Abnormal Psychology

Concepts of Normality

Abnormal Psychology

- Abnormal behavior is difficult to define
  - Based on symptoms people exhibit or report
- Psychiatrists and psychologists use a diagnostic manual (a standardized system) to help diagnose correctly
  - Still have errors
- Symptoms of the same disorder may vary between individuals and groups
- Definition of abnormality can change over time

Deciding Abnormal Behavior

- How do you decide if someone's behavior is abnormal?
  - A series of value judgments based on subjective impressions
- There is a tendency to rely on the subjective assessments of clinicians, in combination with the diagnostic tools of classification systems

Defining Normal

- Behavioral measures tend to be normally distributed (bell-shaped curve)
  - If behavior falls within this bell-curve, it's normal
  - Examples: Intelligence and short-term memory
- Other issues of abnormality are harder to apply to a bell-shaped curve or statistics
  - Obesity is statistically normal, but not desirable
  - High IQ is statistically rare, but is not dysfunctional

Abnormality

- Abnormality: Subjective experience of feeling "not normal"
  - Feeling intense anxiety, unhappiness, distress
- Consider when behavior violates social norms or makes others anxious
  - Cultural diversity affects what people consider "normal behavior"
  - What may fit social norms in one culture may violate social norms in another

Rosenhan and Seligman (1984)

- Seven criteria to decide normality:
  1. Suffering
     - Experiencing distress and discomfort?
  1. Maladaptiveness
     - Behaviors that make things difficult for themselves, rather than helping themselves?
  1. Irrationality
     - Incomprehensible? Unable to communicate reasonably?

Rosenhan and Seligman (1984)

4. Unpredictability
   - Unexpected actions?
5. Vividness and unconventionality
   - Different experiences than other people?
6. Observer discomfort
   - Acting in a way that is difficult to watch? Upsets others?
7. Violation of moral/ideal standards
   - Habitually break the accepted ethical/moral standards?

Rosenhan and Sligman (1984)

- Demonstrates focus on distress to the individual
- Based on what is accepted in society
- Always comparing it to social norms is problematic:
  - Often don't consider the diversity in how people live their lives
  - Different is not always bad or abnormal

Jahoda (1958)

- Six characteristics of mental health:
  1. Efficient self-perception
  2. Realistic self-esteem and acceptance
  3. Voluntary control of behavior
  4. True perception of the world
  5. Sustaining relationships and giving affection
  6. Self-direction and productivity

Jahoda (1958)

- Even normal people don't meet all of these mental health characteristics
- They are largely value judgments
- Not as easy to define psychological health as it is physical health
- What is considered psychologically normal varies between cultures

Changing Definition of Abnormality: Homosexuality

- Older diagnostics saw homosexuality as an abnormality
- DSM-III sees homosexuality as only abnormal if the individual has negative feelings about the sexual orientation
  - DSM-IV: Persistent and marked distress about one's sexual orientation is abnormal
- Attitudes about homosexuality has changed so cannot be considered abnormal
- Shows problems with set ideas of abnormality

Mental Illness Criterion

- Medical model: abnormal behavior is of physiological origin
  - i.e. disordered neurotransmission
  - Treatment addresses the physiological problems (primarily drugs)
- Psychopathology: Abnormal behavior
  - Psychological illness based on the observed symptoms of a patient

Medical Model

- Ethical concerns:
  - Believes it is better to regard someone with a mental disorder as *sick* rather than *morally defective* to remove responsibility
  - Model can be misused/interpreted incorrectly
    - Due to cultural influences
    - At times on purpose for personal gain (politics)

Mental Illness

- Use a classification system today
  - Supposed to be objective
- Medical model is seen as reductionist
- Use a Biopsychosocial approach today to combine all aspects
  - Still not fool-proof

Tomasz Szasz (1962)

- Most mental disorders should be considered "problems in living"
  - Not all are diseases of the brain
- Strange behavior is not always caused by a brain disease
- Frude (1998): Relatively few psychological disorders can be associated with identifiable organic pathology
- Today we have more evidence of brain diseases associated with abnormalities, but we still don't know whether Szasz is absolutely right or wrong

Diagnosing Psychological Disorders

- Psychiatrist has to rely upon patient's subjective description of a problem
- Formal standardized clinical interview with a checklist of questions to ask
- Klienmuts (1967) sees flaws in this process:
  - Information exchange can be blocked due to the relationship between patient and clinician
  - Patient's intense anxiety or preoccupation could hinder the process
  - Clinician's style, experience, and beliefs/theories will affect the diagnosis

Methods of Diagnosing

- Formal standardized clinical interview
- Direct observation of behavior
- Brain-scanning techniques (CAT and PET)
- Psychological testing
  - Like personality tests and IQ tests

Symptoms of a Disorder: ABC's

- ***A***ffective symptoms: emotional elements
  - Fear, sadness, anger
- ***B***ehavioral symptoms: observational behaviors
  - Crying, pacing, physical withdrawal/space
- ***C***ognitive symptoms: ways of thinking
  - Pessimism, personalization, self-image
- ***S***omatic symptoms: physical symptoms
  - Facial twitching, stomach cramping, amenorrhea

Classification Systems

- DSM: *Diagnostic and Statistical Manual of Mental Disorders*
  - Some argue it is gender/culturally biased
- ICD: *International Classification of Diseases*
- Based largely on abnormal experiences and beliefs reported by patients and professional agreement
  - Criteria changes overtime as new editions are published due to new information or professional agreements

Validity and Reliability of Diagnosis

- Reliability:
  - Classification system should make it possible for different clinicians to arrive at the same diagnosis
- Validity:
  - Should be able to classify a real pattern of symptoms which can lead to an effective treatment
  - However: The system is *descriptive* and does not identify any specific cause

Rosenhan (1973)

- Aim: Test the reliability of psychiatric diagnoses
- Study 1: Researchers pretended to hear voices (all but 1 diagnosed with schizophrenia) and stayed in hospital approx 19 days; considered abnormal
- Study 2: Warned hospital that normal people would be pretending to be abnormal; not true; hospital mistook abnormal people to be normal people faking it

Rosenhan (1973)

- Conclusion: It is not possible to distinguish between sane and insane in psychiatric hospitals
- Medical diagnoses can be maid with a lack of scientific evidence
  - Ethical issue: Are treatments properly justified?

Unreliable

- Diagnostic systems have been accused of being unreliable
- With the same manual, two psychiatrists could diagnose the same patient with two different disorders
- Beck et al. (1962): Agreement on diagnosis for 153 participants between two psychiatrists was only 54%

Unreliable

- Cooper et al. (1972): New York and London psychiatrists shown the same videotaped clinical interviews
  - New York psychiatrists were twice as likely to diagnose schizophrenia than London psychiatrists
  - London psychiatrists were twice as likely to diagnose mania or depression than New York psychiatrists

Lipton and Simon (1985)

- 131 patients in New York hospital were reassessed
- Only 16 of the 89 originally diagnosed with schizophrenia were diagnosed again
- 50 were diagnosed with a mood disorder; however, only 15 had been diagnosed with this previously

Unreliable

- There must be a lack of validity if there's a 50:50 chance of reaching the same conclusion
- Probably due to a bias in diagnosis
- Diagnosis may be influenced by the attitudes/prejudices of the psychiatrists
- Overpathologization: When a specific group is consistently assumed to be diagnosed with a certain diagnosis
  - May expect a certain type of person to be depressed (for example) so evaluates them with bias based on culture/clothing/etc

Ethical Considerations

- Stigmatization brought on by the diagnosis
- Labeling anyone as abnormal is iffy because it can be a life-long label
  - Even if symptoms are no longer shown
- Scheff (1966) Self-fulfilling prophecy: people may begin to act as they think they are expected to
  - i.e. Someone diagnosed with depression starts to have suicidal thoughts *after* the diagnosis

Langer and Abelson (1974)

- Videotape of a younger man telling an older man about his job experience
- When viewers were told he was applying for a job, they said he was attractive and conventional-looking (average/positive)
- When told he was a patient, they said he was tight, defensive, dependent, frightened of his own aggressive tendencies (negative)
- Power of schema processing!

Biases that Affect Diagnoses

- Racial/ethnic:
  - Jenkins-Hall and Sacco (1991)
  - 4 women
    - Two European American women; 1 with depression; 1 without depression
    - Two African American women; 1 with depression; 1 without depression
  - African American and European American non-depressed women were rated the same
  - African American depressed woman was rated with more negative terms and seen as less socially competent than the Euro Amer depressed woman

Biases that Affect Diagnoses

- Confirmation Bias:
  - Clinicians have expectations about the people who consult them
  - Assume if the patient is there in the first place there must be something abnormal
  - May overreact and see abnormality where ever they look because that's their job!
    - Example: Rosenhan's study (1973)

Assessment Techniques

- Kahneman and Tversky (1973): Using a greater amount of assessment techniques does not improve the accuracy of a diagnosis

Institutionalization

- If mis-diagnosed, it is very difficult to convince medical staff it's wrong
- Once diagnosed, all behavior is perceived as being a symptom of the illness
  - Illustrated by Rosenhan (1973) where it took a participant 52 days to convince the ward he was not really schizophrenic and that it was a test

Biases that Affect Diagnoses

- Powerlessness and depersonalization:
  - Lack of rights, constructive activity, choice, and privacy in institutions
  - Some attendants even face verbal and physical abuse

Cultural Considerations in Diagnosis

- Concepts of abnormality vary between cultures
- Culture-bound syndromes: disorders that are thought to be culturally specific
  - Neurasthenia is common in China, but not even listed in the Western DSM-IV
- These culture-bound syndromes are now included in a special section of the DSM
- Maybe these are frequent in Western civilizations too!
  - The mindset that these are bound to other cultures can lead to faults in diagnosis; they aren't considered

Reporting Bias

- The way in which patients report their symptoms/issues to doctors
  - What they include/exclude
- Rack (1982):
  - Asians more likely to consult doctors for *physical* issues
  - Deal with their emotional issues personally with their family

Cultural Outlooks

- Cohen (1988) Indian mentally ill people are cursed and looked down on
- Rack (1982) Chinese only label individuals out of contact with reality as mentally ill because of the stigma
- Studying cultures based on mental hospital admission rates can therefore be very misleading
  - Some don't have access to hospitals as well

Cultural Differences

- Marsella (2003) Depression takes a primarily affective form in individualistic cultures
  - Feelings of loneliness and isolation dominate these cultures
- Somatic symptoms are more dominant in collectivist cultures
- Depressive symptom patterns differ across cultures because of cultural variation in sources of stress and resources for coping

Kleinman (1984)

- It is impossible to compare depression cross-culturally because it may be experienced with substantially different symptoms or behaviors
  - Chinese patients feel headaches/back pain
  - Western patients feel guilt and anxiety
- Difficult to accurately diagnose
- Hard to classify disorder's symptoms

Culture Blindness

- Cultural blindness: the problem of identifying symptoms of a psychological disorder if they are not the norm in the clinician's own culture
- Cochrane and Sashidharan (1995): White people are considered the norm; if ethnic groups differ in their behaviors, they're seen as abnormal

How to Avoid Cultural Bias

- Make efforts to learn about the culture of the people being assessed
- Bilingual patients should be assessed in both languages
  - Could use second language as a form of resistance to avoid emotional responses
- Be sure the patient understands the requirements of the task when diagnosing
- Symptoms of disorders should be discussed with practitioners of that culture