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| **Area** | Requirements | **Evaluation** | **Key Study** | **Evaluation of the Key Study** | Application |
| **Historical context of mental health**  | **Historical views of mental illness** * humorism
* trepanning
* asylums

**Defining abnormality** * 4 definitions (DFIMH, DFSN, SI, F2FA)
* a limitation of each
* cultural relativism

**Categorising mental disorders** * DSM-V
* ICD-10
 | * Validity – diagnosis relies on self-report
* Validity – symptoms can overlap, so there is comorbidity
* Reliability
* Subjective (diagnosis is based on the opinions of the psychiatrist)
* Differential diagnosis
 | Rosenhan (1973)On being sane in insane places. | * The research methodology (field experiment)
* The diagnosis and key results for the original and follow up study
* The experience of psychiatric hospitalisation
* The stickiness of psycho-diagnostic labels
* Powerlessness and depersonalisation
 | Characteristics of 1. **affective disorder (bipolar depression)**
* Mania - increased rate of speech, psychomotor agitation
* Depression: to persist for >2 weeks, feelings of worthlessness or guilt, thoughts of suicide
1. **a psychotic disorder (schizophrenia)**
* **Positive symptoms**: 2+ to persist for 1 month, delusions, hallucinations
* **Negative symptoms**: Alogia – speech stops being fluent, avolition – no willpower or care
* and an anxiety disorder (OCD)
* Obsessions - Recurrent and intrusive bad thoughts, product of their own mind
* Compulsion - overt behaviours like washing hands, mental acts like counting, acts are repetitive, time consuming and rigid
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| **The medical model**  | **Biochemical explanation of mental illness** * Due to too many / few neurotransmitters binding to receptors.
* Neurotransmitters are either excitatory or inhibitory.
* Excitatory (e.g. serotonin) make the next cell more likely to fire.
* Inhibitory (e.g. GABA) make them less likely to fire.
* The cause of **specific phobias** is too little GABA

**The genetic explanation of mental illness** * All humans have inherited, through natural selection, certain fears e.g. heights.
* Seligman says that those who did not fear / avoid them, died, so their genes were not passed on

**Brain abnormality explanation of mental illness** * Localisation of function - different brain parts are over / under-active
* Specific Phobias - PFC inhibits the fear response. If it is not functioning effectively, it no longer stops fearful urges being sent from the amygdala.
* **Empirical evidence: Ahs et al (2009)** PET scans showed increased activity in the amygdala and reduced in the PFC for snake phobics
 | **Biochemical** * Aetiological fallacy
* Medicating problematic behaviour
* Palliative v curative

**Genetic** * Correlation not causation
* Nature v nurture

**Brain abnormality** * Psychology as a science
* Correlation not causation
 | Gottesman et al. (2010)Disorders in offspring with two psychiatrically ill parents. | * Valid over time from ICD-8 to ICD-10
* Representative sample but may only apply to Denmark
* Ethical – anonymity assured, but may be unethical to use results to stop people having kids
* Useful to advise people on risks associated with having children - genetic counselling
* Difficult to rule out influence of shared environment
 | **Biological treatment of phobias: medication** * The cause of specific phobias is too little GABA
* GABA is an inhibitory neurotransmitter
* Benzodiazepines are prescribed for specific phobias, such as Valium (diazepam) and Xanax (alprazolam).
* BZs are a depressant – they help to reduce anxiety by increasing the levels of GABA

**Evaluation*** **Empirical Evidence: Pande et al (1999)** - BZs are effective in treating specific phobias
* **Appropriateness**: BZs are available on the NHS for short periods of time
* Palliative not curative
* Can be used alone or in **combination** with other therapies
* Side effects of chemotherapies should ONLY be referred in relation to ‘**treatment compliance’**. Side effects of low doses include: impaired memory, depression, drowsiness
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| **Alternatives to the medical model**  | **The behaviourist explanation of mental illness** * Learnt through classical conditioning, operant conditioning or SLT (D.A.R.R.M.)
* Specific phobias are **initiated** by classical conditioning or SLT and then **maintained** through operant conditioning.
* **Empirical evidence: Watson & Rayner (1920)** Little Albert to fear white furry objects through **ass**ociation with a loud noise.

**The cognitive explanation of mental illness** * **F**aulty / irrational thinking (cognitions) cause abnormal behaviour.
* **Attentional bias** - selectively focus on the fear – hypervigilance
* **Negative appraisal bias** - specific phobics exaggerate the risk of danger and **under-estimate (appraise)** their own ability to cope.
* Pflugshaupt (2005) eye tracking people with specific phobias

**The psychodynamic explanation of mental illness** * Tripartite personality – specific phobias = too much superego
* 5 Psychosexual stages – fixation at the phallic stage (Little Hans)
* Overuse of the ego defence mechanisms (e.g. catastrophizing)
 | **Behaviourist** * Not all behaviour is learnt (e.g. hallucinations in Sz)

**Cognitive explanation** * Research relies on self-reports, so lacks construct validity

**Psychodynamic** * Explanatory power
* Psychology as a science
 | Szasz (2011)The myth of mental illness: 50 years later. | * Psychology as a science (lacks falsifiability, is subjective, is not based on quantitative data or experiments)
* Free will v determinism (wants people to be allowed to show their own free will, even to suicide)
* Ethics
* Reliability of diagnosis
* Nature v nurture
 | **Non-biological treatment of phobias = flooding*** Flooding intends to extinguish the unreasonable fear response.
* No relaxation techniques or step by step build up.
* Individual is exposed repeatedly and in an intensive way with their phobia.
* Fear response cannot be maintained for more than 20 minutes

**Evaluation of Flooding*** It is cost-effective – it can work in a single session
* It is curative
* It is less effective for some types of phobia like social phobias
* The treatment is traumatic for patients – can they ever really give informed consent (other than retrospective consent)
* It is not available on the NHS, which suggests it is not appropriate)

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Key Study Summaries

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|   | Rosenhan  | Gottesman | Szasz |
| Aim  | To test the reliability of diagnoses of psychological abnormality | To calculate the risk to offspring of having both parents with a psychiatric disorder (Sz, bipolar disorder, unipolar depressive disorder) | Update to his essay ‘The myth of mental illness’ from 1960 |
| Sample  | 1st expt = 8 sane people acted as ‘pseudo-patients’ – 5M and 3F. Volunteer sample | Denmark national register 2.7million, opportunity sample  |  N/A |
| Procedure | 1st expt = 12 hospitals in 5 states - pseudo-patients said they had been hearing words: *‘empty’*, *‘hollow’*, and *‘thud’.* When on the psychiatric ward, they behaved as normal. | Correlational analysis study looking at the risk of Sz or bipolar disorder by age 52 years with 0/1/2 parents with Sz, bipolar, unipolar depression | * Unwanted behaviours are defined as mental illness.
* There is an ever growing list of diseases that can be diagnosed and deprive people of their freedom.
* Diagnosis is based on a subjective judgement by a psychiatrist, not objective like taking a temperature or blood test.
* Mental illness is treated as a disease when they are not biological diseases.
* Diagnosis is used to hospitalise and control people without their consent unfairly.
* Mental hospitals and treatment are more like prisons not medical care.
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| Results | 1st expt = 7 out of 8 admitted. When released it was with the label ‘schizophrenia in remission’. Length of stay from 7 - 52 days. Normal behaviour was misinterpreted and described by staff as abnormal. 2nd expt = No pseudo-patients but 41 real patients were believed to be pseudo-patients by 1 or more staff member. | Risk of Sz with 2 parents admitted to psychiatric facility with Sz = 27.3%, 1 parent admitted = 7.0%. Risk of bipolar disorder with 2 parents both being admitted to psychiatric facility with 36.0%, 1 parent admitted = 4.4%, no parent admitted = 0.48%. Max. risks of any disorder for children with 2 parents with Sz = 67.5% or bipolar disorder = 44.2%  | * Since Szasz’s original article, the latest DSM gives patients more rights and power
* large institutions have closed
* and many inhumane treatments such as frontal lobotomies have stopped.
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| Conclusions | Doctors are more inclined to call a healthy person sick (false positive Type 1 error). Diagnoses cannot be very reliable. Labels tend to ‘stick’ even if they are wrong. | There are genetic explanations for some mental illness. There is a genetic overlap for categories of mental illness. | * Suggestion - try and understand the reasons behind patient’s behaviour, and try to help them.
* Patients should have the right to control and define their own lives
* Psychiatrists should not even deprive people of the freedom to take their own lives.
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