

Basic Abnormality Notes

Learn this or fail module 2
 NB: You must also learn APFCC for the named studies

Description AO1	Commentary/Evidence AO1/AO2	Criticism/Evaluation AO2
<p>Definitions of Abnormality</p> <p>Statistical Deviation Any behaviour or attribute that is statistically rare is defined as abnormal</p>	<p>E.g. low IQ. Only 2.5% of people have an IQ below 70. Therefore, anyone with IQ below 70 has abnormally low intelligence. Hallucinations are uncommon in the population. Therefore, anyone who hallucinates is abnormal.</p>	<p>Gives a clear cut-off point between normal and abnormal, so is easy to use Line between normal and abnormal is arbitrary e.g. IQ of 71 is normal, IQ of 69 is abnormal Doesn't consider desirability of behaviour. E.g. IQ of 130+ is equally rare, but not usually considered abnormal. Depression is quite common (10% of people)</p>
<p>Violation of Social Norms Any behaviour that violates the norms and expectations of society is considered abnormal, especially if it causes offence or discomfort in the observer</p>	<p>E.g. talking to yourself. This is generally not expected, as the norm is to talk to other people. Therefore this behaviour is abnormal, especially if done in public where it makes people uneasy.</p>	<p>You can only make judgements about the normality of a behaviour by considering its context e.g. OK to take of your clothes before a shower, not in Tesco's. There are many everyday violations of social norms that are just considered rudeness or eccentricity, so can only apply to persistent/extreme violations Criminals violate social norms but are considered 'bad' not abnormal Social norms differ from society to society, so what is considered abnormal by one person might be normal to another.</p>
<p>Failure to Function Adequately Behaviours are considered abnormal if they are maladaptive i.e. they make it difficult for the person to lead a normal life or threaten the person's well-being</p>	<p>E.g. an obsessive-compulsive who continually washes his hands, interfering with normal life, an agoraphobic who cannot leave the house or an anorexic who self-starves are all abnormal</p>	<p>Some people who are clearly abnormal may function quite well e.g. antisocial personalities, who are more of a danger to others. Some behaviour is risky/self-destructive e.g. extreme sports or smoking, but we don't think people who do it are abnormal We all have times when we can't function well, but aren't necessarily abnormal because of this</p>
<p>Deviation from Ideal Mental Health We define what it is to be mentally healthy e.g. autonomy, ability to cope with stress, accurate perception of environment, loving & intimate relationships. Anyone who doesn't meet the criteria is abnormal</p>	<p>E.g. a depressed person may find it impossible to deal with stress, their relationships may well suffer and they may perceive the environment inaccurately. This makes them abnormal, as they are mentally unhealthy.</p>	<p>If all the criteria are applied strictly then we are all abnormal. The criteria are subjective and vary from society to society Some criteria are difficult to measure e.g. 'self-actualisation'</p>

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<p>Models of Abnormality</p> <p>Four models of abnormality:</p> <ol style="list-style-type: none"> 1. Biological 2. Behavioural 3. Cognitive 4. Psychodynamic 	<p>Each makes different assumptions about the causes of abnormality Therefore each has different implications for how abnormality is treated</p>	
<p>Biological Model</p> <p>Assumptions Experience and behaviour are the result of biological processes Abnormal experiences and behaviour are the result of a biological malfunction e.g. A genetic defect inherited from parents An infection affecting the brain An imbalance of chemicals in the brain An abnormality of the brain or nervous system</p> <p>Implications for Treatment If the disorder is caused by a biological abnormality, then it follows that treatments that change or restore biological functioning will make the person better</p>	<p>Schizophrenia seems to run in families Tertiary syphilis infection causes madness Depression is linked to imbalances of serotonin Phobias may have over-reactive sympathetic nervous systems</p>	<p>Things may run in families because of learning or a shared environment Chemical imbalances might be the effect of a psychological problem, not the cause Very few psychological disorders are clearly linked to a definite biological abnormality</p>
	<p>Drug treatments for depression increase levels of serotonin ECT (passing an electrical current through the brain) can alleviate depressed symptoms Surgery can sometimes help e.g. with extreme anxiety</p>	<p>Treatment is usually fast acting Drug treatment is straightforward for the patient Patients improve about 60% of the time Treatment can have side effects e.g. tremors and dry mouth with drugs, or memory loss with ECT. When treatment is stopped, the patient frequently relapses Drug treatments may be masking the symptoms, not curing them.</p>
<p>Behavioural Model</p> <p>Assumptions A person's behaviour is determined by their environment All behaviour, including abnormal, is learned through three processes:</p> <ol style="list-style-type: none"> 1. Classical conditioning (association) 2. Operant conditioning (reinforcement & punishment) 3. Social learning (observation) 	<p>Phobias are learned when a person associates something unpleasant with a neutral stimulus (e.g. getting bitten by a dog) Anorexia is caused by exposure to role-models who are freakishly thin. The person imitates them to get reinforcement</p>	<p>Focuses on the individual behaviour, so doesn't label people as abnormal Sometimes, abnormal behaviour can be traced to a particular learning experience Often it can not e.g. most spider/snake phobias Not everyone exposed to the same environment becomes abnormal e.g. otherwise all women in the UK would be anorexic</p>

<p>Description AO1 (Behavioural Model)</p> <p>Implications for Treatment</p> <p>If an abnormal behaviour can be learned, it can be unlearned and a new behaviour put in its place.</p> <p>This can be done through classical, operant conditioning and social learning</p>	<p>Commentary/Evidence AO1/AO2</p> <p>Flooding involves exposing the person to a high dose of their phobia. When they calm down they have learned there is nothing to be scared of (classical conditioning)</p> <p>Behaviour modification involves using reinforcements to change the person's behaviour (operant conditioning)</p> <p>Modelling therapy involves exposing the person to people dealing with their phobias (social learning)</p>	<p>Criticism/Evaluation AO2</p> <p>Good with children and people who can't / don't want to talk through their problems</p> <p>Quite effective with phobias (60-70% improvement)</p> <p>Not so effective with e.g. anorexia as it only attempts to change behaviour, not thought processes.</p> <p>Can be distressing and stressful for the client (e.g. flooding)</p> <p>Behaviour modification raises ethical issues (e.g. depriving people of basic rights)</p>
<p>Cognitive Model</p> <p>Assumptions</p> <p>Feelings and behaviour are determined by thinking processes</p> <p>Therefore, if something is wrong with the thinking processes, then the result is abnormal feelings and behaviour.</p> <p>Thinking processes include:</p> <ol style="list-style-type: none"> 1. Perception – interpreting the world & others' behaviour 2. Attribution – working out why people do things 3. Problem solving 	<p>A depressed person perceives things in a negative light and makes inappropriate attributions about others' behaviour. This leads to low mood and withdrawn behaviour</p> <p>An anorexic perceives themselves as grossly overweight when they are severely malnourished. Their self-starvation is a response to this</p>	<p>Plenty of evidence to show that people with psychological problems have abnormal thoughts. However, this could be an effect not a cause.</p> <p>E.g. in depression, a chemical imbalance might lead to a low mood that then leads to negative thinking</p> <p>In anorexia people might misperceive their bodies because of a brain abnormality.</p>
<p>Implications for Treatment</p> <p>If abnormal feelings and behaviour result from abnormal thinking, then it is necessary to change the way the person thinks</p> <p>The treatment involves:</p> <ol style="list-style-type: none"> 1. Identifying the irrational beliefs 2. Challenging them 3. Substituting more rational ones 	<p>In cognitive behaviour therapy for depression, the therapist talks to the client about their perceptions and thoughts and identifies irrational beliefs</p> <p>The client is then given things to do that will challenge those beliefs</p> <p>In the next session, the therapist and client discuss how the client's experiences might lead to different ways of thinking</p>	<p>Quite effective with many disorders including anxiety and depression</p> <p>As effective as drugs (60% improvement) but seems to be longer lasting</p> <p>Doesn't work for all disorders (e.g. schizophrenia)</p> <p>Works slower than drugs and requires engagement and motivation from the client – not always possible.</p>

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<p>Psychodynamic Model</p> <p>Assumptions Conscious thoughts, feelings and behaviour are determined by unconscious processes Being mentally healthy requires a good balance between the id (desires) the superego (morality) and the ego (reality) Repressed desires or traumatic memories in the unconscious can upset the balance of the personality The person develops psychological symptoms as a way of dealing with imbalance in the personality Repressed problems often go back to childhood</p> <p>Implications for Treatment If the problems stem from repressed memories or conflicts stemming from childhood, then these must be brought to consciousness and dealt with is the person is going to get better.</p>	<p>Depression is the result of feeling abandoned as a child. This results in unconscious hostility towards the abandoner (usually the parents) which is turned in on the self. Anorexia may result from sexual abuse in childhood. The sufferer develops a fear of sex/growing up. Self-starvation keeps them in a childlike state</p> <p>In psychoanalysis, the therapist investigates the client's unconscious through free association, word association and projective tests. They identify the unconscious conflicts and help the client to bring them to the surface (catharsis). They then help the client to work through and deal with their repressed feelings</p>	<p>Some evidence to suggest that childhood experiences affect adult mental health. E.g. losing a parent when young increased risk of depression, many people who are abused go on to develop psychological problems Overemphasises childhood. It is unlikely that all psychological problems stem from the first 5 years of life Relies on ideas like the unconscious mind, which are very difficult to test or prove.</p> <p>Works quite well for mild disorders (e.g. anxiety, depression) Takes a long time (2 years+) so time consuming and expensive Can result in the formation of false memories (e.g. of abuse) which may make things worse, not better Encourages the client to become dependent on the therapist – not necessarily good for them.</p>
<p>Eating Disorders</p> <p>Anorexia Nervosa Refusal to eat Weight loss (70% of expected weight) Periods stop Unduly concerned with body weight Purging/excessive exercise Occurs mainly in teenage girls (1-3%)</p> <p>Bulimia Nervosa Bingeing (eating lots of food in one go) Purging (vomiting or laxative abuse) Excessive concern with body weight Feeling that bingeing is out of control Occurs mainly in young women (3%+)</p>		

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<p>Biological Theories of Eating Disorders Due to an inherited genetic abnormality Results in abnormal brain functioning in areas connected with hunger and eating/perception of body Possible chemical imbalance – linked to hormonal changes in adolescence</p>	<p>Both anorexia and bulimia tend to run in families. This suggests a genetic link. Holland et al (1988) – anorexia concordance rates MZ 55% DZ 7% Kendler et al (1991) – bulimia concordance rates MZ 22% DZ 10% Higher MZ concordances suggest a role for genetics. This appears stronger for anorexia than bulimia Jimerson (1997) found that bulimics have abnormally low serotonin levels This suggests that a chemical imbalance may be involved</p>	<p>Might run in families due to learning processes. MZ concordance rates are less than 100% so that must mean the environment also plays a role No study has found consistent evidence that people with EDs have brain abnormalities Bulimia sometimes responds to drugs, anorexia less so</p>
<p>Psychological Theories of Eating Disorders Due to learning influences in the environment Girls exposed to thin role models Want to imitate them, so start dieting (social learning) People give reinforcement for losing weight so the person carries on (operant conditioning) Dieting gets out of control</p>	<p>Barlow & Durand (1995) report that as depictions of the desirable female body shape have got slimmer, EDs have increased in prevalence Nasser (1991) found that Egyptian women in England were much more likely than Egyptian women in Cairo to develop an ED. Other studies have found that EDs are virtually unknown in rural China, but becoming more common in urban China This suggests that EDs are partly a consequence of exposure to Western norms and influences</p>	<p>Not all research says it's culture bound e.g. Hook et al (2000) found that EDs were just as common on Curacao (where the norm is that bigger is better) as in the West Every woman in the West is exposed to the same thin images and pressure to diet, but only 2-3% go on to get EDs. If it was just learning, then most women would have them. Many interview studies of EDs suggest that it's not being thin that's important, it's being in control</p>
		<p>One way of resolving the issue is to use the diathesis stress model. This says it's not either genes or the environment, but both. The person inherits a genetic vulnerability that makes them more susceptible to the disorder. If they are exposed to certain types of environment, the disorder develops. Genetics loads the gun, but the environment pulls the trigger.</p>