Psychopathology: Something to keep in mind....

The process of diagnosing someone with a specific disorder is an inexact science, and struggles with precision in diagnosis & treatment, for many reasons: e.g.,

the perceptions, biases, and errors of psychologists doing the diagnosing (does X meet the criteria? how severely?) and the treatment (e.g., drugs vs. therapy? what kind of therapy? how effective is the practitioner themselves?)

the multi-faceted nature of disorders (e.g., people can be considered to have a disorder by meeting a certain ratio of the behavioural indicators; meaning there can be very little overlap in two people's experience, and yet they have the same disorder? and should receive the same treatment?)

Psychopathology: Something to keep in mind....

- e.g., rates of DID (MPD) have risen from about 70 cases 30 years ago, to tens of thousands of cases today; also 1-2 identities → dozens to hundreds!
- e.g., depression vs. the blues; anxiety disorder vs. being worried; OCD vs. being cautious & detail-oriented
- e.g., or consider ADHD....

ADHD

- 3 key symptoms:
  - **inattention**: distractibility, forgetfulness, disorganization, failure to follow instructions, excessive procrastination, frequently losing items
  - **hyperactivity**: fidgeting, restlessness, inability to remain seated, excessive talking
  - **impulsivity**: difficulty taking turns, interrupting, impulsive spending

  - how different is this from the average kid? Where's the line b/w normal & abnormal?

The Self-fulfilling Prophecy of Labels

- Once someone has been labeled with a disorder, that label carries a great deal of weight, affecting both how they see themselves, how they behave, and how others will see them.

- e.g., “On being sane in insane places”

Evaluating Psychopathology: 3 Macro-Criteria

- 1) Deviance: is the person's behaviour or experience outside of social norms?
- 2) Maladaptive: is it interfering with other, "normal" aspects of life, responsibilities, etc.?
- 3) Personal distress: is the person greatly distressed?

A Continuum, Not a Dichotomy

clearly functional/ normal:

- socially normative

- no distress

- adaptive beh.

clearly dysfunctional/ abnormal:

- socially deviant

- personal distress

- maladaptive beh.

Rates of Psychopathology

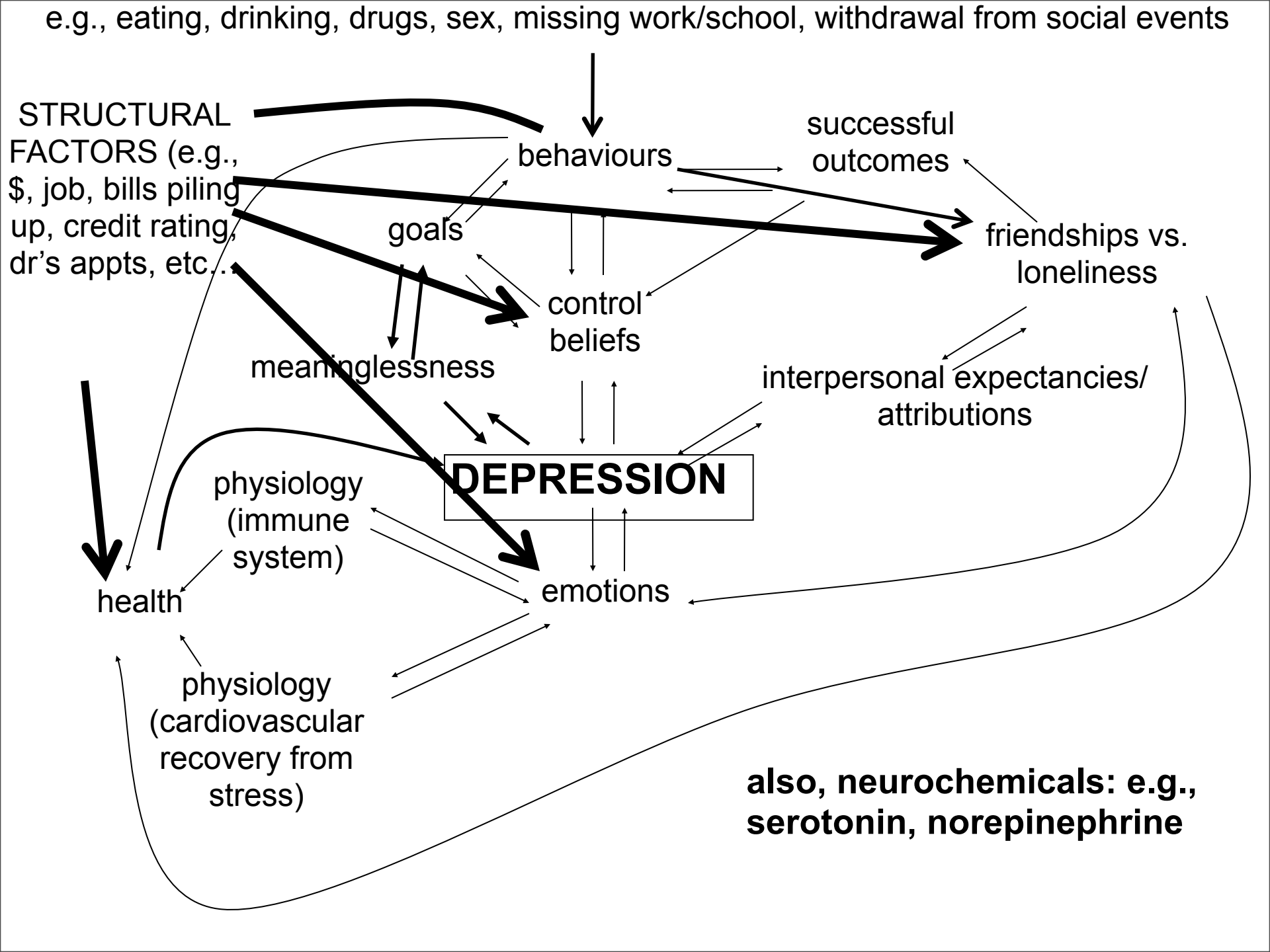
- Psychological disorders are extremely common!
- ~10% of the population suffers from a disorder each year
- estimates of lifetime prevalence = ~44% (although there's a wide range of such estimates, dipping down to about 20%)

Understanding Disorders at Multiple Levels of Analysis

- disorders involve a multifaceted system of factors:
- Neurochemical (e.g., neurotransmitter problems)
- Physiological (e.g., illness, exhaustion)
- Cognitive (e.g., explanatory style)
- Affective (e.g., mood, positive emotions in response to reward)
- Behavioural: (e.g., goal striving, interpersonal engagement/withdrawal, hygiene, work)
- Environmental: (e.g., pollutants, crime, home/ community disorganization)
- Interpersonal: (e.g., family conflict, social isolation)

Depression: Cognitive Factors

- E.g., negative attributional style:
  - blaming oneself excessively for negative outcomes (internal attribution)
  - assuming that one cannot change (stable attribution)
  - catastrophizing and overgeneralizing (global attribution)
  - the result? Hopelessness and inability to make positive changes in one's life.


e.g., eating, drinking, drugs, sex, missing work/school, withdrawal from social events
STRUCTURAL FACTORS (e.g., $, job, bills piling up, credit rating, dr's appts, etc...
behaviours
successful outcomes
goals
friendships vs. loneliness
control beliefs
meaninglessness
interpersonal expectancies/ attributions
DEPRESSION
physiology (immune system)
health
emotions
physiology (cardiovascular recovery from stress)
also, neurochemicals: e.g., serotonin, norepinephrine

The Role We Play in Others' Psychological Disorders

- humans are fundamentally social creatures. Therefore, it's no surprise that social factors play a huge role in psychological disorders, serving as contributing causes to disorders, determine whether people seek help for their disorder, play a key role in the therapeutic process itself (i.e., relationship with warm, empathetic, trusted therapist), can help or hinder therapy, and are a primary resource for coping (social support).

In Conclusion

- disorders are common
- disorders are an extension of ‘normal’
- there is no solid line b/w normal & abnormal: one can get insight into themselves & others through understanding disorders, but to properly diagnose a disorder requires a convergence of multiple indicators

In Conclusion

- disorders have a variety of causes, ranging from biological, to cognitive, to interpersonal, to the larger circumstances of one's life

- we can make a major difference (although not always) to the outcomes of someone with a disorder, sometimes through drugs, sometimes through therapy, sometimes through a combination of both, sometimes through the "common factors" of treatment, sometimes through making "external" changes in the person's circumstances

Treating Psychological Disorders

- we've come a long way....

- now, we know that disorders are multiply determined, and we know that they are often best approached through multiple paths

Treating Psychological Disorders

- 'talk therapy' – e.g., psychodynamic approaches – the importance of common factors: insight & understanding, empathy, accepting & trusting relationship with therapist

- the importance of expressing one's thoughts & feelings: Pennebaker's work on writing about personal trauma

Treating Psychological Disorders

- drugs (esp. short term and in certain cases; e.g., bipolar, schizophrenia, extreme dysfunction)
- behaviour modification (e.g., ABA; token economies) & specific behavioural interventions (e.g., play therapy, social skills training; exercise & nutrition)
- cognitive behavioural therapy (thought restructuring + behavioural skills training)

Multiple Approaches: A Systems Perspective

- e.g., drugs in combination with CBT
- e.g., social skills training, even for schizophrenia
- e.g., a family systems approach: taking a larger perspective, and thinking of disorders as emerging out of a larger pattern of relationships, esp. family relationships
  - e.g., alcoholism & co-dependence
  - e.g., schizophrenia & family support

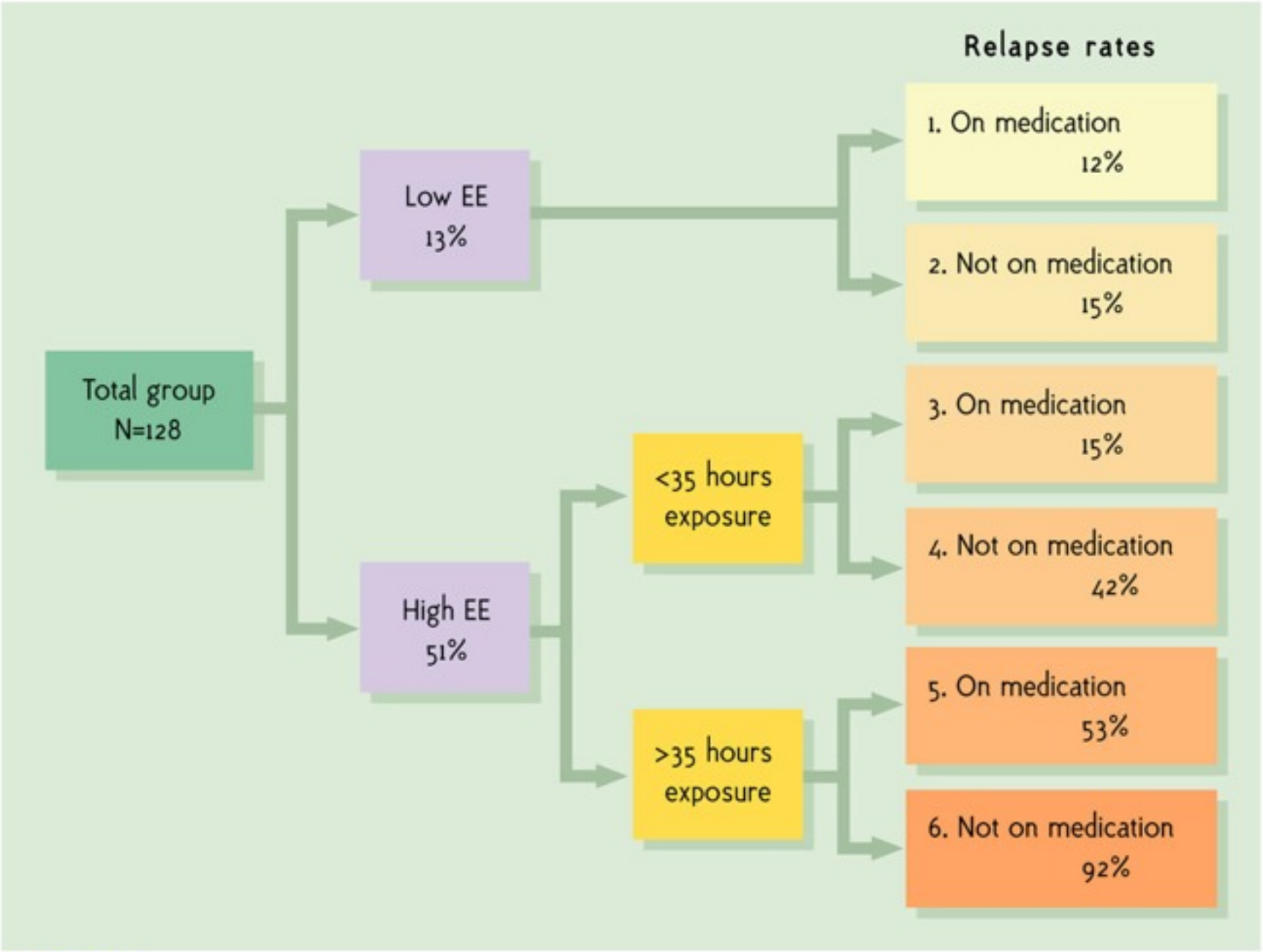


FIGURE 14.4

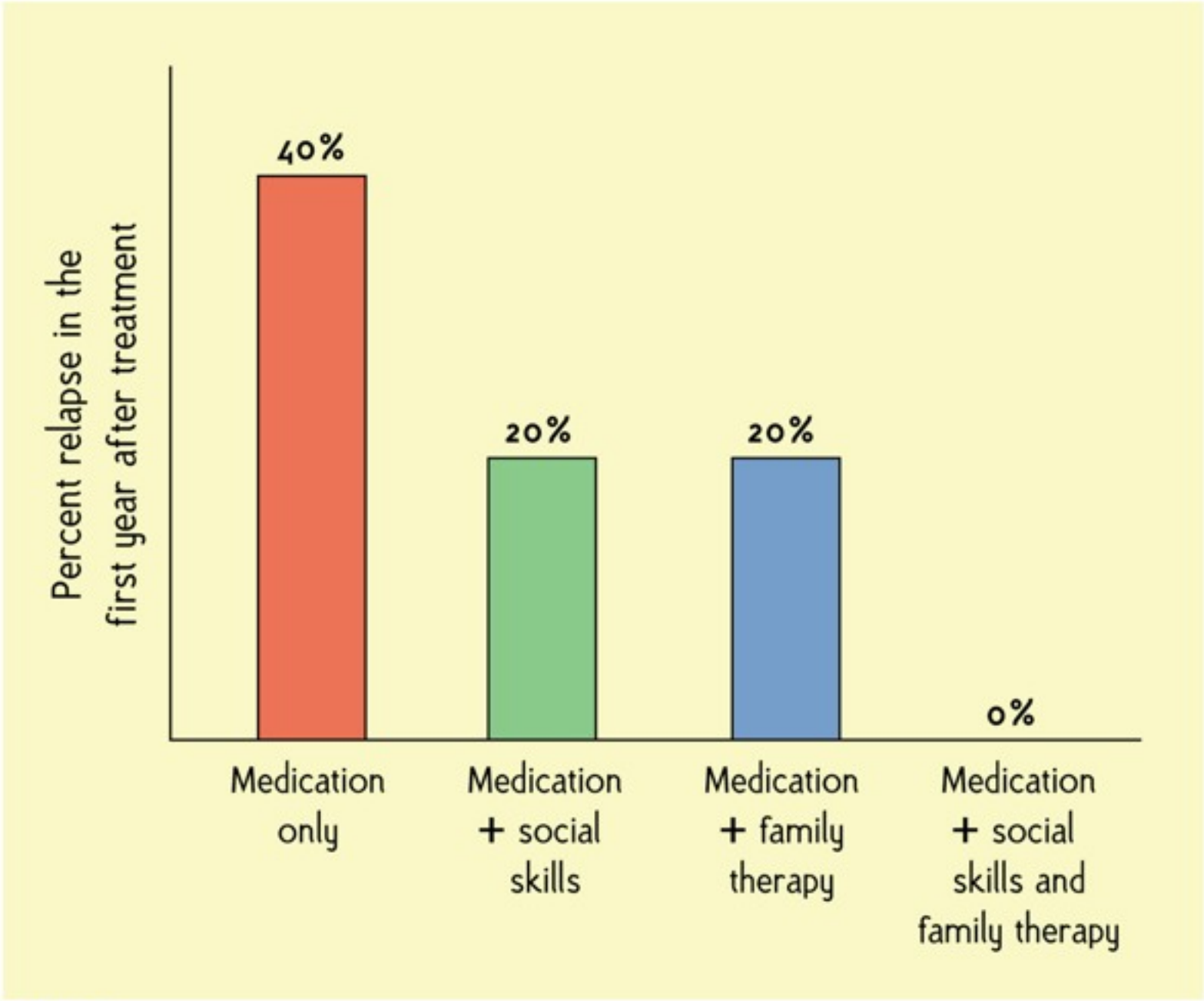


FIGURE 14.16

Cognitive Behavioural Therapy

- cognitive: sees disorder rooted in dysfunctional HABITS of thought

- behavioural: sees disorder rooted in dysfunctional HABITS of behaviour, and deficiencies in particular skills

CBT Example: Social Phobia (social anxiety disorder)

- cognitive aspects: (e.g.,)
  - beliefs that others do not like you
  - beliefs that you don't know how to talk to people, you constantly make a fool out of yourself and others judge you negatively
  - belief that when others do X (e.g., don't return your phone call, forget your birthday, talk to someone else at a party), they are rejecting you

CBT Example: Social Phobia

- behavioural aspects: (e.g.,)
  - withdrawal from social situations
  - inability (unwillingness) to initiate conversations
  - high anxiety in social situations, easily embarrassed & flustered
  - not paying attention to what person is saying, b/c internally over-focused
  - inappropriate self-focus; deficit in active listening skills, eye contact, etc.

CBT Example: Social Phobia

- treatment focuses on improving:
- behavioural skills (e.g., social skills training; active listening, relaxation)
- and developing more positive/functional behavioural habits: (e.g., setting goals to talk to X # of people, attend social events, practicing one's new social skills, etc.)

CBT Example: Social Phobia

- improving cognitive habits: finding ways to intervene in what have become habitually dysfunctional patterns:

- the goal is to get better acquainted with one's thought habits, to gain insight into their unreasonably negative characteristics, and then to develop alternative thought habits

Reframing Dysfunctional Beliefs

- **<u>cognitive restructuring:</u>** learning to reappraise circumstances in less negative ways
- e.g., person left b/c they were tired, didn't return phone call b/c they were busy
- e.g., just b/c that person doesn't like me does not mean I'm dislikable
- e.g., just b/c I felt uncomfortable this time doesn't mean I will always feel that way

Reframing Dysfunctional Beliefs

- **<u>disputing irrational beliefs</u>**:
- I'm no good at anything; I'll never succeed
- I can't handle it if someone doesn't like me
- I made a mistake; my whole life is going to fall apart
- If I do X, life will be wonderful
- Bad things don't happen to good people
- There's nothing I can do about this....

Reframing Dysfunctional Beliefs

- e.g., **benefit finding & post-traumatic growth**: this situation is terrible, but there are also benefits to be found (e.g., lessons, closer relationships, clarification of priorities, gratitude for other blessings, etc.)

The ABCD Process

Adversity (or Activating Event)

Beliefs that automatically follow

Consequences that usually occur

Disputing beliefs (Different perspective)