Psychopathology

- Explanations
  - **Albert Ellis (1962) and Anton Beck (1967)** emphasised a cognitive approach to psychopathology. Stating that it results from **unhelpful ways of thinking** that often reflects learning from **unpleasant experiences.**
  - **Beck (1967)** (responsible for the depression inventory) argues that depressed people are victims of their own illogical self-judgments. Their thinking is dominated by negative schemas. Negative schemas along with cognitive biases or distortions maintain the **negative triad** : Negative thoughts about the self, world and future.
  - **Social Explanations**
    Society and culture have a major impact on whether someone is diagnosed. Poorer, less empowered people suffer higher rates of disorder. Changes in cultural values (e.g. anorexia or bulimia nervosa).
  - **Psychological Explanations**
    Explain clusters of problems with an underlying problem, but this is characterised at a psychological level. These symptoms arise from normal psychological processes acting unhelpfully and so **emphasises experiences**.
  - **Biological Explanations** Our biological constitution is responsible for causing mental illness. The **somatogenic hypothesis** states that psychological problems can be explained by physical or biological impairments. Discoveries about Alzheimer's etc. advocate this approach.
    - **The Somatic Hypothesis** is the cornerstone of psychiatry. It is currently the most prestigious way to characterise mental illness. This approach has been used with depression, bipolar (**mono amine oxidase hypothesis** states that the depletion of serotonin, noradrenaline and/or dopamine underlies the symptoms) and schizophrenia (the **dopamine hypothesis** states that schizophrenia is cause by an excess of the dopamine neurotransmitter). Autism, ADHD and Dementia are also candidates.
      - These suggest **somatic interventions** such as drugs (SSRIs, Tricyclics and MAOIs), ElectroConvulsiveTherapy and Brain Surgery
      - **However,** this is clearly reductionist. It can cast patients as **passive** (i need a doctor) and may underestimate the influence of societal, parental and other extraneous influences.
    - **Szasz (1962)** is major critic of this model. He argues that the idea of mental illness being caused of an underlying disease is wrong as it causes confusion between physical, organic defects and indicates 'problems with the person' similar to having a lost limb. We should consider mental illness as 'diseases of the brain' or 'neurophysiological disorders'.
      - We have no biological or objective markers for most neurotic or psychotic disorders (Frith et al., 1995) and so psychiatrists use symptoms (perhaps overly) to diagnose mental illness.
  - **Religion** Attributes mental illness to demonic possession or divine action.
- **The Scientific Study of Mental Disorders**
  - Exam Question: **Describe some of the challenges involved when defining who is and who is not mentally disordered.**
  - Defining a mental disorder in terms of normality is not sufficient. This is because normality is not only difficult to define within groups but measurably different between groups (culturally, between-schools, between counties etc.). **Abnormality** can also be positive, with eccentricity, high intelligence (e.g. Einstein), excessive bravery etc. all being praised behaviours in the western world.
  - Concerns about **delusions** or **self harm** are also not enough. Not only are they ethnocentric (e.g. scarification is common in some tribes cultures) but the 'line' is difficult to draw. What about piercing? Smoking? Excessive drinking?
  - **A mental disorder** is a "clinically significant behaviour or psychological syndrome... that is associated with present distress... or disability (impairment of one or more important areas of functioning)... must not be merely an expectable response to a particular event" **DSM-IV (Diagnostic and Statistical Manual)**
    - This definition draws on the nature of **discomfort** (distress). This is positive because it stops the 'abnormality' argument ensuing. However, discomfort is not necessary (e.g. Psychopaths) and can stem from society, not the person.
    - It also draws on **maladaptiveness** (disability/ impairment of functioning). This appreciates distress without over simplifying mental illness **but** is a somewhat subjective measure that encourages the idea of normality.
    - It also mentions **unexpectedness** in terms of behaviour being out of proportion with what we would expect given the circumstances. This eliminates problems with overall normality and considers in behaviour in a more situational manner. However, judgements are still subjective and are based on 'norms' or induction.
  - To what extent is it 'scientific'?
- **Diagnostic Manuals**
  These describe a 'taxonomy' of mental disorders. They attempt to be **atheoretical** as they don't define disorders by causes, they aim to describe the mental illness.
  - **DSM-IV 1994 (Diagnostic and Statistical Manual 4th Edition)** American Psychiatric Association. This uses more categories (and so is more specific arguably). Neither manual uses the term 'mental illness' but **'mental disorder'.** This has become more organic in its approach.
  - **ICD-10 (International Classification of Disorders 10th Edition)** World Health Organisation
- **Benefits of Current System**
  - Diagnosis communicates **causes, treatment options and likely outcomes** which is theoretically important for effective intervention and a strong patient-psychologist understanding of what is going on.
  - It can increase **societal tolerance** toward mental illness and help reduce animosity felt by those close to the patient.
  - It can guide the assimilation of more knowledge.
  - It can help to alleviate the 'i'm all alone' feeling.
  - It can help to explain behaviours the patient was otherwise uncomfortable with and in some cases stop the self-perpetuating cycle of feeling strange and being depressed.
  - Though there may be problems with misdiagnosis, is it more humanistic and ethical to make a Type 1 error rather than deny a person treatment.
- **Criticisms of the DSM-IV/ICD-10**
  - It is atheoretical. Yet, the diagnosis is used as an explanation in a circular fashion.
  - It creates **categories** where there are **dimensions.** People differ in the degree to which they experience mental illness.
    - The DSM-IV-TR (Text Revision) (2000) explicitly rejects the use of labels such as 'schizophrenic' and recommends instead 'an individual with schizophrenia'.
  - Giving people a label can be harmful and stigmatising (Rosenhan, Laing)
  - **Within Category Heterogeneity** - Diagnoses differ for the same illness as do symptoms.
  - Labelling may prevent help with any separate or more fundamental problems.
  - The diagnoses are **culture sensitive.** The are arguably culture-bound syndromes that are outside the manuals diagnostic categories. 'Koro' in Asia is an acute panic reaction about the belief that a mans penis will suddenly withdraw into his abdomen. The DSM-IV-TR has an appendix for diagnosis according to culture and ethnicity.
  - **Somewhat Unreliable** The follow up study by Rosenhan (1973) in which psychiatric hospitals claimed that 41 patients were actually pseudo-patients (when in fact they were real) shows that the reliability of diagnosis is negligible. Diagnoses also change over time, which means that the DSM-IV-TR just reflects the views of psychiatric professionals today.
  - **Practitioners are white, middle class males (Winter, 1999)** and so this arguably leads to more black people being diagnosed in the UK than white people and more receive ECT and tranquillisers.
  - **Construct Validity** the constructs are inferred, not proven entities.