness, blurred vision, weight gain, sleepiness**

3. **Lithium carbonates** (precise form of action was unknown some years ago)
   - Useful for **bipolar disorders** and **phobias**, helps to store emotional equilibrium
   - Can cause kidney poisoning
   - Effective way to treat **depression** and **anxiety** in the short term
   - Significantly helping 60 to 80 % of people according to some reports
   - Not equally effective in all cases and may not be better than psychotherapy in the long term

### c) Antipsychotic drugs (Major tranquillizers, Neuroleptic Drugs)

Don’t act on nervous system in the same way as other (serious) drugs do! Drugs for more affected people, where the disorder takes over life (e.g. schizophrenia with hallucinations); they allow people to live more normally and independently again

E.g. (most frequently used) **chlorpromazine**: It blocks the receptor side for dopamine so that it can’t bind, so dopamine levels in the brain are reduced; It reduces the response to external stimulation (good because problem in schizophrenia: louder noises, greater feelings of insecurity, however, bit slower (motor neurons slower). It can be given as long-acting implant or injection; the outcome is that it stabilises mood, reduces hallucinations and paranoia and general level of activity (become a bit lethargic)

- The most disturbed patients have been able to live outside the psychiatric ward
- Antipsychotic drugs are the **most effective treatment for schizophrenia**
- Drugs have to be **strong**: often people have to take **cocktail of drugs to control side effects** (side effects: can be very serious, e.g. movement disorders (contractions of face and body, restlessness…), dry mouth, blurred vision, low blood pressure = faint easily, liver-damage, neuro-muscular effects (sucking and chewing), can slip into coma BUT very effective in clearing up surface of symptoms of ppl function adequately
- Effects wear off quickly (person isn’t in state to know to need to take it again); must be taken **regularly + frequently**
- (Hard to get levels of drugs right; if dopamine levels are high = symptoms, side effects of schizophrenia; if they are too low, then from Parkinson’s!)

### Evaluation of Drug Therapy:

- In general, drugs have been very effective in reducing the number of hospitalised patients
- May help to prevent suicide
- Side effects
- Don’t cure the cause, only symptoms (+/-)
2. **ECT (electroconvulsive therapy)**

ECT is mainly used for patients suffering depression when they don’t respond to any other treatments (Epileptics don’t have schizophrenia = electric storms prevent this! So they tried it on other disorders and found it very effective)

1) Patients are given an anaesthetic and muscle relaxant
2) Two electrodes are attached to a patient’s forehead and an electrical shock of 50-150 watts for between 1/10 of a second to 1 second is briefly passed through the brain.
3) This causes a minor attack (convulsion) that lasts for up to a few minutes
4) After an average of 7-9 sessions the patient may feel considerably less depressed.

- **Learning explanation**
  It acts as a form of punishment so it reduces the undesirable behaviour (depression)

- **Biological explanation**
  Electric shock stimulates the production of adrenalin
  It reduces serotonin-uptake, therefore more serotonin is available
  (Depression = low levels of hormones, ECT pushes them up)

- **Cognitive explanation**
  It resets and restricts mental processes and causes temporary amnesia

**Evaluation**

+ ECT helps approximately 70-80% of depressed patients, used on tens of thousands annually.
  Suggested to be the most effective treatment for depression.
+ Less used than in the past because new drug treatments can make its use unnecessary. Tends to be used only when all other treatments have failed (“last resort” treatment)
  - Ethically its use has been questioned mainly because no-one really knows why it works and it does involve a severe assault on the brain
  - Side effects: minor losses of memory and some mild confusion, deaths: 3.6-9 per 100 000 (BUT this is the same for people who die from anaesthetics!) In severe depression, 11% commit suicide
  - Some associations, e.g. “MIND” (National association for social health) reject ECT because
    o Risk of death
    o Don’t know how it works (BIO, LEARN, COGN explanation)
    o Over-used (quick and easy)
    o Person who is really depressed can’t give actual consent?

**Janecek (1985)**

80% of extremely depressed people treated with ECT respond well to ECT, with drugs it’s only 64%!

**Fink (1985)**

Compared ECT with psycho-therapy: ECT 60% more effective!

3. **Psychosurgery**

Psychosurgery is the use of brain surgery to destroy a small area or to isolate an area by cutting its connections with the rest of the brain. If the area concerned is malfunctioning, this procedure should alleviate the psychological problems that the area is causing.

This kind of treatment dates back a long way, to **trephining** (prehistoric practice of chipping hole in skull of person who behaved strangely). Modern forms are developed from a technique called **lobotomy** used by Moniz in the 1930s. He used it for anti-social behaviour; it involves the removal of the frontal lobes. As we learn from people whose brains get destroyed, it was shown that the personality then changed. For example, Phineas Gage’s frontal lobes were accidentally destroyed, he survived but his personality changed from nice to antisocial. Or **Charles Witman**, a murderer, felt that something was wrong with him. When he died, an autopsy was made and a tumour in his limbic system was found.

However, the technique caused **dreadful side effects** (seizures, extreme listlessness, death)

Today’s procedures are much more precise and have fewer unwanted effects because the parts of the brain are now better known. Nevertheless, psychosurgery is used infrequently, usually only after a disorder has continued for many years and all other treatments have been unsuccessful.

**Evaluation**

- Personality changes (can’t control what changes how – outcomes now much better though)
- For highly aggressive people: have a lobotomy to remove limbic system = ethical problems (for psychosurgery for personality disorders): often no consent, physical and psychological harm (when they are not suffering themselves – are they unhappy?)
Evaluation of biomedical approach (medical model)

- Highly scientific status; credible (associated with medical profession; properly tested, drug trials (precisely, accurately; experimental validity)
- Manages the symptoms that would disable you to use other therapies
- Bio methods have significantly reduced nr. of people in institutions
- The new medications that are continually being discovered have, without doubt, helped huge numbers of people after other interventions have failed. In particular, the treatment of schizophrenia, bipolar mood disorder and depression have been revolutionised by drug treatments (Clozapine, lithium and prozac respectively)
- Fast acting

+/- Short term solution
- Reductionist
- Although biological processes are the basis of all behaviour, in turn they are without doubt affected themselves by our behaviour, thoughts and emotions. Not sure whether biological symptoms are cause or effect! E.g., if we say that depression is caused by a shortage of a neurotransmitter, norepinephrine, it is possible that this shortage itself has been caused by some event that has happened to us in our past. It is probably much more useful and much more accurate to say that our mental life is an interplay of biological, psychological and environmental factors and it is important to examine this interplay rather than just focus on biological variables.
- Only treats symptoms not causes
- Many side effects
- Individual differences in effectiveness + side effects
- Although drugs are effective in many cases, they do not help everyone
- Some disorder may not have a biological basis (but still bio symptoms!!)
- Can be over prescribed, drugs; over-used
- Control is taken away from patient!
- Stigma associated with medical model (normal is good, abnormal is bad)
- Genetic studies are open to many alternative interpretations. Evidence that certain disorders run in families may point to a genetic cause but it could also be that close relatives are more likely to experience similarly harmful psychological and environmental influences

Psychological Models
(Psychodynamic, Cognitive, Behavioural, Humanistic)

4) Psychodynamic Model

Sigmund Freud – most influential person in clinical psychology
Freud’s view: mental illness doesn’t have a physical origin, it arises out of unconscious conflicts which form in early childhood

- Freud’s theory of personality (pre-knowledge):
  A person’s personality has 3 parts:

<table>
<thead>
<tr>
<th>ID</th>
<th>EGO</th>
<th>SUPER-EGO</th>
</tr>
</thead>
<tbody>
<tr>
<td>present at birth; primitive, animalistic, instinctive part; demands immediate satisfaction; governed by pleasure principle</td>
<td>starts at 3 years; conscious, intellectual part; regulates the ID; it’s governed by reality and the need to behave in acceptable ways</td>
<td>starts at 3-5 years; moral component; learnt from others, especially parents; gives people guilt-feelings motivated by anxiety principle</td>
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EGO uses self-defence mechanisms to protect itself, e.g.
- Repression: Forcing a dangerous/threatening memory/idea/feeling/wish out of consciousness and making it unconscious; one of the earliest defence mechanisms used by children (e.g. child represses desire for parent)
- Denial: Refusing to acknowledge certain aspects of reality; refusing to perceive sth because it’s painful, distressing or threatening (e.g. refuse to accept that you’ve got an illness (undesirable))
The psychodynamic model put forward by Freud was based on his theory of psychosexual development:

There are 5 psychosexual stages of development:

**ORAL** (Birth-2)
- **Mouth** is the source of (sexual) pleasure; if you get fixed in this stage you may e.g. be a thumb-sucker as grown up.

**ANAL** (2-4)
- Pleasure from doing poos (e.g. toilet training)
- if you get fixed in this stage (e.g. if you had “poo-times”, were not given any freedom) you may become extremely tidy as grown up (as EGO develops during that stage)

**PHALLIC** (4-5)
- **Boys**: Oedipus conflict: want to be with their mums, dads are competitors – boys have fear of castration which outweighs their desire – they befriend their dads.
- **Girls**: Electra conflict: hope to grow a penis – as this doesn’t happen they identify with their mothers.
- when fixed in this stage (here SUPER-EGO develops) they might end up as homosexual or having problems with intimacy.

**LATENT** (6-11)
- Break from sexual tension; make friends; sexual urges sublimated into sports and hobbies

**GENITAL** (12+)
- (Adolescence)
- Discovering oneself, getting pleasure from (own) genitals, relationships; when fixed in this stage you may not be able to shift the focus from your own body.

- Some psychologists believe that mental disorders are the direct result of psychodynamic conflicts that can not be appropriately dealt with by the defence mechanisms.
  - That is, the defence mechanisms usually provide us with ways to settle conflicts in a way that approximately satisfies both the Id and the Superego.
  - However, for some people these defence mechanisms may be insufficient or dysfunctional, thereby resulting in maladaptive behaviour.
- Alternatively people may be fixated in a certain psychosexual phase.

### Basis of the Psychodynamic Approach to Treatment

The psychodynamic approach to atypical behaviour and abnormality emphasises the role of feelings, conflicts and drives operating at conscious and unconscious levels, in contrast with the biological approach which views the person as an essentially biological being and in contrast with the behavioural approach which is little concerned with understanding reasons or any meditational process. This approach is sometimes referred to as depth psychology.

Psychodynamic theorists maintain that all behaviour whether 'normal' or 'abnormal' arises from underlying psychological forces. These inner forces interact with each other and are often in conflict with each other, hence the term dynamic. Their interaction gives character to the personality producing differences between individuals in the extent to which we are successful in resolving these conflicts. Abnormality and normality then are on the same continuum in the sense that we all experience intrapsychic conflict but abnormal behaviours or symptoms arise when the person is particularly unsuccessful in resolving the conflicts, resulting in anxiety or neurosis. There are various schools of psychodynamic psychology, all beginning with the work of Freud but each adopting other names for their doctrines to indicate deviations from Freudian theory.

The main concepts within Freudian psychoanalysis are:
- The struggle between Eros and Thanatos (the life and death drives)
- The dynamics of the unconscious
- The role of anxiety (neurotic, realistic and moral) and of defence mechanisms
- The tripartite structure of the personality (id, ego and super-ego)
- The processes of psychosexual development (from oral to anal, phallic, latency and genital stage)
Psychoanalytic Treatment

- Any fixation in any of the stages may lead to a psychological disorder in later life
- Neurotic symptoms are the result of conflicts btw. repressed desires and attempts to control them (i.e. conflicts btw. ID, EGO, S-EGO)
- If you can gain access to the repressed desires and gain INSIGHT into your fixation; that will cure your psychological disorder

Following the assumptions of psychoanalytic theory, psychoanalysts view current psychological difficulties as arising from earlier childhood emotional trauma. Each personal history is the history of a series of conflicts, some of which we may be aware, the majority of which we will be totally unaware due to the operation of defence mechanisms. Freud believed that psychological disorders arise from intrapersonal conflicts of which we are unaware, conflicts which have been repressed to the unconscious. Particularly important conflicts in Freud's view are the conflicts between the ego and superego and between Eros and Thanatos, that is, between the sexual and aggressive drives. The key assumption here is that a person's present disorder can be successfully resolved only by understanding their unconscious basis in the early relationships with parents.

The aims of psychoanalysis therefore, are:
- To free the id's impulses from excessive control by the ego
- To strengthen the ego
- To alter the contents of the super-ego so that it becomes less oppressive and more accepting

These amount to a re-education of the ego. Freud considered this possible and effective for a range of disorders in which the person has a degree of appreciation of reality, such as anxiety disorders like phobias, anorexia, bulimia and depression as well as obsessive compulsive disorders. He did not think it would help the psychotic but could be used with the neurotic. The neurotic is someone who uses defence mechanisms excessively and whose libido gains expression through bodily symptoms such as slips of the tongue and other 'mistakes' (so-called parapraxes), ritualistic compulsions, temporary paralyses and so on. The neurotic has a distorted perception of reality and in order to remove the symptoms must gain access to the repressed feelings that give rise to them. By gaining this insight, the conflict will be reduced or resolved and the symptoms removed. This is the recovery of unconscious memories, achieved by various techniques.

Treatment – Therapeutic Techniques and Procedures

Due to the nature of defence mechanisms and the inaccessibility of the deterministic forces operating in the unconscious, psychoanalysis in its classic form is a lengthy process often involving 2 to 5 sessions per week for several years. This approach assumes that the reduction of symptoms alone is relatively inconsequential as if the underlying conflict is not resolved, more neurotic symptoms will simply be substituted. The analyst typically is a 'blank screen', disclosing very little about themselves in order that the client can use the space in the relationship to work on their unconscious without interference from outside. The psychoanalyst uses various techniques as encouragement for the client to develop insights into their behaviour and the meanings of symptoms, including free association, interpretation (including dream interpretation), resistance analysis and transference analysis.

Free association

Lie on coach; therapist introduces a topic (i.e. word) and the client talks about it, responds what comes into his mind (repressed feelings will eventually come out)

The client simply tells everything that occurs to consciousness without attempting to edit it in any way. Sometimes stimulus material may be used such as words or images but the main idea is for the client to find a way of lifting repressions. Nothing the client says is taken at face-value. In fact, the more rational it is, the more likely it is to be covering up or repressing something meaningful at an unconscious level. Clues to the nature of repressed material are given by attempts to change subject, significant omissions, forgetting or losing track.
- **Hypnosis**

  Used to uncover repressed thoughts; e.g. Case Study Anne O. (Josef Breuer): Paralysis, nervous cough. She was diagnosed with hysteria. When she was hypnotised, the memory that when she was sitting next to her dying father when hearing dance music and thinking she’d rather be dancing was uncovered. This had made her feel guilty. Freud implies that her illness was a result of the grief felt over her father’s real and physical illness that later led to his death.

- **Interpreting Dreams**

  *Interpretation* is used by the analyst offering suggestions for the meaning of some of the client’s behaviours. It is a hypothesis, not a definitive solution to the problem and the *client’s response* to the interpretation can often be more indicative of unconscious motives than the actual interpretation itself. Material for interpretation may come from free association or there may be the *interpretation of dreams*.

  **Interpreting dreams**: Freud considered dreams to be the “road to the unconscious’ as it is in dreams that the ego’s defences are lowered so that our mind is less vigilant during sleep and repressed things come through to awareness, usually in distorted form to make them more acceptable (e.g. go up a ladder = want to have sex). Freud distinguishes between the *manifest content* of the dream, the consciously remembered material, and the *latent content*, the symbolic meaning of the dream. Dream interpretation involves the *translation* of the (inevitably distorted) manifest content into the (truthful) latent meaning. Understanding the various distorting processes would help us to understand the latent meaning of a dream. The process of *condensation* is the joining of two or more idea/images into one. For example, a dream about a man may be a dream about both one’s father and one’s lover. A dream about a house might be the condensation of worries about security as well as worries about one’s appearance to the rest of the world.

- **Transference**

  Therapist is out of sight, client lies on coach. Therapist tries to become an object onto which the client can express all his feelings (e.g. client: you stupid chair, I hate you... = feelings towards father projected on chair)

  The outcome of therapy is a purging of emotions = catharsis (comes with insight, once you really understand yourself... e.g. cry and cry out all feelings)

- **Applications of Psychoanalysis**

  Psychoanalysis (along with Rogerian humanistic counselling) is an example of a *global therapy* which has the aim of helping clients to bring about *major change in their whole perspective on life*. This rests on the assumption that the current maladaptive perspective is tied to deep-seated personality factors. *Global therapies stand in contrast to approaches which focus mainly on a reduction of symptoms, such as cognitive and behavioural approaches, so-called problem-based therapies.*

- **Evaluation**

  + This may be a placebo effect: if the therapy doesn’t work, talking about yourself works (people feel valued when someone listens to them)
  + Try to get to the cause of the problem (rather than just treating symptoms)
    - Not scientifically rigour
    - Based on case studies of INTERNAL processes (unquantifiable, immeasurable), can’t be generalised
    - Therapy is expensive and time consuming
    - Only works with people who can speak (are verbally capable)
    - Too much emphasize on early (childhood) experience, current conflicts can be overlooked
    - Depends heavily on the therapist’s interpretation
    - Overemphasize on sex
    - Problems of false-memory syndrome with hypnosis
The Behavioural Model

The behavioural model (or approach) for abnormal behaviour is based on the learning perspective, so it suggests that sufferers have **learned inappropriate behaviours**.

- Learning perspective assumes that the maladaptive behaviours are learned, and that they can best be understood by examining the environment in which the person is (or was) and their perceptions of that environment.
- In this case, the focus is on the symptoms as they are seen as simple learned responses that have been conditioned and, therefore, can be unlearnt.

**Behavioural theorists have a deterministic view of human functioning:** they believe that our actions are determined largely by our experiences in life. They concentrate on specific behaviours, the responses that an organism makes to the stimuli in its environment, and on the principles of learning - the processes by which behaviours change in response to the environment. Many learned behaviours are adaptive, but abnormal and undesirable behaviours can also be learned.

**Explanations and Therapies**

*Main explanations: Classical conditioning, Operant conditioning, Social learning*

1) **Classical Conditioning - Association**

Learning by association; if 2 events occur close together then one is learned as being linked to the other

<table>
<thead>
<tr>
<th>Pavlov's experiment:</th>
<th>1. Food</th>
<th>salivation</th>
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<tr>
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<td>UCS</td>
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<tr>
<td>2. Food + Bell</td>
<td>salivation</td>
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<td></td>
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Abnormal behaviours can be explained in this way. E.g.: Little Albert (Watson & Rainer (1920)) had a fear (unconditioned) response to a loud noise (unconditioned stimulus). The noise was paired with a rat (white and flurry, conditioned stimulus) and soon Albert had a fear (conditioned) response to that rat alone. He generalised his conditioned response to various white and fluffy things. The fear response may have persisted throughout his life; he might have avoided all those things so good that he never learned how harmless they are.

- **Aversion therapy**
  - Association broken in unethical way (harsh treatment)
  - Mostly used for alcoholics and paedophiles
  - Make them learn to associate, e.g. alcohol with unpleasant things (give them a drug that makes them throw up when they drink alcohol) – so replaces association with unpleasant sensation

**Evaluation**

+ Smokers: smoke every 6 seconds until sick of it – is found to work
- Unethical

- **Flooding**

Flooding therapists believe that clients will stop fearing things when they are exposed to them repeatedly and made to see that they are actually harmless. Phobic patients have maximum exposure to their fear-stimulus (e.g. put them in a room with spiders). Initially they are flooded with fear but that subsides and the fear-association is broken as they see that no real danger exists.

**Evaluation**

+ Works most effectively with anxiety-related disorders (e.g. phobias)
- Ethics; deliberately designed to produce high levels of fear
- Often won't stay long enough (e.g. in that room) for fear to subside = unsuccessful
Systematic Desensitisation (Counter-conditioning)

Mostly used with anxiety disorders (e.g. phobias)
Replace fear with relaxation response

3 Stages:
- Patient trains relaxation techniques
- Construct hierarchy of anxiety (“fear hierarchy”) with situations/objects that are minimally feared and ending with those most fearsome
- Therapists then have the clients either imagine or physically confront each item on the hierarchy while they are in a deep state of relaxation. Step by step they move up the hierarchy until they can relax in the presence of all the events

Evaluation
+ More ethical
- Only useful when a single stimulus has been identified (e.g. spider) – works less effective with general fear (e.g. of all black animals)
- Involves a lot of commitment, time and energy (more expensive)
- Patients are asked to put themselves in anxiety provoking situation outside therapy, don’t usually do that though, so this is just for inside the lab and hard to transfer outside to real life (fear isn’t there everyday and you don’t “seek” for it, so training could be for nothing)

2) Operant Conditioning - Reinforcement

Here humans learn to behave in certain ways because they receive reinforcements (which strengthen behaviours) or punishments (which weaken behaviour). Many abnormal behaviours may develop as a result of reinforcement. Some people may learn to abuse alcohol and drugs because initially such behaviours brought feeling of calm and pleasure. Others may exhibit bizarre behaviours because they enjoy the attention they get.

Therapies focus on maladaptive (abnormal) behaviour and on the reinforcers that maintain that behaviour. When the therapist has a clear idea of the reinforcer, he gives the patient an increase of rewards for normal behaviour and a decrease of rewards for abnormal behaviour.

Token Economies
- Used with institutionalised patients (e.g. have a disorder that make it difficult to manage daily life) and anorexics
- Patients are given Tokens (secondary reinforcers that can be exchanged for primary reinforcers = food, a visit, watching TV...) for behaving in certain ways
- No rewards are received when displaying psychotic behaviours
- In America they often use negative reinforcers, too (e.g. take away privacy if you behave abnormally) = cultural differences

Evaluation
+ Most effective are praise and encouragement as rewards – even more effective when given by ordinary people (family members...)
- Individual differences of how affective this is
- Seems to work very well in institutions but behaviour can’t be transferred outside in real world

BIO-Feedback

Relaxation techniques are learned and the bodily responses are monitored (e.g. the hear rate) so that the patient observes the technique’s effect (the effectiveness of relaxation technique reflects back to him). He learns how to control his responses.

Evaluation
- Success has been exaggerated, relaxation on its own is just as effective (bio-feedback is not needed!)
### 3) Social learning theory - Modelling

Suggests that you learn from models – from **watching others** (the closer the people are to you, the more likely you are to learn from them). E.g. children may acquire language, facial gestures etc. by **imitation**. Abnormal behaviours can be acquired too, for example children of poorly functioning people may themselves develop maladaptive reactions because of their exposure to inadequate parental models. (See example **Bobo Doll** LP-booklet)

- **Observational-learning therapy**

The basic design is for therapists to demonstrate appropriate behaviours for clients, who through a process of **imitation** and **rehearsal** acquire the ability to perform the behaviours in their own lives. I.e. the therapist acts as a model, they “conquer” the client’s feared object through a series of graded steps, then the patient does the same.

In some cases, therapists model new emotional responses for clients e.g. calmly handling snakes to show that it is possible to be relaxed under such conditions.

### Evaluation

- Useful for phobias
- 90% success rate, can be used in group therapy (every one supports one another, e.g. AA for alcoholics)
- However, if someone fails, domino effect = someone else will go down, too (e.g. pro-anna)

### General Evaluation of Behavioural Therapies (all 3)

- **Firm, scientific basis** (behavioural explanations and treatments can be **tested in the lab** – results have given considerable support to the behavioural model)
- **Clear procedures** = makes therapies **easy to administer**
- **Quite successful** for a target of disorders (mostly **anxiety-related** ones (e.g. phobias) but also depression and sexual disorders)
- Effectiveness is considerable when compared to the relatively **short duration** and **low overall cost** of therapies

  - Principles stem from **animal studies** (e.g. Pavlov) – humans have higher ways of communication so it can’t be generalised
  - Over-simplistic way of looking at people = **reductionist**
  - Only treats **symptoms** (underlying **cause remains**); Behaviourists argue, symptoms are all that matters (however, if symptoms of e.g. anorexia are cured, others, e.g. depression, might replace it)!
  - Although researchers have induced specific symptoms through conditioning, they have not established that such symptoms are usually acquired in this way.
  - Have found that if clients could make a **behavioural AND cognitive change**, it’s very effective
  - The behavioural perspective is simplistic - its overlooks the human capacity to think critically. Some behaviourists have recognised the need to look at cognitive behaviours and have developed cognitive behavioural theories!

### Cognitive behavioural therapy

*(Combination of behavioural (operant conditioning) and cognitive therapy)*

- **Very effective** as it combines the best bits of both therapies – uses **behaviour-modification** techniques and incorporates **cognitive procedures** to change maladaptive thoughts (“thought-stopping”)
- It’s about recognising one’s own thought-processes (try to rationalise what you are thinking); treat them new ways of thinking
- E.g. anorexic: Behaviour: learn to eat properly again; Cognitive: change thoughts

### Evaluation

- If you can alter a person’s thoughts of themselves, this is lasting! Most successful, powerful type of therapy!
- Time consuming
6) Cognitive Model

- These psychologists place an emphasis on cognitive factors in the sense that the perception of the environment is seen as important.
- **Faulty perceptions, catastrophising** and **negative thoughts** all lead to abnormal behaviours.
- People who have mental disorders have **distorted** and **irrational thinking** – rather than maladaptive behaviour.
- Dysfunctional behaviour can best be understood by examining the environment in which the person is (or was) and their **perceptions of that environment**.
- Therapy usually involves trying to **change that perception**.

**Kovacs and Beck** believe that maladaptive behaviour is caused by **faulty and irrational thinking** processes, e.g. making incorrect influences ("you’re looking like you’ve lost weight" – you assume, that person thought you were fat) or not being able to distinguish between imagination and reality. They emphasise the role of thoughts (people **catastrophise** and **over-generalise** ("if this relationship doesn’t work, none will")).

According to the cognitive model, to understand human behaviour, we must **understand the content and process of human thought**. When people display abnormal patterns of functioning, cognitive theorists assume that **cognitive problems** are to blame. Like the behaviourists they reject a medical illness view of abnormal psychological functioning. In the early 1960’s two clinicians, Aaron Beck and Albert Ellis, proposed cognitive theories of abnormality.

**Treatment**

The cognitive therapist teaches clients how to **identify distorted cognitions** through a process of **evaluation**. The clients learn to discriminate between their own thoughts and reality, they learn the influence cognition has on their feelings, and to recognise, observe and monitor their own thoughts.

**Rational Emotive Therapy (Ellis (1962))**

Ellis proposes that each of us holds a unique set of **assumptions about ourselves and our world** that serve to guide us through life and determine our reactions to the various situations we encounter. Unfortunately, some people’s assumptions are largely **irrational**, guiding them to act and react in ways that are **inappropriate** and that prejudice their chances of happiness and success. These are “**basic irrational assumptions**”, for example:

- *The idea that one should be thoroughly competent at everything*
- *The idea that is it catastrophic when things are not the way you want them to be*
- *The idea that people have no control over their happiness*
- *The idea that you need someone stronger than yourself to be dependent on*
- *The idea that your past history greatly influences your present life*

Ellis’ therapy challenges these **irrational thoughts** with **rational arguments**.
Ellis’ Rational Emotive therapy
Assumption that people contribute to their own psychological problems and symptoms by the way they interpret events and situations; so a reorganisation of one’s self-statements will result in reorganisation of one’s behaviours
- Irrational assumptions are pointed out in a confrontational, often humorous way
- Then uses of alternative assumptions are modelled (e.g. after criticising a man’s perfectionist standards he may say “so what if you got a crap grade on your essay? It was only one essay - no more than that. It doesn’t mean that you are useless!”) (They learn to replace negative with positive thoughts)
- Rational emotive therapists have cited many studies (with anxieties or non clinical problems such as mild fear of snakes and recently also on clinical subjects) in support of this approach.

Cognitive Restructuring Therapy (Beck (1976))
Beck’s approach is similar to Ellis in that it emphasises recognising and changing negative thoughts and maladaptive beliefs. Beck believes that a person’s reaction to specific upsetting thoughts may contribute to abnormality. As we confront the many situations that arise in life, both comforting and upsetting thoughts come into our heads. Beck calls these unbidden cognition’s automatic thoughts (personalized notions that are triggered by particular stimuli that lead to emotional responses). When a person’s stream of automatic thoughts is very negative you would expect a person to become depressed (I’m never going to get this essay finished, I’m getting fat, I have no money, my parents hate me).
In addition, Beck identifies a number of illogical thinking processes including:
- Selective attention: seeing only the negative features of an event
- Magnification: exaggerating the importance of undesirable events
- Overgeneralization: drawing broad negative conclusions on the basis of a single unimportant event
These illogical thought patterns are self-defeating and can cause great anxiety or depression for the individual.

Beck’s Cognitive Restructuring Therapy
Beck’s system of therapy is similar to Ellis’s, but has been most widely used in cases of depression.
- Therapists help clients to recognise the negative thoughts and errors in logic that cause them to be depressed.
- Therapists guide clients to question and challenge their dysfunctional thoughts, try out new interpretations, and ultimately apply alternative ways of thinking in their daily lives.
- The therapy has also been successfully applied to panic disorders and other anxiety disorders.

Self Instructional Therapy (Meichenbaum)
He assumes that all problems are caused by negative self-defeating and inner dialogues.
- Therapy identifies the problem by encouraging the patient to think positively
- The aim is to give the patient control of his behaviour through guiding self-thought that gradually becomes covert and self-generated.
- In individual is encouraged to do self-talk to calm themselves down

Evaluation of the Cognitive Approach and Treatments
Evaluation of the Cognitive Model
+ Gives people the power to change themselves and increases their self-belief
+ Gives them the responsibility for changing their undesirable behaviours
+ The therapies focus on people’s experiences and feelings and interpretations (personal touch)
+ Don’t need to be institutionalised
+ Many people with psychological disorders, particularly depressive, anxiety, and sexual disorders have been found to display maladaptive assumptions and thoughts
+ Cognitive therapy has been very effective for treating depression, and moderately effective for anxiety problems
- Ignores other factors, e.g. genetics
- Unclear whether negative thinking is the CAUSE or EFFECT of the disorder
- Ethics: The model assumes that the disorder is the patient’s OWN FAULT – attaches blame to the individual, takes away social factors (e.g. grief, not enough money) that could be the cause
Humanistic Model

- This perspective follows from the Humanist views of personality development such as those of Maslow & Rogers.
- The general assumption of that view is that we are all trying to reach "self-actualization" but to do so we must learn to not over-value other’s perceptions of us.
- According to this view, mental disorders occur precisely when people become oversensitive to the demands, criticisms and expectations of others.
- Therapy involves helping people not to do this and, instead, to focus on being who they are.

Basis

- Humanistic psychologists maintain that human beings are naturally good. The goal of people is to fulfil their potential to self-actualise.
- Abnormal behaviour is the result of roadblocks that people encounter on the path to self-actualization whereby people become detached from their true selves and adopt a distorted self-image which leads to emotional problems.
- Carl Roger believed that you have your true self – what you really are – and an ideal self – what you would like to be ("to fit" in the society, what the society expects of one... Society accepts us with “conditions of worth” = tick boxes you are supposed to have)
- The greater the gap between these two selves is, the more likely you are to have a psychological disorder.

Treatment

According to Rogers, clients need to focus on their current subjective understanding (current perception and how we live in the here-and-now) rather than on someone else’s interpretation of the situation – no one else can know how we perceive, we behave as we do because of the way we perceive our situation; we are the best experts ourselves.

Rogers believes that a major consequence of being totally accepted by others (unconditional positive regard) is total acceptance of us by ourselves – so the acceptance of one’s true self. However, if people only value us when we behave in certain ways, we are likely to do those things which please them. So this will lead to be like the “ideal self”

According to Rogers, we want to feel, experience and behave in ways which are consistent with our self-image and which reflect what we would like to be like, our ideal-self. The closer our self-image and ideal-self are to each other, the more consistent or harmonizing we are and the higher our sense of self-worth.

As we prefer to see ourselves in ways that are consistent with our self-image, we may use defence mechanisms like denial or repression in order to feel less threatened by some of what we consider to be our undesirable feelings.

The greater the gap between the ideal self and self-image, the greater the chance of confusion and maladjustment and the lower the person’s ability to function satisfactorily.

- **Treatment: Client-centred therapy**
  - (focus on supporting the person's achievement of their potential and their life goals)
  - The aim of the therapy is to shorten the gap between true and ideal self
    - Environment has to have empathy, unconditional positive regard and genuineness (if a person offers these 3 qualities in a relationship, they offer a therapeutic context to the other person (very important is the relationship between client and therapist (has to be warm, genuine and understanding))
    - “Talking therapy”, positive, gives time and attention (if any techniques: listening, accepting, understanding, sharing = attitude-orientated than skills-orientated)
    - Emphasise on the person understanding his world and himself
    - The goal of counselling is for the person to become “fully functioning”
    - Outcome: accept your true self

Evaluation

- Optimistic view about human nature, assumes we all have the tendency for self-growth
- Not measurable
- Doesn't take into account past experiences, only now and here (?)
Social and Environmental Theories

Socio-Cultural Perspective
- What is considered normal behaviour in some cultures (or at some times in history) might be considered maladaptive in others. e.g., suicide in samurai Japan
- These differences in cultural "norms" seem to have an effect on the incidents of mental disorders
- Specifically, certain mental disorders appear not to occur in some cultures. Clearly then, socio-cultural factors do play some role in causing some mental disorders

8) The Diathesis-Stress Model (one socio-cultural model)
- One popular approach to approach these different potential causes of any mental disorders is the diathesis-stress model.
- This theory was originally introduced as a means to explain some of the causes of schizophrenia (Zubin & Spring (1977))
- It assumes that a disposition towards a certain disorder may result from a combination of one’s genetics and early learning – so it’s a theory that stipulates that behaviour is a result of both genetic and biological factors ("nature"), and life experiences ("nurture").
- According to this model, mental disorders are produced by the interaction of some vulnerability characteristic, or predisposition, and a precipitating event in the environment.
  - The greater the underlying vulnerability (e.g. when the whole family has the disorder), the less stress is needed to trigger the disorder.
  - Where there is a smaller genetic contribution (e.g. if only one parent had the disorder), greater life stress is required to trigger the disorder.
  - However, having a disposition (a diathesis towards a disorder) does not mean that one will necessarily develop the disorder because the trigger, i.e. early learning of it (stress), may not occur.

Perris (1987) – Depression
- Suggests biological vulnerability could result from inherited defects in neurohormonal systems regulating the response to stress or from sensitization resulting from damage to neurohormonal systems by early experience.
- Depression could result if negative experiences were to activate the dysregulated neurohormonal system.

+ This model takes the strengths from both, biological and learning perspective (considers environmental affects and scientific backup)
+ The model has had profound benefits for people with severe and persistent mental illnesses (in their family history) through
  - stimulating research into …
    - The common stressors that people experience with disorders such as schizophrenia
    - How to mitigate this stress, and therefore reduce the expression of the diathesis
    - How to develop protective factors. E.g. skill building (especially problem solving and basic communication skills) and the development of support systems for individuals with these illnesses
  - Allowing mental health workers, family members, and clients to create a sophisticated personal profile of what happens when the person is doing poorly (the diathesis), what hurts (the stressors), and what helps (the protective factors)
    - This has resulted in more humane, effective, efficient, and empowering treatment interventions

- People may “give up” when they know that they have a disposition and may use this to excuse behaviour ("when my whole family had it, I'll surely have it, too, one day" – so may not do anything about it, that could help not triggering the illness; There are individual differences in how people react with the info when they are genetically disposed!)
- The model doesn’t explain disorders such as autism that are present from birth (no trigger!)
Diagnosis and Classificatory Systems

There are two main classification systems used in the UK for the diagnosis of mental illness:

- DSM IV
- ICD 10

  - purpose and functions of diagnosis
  - usefulness of classificatory systems
  - gender, cultural and ethical considerations in the diagnostic process

The Role of Classification systems

Psychiatrists conduct clinical interviews; info is gained from what clients say and the way they say it (subjective and objective). They use psychometric (turning person into nr.) tests (e.g. intelligence and personality tests). They do a behavioural assessment which is a record of the behaviour and thoughts that the patients wants to change.

The ROLE is to effectively diagnose a disorder
- Creates standards that everyone adheres to, works on
- Useful in accessing whether a person improves or deters
- Acid decision on treatment
- Can indicate the cause of the disorder
- They act as a short hand (coding system) between positions (instead of saying symptoms, e.g. “on scale 7”)

1. DSM IV (used in the USA)

- Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision
- Last major revision was in 1994
- Includes all currently recognized mental health disorders
- Can be used by many different orientations (cognitive, behavioural...)
- Designed for various uses (clinic, therapists, psychiatrists, social workers...)
- Necessary tool for collecting accurate public health statistics

5 dimensions are assessed = axes = levels at which clients are: enable psychiatrist to go to the book (with the 3 components below) and diagnose their real disorder

- **Axis 1**: Clinical Syndromes (look for features, symptoms)
- **Axis 2**: Developmental Disorders and Personality Disorders (look for additional disorders,....)
- **Axis 3**: Physical Conditions (look for medical disorders → might influence the client’s disorder)
- **Axis 4**: Severity of Psychosocial Stressors (look at personal circumstances that could have added to stress, e.g. unemployment, death of a loved one...)
- **Axis 5**: Highest Level of Functioning (the client’s level of functioning at the present and within the previous year are rated so that the psychiatrist can understand how the above axes are affecting the person and what changes could be expected)

3 Major Components:

- **Diagnostic classification**: list of mental disorders • make DMS diagnoses by selecting right disorder through looking at symptoms • diagnostic label associated with diagnostic code derived from coding system used in the US
- **Diagnostic criteria**: for each disorder in DSM, the symptoms that must be present are indicated (set of diagnostic criteria) in order to qualify for a diagnosis or those symptoms that mustn’t be present (inclusion/exclusion criteria) • provide a compact description of every disorder • increase diagnostic reliability (different uses will assign same diagnosis)
- **Descriptive text**: accompanies every disorder, describes disorder under headings such as symptoms, culture and gender patterns...
2. ICD 10 (used in the UK)
- The *International Statistical Classification of Diseases and Related Health Problems, 10*th
  Revision is a coding of diseases, signs, symptoms, complaints, social circumstances and 
  external causes of injury or diseases, as classified by the WHO
- Work on it began 1983 and was completed in 1992
- Chapters on each type of disorder (e.g. Mental and behavioural disorders, but also such as 
  diseases of the NS...); that one is further divided (e.g. schizophrenia, mood affective 
  disorders,...). Here, there are the different types (e.g. Paranoid, Catatonic schizophrenia...) 
  under which (more classifications and) symptoms are found. Therapists decide which disorder 
  best describes the client – there are no axes.

**Comparison of DSM IV and ICD 10**

<table>
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<tr>
<th>Similarities</th>
<th>Differences</th>
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| - Both use the term “mental disorder” | - DSM has a larger nr. of discrete categories 
  (that stand alone) |
| - Each disorder has a list of symptoms | - DMS doesn’t focus on what causes the 
  disorder when diagnosing |
| - Neither use a distinction between neurotic and psychotic disorders | - DMS uses 5 axes, ICD hasn’t got any |
| - Both have explicit criteria (on how to use it) | - DSM concentrates on mental disorders, ICD doesn’t |

**Evaluation of Classification Systems**

1) Reliability

**Rosenham (1973) – “Being sane in insane places”**
Ground braking study on how poor diagnosis worked back then; tried to test how well Americans 
recognised schizophrenia
- 8 people he knew well phoned various hospitals (cross 5 states) and said they heard empty, 
hollow voices. From the appointment onwards they behaved normally and all life details that 
had to give were correct. Anyway, 7 were diagnosed schizophrenic and 1 manic depressive
- The pseudo-patients stayed in hospitals – behaving normally all the time (the other patients 
  often detected their sanity!) – until they were diagnosed as fit (shortest stay: 7 days, longest 
  stay: 52 days, average: 19 days)
- Follow up study to check the poor reliability of diagnosis: A teaching hospital was told to expect 
  pseudo-patients over 3 months period. Not a single pseudo-patient was sent, still, out of 139 
  patients, 41 were diagnosed as pseudo-patients by staff and 23 by psychiatrists (19 by both)

**Cooper et al (1972)**
found that NY-psychiatrists were twice as likely to diagnose schizophrenia than Londoner ones, 
who in turn were twice as likely to diagnose mania or depression.

**Beck et al (1962)**
found that, due to vague criteria for diagnosis, the agreement of 2 psychiatrists on diagnosis was 
only 54%.

**Lipton & Simon (1985)**
re-diagnosed hospitalised patients from NY. Their diagnosis was then compared with the original 
one; only 16 from previous 89 were re-diagnosed with schizophrenia and only 15 from previous 50 
were re-diagnosed with a mood-disorder.

This shows that we need classification systems (i.e. diagnostic manuals) in order to diagnose right, 
i.e. the same.
2) Labelling

**Schef (1966)** highlighted the effects of labelling

1) **Self-fulfilling prophecy** (P begins to act as he is expected → may worsen his disorder)
2) **Distortion of behaviour** (once label is attached, P's actions are interpreted as to be due to that disorder)
3) **Over-simplification** (labelling can make a classification a real physical disorder rather than just a term used by doctors to help diagnosis)
4) **Prejudice** (a lot of stigma behind mental disorder!)

**Langer & Abelson (1974)**

showed P a video of a man describing his job experience; if P were told he was a job applicant, they described him as attractive. If they were told he was a mental patient, he was seen as defensive, tight and dependent.

**Farina et al (1980)**

took a pair of male college students, told 1 that the other had been a mental patient and he automatically perceived him as inadequate, incompetent and unlikeable.

3) Institutionalisation

Based on **Rosenham's study** and the problems that the pseudo-patients encountered when they were institutionalised: PPs found it hard to convince staff that they were alright. Any behaviour that they exhibited was perceived as a symptom and therefore a reason not to be discharged.

**Problems** (the behaviour exhibited was all regarded as being symptomatic of schizophrenia, e.g.):

- They had only changed one detail (that they heard voices) but now all their history became distorted to emphasize instability (a symptom of schizophrenia)
- PPs took notes; Nurses assumed they “engaged in writing behaviour” which was implied to be a sign of the disorder
- Pacing the corridors out of boredom was seen as nervousness (taken to be a sign of the disorder)
- Coming early to dinner was interpreted as “oral acquisitive nature of the syndrome”

**Other aspects of institutionalisation noted** in the study included:

- Lack of normal interaction: when they asked staff when they would be discharged, staff just gave a brief answer but didn’t even make eye contact...
- Powerlessness and depersonalisation: produced through the lack of rights, activity, choice and privacy
- Dependency: because it’s so difficult to be released from a psychiatric ward once admitted, some residents become totally dependent upon the doctors and nurses for their survival (never cook, work, interact with other humans... → lose ability to function in real world)

4) Bias in Diagnosis

Classification Systems aren’t 100% objective because diagnosis may be influenced by the attitude and prejudice of the psychiatrist or the test (DSM, ICT); e.g. black woman is more likely to be diagnosed mentally ill because psychiatrist expects her to be more likely to be so.

**3 Types of Bias**

- **RACIAL**
  - **Jenkins-Hall & Sacco (1991)**: looked at the effect of valuation given by white therapists; they watched 4 videos of clinical females in interviews (white-depressed, white non-depressed, African-American depressed, A-A non-depressed). Diagnosed not depressed clients the same but rated the depression of the A-A depressed one more negatively than the white one’s.
- **MISCONCEPTION**
  - Clinicians have pre-conceived ideas about the nature of mental disorders → influences their interpretation of symptoms
- **EXPECTATION**
  - Psychiatrists have an expectation of people to come to them because they have a mental disorder so they diagnose them with a mental illness (“reading in syndrome”)
5) **Sick Role**

Defines the patient as the illness not as having the illness (disorder schizophrenic NOT person with schizophrenia)

**Coman (1995)** studied **Rosenheim's study** and found that staff that spent little time with patient made them feel invisible which made them feel ill and deficient

6) **Expert Role**

Opposite to sick role: if patient think that the clinician is fulfilling the expert role then they act in ways they believe is expected of them (exhibit demand characteristics). This leads to the demonstration of symptoms which have no basis outside the relationship (it’s as thought the relationship has created the symptoms)

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Classifying Mental Disorders - Potential Benefits

- Often, before any disease or syndrome can really be understood, the collection of symptoms that characterize that disease must be specified.
- All systems stem from the work of **Emil Kraepelin (1913)** who put together a group of signs and symptoms which he called ‘disease states’.
- Then he described diagnostic indicators associated with each state.

Classifying Mental Disorders - Potential Risks

- Pigeon-holing someone as having some mental disorder can be detrimental in at least three ways.
- First, classifying someone’s deviant behaviour as a disease relieves them of the responsibility of controlling the behaviour.
- Second, being classified as having some disorder has a stigma attached to it that can be harmful to the patient, and can bias the way in which others examine and treat the symptoms.
- Third, “labelling” a disease is sometimes seen as understanding it … and nothing could be further from the truth. A label is not an explanation.