Adult Psychopathology

Historical Conceptions, Categorization, and Basic Models of Gene and Environment Influences
Historical Conceptions of Abnormal Behavior

- Major psychological disorders have existed across time and cultures

- Causes and treatment of abnormal behavior varied widely, depending on context
The Supernatural Tradition

- Deviance = Battle of “Good” vs. “Evil”
  - Etiology- devil, witchcraft, sorcery
    - Great Persian Empire (900 to 600 BC)
    - 14th and 15th century Europe
    - Salem witch trials in US

Treatments- exorcism, torture, and crude surgeries

This is not as “out-there” as you might think- AIDS example.
The Supernatural Tradition

• Other Worldly Causes
  – Moon and stars
    • lunacy
    • Failure to attend to Base-rates
      (Kelly et al., 96)

– Modern examples?
  • Astrology
  • Barnum effect
The Biological Tradition

- **Hippocrates** (460-377 BC)
  - Father of modern Western medicine
  - Etiology = physical disease
    - Brain pathology
    - Head trauma
    - Genetics
    - Psychosocial factors
      - Stress, family
  - Precursor to somatoform disorders
    - Hysteria
The Biological Tradition

- **Galen** (129-198 AD)
  - Hippocratic foundation
    - Galenic-Hippocratic Tradition
  - Humoral theory of mental illness
  - Etiology = brain chemical imbalances
  - Treatments = Environmental regulation
    - Heat, dryness, moisture, cold
    - Bloodletting, induced vomiting
The Biological Tradition and the 19th Century

- Syphilis and General Paresis
  - STD with psychosis-like symptoms
    - Delusions
    - Hallucinations
  - Etiology = bacterial microorganism
    - Louis Pasteur’s germ theory
    - Malaria burned away STD!

- Biological basis for madness
- John Grey and AJP!
The Development of Biological Treatments

- Mental Illness = Physical Illness

- The 1930’s
  - Insulin shock therapy
  - Brain surgery
  - ECT

- Benjamin Franklin (1750s)

- Treatment for depression?
The Development of Biological Treatments

• The 1950’s
  – Psychotropic medications
    • Increasingly available
    • Systematically developed
  – Neuroleptics
    • Reserpine and psychosis
  – Tranquilizers
    • Benzodiazepines and anxiety
Consequences of the Biological Tradition

• Increased hospitalization
  – “Untreatable” conditions

• Improved diagnosis and classification
  – Emil Kraepelin
    • First to distinguish among various psychological disorders, seith that each may have a different age of onset and time course, with somewhat different clusters of presenting symptoms, and probably a different cause. Father of Schizophrenia classification still used today! For now…

• Increased role of science in psychopathology
The Psychological Tradition: Ancient Contributions

• **Plato, Aristotle, and Greece**
  – Etiology
    • Social and environmental factors
  – Treatment
    • Reeducation via discussion
    • Therapeutic environments

• Similar practices in ancient Muslim countries
The Psychological Tradition

• Moral Therapy
  – “Moral” = emotional or psychological
  – Treating patients normally
  – Encouraging social interaction
  – Focus on relationships
  – Individual attention
  – Education
The Psychological Tradition: Moral Therapy

- Key figures in humanistic reform:
  - France
    - Philippe Pinel (1745 – 1826)
    - Jean-Baptiste Pussin
  - United States
    - Benjamin Rush (1745 – 1813)
Asylum Reform and the Decline of Moral Therapy

• Declines in the Mid-19th Century
  
  – Increased numbers of patients
    • Immigrants
    • Homeless
      – “Mental Hygiene Movement”
        » Dorothea Dix (1802-1887)
        Because of her excellent work (making certain that everyone who needed help got it; e.g., homeless), there was an unforeseen consequence: namely, the hospitals became over-crowed and quality went...

  – This also coincided with increased “untreatable cases”, a result of the noted biological approach

  – Staffing problems

  – Outcome = decreased treatment efficacy
  – Prominence of the biological model was final blow to the flailing movement
• Peak in 1950s (500,000 residents in US)
• There are a lot of misconceptions today
• It’s important to consider how things currently stand
  – Szasz, Costs (e.g., $1/4^{th}$ of an average state’s budget in the 1870s), Meds
  – The community mental health act
  – $1/3^{rd}$ of homeless have schizophrenia
  – Insurance
The Psychoanalytic Tradition - Background

- **Anton Mesmer** (1734 – 1815)
  - “Mesmerism” and hypnosis
  - Suggestibility

- **Jean Charcot** (1825-1893)
  - Hypnosis as treatment
  - Mentor to Freud

- **Josef Breuer** (1842-1925)
  - Furthered hypnosis treatments
  - Collaborator with Freud
  - **Unconscious:** patients felt better after, but didn’t link emotional issues to psychological problems.
  - **Catharsis:** It is therapeutic to recall and re-live trauma that has been made unconscious, and to relieve accompanying tension.
  - **Insight:** to have a deeper understanding of current emotions and earlier events.
### Freud’s Structure and Function of the Mind

<table>
<thead>
<tr>
<th>Type of thinking</th>
<th>Driven by</th>
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<tbody>
<tr>
<td>Conscience</td>
<td>Moral principles</td>
</tr>
<tr>
<td>Logical; rational</td>
<td>Reality principle</td>
</tr>
<tr>
<td>Illogical; emotional; irrational</td>
<td>Pleasure principle</td>
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**Diagram:**

- **Superego:** Conscience
- **Ego Mediator:** Logical; rational
- **Id:** Illogical; emotional; irrational

**Intrapsychic conflicts**

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Psychoanalysis - Defense Mechanisms

• Ego fights to stay on top of the Id and Superego

• Conflicts produce anxiety that threatens to overwhelm the poor ego. The anxiety is a signal that alerts the ego to marshal defense mechanisms: unconscious protective processes that keep more primitive emotions associated with conflicts in check, so that the ego is free to continue its coordinating function (and not too overwhelmed).

• Coping strategies include:
  – Displacement
  – Denial
  – Rationalization
  – Reaction formation
  – Projection
  – Repression
  – Sublimation
Defense Mechanisms

Let's say you are angry with a professor because he is very critical of you. Here's how the various defenses might hide and/or transform that anger:

**Denial:** You completely reject the thought or feeling.
- "I'm not angry with him!"

**Suppression:** You are vaguely aware of the thought or feeling, but try to hide it.
- "I'm going to try to be nice to him."

**Reaction Formation:** You turn the feeling into its opposite.
- "I think he's really great!"

**Projection:** You think someone else has your thought or feeling.
- "That professor hates me."
- "That student hates the prof."

**Displacement:** You redirect your feelings to another target.
- "I hate that secretary."

**Rationalization:** You come up with various explanations to justify the situation (while denying your feelings).
- "He's so critical because he's trying to help us do our best."
Defense Mechanisms Continued:

- "**Intellectualization:** A type of rationalization, only more intellectualized.

- "This situation reminds me of how Nietzsche said that anger is ontological despair."

- **Undoing:** You try to reverse or undo your feeling by DOING something that indicates the opposite feeling. It may be an "apology" for the feeling you find unacceptable within yourself.

- "I think I'll give that professor an apple.

- **Isolation of affect:** You "think" the feeling but don't really feel it.

- "I guess I'm angry with him, sort of."

- **Regression:** You revert to an old, usually immature behavior to ventilate your feeling.

- "Let's shoot spitballs at people!"

- **Sublimation:** You redirect the feeling into a socially productive activity.

- "I'm going to write a poem about anger."
Later Developments in Psychoanalytic Thought

- Freud’s students de-emphasize sexuality
  - Carl Jung (1875-1961)
    - Collective unconscious
    - Scientology?
    - Enduring personality traits
      - Introversion vs. extroversion

- Alfred Adler (1870-1937)
  - Birth order
  - Inferiority complex
  - Striving for superiority
  - Self-actualization
The Shadow Exercise

• "Think of someone you know whom you don't like very much. Maybe you even hate this person. On a piece of paper, write down a description of that person. Write down what it is about this individual's personality that you don't like. Be as specific as you can."
The Behavioral Model

Classical Conditioning

- Ivan Pavlov (1849-1936)
- Cancer Chemo example

Stimulus Generalization

- Ubiquitous form of learning

- Unconditioned stimulus (UCS)
  - Unconditioned response (UCR)

- Conditioned stimulus (CS)
  - Conditioned response (CR)
The Behavioral Model - Operant Conditioning

- **E.L. Thorndike** (1874 – 1949)
  - Law of effect: consequences shape behavior

- **Wolpe** and the beginnings of behavioral treatments: systematic desensitization

- **B.F. Skinner** (1904 - 1990)
  - Behavior “operates” on environment
    - Operant conditioning
  - Reinforcements
  - Punishments
  - Behavior “shaping”
The Behavioral Model

- Behaviorism
  - John B. Watson (1878 - 1958)
    - Scientific emphasis: “psychology can be just as scientific as physiology”
    - Objective
    - Radical empiricism

- All of Watson’s exclamations were due to his belief that children should be treated as a young adult.

- In his book, he warns against the inevitable dangers of a mother providing too much love and affection. Watson explains that love, along with everything else in the world, is conditioned.

- Watson supports his warnings by mentioning invalidism, saying that society does not overly comfort children as they become young adults in the real world, so parents should not set up these unrealistic expectations.

- Further emphasizing nurture, Watson said that nothing is instinctual; rather everything is built into a child through the interaction with their environment. Parents therefore hold complete responsibility since they choose what environment to allow their child to develop in.
The **Diathesis-Stress Model**

Disorder

Life events (stressor)

Genetic vulnerability (diathesis)

Person #1 becomes alcoholic

Stressor: long bouts of drinking in college

Diathesis: genetic tendency to become alcoholic

Person #2 doesn't become alcoholic

Alcoholism
Reciprocal Gene-Environment Model

People with a genetic predisposition for a disorder may also have a genetically driven tendency to create environmental risk factors that promote disorder. (this can confuse understanding of the etiology or confound studies!)

- Genes shape how we create our environments
- Inherited predispositions or traits that increase one’s likelihood to engage in activities or seek out situations
- Life events literature
DSM Five
The Good, The bad, and the...
and the Sometimes Labyrinthian
Results due to Last Minute Compromises, Poor Overarching Vision, and Outside Influence
The dangers of a diagnostic system

During the repressive 1950's, Dr. Evelyn Hooker undertook ground breaking research that led to a radical discovery: homosexuals were not, by definition, "sick." Dr. Hooker's finding sent shock waves through the psychiatric community and culminated in a major victory for gay rights - in 1974 the weight of her studies, along with gay activism, forced the American Psychiatric Association to remove homosexuality from its official manual of mental disorders.
Diagnosis **categorical** vs. **dimensional** vs. **prototypical**.

- **Classical (or pure) categorical approach** - assumes that each disorder is unique (i.e., different) with its own unique underlying pathophysiological cause. Only one set of criteria is needed for a given disorder and all must meet all of the criteria to receive a diagnosis. Common in medicine, but not in psychopathology.

- **Dimensional approach** - places symptoms on several dimensional ratings; a view that is problematic when theorists cannot agree on the number and types of required dimensions.

- **Prototypical approach** - categorical approach that combines features of the other approaches. Identifies essential features of a psychological disorder so that it can be classified, but allows for nonessential variations that do not necessarily change the classification (e.g., there are several ways one could meet criteria for major depression or panic disorder, but still get the diagnosis). The DSM-IV-TR is based on this approach.
Critique #1: Heterogeneity within each diagnosis

DSM-IV Criteria for Conduct Disorder: 3 or more of the following in the last twelve months.

1. Bullies, threatens, or intimidates others.
2. Initiates physical fights.
3. Used a weapon that could cause serious physical harm.
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Stolen while confronting victim.
7. Forced someone into sexual activity.
8. Deliberately engaged in fire setting.
9. Deliberately destroyed others’ property.
10. Has broken into someone else’s house, building, or car.
11. Often lies to obtain goods or favors.
12. Has stolen items of nontrivial value.
13. Often stays out at night despite parental prohibitions.
14. Has run away from home overnight.
15. Is often truant from school.
Symptoms of ADHD
- Talks excessively
- Easily distracted
- Often “on the go” or acts as if “driven by a motor”
- Engages in dangerous activities without considering potential consequences

Symptoms of Mania
- More talkative than usual or pressure to keep talking
- Distractibility
- Increased goal-directed activity or psychomotor agitation
- Excessive involvement in pleasurable activities that have potential for painful consequences
Critique #3: High Rates of Comorbidity
Critique #4:
DSM-IV diagnoses are assumed to be categorical

Categorical model:
• Dichotomous yes/no diagnosis
• Major Depression vs. not depressed

Dimensional model:
• Individual differences without diagnostic categories
• More vs. less depressed
Individuals with 4 or more positive symptoms receive the diagnosis of “Generalized Anxiety Disorder”
Pros and Cons of the Dimensional Model

**Positive Aspects**
- Probably the way the world works
- Uses all available information about a person
- Better description of each individual

**Drawbacks**
- Many practical decisions are categorical
  - Therapy
  - Medication
  - Insurance
- Less user friendly
### Pros and Cons of Diagnostic Labels

<table>
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<tr>
<th><strong>Drawbacks</strong></th>
<th><strong>Benefits</strong></th>
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<tr>
<td>Most labels have negative connotations</td>
<td>Makes communication easier</td>
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<tr>
<td>May lose sense of individual</td>
<td>Gives name to condition that is leading to distress</td>
</tr>
<tr>
<td>- Autistic vs. person with symptoms of autism</td>
<td>- Support from others with similar difficulties</td>
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<tr>
<td>Self-fulfilling prophecy</td>
<td></td>
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<tr>
<td>- Influence behavior</td>
<td></td>
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<tr>
<td>- Influence opinion of others</td>
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Critique #5: Vague, non-specific criteria in Histrionic Personality Disorder

• A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

• (1) is uncomfortable in situations in which he or she is not the center of attention

• (2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior

• (3) displays rapidly shifting and shallow expression of emotions

• (4) consistently uses physical appearance to draw attention to self

• (5) has a style of speech that is excessively impressionistic and lacking in detail

• (6) shows self-dramatization, theatricality, and exaggerated expression of emotion

• (7) is suggestible, i.e., easily influenced by others or circumstances

• (8) considers relationships to be more intimate than they actually are
DSM V

- *A Mental Health Bible?

- Three Sections:
  - 1) How to use it
  - 2) The disorders
  - 3) Miscellaneous.
    - dimensional scales for:
      - Symptoms or issues across illness
      - Personality
    - Global functioning
    - Culture
    - Codes for medical conditions as well as life event issues
    - Disorders that will be in DSM VI maybe (e.g., persistent complex bereavement disorder)
The Axis system : ( 

![Image of a dog playing with a toilet](image-url)
• DSM IV had a large number of narrow diagnostic categories (to promote reliable assessment) and this led to comorbidity and “not otherwise specified” (NOS) being the rule rather than the exception.

• Solutions:
  – added more Specifiers (e.g., in early remission, in full remission; how severe) and provided two new categories for previous NOS:
    • other specified disorder (now with a list of possibilities). This is tailored to each disorder (e.g., other specified obsessive-compulsive and related disorder)
    • unspecified.
  – Also added an experimental dimensional system
  – Added a new section entitled “other conditions that may be a focus of clinical attention” at the end of section 2 to cover conditions that may be a focus of clinical attention or otherwise affect diagnosis, course, prognosis, treatment etc. These used to be lumped into NOS or adjustment. They are technically not mental disorders

• The goal of revising minor points and adding the ability for clinicians to add more details to each disorder was to make the categories less narrow but still reliable. It’s a balancing act.
• DSM IV treated culture and gender in a clunky fashion

• Solutions:
  – new section 3 attention to rating this in greater detail and more systematically
    • Cultural syndrome
    • Cultural idiom of distress
    • Cultural explanation of perceived cause
  – Attention to gender on multiple levels
    • Specific symptoms have been added to various pertinent classifications,
    • Specifiers -perinatal onset of mood episode-
    • Disorders such as PMDD
    • A new gender related diagnostic issues section.

• For this class we will address gender as it pertains to each of the individual disorders.
• DSM IV considered each diagnosis as categorically separate from health and from other diagnoses (the multi axis system) and missed the widespread sharing of symptoms and risk factors across many disorders that is apparent in real life. Axis 4 was rarely used and Axis 5 had questionable validity and reliability (or utility).

• There was a poor separation between disorders and disability and this has been a long-term goal of APA for several editions.

• Solution:
  - Combine Axes 1-3 so that each disorder had relevant information tied to it specifically rather than a more global approach (provide example of Axes).
  - Use ICD-9-CM V and new Z ICD-10 Z codes to cover related psychosocial and environmental problems (previous Axis IV) (contained in “Other conditioned That May be a Focus of Clinical Attention” at the end of section 2).
  - Use the World Health Organization Disability Assessment Schedule (WHODAS) instead (section 3).
• DSM IV had issues with categorization

• However, a pure dimensional approach was not practical (APA decided at the very very last minute!)

• Solution:
  – An experimental (section 3) non-diagnostic measure “Cross-Cutting Symptom Measures” that rates various problems such as anxiety across disorders: for the purposes of Abnormal, we will ignore this.

  – put in more dimensional specifiers throughout the disorders (tailored to each disorder)

  – For personality disorders (PDs), which had the most complaints about dimensions, they also added a special dimensional section in section 3 (to supplement what is in the main section 2).
In a few weeks, the American Psychiatric Association will release its new edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). This volume will tweak several current diagnostic categories, from autism spectrum disorders to mood disorders. While many of these changes have been contentious, the final product involves mostly modest alterations of the previous edition, based on new insights emerging from research since 1990 when DSM-IV was published. Sometimes this research recommended new categories (e.g., mood dysregulation disorder) or that previous categories could be dropped (e.g., Asperger’s syndrome).

Patients with mental disorders deserve better. NIMH has launched the Research Domain Criteria (RDoC) project to transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system.

That is why NIMH will be re-orienting its research away from DSM categories. Going forward, we will be supporting research projects that look across current categories – or sub-divide current categories – to begin to develop a better system. What does this mean for applicants? Clinical trials might study all patients in a mood clinic rather than those meeting strict major depressive disorder criteria. Studies of biomarkers for “depression” might begin by looking across many disorders with anhedonia or emotional appraisal bias or psychomotor retardation to understand the circuitry underlying these symptoms. What does this mean for patients? We are committed to new and better treatments, but we feel this will only happen by developing a more precise diagnostic system. The best reason to develop RDoC is to seek better outcomes.
Overall Changes

• Some Key organization differences and split disorders:
• Changes to inclusions/exclusion
• Some Name Changes (this one is really frustrating)
• Some Really Useful additions (Anxious specifier in depression)
• Some More Questionable things added
Why Revision is ultimately good

• Failsafe
David Maisel, Library of Dust: The work depicts individual copper canisters, each containing the cremated remains of patients from the Oregon State Hospital.

The 5000 patients died at the hospital between 1883 (the year the facility opened, when it was called the Oregon State Insane Asylum) and the 1970's. All have remained unclaimed by their families.