PL3106 — ABNORMAL PSYCHOLOGY

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1 INTRODUCTION

Lecture 1
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There isn't a satisfactory definition for the term **abnormality**. However, there are some common indicators of abnormality, which include:

- **Subjective distress**: if people are experiencing psychological pain or discomfort.
- **Maladaptiveness**: not adjusting adequately or appropriately to the environment or situation.
- **Statistical deviation**.
- **Violation of social standards**: when people fail to follow the conventional social and moral rules of their cultural group, we may consider their behavior abnormal, depending on the *magnitude of the violation* and on *how commonly the rule is violated by others*.
- **Interpersonal discomfort**.
- **Irrationality & unpredictability**: our evaluation of whether a person can control his/her behaviour.
- **Risk to self and/or others**.

However, it should be noted that no single indicator is sufficient in and of itself to define or determine abnormality.

1.1 *Cultural Influences*

Culture plays an important role in determining what is and is not abnormal; what is seen as a disorder in one culture might be highly valued, encouraged, or even rewarded in another culture, depending on an individual's:

- current circumstances,
- social norms,
- cultural norms, and
- language.

For example, the ability to hear (nonexistent) voices may be viewed as a blessing in certain societies, but as a curse/psychological disorder in many others.

Cultural factors also **influence the presentation of distress and the determination of an individual's coping**. There is considerable variation in the way different cultures perceive abnormality:

- deviance from the (perceived) norm,
- moral (may lead to personal culpability),
- medical (as being a disease, or having some biological origin),
- psychological (as having cognitive, emotional, or behavioural difficulties),
- spiritual (i.e., influenced by metaphysical beliefs),

These perceptions may change over time, and are occasionally shaped to serve political agendas (e.g., LGBT). (Unfortunately), they have a significant impact on how individuals are treated when they are experiencing psychological distress. For example, Western cultures tend to be more normalizing and compassionate, whereas Eastern cultures often attribute the causation of psychological distress to social, familial, or spiritual problems (i.e., blaming the individual for the illness).

1.2 *Diagnosis & Classification*

epidemiology: the study of the distribution of diseases, disorders, or health-related behaviours in a given population

prevalence: the number of active cases in a population during any given period of time

incidence: the number of new cases in a population over a given period of time

According to the DSM-5, a **mental disorder** is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, behavioural, or developmental processes underlying mental functioning.

Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual.

However, there are several issues with the current approach to mental health.

- dichotomous/binary concept of mental illness vs well-being.
  - a better alternative would be to view normality and mental ill-health as continuous, intertwined concepts based on a spectrum, incorporating dimensions of emotional distress and coping.
- mental illness as a disease.
  - this view of mental illness contributes to hopelessness and helplessness in individuals.
  - the diagnostic criteria of various mental health conditions (e.g., schizophrenia) are not scientifically correct, and fails to serve any medical purposes.

- diagnosis as a social construct.
  - language is important in the development of a personally meaningful narrative; we construct, interpret, and understand out experiences through the language we use to describe them.
  - who we think we are influences our coping abilities.
- diagnosis as a cluster of symptoms.
  - there are often overlap between diagnoses, as well as numerous comorbidities (i.e., having multiple illnesses at once).
  - multiple diagnoses given to an individual can result in greater self-stigmatization, while not helping the individual to understand how to overcome and maintain distress, the source of difficulties, nor the development of the problem.
- diagnosis being entirely deficit-based.
  - there is a prioritization of individual weaknesses over strengths and potential recovery.
  - there is also an over-focusing of what is wrong with an individual, rather than enabling and encouraging what is right.
  - overall, diagnosis serves to simplify presentation rather than to encourage meaningful understanding.

So, does "mental illness" objectively exist? Till now, scientific research has not shown concrete evidence of a "mental illness gene" that can be inherited. Furthermore, neurochemical changes are associated with our life experiences (i.e., they don't only manifest in negative environments, but also under positive circumstances, e.g., when people are happy), and therefore they should not be treated as evidence of having a "mental brain disease". What objectively exists are prologed and acute experiences of emotional distress that can be described, interpreted, and appraised via socially and linguistically constructed labels, which could be deeply stigmatizing.

1.2.1 An Alternative to Diagnosis

A meaningful alternative to diagnosis would be to conceptualize human difficulties based on the **4Ps formulation**:

- **Predisposing** (vulnerability factors): e.g., upbringing, past traumas, life history, etc.
- **Precipitating** (triggering factors): e.g., current experiences.
- **Perpetuating** (maintaining factors): e.g., unhelpful strategies, ineffective coping, etc.

- **Protecting** (modifying factors): e.g., individual strengths, abilities, interpersonal supportive networks, etc.

We need to take into account the importance of:

- past experiences,
- past interpersonal relationships,
- beliefs and assumptions of the self, others, and the world,
- appraisals of current experiences,
- strengths and abilities,
- coping strategies and supportive networks,
- hierarchy of values and pursuit of meaningful goals, etc.

2 CONCEPTUALIZATION OF PSYCHOLOGICAL DISTRESS

Lecture 2
18th January 2022

2.1 *Factors & Causes of Abnormal Behaviour*

Causal factors of mental health come in the following forms:

- **Necessary cause**: X is a condition that *must exist* for problem Y to occur ($X \implies Y$).
- **Sufficient cause**: the presence of condition X guarantees the occurrence of problem Y ($Y \implies X$).
- **Contributory cause**: condition X increases the probability of problem Y developing, but is neither necessary nor sufficient for Y to occur.

There are also several variations of risk factors in mental health, including:

- **Distal risk factors** (i.e., predisposing factors): factors occurring relatively early in life, contributing to the predisposition to the development of particular mental illnesses.
- **Proximal risk factors** (i.e., precipitating factors): factors that operate shortly before the occurrence of symptoms.
- **Reinforcing risk factors** (i.e., perpetuating factors): factors that maintain emotional distress and maladaptive behaviour.

2.2 *Diathesis-Stress Models*

diathesis: vulnerability, or a predisposition toward developing a disorder that can derive from biological, psychological, or sociocultural causal factors

stress: the response or experience of an individual to demands that he or she perceives as taxing or exceeding his or her personal resources to cope and adapt

Diathesis-stress models are used to describe mental disorders which are believed to develop when an individual who has a *preexisting vulnerability* for that disorder experiences a major *stressor*. Different stressors may differ in some of their characteristics, including their:

- **severity**
- **chronicity**: how long has a particular stressor been present in an individual's life?
- **timing**: at which particular segment of the individual's life did the stressor occur?
- **degree of impact**: overall impact of the stressor on the individual's biopsychosocial and daily functioning
- **level of expectation**: how expected has the stressor been in the individual's life?
- **controllability**: to what extent does the individual feel that they are able to control the stressor?

When diathesis (which are relatively distal necessary or contributory factors that are not sufficient to cause mental ill-health) and stress interact with each other, they would lead to an increased risk for an episode of mental ill-health in an individual. Some proposed models include:

- the **additive model**, where individuals with higher levels of a diathesis is believed to need only a small amount of stress before a disorder develops, as compared to individuals with lower levels of the diathesis.

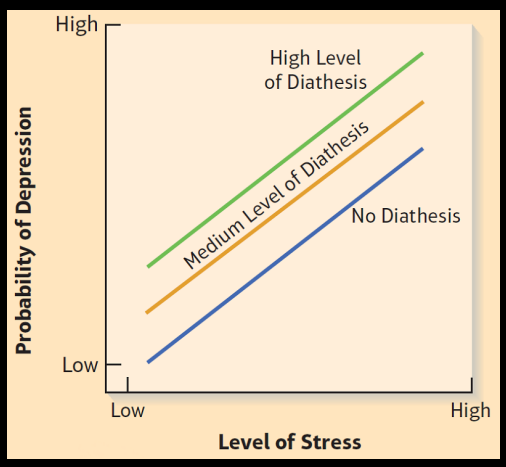

Figure 1: An additive model for depression.

- the **interactive model**, which believes that some amount of diathesis must be present in an individual, before stress will have any contributory effect.

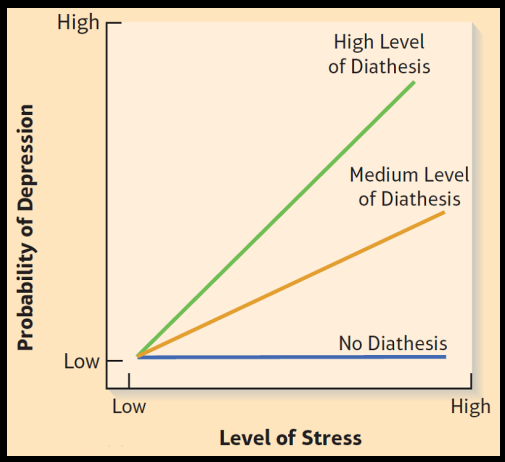

Figure 2: An interactive model for depression.

More complex models have also been proposed, but they are not included in this document.

protective factors: constructive influences (distal or proximal) that contribute to the development of effective coping strategies

In contrast to risk factors that increase the likelihood of negative outcomes, **protective factors** decrease the likelihood of negative outcomes among those at risk. Protective factors often lead to **emotional resilience**, which is the ability to adapt and effectively cope with difficult circumstances. The interaction of protective factors and effective coping strategies would give rise to a decreased likelihood of negative emotional outcomes associated with stressors that are present in an individual's life.

2.3 *Perspectives to Causation in Mental Health*

There are several different perspectives which can be used to study and explain mental ill-health, including:

- **biological perspectives**, e.g. factors contributing to neurodevelopmental and neurodegenerative syndromes.
- **psychological perspectives**, e.g., cognitive-behavioural, importance of appraisals and beliefs, information processing, behavioural responses, etc.
- **social perspectives**, e.g., socialization into unhelpful behaviour, interpersonal traumas, etc.
- **cultural perspectives**, e.g., over- and under-controlled behaviour.

- **economical perspectives**, e.g., poverty and deprivation of basic needs.

2.3.1 Cognitive-Behavioural Conceptualization Models

There are some models which are often used in cognitive-behavioural therapy, including sequential models, maintenance models, and longitudinal models. The **sequential formulation model** is based on the concept of *cognitive mediation*, which attempts to modify individuals' beliefs about a triggering event or experience. The model involves the identification of the following steps:

cognitive mediators: mental processes or activities that take place between the occurrence of a stimulus and initiation of an associated response

1. **Antecedent**: an external or internal experience/event.
2. **Belief** (about the antecedent): the individual's cognition, interpretation, or appraisal of the antecedent.
3. **Consequences** (of having the belief): the emotional, behavioural, physical, and information processing consequences as a result of having the belief.

The **cross-sectional (maintenance) formulation model** is built upon the sequential model, and it expands upon and emphasizes on the consequences and their relationship with the patient's beliefs.

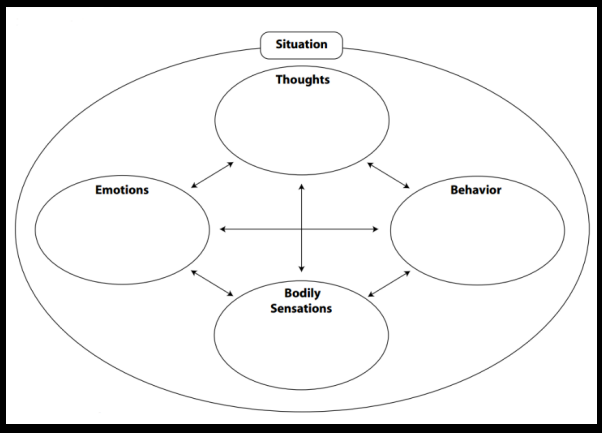

Figure 3: The maintenance formulation model.

Figure 4 on the next page illustrates how the maintenance formulation model could be applied to a case of clinical depression.

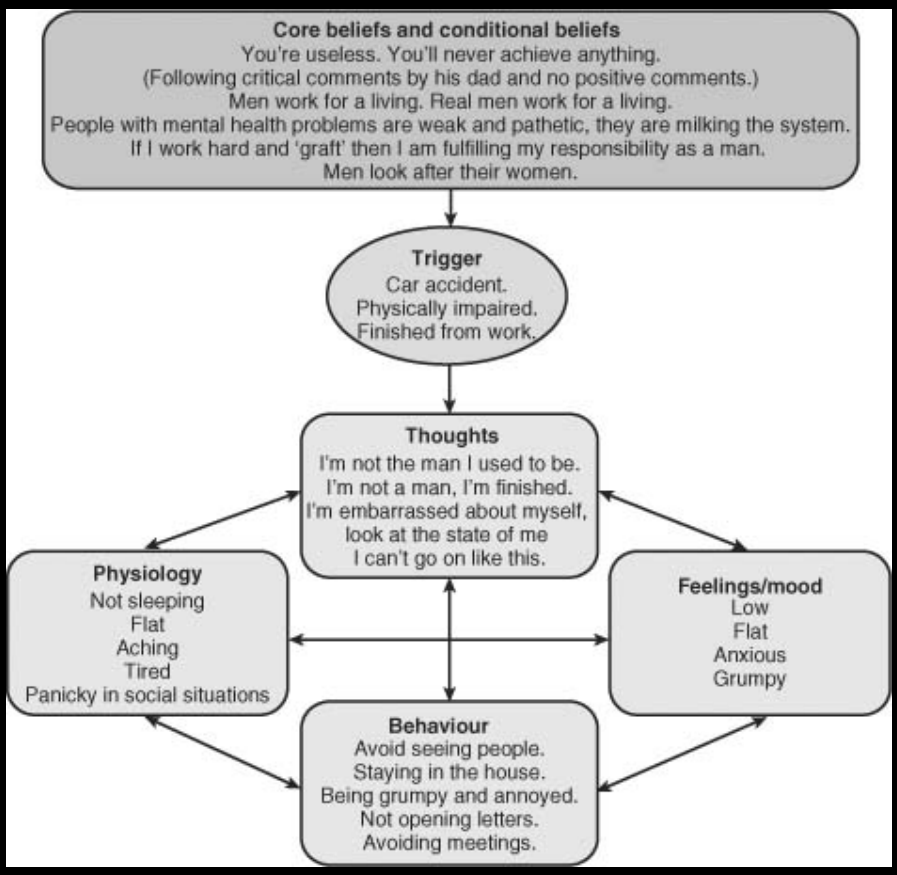

Figure 4: The maintenance formulation model applied to a case of depression.

The **longitudinal (developmental) formulation model** is another common model used in cognitive behavioural treatments. It involves the identification of the following:

1. **Early significant life experiences**: i.e., distal causes; e.g., rejecting parents, childhood bullying.

2. **Core beliefs**: about the self, others, and the world; e.g., "I am a waste of time", "People always abandon me", etc.

3. **Unhelpful assumptions and rules for living**: e.g., "I must always please others, or else they will reject me".

4. **Critical incident**: violation of unhelpful assumptions and rules for living; e.g., breaking up of a relationship.

5. (Unhelpful) **thoughts**, (negative) **emotions, physical reactions, & behaviour**.

3 PSYCHOLOGICAL ASSESSMENT AND TREATMENT

Lecture 3
25th January 2022

3.1 *Psychological Assessment*

The ultimate goal of psychological assessment is to *develop a formulation* (i.e., understand the idiosyncratic nature of the problem, how problems develop and sustain, and what can be done). Therefore, the following needs to be considered during the assessment:

- history, development, and overall duration of the problem.
- current severity of emotional distress.
- frequency and duration of episodes (of e.g., anxiety, low mood, voices).
- what exactly is problematic/distressing for the client?
- how is his/her functioning affected?
- previous treatments and therapies.
- existing sources of support, social networks, and ways of coping.
- strengths, abilities, skills, values, and personal goals (which can be reinforced during treatment).

There are some variations to how psychological assessment could take place, including:

- clinical interviews
  - may be unstructured, semi-structured, or structured interviews.
  - interviews may be held with the individual and/or their close relations.
- behavioural observation (e.g., of social interactions, problem solving, etc.)
  - may take place in natural environments, or in laboratory/therapeutic settings.
  - tools such as self-monitoring charts (e.g., mood, thoughts) and rating scales may be utilized.
- self-report questionnaires and neuropsychological test batteries
  - there are different toolkits for different aspects, e.g.:
    - intellectual ability tests: WAIS, WISC
    - personality tests: MMPI, MCMI
    - mood questionnaires: BDI
    - anxiety questionnaires: BAI

Different tools differ in their reliability, validity, and extent of standardization.

3.2 *Psychological Treatment*

Treatment usually consists of a two-way collaborative process between clinicians and clients.

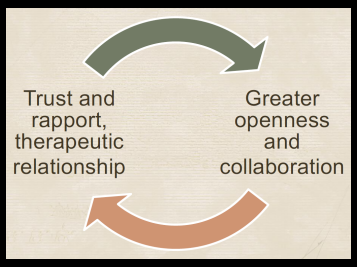

Figure 5: The therapeutic alliance.

3.2.1 Cognitive Behavioural Therapy

The main treatment goals in CBT include:

- reduction in emotional distress.
- improvement in mood.
- improved coping with problematic events.
- enhanced overall well-being.
- pursuit of idiosyncratic goals.
- improved perception of self.
- functional and helpful perception of events, others, and the world.
- improved relationships.

To achieve these goals, CBT treatment has the following characteristics:

- formulation based approach.
- 'here and now' approach: improvement of coping with current problems.
- continuum approach: treating mental health problems as arising from extreme versions of normal processes.
- scientific approach: based on empirical evidence.
- explicit focus on cognitive mediation and maintenance of emotional distress.
- sound therapeutic relationship and collaboration seen as essential.
- active and structure sessions.

- therapeutic task assignments: practice of coping and reality checks of ideas and beliefs in real life are necessary in the process of recovery.
- guided discovery: synthesizing knowledge through Socratic dialogue.

Note that CBT is a scientific approach because:

- the outcomes of CBT interventions have been evaluated in a large number of randomized controlled trials, qualitative and quantitative clinical studies, and single subject design studies.
- when using CBT with clients, it is good practice to use measures (e.g., standardized scales) to measure whether the desired change and progress actually occur.
- when formulating with a client, we develop hypotheses and test them out in practice via behavioural experiments,
- evidence is gathered to increase cognitive flexibility and encourage consideration of alternative explanations.
- clients are encouraged to test out (i.e., reality check) whether what they believe is true.

The process of learning helpful coping competencies in CBT is similar to the process of us picking up new skills as we grow up. Specifically, we go through the following steps:

1. **unconscious incompetence**: you don't know that you don't know how to do something.
2. **conscious incompetence**: you know that you don't know how to do something, and it bothers you.
3. **conscious competence**: you know that you know how to do something, but it takes effort.
4. **unconscious competence**

This is propelled in CBT via a therapeutic learning process, which consists of cycles of **cognitive restructuring strategies** and **behavioural interventions.**

cognitive restructuring strategies: guided exploration of helpful ideas, synthesis of existing knowledge, etc.

behavioural interventions: exposure, reality testing, practice of skills, experiential learning, etc.

Lecture 4
8th February 2022

4 ANXIETY DISORDERS

Fear and **anxiety** share a variety of commonalities, including:

- cognitive changes,
- physiological responses,
- behavioural reactions, and

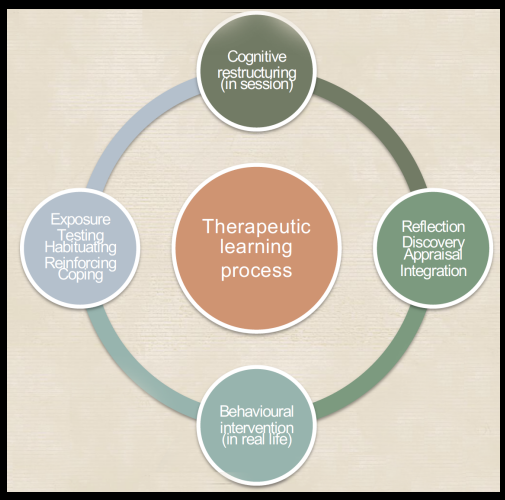

Figure 6: The cycle of a therapeutic learning process.

- neurochemical changes.

Specifically, anxiety leads to the following changes:

- **Cognitive/Information processing**:
  - hypervigilance (i.e., scanning surroundings for threats)
  - preoccupation with perceived source of threat
  - reasoning biases
  - selective memory retrieval
  - selective attention and rejection/omission of contradictory data
  - worry and anticipation of a threatening event
- **Neurochemical**:
  - inhibitory/excitatory disruption of neurotransmitters, e.g., dopamine, serotonin, norepinephrine, GABA, etc.
  - transient hormonal changes, e.g., "adrenaline rush"
- **Physiological**:
  - muscular tension and/or stiffness
  - stomach and chest tightness, hyperventilation
  - increased heart rate and pulse
  - trembling and shaking
  - sweating
- **Behavioural**:
  - fight, flight, and freeze responses
  - escape and withdrawal
  - avoidance

  - inaction (due to indecisiveness)

However, they can also be distinguished based on their triggers; fear is a response to an *objective threat*, whereas anxiety is a reaction to an *imagined threat*.

4.1 *Overview of Anxiety Disorders*

There are several common factors across anxiety disorders, such as:

- subjective threat orientation (i.e., preoccupation, fixation, and anticipation)
- experience of significant emotional distress
- impairments in interpersonal functioning
- disabling intensity of physical symptoms
- cognitive bias of emotional reasoning (i.e., strong emotions misinterpreted as evidence of threat)
- maintaining function of safety behaviours (e.g., escape/withdrawal, avoidance, etc.)

Typically, the severity of anxiety is *proportional to* the individual's subjective perception of danger, and the subjective appraisal of one's own ability to cope.

4.1.1 CBT for Anxiety

Cognitive behavioural therapy is a preferred treatment choice for anxiety, since it has been supported with empirical evidence (e.g., RCTs, clinical studies, meta-analyses, etc.) and demonstrated to be effective across diagnostic clusters of anxiety disorders.

Some of its key treatment goals include:

- graded exposure to perceived source of threat
- gradual abandonment of safety behaviours
- desensitization
- effective management of worry
- development of helpful coping strategies
- overall reduction in emotional distress
- enhancement of quality of life
- increase in subjective wellbeing

4.2 *Specific Phobia*

Individuals with **specific phobias** tend to have strong and persistent distress (usually excessive and unreasonably) related to and triggered by a specific object or situation. They also demonstrate a tendency to avoid these triggers.

Specific phobias generally involve:

- animals (e.g., dogs, spiders, insects)
- environments (e.g., heights, water)
- blood-injection-injury
- situations (e.g., tunnels, elevators, bridges)
- others (e.g., choking, vomiting)

Figure 7 below illustrates a maintenance/cross-sectional formulation model for a specific phobia of spiders.

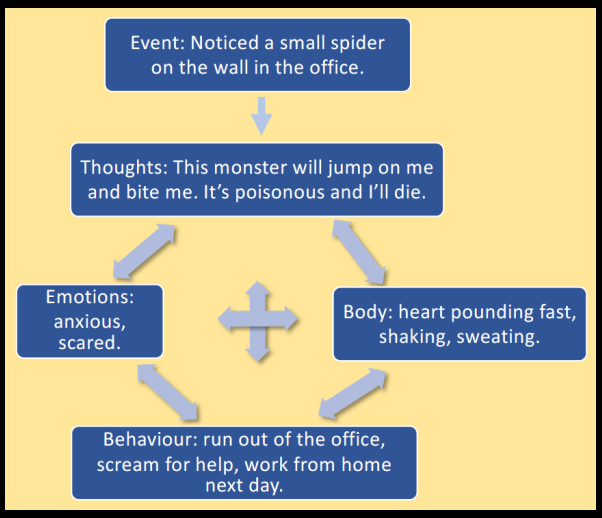

Figure 7: An example of a maintenance formulation for arachnophobia.

4.3 *Panic Disorder*

Individuals with **panic disorder** tend to have catastrophic and highly distressing misinterpretation of their personal experiences, particularly their bodily sensations. Their physiological reactions associated with anxiety are often perceived to be threatening and dangerous, which usually results in:

- nausea and dizziness,
- hyperventilation,

- heart palpitations,
- chills or hot flashes,
- sweating,
- trembling/shaking, and
- numbness and tingling.

Figure 8 below illustrates a maintenance/cross-sectional formulation model for a panic attack.

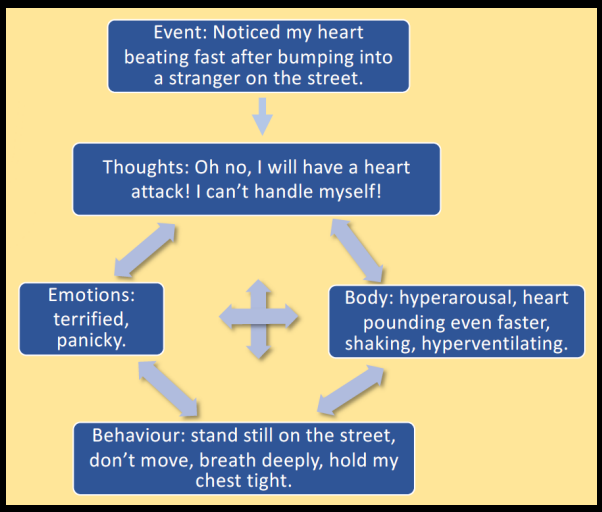

Figure 8: An example of a maintenance formulation for a panic attack.

4.4 *Society Anxiety Disorder*

Individuals with **social anxiety disorder (SAD)** tend to have disabling emotional distress triggered by threatening misinterpretations of one or more specific social situations. This is usually caused by catastrophic predictions of being exposed to interpersonal scrutiny, negative evaluation by others, public humiliation, rejection, etc.

SAD can be further broken down into two subcategories, namely:

- performance-related SAD (e.g., public speaking)
- non-performance-related SAD

Figure 9 below illustrates a maintenance/cross-sectional formulation model for social anxiety.

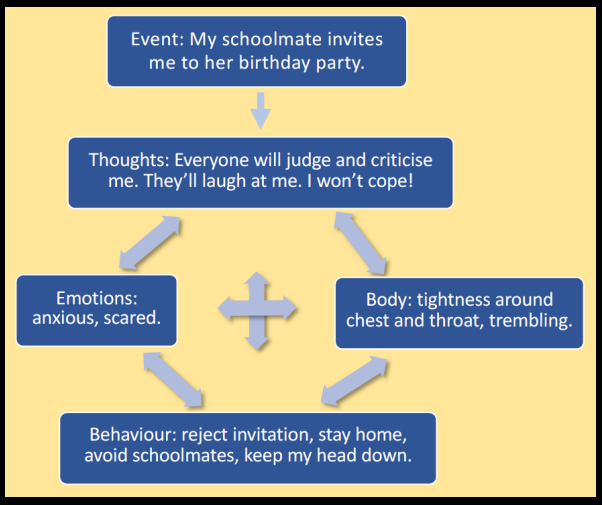

Figure 9: An example of a maintenance formulation for an instance of social anxiety.

4.5 *Obsessive Compulsive Disorder*

Obsessive compulsive disorder (OCD) is a condition that causes people to have upsetting thoughts and behaviours. People with OCD have **obsessions**, which are unwanted thoughts, images, or impulses that cannot be controlled, making individuals feel frightened, anxious, distressed, or ashamed. People with OCD tend to engage in **compulsions** (i.e., tasks, behaviours, or rituals) to neutralize their obsession, helping to reduce their negative feelings.

Figure 10 below illustrates a maintenance formulation model for OCD.

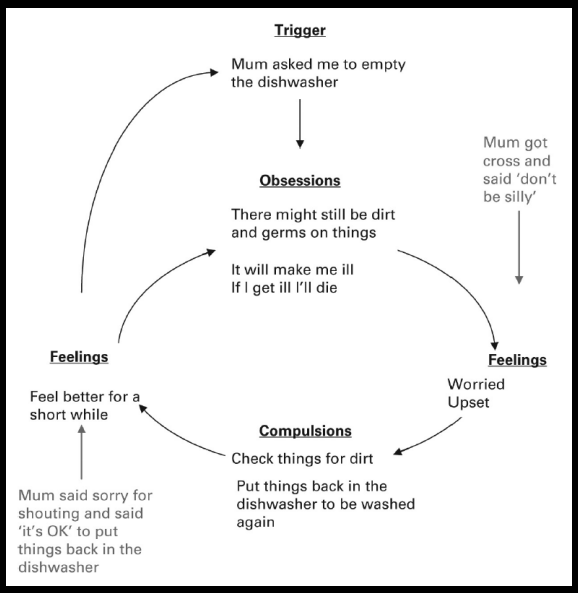

Figure 10: An example of a maintenance formulation for an instance of OCD.

4.6 *Generalized Anxiety Disorder*

Individuals with **generalized anxiety disorder (GAD)** tend to have worry excessively and uncontrollably, which results in significant emotional and physiological consequences on the individual and their quality of life. A central cognition which is held by many individuals with GAD revolves around the following idea:

in GAD, worry tends to consists of a successive chain of fearful scenarios, building upon each other and chaining into increasingly catastrophic directions

> "The world is a dangerous place. I might not be able to cope with whatever happens in the future. Hence, I must anticipate all bad things that may happen, so that I can be prepared or avoid them altogether."

The key "worry themes" in GAD comprise of:

- health,
- finances,
- relationships and family,
- work/school, and
- safety.

According to Wilkinson et al. (2011), normal and pathological worry should be thought of as opposite ends of a continuum or spectrum. Specifically, *normal worry* is a response to a specific trigger, controllable, time-limited, and serving a problem-solving purpose; on the other hand, *excessive worry* is often subjectively perceived to be uncontrollable and not time-limited, and results in unhelpful behavioural manifestations and emotional exhaustion.

Individuals with GAD generally have the following manifestations/symptoms:

- **Behavioural**:
  - pacing
  - agitation/irritability
  - restlessness/nervousness
  - nail biting, smoking, etc.
- **Psychological**:
  - emotional exhaustion
  - prolonged anxiety
  - feeling tuned out and separated from the world
  - sense of impending doom
  - demoralization
  - fatigue

- **Cognitive**:
  - distractability and reduced concentration
  - memory problems
  - indecisiveness
  - hypervigilance
- **Physiological**:
  - back/neck pain
  - muscle tension
  - chest pain
  - upset stomach
  - nausea, dizziness, headaches, etc.

Individuals with GAD also have a tendency to detach from objective reality, i.e., they spend time in a theoretically possible, but yet nonexistent future. Hence, they spend limited time attending to, and engaging with, the real world that is around them.

Figure 11 below illustrates a maintenance/cross-sectional formulation model for GAD.

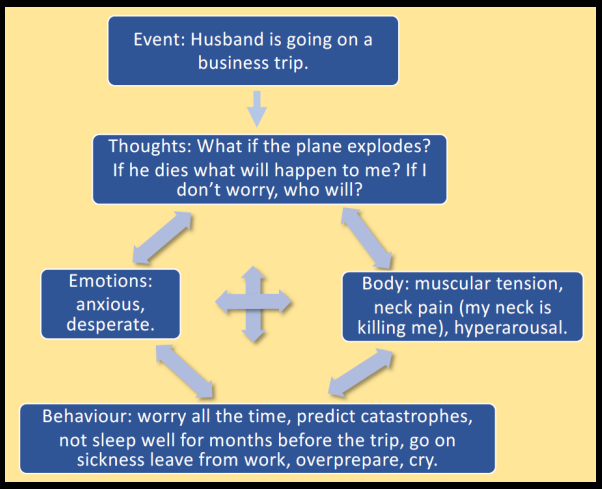

Figure 11: An example of a maintenance formulation for an instance of GAD.

5 DEPRESSION AND SUICIDE

Lecture 5
15th February 2022

Sadness and **depression** are similar yet distinct. Sadness is a human emotion that all individuals would feel at certain times during their lives, in situations that cause emotional upset or pain; as with other emotions, sadness is temporary and fades with time. On the other hand, depression is a longer-term mental illness, which impairs social, occupational, and other important aspects of functioning.

5.1 *Unipolar Depressive Disorders*

Major depressive disorder (MDD) is diagnosed by having 5 or more of the following symptoms, present for at least 2 weeks, causing distress and/or impairment in daily functioning in the individual; minimally, either (1) or (2) must be present:

1. depressed or low mood
2. loss of interest or pleasure
3. significant change or loss of > 5% body weight, or decreased/increased appetite nearly every day
4. sleep disturbance
5. agitation or feelings of being slowed down
6. loss of energy or feeling fatigued virtually everyday
7. feelings of worthlessness, low self-esteem, or tendency to feel guilty
8. difficulties in thinking or concentrating
9. thoughts of ending life

On the other hand, **persistent depressive disorder (dysthymia)** is diagnosed by having depressed mood for most of the day on most days (i.e., never been without symptoms for more than 2 months at a time), for a period of at least 2 years, with at least 2 of the following symptoms:

1. poor appetite or overeating
2. insomnia or hypersomnia
3. low energy or fatigue
4. low self-esteem
5. poor concentration or difficulty making decisions
6. feelings of hopelessness

If individuals have MDD for more than 2 years, they could be given a comorbid diagnosis of persistent depressive disorder (a.k.a. *double depression*).

Unipolar depressive disorders have a lifetime prevalence (i.e., proportion of a population who at some point in life has ever had the characteristic) of 6.3%, making it the most prevalent psychological disorder in Singapore. It is more common in women, and among people with ages 18 to 35. The probability of treatment contact is relatively low at 55.5%, and the median treatment delay sits at 4 years.

Some of the causal factors of unipolar depressive disorders include:

- stressful life events (the number of stressful events is proportional to the probability of depressive symptoms and episodes)
- childhood maltreatment (the severity of maltreatment is proportional to the probability of MDD)

5.2 *Suicide*

Suicide is a major problem in severe psychological disorders (particularly in depression), with up to 50% of individuals with MDD attempting suicide at least once. The risk of suicide increases with age, starting from around age 12. In general, women are more likely to attempt suicide, but men are more likely to complete suicide as males tend to turn towards more violent means.

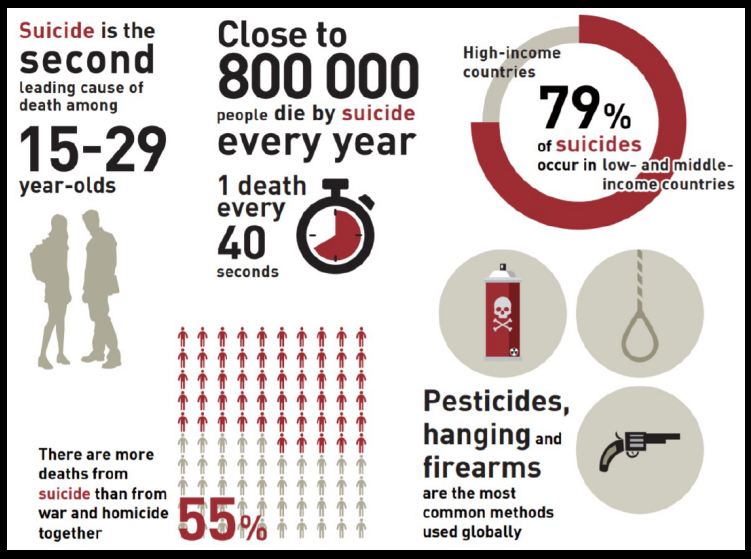

Figure 12: Some facts and figures about suicide.

Suicide is often preventable with the provision of support and treatment, as seen in the infographic in figure 13:

Figure 13: Infographic illustrating effective preventive measures.

There are several common myths about suicide, including:

1. There are no warning signs.
    - Most people do tell others about their suicidal intentions (up to 70%).
2. Talking about suicidal ideation increases the likelihood that someone will kill themselves.
    - Talking is likely to prevent a suicide by making help accessible to the individual.
    - It is also useful for gauging the severity of threat and guide the development of a risk management plan.
3. Suicidal people always want to die.
    - Many people are in fact grateful when suicide is prevented.
    - Most people are ambivalent about taking their own lives.

5.3 *Cognitive Behavioural Understanding of Depression*

From the cognitive behavioural perspective, there are several developmental, maintenance, and risk factors contributing to depression.

- Examples of developmental factors include:
    - role of early/significant life experiences
    - formation of dysfunctional, self-defeating core beliefs and unhelpful rules for living
    - cognitive depression triad
- Examples of maintenance factors include:
    - rumination

  - social withdrawal and isolation
  - self-blame (or even self-hatred/disgust)
  - inactivity, abandonment of pleasurable tasks
- Examples of risk factors include:
  - self-neglect
  - suicidal cognitions, plans, and attempts
  - hopelessness and helplessness

There are several CBT formulation models used to capture the development of depression in an individual. Figure 14 below illustrates a maintenance/cross-sectional formulation model for depression, whereas figure 15 illustrates a longitudinal formulation model.

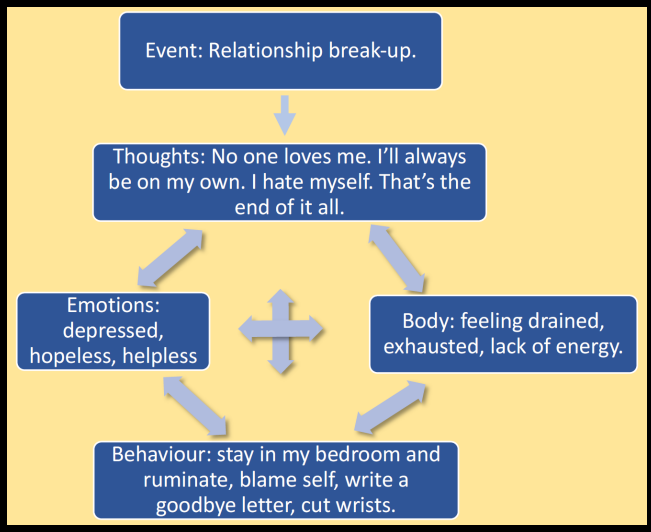

Figure 14: An example of a maintenance formulation for an instance of MDD.

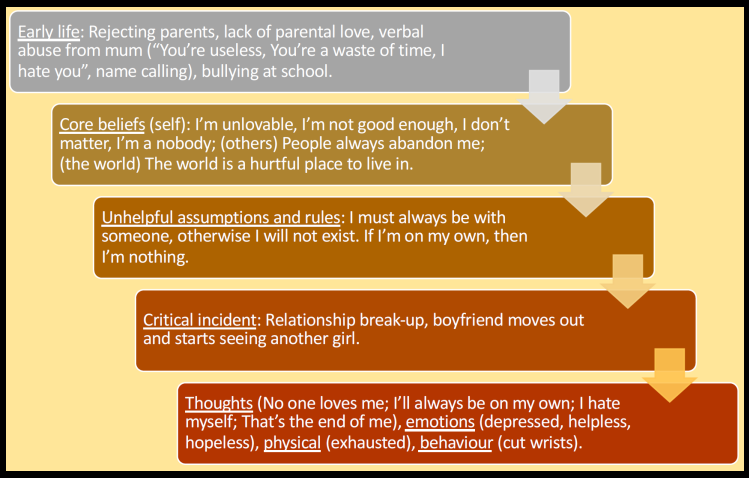

Figure 15: An example of a longitudinal formulation for an instance of MDD.

5.3.1 CBT for Depression

Cognitive behavioural therapy is a preferred treatment choice for depression as well, since it has been supported with empirical evidence (e.g., RCTs, clinical studies, meta-analyses, etc.) and demonstrated to be effective across diagnostic clusters of depressive disorders.

Some of its key treatment strategies include:

- behavioural activation,
- cognitive restructuring, and
- therapeutic homework tasks.

6 PSYCHOSIS

Psychosis describes a loss of contact with reality. Some of the symptoms associated with psychosis include:

- **Hallucinations**: sensing of things which aren't present.
- **Delusions**: false beliefs that are not based in reality.
- **Disorganized thinking/behaviour**: jumbled or difficult to understand speech/thinking/writing.
- Reduced emotional expression.

6.1 *Schizophrenia*

While psychosis describes the *experience* of losing touch with reality, **schizophrenia** is a diagnostic cluster of symptoms, including:

- Positive/Psychotic symptoms:
  - Delusions
  - Hallucinations
  - Disorganized speech and behaviour
- Negative symptoms:
  - Loss of interest in daily life
  - Reduction in affect/emotions
- Cognitive deficits

However, the diagnosis of schizophrenia has often been critiqued for:

- being a socially constructed artefact.
- being a meaningless, overlapping cluster which is insufficient to capture the diversity and individuality of presentations.
- lacking scientific validity and reliability.
- pathologizing experiences, resulting in widespread stigma in the general population.

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Note-taking for this module was halted here due to time constraints.

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