Emil Kraepelin
- Identified various clusters of symptoms, gave them a diagnostic label, and reported on their cause
- Measured the effects of various drugs on abnormal behaviour

Franz Mesmer
Abnormal behaviour due to physical factors and interpersonal factors

Charcot
- Hysterical disorders and hypnosis were not the result of neurological weakness but were the effects of suggestion

Sigmund Freud
- Abnormal mind resulted from the interaction of forces within the mind.

Ivan Pavlov
- Explained how particular responses occurred when particular stimuli are exposed.

Watson
- Fears are the result of classical conditioning rather than unconscious conflicts.

Physiological explanations: Early 1950s
- Physiologically based method of treatment introduced.
- Antihistamines given to patients suffering from schizophrenia. Rise in psychopharmacology.

Current perspectives on abnormal behaviour: Modern day care
- Move from hospital to community care
  - Minimise use of hospital facilities and aim to maintain people in the community in which they live
  - Treatments by GPs, outpatient units
  - Multidisciplinary teams eg., CAT

The aetiology of mental health problems
- Genetic models

- Biological models
- Psychological models
- Sociocultural models
- Systemic models
- Biopsychosocial models

Current perspectives on abnormal behaviour
1. Different disorders may stem from different causes
2. Any one disorder may result from more than one cause
3. Different causes may combine to result in a disorder

Why have a diagnostic system?
- to organize knowledge
- to communicate about individuals who suffer from abnormalities
- to identify who should be treated and in what way
- legal and social purposes

Diagnostic system most widely known and used:
Diagnostic and Statistical Manual of Mental Disorders (DSM)

Multi-axial Classification system:
Axis 1:
  - includes all categories except Axis 2 disorders
  - clinical syndromes

Axis 2:
  - Personality disorders and mental retardation
  - More stable, long-standing problems

Axis 3
  - general medical conditions relevant to the mental disorder

Axis 4:
  - Psychosocial and environmental problems that may be contributing to the disorder e.g. education, occupation etc

Axis 5:
  - Current level of adaptive functioning
Dysthymic Disorder (DD)
- chronically depressed or irritable mood for more less than or equal to two years plus two of the following:
  - appetite disturbance
  - sleep disturbance
  - decreased energy
  - low self esteem
  - concentration problems
  - feelings of hopelessness

Bipolar disorders

Bipolar 1 disorder (manic depressive)
- more than one manic episode and possible past manic depressive episodes
- Mania
- Elevated, expansive or irritable mood
- More then 1 week and less then 3 weeks of the following:
  - Inflated esteem of grandiosity
  - Decreased need for sleep
  - More talkative then normal
  - Racing thoughts/flight of ideas
  - Distractibility
  - Increase in activity directed at achieving goals
  - Excessive involvement in potentially risky behaviors

Bipolar 2 disorder
- severe depression
- hypomanic episodes:
  - manic episodes that are not severe
  - don’t interfere with daily functioning
  - don’t involve hallucinations/delusions

Seasonal Affective Disorders (SAD)
Clinical features include:
- fatigue
- excess sleep
- craving for carbs
- weight gain

Woman affected more then men
Common in young adults

Postpartum depression
- severe mood changes
- disturbance in appetite/ sleep
- low self esteem
- difficulties in maintaining attention and concentrating

AGE OF ONSET

Bipolar Disorders
- range being from childhood to 50 years, mean age 30

Describe the various causes of mood disorders

PSYCHOLOGICAL THEORIES FOR MOOD DISORDERS
No single cause for mood disorders

Triggers of depression
- following stressful life event e.g. loss, unemployment, relationship problems work stress etc

Other possible risk factors
- Marital dissatisfaction and depression:
  Men at higher risk of developing this etc
  - Social support
  No close supportive friends/family, social support important in recovering as well

PSYCHOLOGICAL PERSPECTIVES

Psychoanalytic View:
- unconscious conflicts associated with grief and loss
- depression comes from anger turned inwards

Cognitive view
- thoughts and beliefs influence emotional state
- thoughts and beliefs biased towards negative interpretations

Learned helplessness
- individual has a sense of no control of their life, acquired though unpleasant experiences etc

COGNITIVE PERSPECTIVE

Negative cognitive style
- interpret everyday events in negative way
- negative view of self, world, future

BIOLOGICAL AND SOCIAL PERSPECTIVES

Neurochemistry
- low levels of depression
- high levels of mania
- low levels of serotonin
- genetic

Environmental
- stressful life events
- lack of social support

Multinational studies on depression have found that depression is increasing
- M age 25-29 years 
- 75% or more are woman

Social Anxiety Continuum

<table>
<thead>
<tr>
<th>Mild social awkwardness</th>
<th>Shyness</th>
<th>Social Phobia</th>
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Social Anxiety Disorder

- persistent fear/avoidance of social situation e.g. meeting strangers, public speaking
- fear of acting in a way that will be humiliating etc
- excessive or unreasonable fear
- either avoided or endured
- difficulty forming close relationships
- marked underachievement
- low natural recovery rate
- low treatment seeking rate

Acute and Post Traumatic Stress Disorder

- can occur following the experience or witnessing life-threatening events e.g. military combat, terrorist incidents, natural disasters
- people over retrieve through nightmares/flashbacks
- difficulty sleeping, feel detached etc

OCD

Prevalence of OCD

- 2.6% of population
- Males and females equally
- Most often begins in early adolescence to mid 20s
- Peak age of onset: males- 13-15, females- 20-24

OBSESSIONS:
- Are the thoughts.
- Intrusive, nonsensical thoughts, images, urges, beliefs that person tried to resist/eliminate
- E.g. contamination, repeated doubts like locking the door
- Most common obsessions are having things in particular order, aggressive or horrific impulses
- People with obsessions may attempt to neutralise them with actions= compulsions

COMPULSIONS
- the actual actions
- Repeated thoughts or functionally impairing behaviours designed to suppress intrusive thoughts and provide relief
- e.g. checking lock on door three times

People with OCD have often suffered loss or attachment issue which was dealt with through development of compulsive coping behavior

Various models of aetiology of anxiety disorders

➔ Aetiology

BIOCOLICAL

- parts of brain are possible sites for pathology
- possible chemical imbalance
- possible genetic basis

PSYCHOANALYTIC

- unconscious internal conflicts

COGNITIVE BEHAVIOURAL

- focus on role of control and helplessness

HUMANISTIC

- peoples basic natures are not expressed when they are caught between two conflicting self concepts

Pharmacological and psychological interventions for anxiety disorders

➔ Pharmacological
- some short term success
- problems with cognitive and motor functioning, and psychological and physical dependence

➔ Psychological
- CBT
- Cognitive restructuring
- Relaxation training
- Worry exposure assignments