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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 |
| **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 |
| **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) |

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. |
| 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. |
| 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. |