

Statistical Infrequency

- **Mathematical method** for defining abnormality. Rare = abnormal.
- Human attributes fall into a normal distribution within the population. **Standard deviation** informs us how far scores fall on either side from the mean. E.g. 2 SD's away from the mean IQ = abnormal.

Deviation from Social Norms

- Abnormality is when a behaviour does not fit within what is **socially acceptable**.
- Social norms are implied, unwritten rules that society must follow.
- Culture can impact what is considered 'abnormal' and acceptable.

Deviation from Ideal Mental Health

- There are 6 criteria for 'normality' and you must meet them all.
- Personal autonomy, self-actualisation, positive self-attitude, resistance to stress, environmental mastery, accurate perception of reality.
- If one criterion is not met, you are deemed abnormal.

Failure to Function Adequately

- Abnormality is failing to cope with everyday life, e.g. hygiene, and work.
- Failure to function refers to unpredictability, maladaptive behaviour, personal distress, irrationality, observer discomfort, violation of moral standards, and unconventionality.
- It can be assessed with the Global Assessment of Functioning scale.

Evaluating Statistical Infrequency

- Takes the whole population into account unlike other definitions.
- Many criticise quantifying abnormality despite it being objective.
- It does not account for rare and desirable behaviours
- Even abnormal behaviours can occur frequently, such as depression.

Evaluating Deviation from Social Norms

- It is flexible and recognises that age and context alter perceptions of behaviour. Social norms also help society to be ordered.
- Social norms change over time, therefore this definition must too.
- Cultural differences make it hard to understand what is 'acceptable' unless you are in the culture for a long time.

Evaluating Deviation from Ideal Mental Health

- Individuals who are struggling can have targeted intervention if their behaviour is not 'normal'. E.g. help with their self-attitude.
- It is a positive definition, focusing on what is helpful for the individual
- It is practically impossible to achieve all six criteria
- The criteria are culturally biased. E.g. some cultures value dependence.

Evaluating Failure to Function Adequately

- It focuses on the individual and identifies when someone needs help.
- This is observable meaning others can help identify abnormality.
- Behaviours may be an issue for others, but not for the individual.
- Cultural differences need to be considered when determining what is 'normal' functioning.

OCD is classified as an anxiety disorder and has two main components: **obsessions** and **compulsions**.

Clinical Characteristics: repetition & compulsions (behavioural), anxiety & depression (emotional), and selective attention & obsessive thoughts (cognitive).

Biological Explanation of OCD

Genetics: OCD is inherited. The COMT gene is associated with regulating dopamine. The SERT gene is linked to lower levels of serotonin.

Neural/Neurotransmitters: High dopamine and low serotonin are implicated (note, this is not always caused by genetics).

Neural/Brain: The **basal ganglia** influence the coordination of movement. Patients who suffer head injuries in this region often develop OCD-like symptoms, following their recovery. The **orbitofrontal cortex** converts sensory information into thoughts and is more active in those with OCD.

Biological Treatments of OCD

Antidepressant drugs: SSRIs increase the level of serotonin available in the synapse by preventing it from being reabsorbed into the sending cell, increasing what is received by the post-synaptic neuron, improving mood.

Antianxiety drugs: Benzodiazepines work by enhancing the action of the neurotransmitter GABA, which tells neurons in the brain to 'slow down' and 'stop firing'. BZs quieten the brain and reduce anxiety associated with OCD.

Evaluation of the Biological Explanation of OCD

- **Research support:** Lewis (1936) found that 37% of the patients with OCD had parents with the disorder and 21% had siblings who suffered it, supporting genetics.
- **Research support:** Nestadt et al. (2010) found 68% of MZ twins and 31% of DZ twins experience OCD, supporting genetics.
- **Research support:** Max et al. (1994) found that when the basal ganglia is disconnected from the frontal cortex during surgery, OCD-like symptoms are reduced.
- The explanation is biologically reductionist, focused on the role of nature.
- Good implications for treating OCD, such as SSRI medication.

Evaluating Biological Treatments of OCD

- **Research support:** Soomro et al. (2008) found that SSRIs were more effective than placebos in the treatment of OCD, in 17 different trials.
- They are cost effective in comparison to psychological treatments, like cognitive behavioural therapy (CBT).
- Drugs are non-disruptive and can be taken until the symptoms subside. They do not require motivation and engagement like CBT.
- Some experience mild side effects like indigestion, while others experience more serious side effects like hallucinations.
- Once a patient stops taking the drug, they are prone to relapse, suggesting biology alone cannot explain or treat OCD.

Depression is a category of **mood disorders**, characterised by low mood or loss of pleasure in activities for a prolonged period of time.

Clinical Characteristics: reduced appetite & sleep (behavioural), anger & feeling worthless (emotional), negative thoughts & inability to concentrate (cognitive).

Cognitive Explanation of Depression: Beck

Cognitive biases cause depression, such as catastrophising, and **negative self-schema** cause people to interpret information about themselves negatively.

This maintains a **negative triad** of thoughts (about the self, world, and future).

Cognitive Explanation of Depression: Ellis

Depression is caused by an **activating event**, followed by an irrational belief and consequences. This is the **ABC** model.

Cognitive Treatments of Depression

CBT identifies irrational thoughts. The patient and therapist will work together to challenge these irrational thoughts, by discussing evidence for and against them. Patients test their beliefs through behavioural experiments and homework.

REBT aims to **dispute** the beliefs of patients. E.g. **logical disputing** – where the therapist questions the logic of a person's thoughts, and **empirical disputing** – where the therapist seeks evidence for a person's thoughts.

Evaluation of the Cognitive Explanation of Depression

- Positive implications for treating depression, such as CBT and REBT which help to challenge and change irrational thoughts.
- It does not explain the origin of the irrational thoughts or faults
- **Research support: Boury et al. (2001)** found that patients with depression were more likely to misinterpret information negatively (cognitive bias) and feel hopeless about their future (negative triad), which supports the cognitive explanation.
- Biological explanations of depression (e.g. low serotonin) are more compatible with the aims of science, and objective.

Evaluating Cognitive Treatments of Depression

- **Research:** March et al. (2007) found that CBT was as effective as antidepressants, in treating depression. However, a combination of CBT and medication was most effective.
- It requires motivation so those with severe depression may not engage with CBT or attend sessions. Alternate treatments may be more suitable.
- CBT might overemphasise the role of cognitions. It suggests that irrational thinking is the primary cause of depression and CBT does not take into account other factors.

Phobias are categorised as an **anxiety disorder** which causes an irrational fear of a particular object or situation.:

Clinical Characteristics include: avoidance and panic (behavioural), fear and anxiety (emotional), and selective attention and irrational beliefs (cognitive).

Behavioural Explanation of Phobias

Mowrer (1947) put forward a **two-process model**. Classical conditioning explains how phobias are acquired, but operant conditioning explains how they are maintained.

Classical conditioning: a neutral stimulus is associated with something that is feared already. After pairing/associations, the neutral stimulus becomes the conditioned stimulus, producing fear.

Operant conditioning: avoidance negatively reinforces the phobia.

Behavioural Treatments of Phobias

Systematic Desensitisation: The patient and therapist create a fear hierarchy to work through gradually. Relaxation techniques are taught. The goal is 'reciprocal inhibition' where two emotional states cannot exist at once – once the patient is relaxed in the presence of their phobic stimulus, counter-conditioning is achieved.

Flooding: exposes the individual to the anxiety-inducing stimulus immediately. It prevents avoidance until the extinction of the phobia occurs.

Evaluation of Behavioural Explanation of Phobias

- **Research support:** Watson and Raynor (1920) demonstrated that a fear response could be induced through the process of classical conditioning in the case of Little Albert, who learned to fear white rats.
- Positive implications for treating phobias, such as flooding or systematic desensitisation.
- Alternative factors are not considered. For example, cognitions are not included, and Bounton (2007) claims that evolutionary factors could play a role in phobias, e.g. phobias of potentially dangerous species.

Evaluating Behavioural Treatments of Phobias

- **Research support:** McGrath et al. (1990) found that 75% of patients with phobias were successfully treated using systematic desensitisation.
- The treatments cannot help with all phobias, such as those that we have evolved to have, or social phobias.
- Systematic desensitisation is often favoured as a treatment for phobias in comparison to flooding, as it is less traumatising.
- Flooding is more cost-effective due to the immediate nature of it.
- Although a phobia may be successfully removed through counter-conditioning another may appear in its place (symptom substitution).