ATYPICAL PSYCHOLOGY

How do we define abnormality? A major issue to be faced by those who study and treat abnormal behaviour lies in the question ‘when does behaviour come abnormal’? There is no separating normal behaviour and abnormal behaviour:-

Psychopathology is a scientific study of mental disorders, the immediate problem this shows is what constitutes a mental disorder and should this be regarded as ‘mental illness’. Mental disorders are treated mainly by psychiatrist doctors who specialize in the study and treatment of mental abnormality describing the disorders by DSM- IV and ICD10 later on.

One of the most difficult tasks for those working within the field of abnormal psychology is to define abnormality. Definitions of what constitutes abnormal behaviour have changed dramatically through history. Any behaviour that seemed outside an individuals control was thought to be the product of supernatural forces, for example exorcism was one of them. The definition of abnormality itself remains a judgement; abnormality is described in several ways.

Applying abnormality to psychology is very complex, what is normal? Whose normal? For what age? For what culture? Some would classify or argue that what is ‘good’ as normal and what is ‘bad’ as abnormal. Definition brings up many of the same questions. There are many more ways of showing a more objective reference point.

One way of defining abnormality is statistical infrequency; such statistics inform us about things such as what age is most typical for women (and men) to have their fist baby, the average shoe size for 10 year old children, how many people read certain magazines or daily newspapers etc.

Those who stray from the average on the statistical infrequency diagram are then considered abnormal. This definition has its problems it does not recognize valuable derivations such as a genius neither does it recognize a maladaptive behaviour like smoking and drinking, nonetheless this method is both objective and scientific.
In some situations it is appropriate to use a statistical criterion to define abnormality for example mental retardation is defined in terms of the normal distribution using the concept of standard deviation to establish a cut-off point for abnormality.

A very simple idea that can be used to classify abnormal behaviour is personal distress, basically if a person is content with their life then they are of no concern to the mental health field, However if a person's thoughts or behaviours are causing them personal discomfort or unhappiness, then they will be considered abnormal.

Defining the 'norm' for any group of people is something that is usual, regular or typical. If the table can define what is **most common** then it can define what is **not common** i.e. abnormal. For example it is **not the 'norm'** when you have your first baby when you're over 40 and less than 20.

DSM-IV

Psychiatric diagnoses are categorized by the diagnostic and statistical manual of mental disorders 4th edition better known as DSM-IV. This covers all mental health disorders for both children and adults.
It assesses five dimensions listed on next page.

“Axis 1 – clinical syndromes”

This lists all the mental health disorders for example depression, schizophrenia, social phobia etc

“Axis II – developmental disorders and personality disorders”

Developmental disorders include autism and mental retardation which are first evident in childhood

Personality disorders are clinical syndromes which have more long lasting symptoms; they include paranoid, antisocial and borderline personality disorders

“Axis III – physical and medical conditions”

Lists any medical conditions that could affect a person’s mental state and hence would be relevant to understanding and treating a disorder.

“Axis IV- psychosocial problems”

These are problems that might affect the diagnosis, treatment and prognosis of a diagnosed disorder, for example a person may have experience a stressful event such as divorce or loss of a loved one.

"Axis V – level of functioning"

On this the clinician provides a rating of the person's psychological, social and occupational functioning

Major categories in ICD-10

"Symptomatic mental disorders- dementia in Alzheimer's disease; organic amnestic syndrome; personality and behavioural disorders due to brain disease, damage and dysfunction."

"Mental and behavioural disorders due to psychoactive substance use- substances include alcohol, cannabinoids, cocaine, and hallucinogens."

"Schizophrenia and delusional disorders - schizophrenia (paranoid, hebephrenic, catatonic, undifferentiated, residual")

"Mood (affective) disorders- manic episodes including hypomania, bipolar affective disorder, depressive episode, recurrent depressive disorder, persistent mood."

"Neurotic stress related- phobic anxiety disorders, social phobias, anxiety disorders (including panic disorders), obsessive compulsive order, and reaction to severe stress."

"Behavioural syndrome- eating disorders including anorexia and bulimia, sleep disorders including sleep walking and night terrors, sexual dysfunction including lack or loss of sexual desire."

"Disorders of adult personality and behaviour- specific personality disorders (including paranoid, schizoid, dissocial, emotionally unstable")

"Mental retardation- mental retardation which is mild severe or profound"

"Disorders of psychological development- specific disorders of speech or language**,** reading, spelling, arithmetic and scholastic skills. Pervasive developmental disorder including (childhood autism, atypical autism and Rett's syndrome")

Behavioural and emotional disorders- mixed disorders of conduct and emotion
The range of behaviours listed above has been classified abnormal. Some abnormal behaviours are acute, resulting from certain stressful events whereas others are severe and lifelong. Some abnormal behaviours result from disease, others are through faulty learning experiences. Each person's behaviour and emotional problems are unique; no two individuals behave in exactly the same way or share the same life experiences.

Labeling induces us to overlook the unique features of each case and to expect the person to conform to the classification. Label for maladaptive behaviour is not an explanation of that behaviour; the classification does not say how the behaviour originated or what maintains the behaviour. How ever, enough similarities exist for mental health professionals to classify cases into categories.

Psychopathologies

Developmental of psychopathology is the study of psychological problems in the context of human development. I am going to critically evaluate the explanation and treatments of at least three different Psychopathologies.

Schizophrenia

What is schizophrenia?

Schizophrenia is a medical term for people who, through no fault of their own have developed a serious problem in which their thoughts, feelings and behaviour have become very disturbed.

Schizophrenia is among the most debilitating and the most complex of the psychoses. Common symptoms include hearing voices, jumbled thoughts, delusions, feeling watched and controlled, and losing emotional feeling.

There are several types of schizophrenia, simple schizophrenia only ICD distinguishes this type; Hebrephrenic (disorganized) schizophrenia, Catatonic Schizophrenia, paranoid schizophrenia, undifferentiated schizophrenia.

Schizophrenia is a severe mental illness characterized by a variety of symptoms,

- Hallucinations (i.e. seeing, hearing, smelling, sensing or tasting things that other people do not see, hear smell, sense or taste for example the person

who may hear voices which command him or her to behave in certain ways.

- Delusions (i.e. false beliefs that are firmly held despite objective and contradictory evidence, and despite the fact that other members of the culture do not share the same beliefs, for example the person may believe that he or she is Jesus Christ, or that he or she is being followed, poisoned, or experimented upon)
- Thought disturbances in which the person believes that thoughts are being inserted into or withdrawn from the mind; are being broadcasted to others; or are being echoed in the mind
- Disordered thinking which results in coherent or irrelevant speech.
- Negative symptoms such as extreme apathy, lack of spontaneous speech, leading to disturbances in social or occupational functioning (or, if onset is in childhood or adolescence, a failure to reach expected academic, occupational or interpersonal achievement).

There is no single specific symptom that is required for a diagnosis of schizophrenia

"Early warning signs"

- Inability to sleep, unusual waking hours
- Social withdrawal, isolation, indifference
- Deterioration in social relationships
- Hyper activity, or inactivity,
- Inability to concentrate, difficulty in making decisions

- Hostility, suspicision, fearfulness
- Over reaction to peer or family disapproval
- Deterioration in personal hygiene
- Excessive writing or childlike writing without clearing meaning
- Unusual emotional reactions
- Flat expressions
- Staring, not blinking or blinking constantly
- Unusual sensitivity to stimuli noise/light
- Smelling and tasting things differently
- Peculiar use words or language structure
- Bizarre behaviour: refusal to touch people, constant wearing of gloves, shaving body hair, cutting ones self, threats of self mutilation

Negative symptoms

Lack of motivation- is a of energy or interest in life that is often confused with laziness, because the ill person has very little energy, he or she may not be able to do much more than sleep and pick at meals. Life for the person with schizophrenia can be experience as devoid of interest.

Blunted feelings or blunted affect refers to a flattening of the emotions, because facial expressions and hand gestures may be limited or non existent, the ill individual seems unable to feel or show any emotion at all. This does not mean that the individual does

not feel emotions and is not receptive to kindness and consideration. He or she may be feeling very emotional but cannot express it outwardly. Blunted affect may become a stronger symptom as the disease progresses.

Depression- involves feelings of helplessness and hopelessness. Often the person believes that he or she has behaved badly, has destroyed relationships, and is unlovable. Depressed feelings are very painful and may lead to attempts of suicide. Biological changes in the brain may also contribute to depression.

Social withdrawal- as a result of feeling no safety in being alone and being so caught up in his or hers feelings and fearing that he or she cannot manage the company of others. People with schizophrenia frequently lack the resources needed to show interest in socializing.

Positive symptoms

Hallucinations- A person with schizophrenia may hear voices or see visions that are not there, or experience unusual sensations on his or hers body. Auditory hallucinations are the most common involving hearing voices that are perceived either insides or outside the persons body. Sometimes the voices are complimentary, reassuring and neutral. Sometimes they are threatening, punitive, frightening and may command the individual to do things that may be harmful.

Delusions- many people with schizophrenia suffer from delusions and are termed paranoid, they believe that they are being watched or spied upon. A common delusion

is that ill person thinks that their thoughts are being broadcasted over the radio or television, or that other people are controlling their thoughts.

Thought disorder- refers to problems in the way that a person with schizophrenia processes and organizes thoughts. For example, the person may be unable to connect thoughts into logical sequences. Racing thoughts come and go so rapidly that it is not possible to catch them, because thinking is disorganized or fragmented, the ill person's speech is often incoherent and illogical. Thought disorder is frequently accompanied by inappropriate emotional responses; words and mood do not appear in tune with each other. The result may be something like laughing when speaking or frightening events.

Altered sense of self- is a term of describing a blurring of the ill person's feeling of who he or she is. It may be a sensation of being bodiless, or non-existent as a person. The ill individual may not be able to tell where his or her body stops and the rest of the world begins. It may be as if the body is separated from the person.

Behavioural model

Schizophrenia can be explained in terms of conditioning and observational learning, schizophrenics show behaviour when it is more likely than normal behaviour to receive rein-forcement.

Schizophrenic behaviour can be modified through conditioning, although there is little information to suggest that such techniques can make major changes to the expression

of thought disorders. It is difficult to see how schizophrenic behaviour patterns can be acquired when people have no opportunity to observe such patterns.
The behavioural model has little contribution of the above to make the understanding of the causes of schizophrenia.

Psychodynamic model

Schizophrenia has one way of psychodynamic explanation, the disorder results from an ego that has difficulty distinguishing between the self and the outside world.
The major psychodynamic account of schizophrenia attributes the disorder to regression to an infantile stage of functioning.
Freud believed that schizophrenia occurred when a person's ego either became over whelmed by the demands of the id or was besieged by unbearable guilt from the superego. The ego retreats to the oral stage of psychosexual development, a stage in which the infant has not yet learned that it and the world are separate. Initially, regressive symptoms occur and the person suffering with schizophrenia may suffer experience of delusions of self importance. Their fantasies may become confused with reality which gives increase to hallucinations and delusions as the ego tries to regain reality.

Cognitive model

Cognitive supporters believe that involving thought, perception, attention and language, are a cause rather than consequence of the disorder. Maher (1968) believes that a fault occurs in the minds of schizophrenics when they process information, which gives them a bizarre use of language.

The cognitive model proposes that catatonic schizophrenia may be a result of breakdown, the human brain processes information to a limited extent, it suggests that the lack of interaction with the outside world can cause the person to be less social there fore schizophrenia can become worse.

Biochemical influences

Some people inherit an error of metabolism which causes the body to break down naturally occurring chemicals into toxic ones. These toxic chemicals are held to be responsible for the characteristics for schizophrenia

Following an examination a doctor will ask questions about how the problem started, about the person's family history, work, environment/community, stressful events, health and previous medication they have received. The doctors and nurses will be watching and asking questions to get a better idea about the person and their problems. Often the doctor may talk to the family to get more information.
The doctor will then use the information to make a diagnosis. There is no special test for schizophrenia, so it is not always easy to diagnose it straight away, sometimes the doctor may not be sure that it is the right diagnosis for them so he or she would have to watch the person for a little while deciding whether the person has schizophrenia or not. In the hospital the doctors and nurses should decide on a plan of treatment. The treatment nearly always includes medication. Going into hospital is only a part of the treatment. The main aim for hospital treatment will be to reduce symptoms and get the person out of hospital and living back at home. His is sometimes called REHABILITATION. The family has an important job to play by helping the person get back to normal way of living as far as possible

The amount of medication varies for different people, depends on such things as a persons height and weight. At first the person will be given a high dose to reduce the symptoms quickly. The dose will be cut down to the lowest amount possible. The main medicine which is given to reduce schizophrenic symptoms are called 'neuroleptics'. Other types of medicine may also be used;

- To stop side effects
- To help the person sleep
- To calm the person down
- To reduce the persons anxiety

There is some evidence that the brain produces its own internal hallucinations for example "Smythies (1976) reported small amounts of hallucinogen – like chemicals in the cerebrospinal fluid of schizophrenics whilst Murray et al (1979) reported that hallucinogen dimethyltryptamine (DMT) was present in the urine of schizophrenics, when DMT levels decreased schizophrenic symptoms also decreased. However, later research indicated that the characteristics of schizophrenia were different to those produced by the hallucinogenic drugs, and researchers turned their attention to other bio-chemical agents"

"Anti-psychotic drugs relieve florid psychotic symptoms such as thought disorder, hallucinations, and delusions and prevent relapse. Although they are usually less effective in apathetic withdrawn patients, they sometimes appear to have an activating influence. Patients with acute schizophrenia generally respond better than those with chronic symptoms"

Long term treatment of a patient with a definite diagnosis of schizophrenia may be necessary even after the first episode of illness in order to prevent the manifest illness from becoming chronic. Withdrawal of drug treatment requires careful surveillance because the patient who appears well on medication may suffer a disastrous relapse if treatment is withdrawn inappropriately.

"Anti psychotic drugs are considered to act by interfering dopaminergic transmission in the brain by blocking dopamine receptors which may give a rise the extrapyramidal effects. Anti-psychotic drugs may also affect cholinergic, alpha-adrenergic, histaminergic and serotonergic receptors."

Medication

- "Neuroleptics such as clozapine, zotepine, olanzapine, amisulpride, quetiapine, risperidone, sertindole," these drugs is are used for the typical schizophrenic with the symptoms such as delusions and hallucinogens
- Carry out ECG repeated periodically and reduced dose if prolonged
- Carry out blood pressure, regular pulse and temperature checks ensure the patient maintains adequate fluid intake.

What causes schizophrenia?

Researchers do not know what actually causes schizophrenia. They are always looking at many possible reasons which might explain why people develop schizophrenia. Although there is good evidence that severe schizophrenia is probably caused by brain malfunction, in some cases it may be caused by influenza affecting the fetus when it is in the mother's womb.

Anyone, anywhere in the world has a one in hundred chance of developing schizophrenia some time during their lifetime. It occurs in both men and women and often begins when someone is in their early twenties.

Anorexia

Anorexia is a very secretive illness and anorexics often feel ashamed of their behaviour and try to pretend that there is nothing wrong. However, it is obvious when someone is suffering from this disorder because it involves severe weight loss. This weight loss can be so extreme that sufferers may die of starvation. The faster the weight loss, the more dangerous the illness, because the body has no time to adjust and a sufferer can die when their heart simply stops beating.

Weight loss however is not the only symptom of anorexia. There are other signs that someone is suffering from this illness. People with anorexia seem to lose confidence and start to become quieter and more withdrawn than usual, often isolating themselves from their friends and family. They become totally preoccupied with thoughts of food because their body is starving and their mind can only focus on nothing but eating. Sufferers find that they want to cook complicated meals and then sit and watch the rest of their family eat, while they have nothing. They avoid food at all costs and can seem angry or frightened if offered a meal or a snack.

The suffer has a terrible fear of becoming fat and cannot se how thin they really are. They often start to wear many layers of baggy clothing, not only because they want to hide their body but also because they are very cold. As they are eating no food, they have no fuel to keep their body warm and their feet and hands can turn blue. A fine

covering of dark hair called ‘lanugo’ starts to grow on the sufferer’s chest, stomach arms and face. This is the body’s way of trying to keep itself warm.

Anorexics often feel physically very ill since their bodies are trying to function without any food. Fainting and dizziness are common problems and anaemia is another side effect of anorexia. Aneamia occurs when there is not enough iron in the blood. This means that the sufferer often feels short of breath and very light headed. Restlessness at night (insomnia) and muscle spasms often occur. They can develop constipation because they are just not eating enough food to keep their bowels working properly. This leads many anorexics to turn to laxatives and they can become addicted to them very quickly.

There are many emotional as well as physical changes when someone develops anorexia nervosa. They may find it hard to concentrate and as a person’s weight drops, their brain shrinks in size too. Sufferers often fell moody and irritable and may become snappy with friends and family. Depression is also a common problem that is associated with anorexia and other eating disorders.

Anorexia nervosa is an illness about control, the sufferer feels in control when they restrict the amount of food they eat but the reality is very different. The illness is actually in control of the sufferer because once a person starts down the anorexia road, it is very difficult to turn things around without a lot of help, encouragement, support and love. Anorexia is an addiction and to fell good, the sufferer needs to ct down on more and more food everyday. A lot of anorexics also try to exercise as much as possible, often running everywhere rather than walking normally.

Anorexia nervosa is sometimes called the “slimmer’s disease”. I believe this is an unfair description because it is very rare for people to develop anorexia simply because of a desire to lose weight. At least 75% of the people who develop this illness

have never been over weight and so there have to be other reasons why theses disorders start.

What all anorexics seem to have in common is a distorted body image, a belief that they look and are greatly overweight when, in fact they are severely underweight. They are also particularly vulnerable to ordinary life events, have rather obsessive personalities and tend to avoid situations they fear. They have low self esteem and seem incapable or afraid of managing their own lives. Some anorexics can not control their desperate need to eat and find a solution in starving, then going on a binge of eating and then finally making them selves vomit (this is known as secondary anorexia or bulimia nervosa)

Psychodynamic model

Psychodynamic model proposes that the disorder may represent an unconscious effort by a girl to remain pre- pubescent. It has been argued that, as a result of overdependence on the parents, some girls fear becoming sexually mature and independent. In order to achieve puberty, we must attain a particular level of body fat, and there is evidence to suggest that anorectics will eat, provided they do not gain weight. The weight loss prevents the rounding of the breasts and hips and the body takes on a boy-like appearance. Theorists say that this is a way of avoiding the issue of sexuality in general and the prospect of pregnancy in particular. Some say that anorexia can result in overdependence of the family hence thinness and starvation to gain self control and independence.

Anorexia nervosa can be called a phobia concerning the possibilities of gaining weight. The phobia is assumed to be the result of the impact of social norms, values

and roles. In at least some occupations such as ballet dancing or modeling there is a great deal of pressure on women to be thin.

Bulimia

Like anorexia, bulimia is a very secretive illness but unlike anorexia, it can be hidden from the outside world since sufferers are frequently a normal weight. Many anorexics fear that they will turn from anorexia to bulimia as they recover and start eating. Although some people suffer from both bulimia and anorexia, they are in fact two separate illnesses and research has shown that one does not necessarily lead to the other. Certainly in my case, I suffered from anorexia for fourteen years but never had any bulimic episodes.

Bulimia usually develops later than anorexia. Whereas anorexia is often present in young girls aged between 10 and 16, bulimia rarely takes hold until the late teens.

Unlike anorexics, who maintain a strict control over their food intake, bulimics find it harder to limit the amount of food they eat. Quite often, feelings of hunger cause them to binge on large quantities of the food they so desperately want. This is the food that they have denied themselves while on their 'restricted' diet. It is usually high in fat and sugar such as chocolate, cookies and crisps. A binge can last for a long time but on average, bulimics say they binge for around two hours. During that time a large amount of food can be eaten, for example as much as 30,000 calories during just one binge. This is the equivalent of about 15 day's food.

Many bulimics say they feel totally out of control during a binge and simply force extra food into their mouths without even tasting what they are eating. It is not

unheard of for bulimics to eat frozen or uncooked food, stale food from dustbins or even pet food.

Following a binge, bulimics usually suffer tremendous guilt as well as physical pain from the large amounts of food they have eaten. This guilt, together with a fear of gaining weight, leads the sufferer to find ways of getting rid of the food they have so recently eaten. Self-induced vomiting is common and is when sufferers force themselves to be sick. Some people may take medicines called emetics to make themselves vomit. Another method used to dispose of the food is purging. This is when bulimics take laxatives to cause food and drink to pass through their body much faster. Both vomiting and purging are extremely dangerous ways of 'dieting' and can lead to serious medical problems or even death.

Although bulimia nervosa is the most hidden of all the eating disorders, there are telltale signs that show a person is suffering from this illness. Their skin often has a pale green tinge due to the constant vomiting. Teeth can also suffer and frequent dental appointments may be needed. When a person vomits, their teeth come into contact with stomach acid, which is very harmful. Tooth enamel is gradually worn away until the teeth themselves start to decay. Many sufferers brush their teeth immediately after vomiting, to remove any telltale smell on their breath. However, this is unwise because it spreads the acid around all the teeth. Rinsing with antiseptic mouthwash or fresh water is considered a safer option although this is still unlikely to stop the decay caused by vomiting.

Small red spots appearing around the eyes due to broken blood vessels are another sign of bulimia. A puffiness of the cheeks (often known as "chipmunk cheeks") can occur because of the constant vomiting. The sufferer's throat is usually sore and

mouth ulcers can form. Stomach and bowel problems may also be very common, due to both the vomiting and purging. In addition, the sufferer's hair often starts to fall out although doctors are unsure why. As with anorexia, there are also long-term effects such as bone damage caused by a change in the level of female hormones in the body. Bulimia can affect a woman's monthly period and it may become heavier and irregular.

Depression, moodiness and irritability are also symptoms of bulimia. Obviously there are exceptions to every rule but there are certain characteristics bulimics tend to have. They are often bubbly, warm and social people but can change when they are trying to cope with their feelings after a binge. They may become irrational, angry, withdrawn or depressed. This means they often have stormy relationships with friends and family, as their moods can prevent people getting close to them.

Bulimics often feel confused about their feelings and emotions. They no longer eat simply because they are hungry but to fill an emotional need instead. For them there are only extremes. They are either totally empty and starving hungry, or uncomfortably full following a binge. Recovery from bulimia is all about learning to eat a normal amount each day without feeling a need to vomit.

Like anorexia, bulimia is a very dangerous illness that requires medical attention and it is very important to contact a doctor if you are exhibiting any of these symptoms.

Evaluation of both anorexia and bulimia

Unfortunately the activity of being bulimic often actually works against the body becoming slim, healthy and fit, For example, someone with bulimia and worried about their weight will often skip breakfast. If they were to eat something like

porridge then their metabolic rate would increase and they would more effectively burn calories, and foods like porridge provide a long term energy release so that the person isn't 'starving' by lunchtime. Almost invariably when the person stops being bulimic and starts to eat a healthy balanced diet they usually find it astonishingly easy to lose excess weight. Most bulimics know more about nutrition than many nutritionists.

Some anorexia nervosa suffers show some symptoms of bulimia. The fact that some categories of anorexia and bulimia nervosa overlap has convinced a number of researchers to start questioning whether they might in fact be one single disorder. Bulimia nervosa is not usually regarded as life threatening when compared with anorexia nervosa, however it takes longer to manage and overall it is worse in the long term it is an ongoing disorder (Russell 1979). Bulimic behaviours are more common in the general public than anorexia.

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