Psychology essays - abnormal psychology

ASSIGN BUSTER

Abnormal Psychology

Task1.

The psychodynamic explanation for phobias assumes that abnormal behaviour such as phobias is the product of some form of inner conflict. The psychodynamic perspective regards the abnormal behaviour as the symptom – not the cause of the problem. Behaviour is considered to be only the expression of the problem, not the problem itself, therefore the psychodynamic approach believes that addressing the phobic behaviour without looking at the underlying cause of it, will be ineffective-and lead to symptom substitution- i. e. the expression of the problem in a new way. The suggested treatment from the psychodynamic approaches requires gaining awareness and understanding of the underlying conflicts, which represent the true cause of the phobia. Treatment is often through counselling and psychoanalysis. This involves the client talking to the therapist about their past experiences and detailing any significant events, which may have lead to phobic reactions to certain stimulus forming. The client is encouraged to free-talk – i. e. say anything that comes into their head. The job of the therapist is to interpret this speech and identity possible triggers in their clients life that may have resulted in a phobia. For example, Freud is famous for highlighting the case of the boy (Little Hans) who was scared of horses. Freud reasoned that Little Hans had developed a phobia towards horses because of feelings he felt towards his father. These feelings Freud interpreted from Little Hans therapy sessions were of jealousy and fear towards his father. These anxieties were assumed to be caused by the feelings of admiration Little Hans felt towards his mother. Freud suggested

that the horse represented Little Hans castration anxiety from his father (i. e. from the horse potentially biting him). Therefore, instead of expressing fear towards his father, (which would then expose his feelings towards his mother), Little Hans displacing his emotions onto the horse. For the psychodynamic approach this explanation holds valid, due to the therapist dealing with underlying and unconscious thoughts. However, the psychodynamic perspective has faced a lot of criticism for its unscientific approach to treating clients. Firstly, this method of analysis puts the therapist in an unethical position of power. The therapist is responsible for the reasoning of the client's behaviour – whether this reasoning is correct or not, it lacks validity as the client may not share the same views. Furthermore, the psychodynamic approach is largely based on case study research – therefore it is very difficult to test for reliability – as every case is different – e. g. the results gained from one client may not be appropriate for another client. For example, a number of people may have a phobic reaction to the same stimulus – but for a completely different reason. Therefore, the usefulness of the psychodynamic approach is put into question – due to the nature of this approach's assumed ability to tackling unconscious material.

In contrast, the behaviourist perspective explains phobias in regarded to faulty learning patterns, acquired through processes of conditioning and learning. Behaviourist suggest that behaviour is learnt through a processes of conditioning – i. e. a behavioural reaction is learnt in conjunction with the presence of a particular stimulus. Often phobic behaviours are a result of associations between certain stimulus and bad feelings. For example, if a child is scared of the dark, the behaviourist approach would suggest that the

child may have experienced a frightful event in the dark and links the dark with feeling frightened. For example, the child may have heard unexplained noises in the dark (which may have been caused by a glass falling on the floor-but in the dark this can not be seen). Therefore, unlike the psychodynamic approach – the phobic behaviour is the problem – not the underlying cause. From the behaviourist perspective phobias represent learned fears. Unlike the psychodynamic approach, it is not the circumstances under which abnormal behaviour was acquired in the past that is important, but rather the need to modify it in the present. The behaviourist perspective argues that a process of behavioural modification is effective in the treatment of phobic behaviours. This process often involves the client making a hierarchical list of feared situations relating to the phobic object, and then to work through them –gradually being exposed to the most feared situation. The behaviourist approach works on the principle that two emotions of anxiety and calm cannot be felt at the same time. Therefore, in conjunction with learning to be exposed to fearful situations, the client also learns methods of relaxation (breathing techniques) to practice whilst in these fear provoking situations. The behaviourist approach has been attacked for ethical concerns to the client – in that exposure to these frightening situations may cause more emotional distress than good. However, the behaviourist approach appears more useful than the psychodynamic approach in treating the phobic behaviour. However, it may not uncover why the behaviour developed in the first place. Therefore, as the psychodynamic approach suggests, the client may simply displace their fear onto a new stimulus – i. e. symptom substitution. Therefore, a combination of the two approaches may be useful in the treatment of phobias.

Task 2.

1. Abnormality refers to psychological, physical or behavioural characteristics of the individual that deviate from the statistical norm in a given population. This deviation often presents dysfunctionality. This definition has a major weakness in that there are some times of behaviour that deviate from the norm – that are not considered dysfunctional – for example, a gifted child or an expert physician.

2. The two classification systems that are used in Europe and the USA to diagnosis abnormal behaviour are the International Classification of Diseases 10 and the Diagnosis Manual of Mental Disorders IV.

3. The essential difference between the ICD and DSM is how the two manuals diagnose social anxiety disorder and agoraphobia. The DSM differentiates between the two conditions on the basis of fear of social situations – whereas the ICD suggests that if the distinction between social phobia and agoraphobia is difficult, a diagnosis of agoraphobia should be given.

4. Psychosis refers to the severe disturbance of an individual’s emotions and thinking – these feelings are out of touch with reality. With Psychosis the whole person is involved in the experience. In contrast, Neurosis refers to an individual’s high level of anxiety – however this anxiety is felt in touch with reality. Neurosis is expressed through anxiety disorders – such as Obsessive Compulsive Disorders – which unlike psychosis only partially involves the person it is affecting.

5. The medical model suggests that abnormal behaviour is caused by a physical dysfunction, i. e. an illness – that has occurred due to a chemical or anatomical defect. The medical model believes that this physical dysfunction is genetic and caused by trauma or disease.

6. The medical has been successful in its ability to predict treatment that will affect physical dysfunctions. For example, an understanding of the physical mechanisms that have triggered the disease makes it easier to come up with a treatment that will prevent this behaviour from re-occurring. Also the fact that the medical model suggests that abnormality is genetic can provide predictions within the family environment. However, this approach does not take into account how the social world can play an important role in the potential formation and endurance of abnormal behaviour.

7. 1. Anti depressants (serotonin-reuptake inhibitors). These drugs act upon the brain’s chemistry and help to re-balance the serotonin levels within the brain. Serotonin reported to be lower in individuals who experience depression. However, caution has been raised about the potential side effects that these drugs have on the individual.

7. 2. ECT – invasive therapy – applying electric shocks to person’s brain. Caution is warned as to the ethical consideration and humanity of this technique.

8. Rosenhan’s (1973) conducted a study called ‘ On being Sane in sane places.’ His study involved the investigation into whether the sane can be distinguished from the insane (and also whether degree’s of insanity can be distinguished from each other). Rosenhan got 8 pseudo patients to gain

admission to several hospitals – on the grounds that they presented themselves to the doctors as hearing voices. All eight patients gained access on this pretence. What this shows us about the diagnosis of abnormality is that it is based on a set of criteria to be fitted into. If the symptoms are shown, then the label fits – even if these ‘ symptoms’ are not real. Diagnosis is seems is a labelling process.

9. What does other research tell us about the reliability of these models?

The reliability of the medical model has been put into question due to the validity of defining what’s ‘ abnormal’ and what’s ‘ normal’. It is important to note that decisions about abnormal behaviour can not avoid certain flaws. For example, diagnosis of abnormality relies on a subjective assumption by the clinician, which is based on valued judgements of the medical profession. Abnormality is also determined by which social context it is displayed in – therefore behaviour may be interpreted in the way abnormal behaviour is interpreted in its social setting. Furthermore, the concept of abnormality is influenced by statistical concepts of normality. This can prove problematic even in trained professionals (Broverman et al, 1970) – as statistics of normality are bound to political and social ideology. Behaviour which does not conform to social demands at any given time – may be rendered abnormal. However these assumptions inevitably change over time and place – therefore the reliability is going to suffer as a consequence. Not only does the concept of abnormality differ over time, but it can differ between doctors who diagnosis patients – and also between different cultures. Cooper (1967) found that US doctors were more likely to diagnosis schizophrenia than British doctors. This may highlight the concerns of previous labels given

to individuals by previous doctors, which distort the views of proceeding visits to the doctor.

The issue of labelling is highlighted in Rosenhan's (1973) study. Rosenhan argues that the notion of abnormal behaviour is a direct consequence of the labelling process. In support, Lindsay (1982) asked patients in a general hospital to rate the video recorded behaviour of a two sample groups – one that was alleged to have schizophrenic individuals in, the other included control subjects. One group was told nothing about the people in the video being rating, but two other groups were told either correctly or incorrectly, which the schizophrenics and which were not. The results of Rosenhan (1973) research would suggest that where information about a person's psychiatric status is withheld, the ratings should not differ according to whether the subjects in the video were actually schizophrenic. However, for the group that was told that the patients in the video clips were schizophrenic, their assessment of behaviour should assume more abnormal tendencies are being displayed. In fact, Lindsay found that the patients who actually had schizophrenia were rated more as abnormal regardless of whether any information given about them was accurate. Therefore, these results dispute the claim that Szasz (1972) made about abnormality or mental illness serving as a labelling effect to control society. However, this research does show us how personal perceptions of abnormality may affect the reliability of this labelling system. Miller and Morley (1986) conclude that the labelling process is far from a completely empty one, and that there is a reality of some kind behind it. In addition, they also point out that the patients taped by Lindsay were all fairly new cases. Therefore the

individual’s had not had long to adapt to their label and change their behaviour accordingly- as Szash may argue may have happened.

The attempt to classify abnormal behaviour is a fundamental part of the medical model of mental illness. The medical model of abnormal behaviour is used by psychiatrists to diagnose patients exhibiting abnormal behaviour. Psychiatrists are trained to regard mental illness as comparable to other kinds of physical illness. However, the symptoms are behavioural and cognitive rather than physical. However, although the difference is acknowledged, psychiatrists are encouraged to treat abnormal behaviour as preventable or curable by physical means – for example, with the use of drugs-to target the two main problem areas – i. e. that of the mind or that of the body. Therefore, in this instance mind and body are treated as similar entities. Szasz (1972) has attacked the medical model for classifying and treating illness in one of two groups in regards to the assumed aetiology of the disease. The medical model categorises physical diseases of the body as being organic and illness of the mind are termed functional disorders. However, Szasz (1972) argues that the distinction between the two is really a difference between a ‘ disease of the brain’ (not of the mind), or neurophysiologic disorder and ‘ problems in living’. Therefore, these distinctions rid the notion of abnormal behaviour and therefore rid the potential problems that this label contributes to the medical model. Referring back to Rosenhan’s study – the diagnosis tool that was applied to research was the DSM-II. The DSM is currently in its 4th edition. Therefore, although the medical model has been criticised for its lack of reliability – it does acknowledge social and cultural and medical movements which make it

more robust. For example, Sarbin and Mancuso (1980) highlight the fact that for a diagnosis of Schizophrenia, the characteristic of hallucinations must be repeated on several occasions, whereas Rosenhan's pseudo patient made only one report of this behaviour.

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