DYSFUNCTIONAL BEHAVIOUR

• DIAGNOSIS

• EXPLANATIONS

• TREATMENTS
DIAGNOSIS OF DYSFUNCTIONAL BEHAVIOUR

Areas to learn about:

• CATEGORISING

• DEFINITIONS

• BIASES IN DIAGNOSIS
CATEGORISING DYSFUNCTIONAL BEHAVIOUR

• There are two main diagnostic manuals used to categorise dysfunctional behaviour: ICD & DSM

• **International Classification of Diseases & Related Health Problems (ICD-10):**
  • Published by World Health Organisation (WHO)
  • Used in many countries (outside USA)
  • Psychiatric diagnosis across cultures
  • **ICD-10:** Each disorder - description of main features (can be ‘confident’/‘tentative’)
  • Each disorder given code (eg; A00 - Z99)
  • Categories include: dementia, schizophrenia, mood disorders, personality disorders.
CATEGORISATION: Diagnostic & statistical Manual of Mental Disorders (DSM-IV)

- Mainly used in USA
- DSM-1IV: Compiled by over 1000 people to produce practical guide to clinical diagnoses.
- Multi-axial tool: Axis 1; clinical disorders
  - Axis 2; personality disorders
  - Consideration of physical condition
  - Social / environmental problems
- Patient’s functioning assessed on scale from 1 - 100
- Classifications include: learning disorders, dementia, sleep disorders, sex & gender identity disorders, etc.
- Significant training & experience needed for accurate diagnosis
DEFINITIONS OF DYSFUNCTIONAL BEHAVIOUR

- ROSENHAN & SELIGMAN (1995): Identified 4 definitions of abnormality which extend diagnostic criteria:

1. **Statistical Infrequency**: behaviour that is not seen very often in society. (But…can include behaviours such as high IQ, & not substance abuse….)

2. **Deviation from Social Norms**: behaviour that society does not approve of. (But..cultural differences…)
3. **Failure to Function Adequately**: when a person is unable to function independently in society. EG:
- Dysfunctional behaviours (eg; OCD)
- Distressing behaviours (agoraphobia)
- Unpredictable behaviour (eg; mood swings)
- Irrational behaviour (eg; paranoia)

4. **Deviation from Ideal Mental Health**: lacking any of the following: *Jahoda (1958)*
- positive self view
- capable of personal growth
- independent
- accurate view of reality
- resistant to stress
- adaptable to environment

- **Problems** with these definitions??
Culture bias (ethnocentrism) / individual differences?
BIASES IN DIAGNOSIS

In what ways could diagnosis be biased?

• KEY STUDY: FORD & WIDIGER (1989): Sex Biases in Diagnosis of Disorders
  • Method: Self-report
  • Participants: 354 clinical psychologists (mean 15.6 years experience). Randomly selected from National Register in 1983
  • Procedure: Ps given one of 9 case histories: patients with anti-social personality disorder (ASPD) or histrionic personality disorder (HPD), or mixture of both. Diagnose each case study on 7-point scale according to disorders (eg; anti-social, narcissistic, alcohol abuse)
FORD & WIDIGER continued

• **Findings:**
  - **ASPD:** correctly diagnosed
    42% in men & only 15% in women
  - Women more likely to be incorrectly diagnosed with **HPD** (46%)
  - **HPD** correctly diagnosed in 76% females & 44% males

• **Conclusion:** Psychologists biased by stereotypical views of genders:
  - females diagnosed with **HPD**
    (excessive emotion, attention seeking, inappropriate seductiveness)
EXPLANATIONS OF DYSFUNCTIONAL BEHAVIOUR

• Three approaches:
  • BEHAVIOURAL
  • BIOLOGICAL
  • COGNITIVE
EXPLANATIONS: BEHAVIOURAL

• **Behaviourism**: dysfunctional behaviour learnt by;
  - Classical Conditioning *(Watson & Raynor, 1920)*
  - Operant Conditioning *(Skinner, 1938)*
  - Social Learning *(Bandura, 1961)*

• **KEY STUDY**: **WATSON & RAYNOR (1920): Study of Classical Conditioning (Little Albert)**
  
  • **Aim**: to see if it is possible to induce fear of previously unfearred object by CC
  
  • **Method**: Case Study (in controlled lab. conditions)
  
  • **Participant**: Little Albert; 11 months old, ‘unemotional’, no fearful reactions to rat, rabbit, monkey, coat, mask, cotton wool, but alarmed at steel bar hit by hammer (!)
WATSON & RAYNOR continued

- **Procedure**: Five sessions over several weeks:
  - **Sessions 1 & 2**: Albert presented with rat & steel bar struck. Progressively rat presented without loud noise. Albert: crying, crawling away.
  - **Sessions 3 & 4**: presented with rat, then rabbit, dog, cotton wool, & Santa mask (interspersed with toy blocks). Fear is transferred.
  - **Session 5**: One month later - tested with various stimuli. Fear response still evident.

- **Conclusion**: Fear learnt by classical conditioning
EXPLANATIONS: BIOLOGICAL

• Biological approach assumes biology (genetics, brain structure, hormones) cause dysfunctional behaviour.

• KEY STUDY: GOTTESMAN & SHIELDS (1976): Review of adoption, twin & family studies of schizophrenia:
  
  • Method: Review of adoption / twin studies (1967-76): 3 adoption studies & 5 twin studies
  
  • Participants: 711 from adoption studies & 529 from twin studies
GOTTESMAN & SHIELDS continued

- **Procedure**: Incidences of schizophrenia analysed from various studies.
  - **Adoption studies**: adoptive parents & siblings compared to biological parents & siblings.
  - **Twin studies**: concordance rates for monozygotic and dizygotic twins compared.

- **Findings**: Increased incidence of schizophrenia in adopted children with schizophrenic biological parent. (but no link between adopted schizophrenics & adoptive parents)
  - **Twin studies**: Higher concordance rates for schizophrenia in monozygotic twins (eg; 58% compared to 12% for dizygotic twins)

* **Conclusion**: Significant genetic influence - schizophrenia (but not 100%........)
EXPLANATIONS: COGNITIVE

• **The cognitive approach** assumes that dysfunctional behaviour is due to faulty processing of information (the way we attend to, perceive & store info) & this leads to distorted thinking & behaviour.

• **KEY STUDY: BECK et al (1974): Interviews with patients undergoing therapy for depression**
  
  • **Aim**: to understand cognitive distortions in patients with depression
  
  • **Method**: clinical interviews
  
  • **Participants**: 50 patients diagnosed with depression (16M, 34F, median age = 34) Middle/upper classed & average + IQ
  
  • **Design**: Independent measures: patients compared to non-depressed patients. Matched for age, sex, class.
BECK et al continued

- **Procedure:** Interviews & retrospective reports of patients’ thoughts before session (eg; from diaries), & during session. Records kept of verbalisations.

- **Findings:** Differences in thoughts of depressed patients compared to non-depressed:
  - low self-esteem, self-blame, greater anxiety, & paranoia. Stereotypical responses (Eg;……….?)
  - Distortions; automatic, involuntary & persistent

- **Conclusion:** Depressed patients have cognitive distortions that are unrealistic & illogical
TREATMENTS OF DYSFUNCTIONAL BEHAVIOUR

• What treatments are you aware of?
• How could you treat dysfunctional behaviours?
• Three Approaches:
  • BEHAVIOURAL (phobia)
  • BIOLOGICAL (depression)
  • COGNITIVE (depression)
TREATMENTS: BEHAVIOURAL

• **KEY STUDY: MCGRATH (1990):** Treatment of noise phobia

  • **Aim:** to treat noise phobia using **systematic desensitisation**
  • **Method:** case study
  • **Participant:** Lucy; 9 yrs old with fear of sudden loud noises: balloons, fireworks, party-poppers, etc.
  • **Procedure:** Series of sessions:
    - Session 1; Lucy constructed hierarchy of feared noises. Taught breathing/relaxation/imagery & ‘fear thermometer’
    - Further sessions; Lucy learnt to pair feared noise with relaxation. Progressive closer introduction to objects/noises with Lucy’s control.
Findings: Lucy able to cope with feared objects as sessions progressed.

Eg: balloons: at first, cried & distressed at balloon being burst several metres away. In 5th session was able to pop balloon herself. Similar findings with party poppers & cap gun.

Fear thermometer scores decreased:
Balloons - 7/10 to 3/10
party-poppers - 9/10 to 3/10

Conclusion: systematic desensitisation successful treatment for noise phobia. Important factors: control, fear inhibitors (relaxation, breathing, etc)
TREATMENTS: BIOLOGICAL

• KEY STUDY: **KARP & FRANK (1995):** Combination therapy & depressed women

• **Aim:** to compare drug treatment & non-drug treatment for depression

• **Method:** Review article of previous research*

• **Participants:** focused on women (various)

• **Procedure:** depression analysed using variety of depression inventories / assessment of symptoms by health professionals

• **Findings:** Most studies found adding psych. treatments to drug therapy did not improve effectiveness. Some research; less attrition with combined therapy

• **Conclusion:** No enhanced outcomes with combined therapy compared to drug only.
TREATMENTS: COGNITIVE

• One type of Cognitive Therapy: Rational Emotive Therapy (RET) Ellis (1991)
• Ellis identified ABC’s of RET:
  • A’s: Activating events that contribute to dysfunction (eg; failing exam)
  • B’s: Beliefs arising from events (eg; ‘I’m stupid”)
  • C’s: Consequences of faulty or illogical beliefs (eg; depression, anxiety, etc)

• Various studies show effectiveness of therapy (eg; Ellis, 1955)
• However, not suitable for all individuals or all disorders
Rational Emotive Therapy
Albert Ellis

How changing one’s thinking can help to overcome emotional problems –
As you think, so you feel.
Starter Activity: Beliefs

• Go through the handout and indicate agree / disagree next to each statement

• Count up - How many of these beliefs do you agree with?
• How many do you disagree with?
• What do you think about these statements?
Sample self-beliefs underlying undesirable emotions and behaviour – How could you change these beliefs?

• I need love and approval from those significant to me – and I must avoid disapproval from any source.
• To be worthwhile as a person I must achieve, succeed at whatever I do, and make no mistakes.
• I shouldn’t have to feel discomfort and pain – I can’t stand them and must avoid them at all costs.
• Every problem should have an ideal solution – and it’s intolerable when one can’t be found.
• Things must be the way I want them to be, otherwise life will be intolerable.
• My unhappiness is caused by things that are outside my control – so there is little I can do to feel any better.
Key Assumptions of The Cognitive Perspective

• Individuals who suffer from mental disorders have distorted and irrational thinking – which may cause maladaptive behaviour.

• It is the way you think about the problem rather than the problem itself which causes the mental disorder.

• Individuals can overcome mental disorders by learning to use more appropriate cognitions.

• Aim – to be positive and rational.
What are irrational self defeating beliefs?

• They distort reality: *awfulising, can’t-stand-it-itis, demanding* and *people-rating*;

• They block you from achieving your goals and purposes;

• They create extreme emotions which persist, and which distress and immobilise; and

• They lead to behaviours that harm yourself, others, and your life in general.
Dysfunctional thinking

- **Awfulising**: using words like 'awful', 'terrible', 'horrible', 'catastrophic' to describe something - e.g. 'It would be terrible if …', 'It’s the worst thing that could happen', 'That would be the end of the world'.

- **Cant-stand-it-itis**: viewing an event or experience as unbearable - e.g. 'I can’t stand it’, 'It’s absolutely unbearable’, I’ll die if I get rejected’.

- **Demanding**: using 'shoulds' or 'musts’ - e.g. 'I should not have done that, 'I must not fail', 'I need to be loved’, 'I have to have a drink’.

- **People-rating**: labelling or rating your self (or someone else) - e.g. 'I’m stupid /hopeless /useless /worthless.’
Rational thinking = *Realistic thinking*

- It is **based on reality** - it emphasises seeing things as they really are, seeing things in perspective,
- It **helps you achieve your goals** and purposes,
- It **creates realistic emotions** that you can handle,
- It helps you **behave positively** in ways which promote your aims and survival.
The ABC’s of feelings & behaviours

• American psychologist Albert Ellis is the originator of Rational Emotive Therapy. He developed the ABC model to demonstrate this:
  • (‘A’) refers to whatever started things off: a circumstance, event or experience - or just thinking about something which has happened.
  • This triggers off thoughts (‘B’), which in turn create
  • a reaction - feelings and behaviours - (‘C’).
Ellis (1955): The ABC model (RET)

A: Activating event
Alex receives a very poor mark for his psychology essay

B: beliefs about A
rational beliefs
Alex tells himself that he did not really spend enough time on researching, planning and writing the essay, as he has been too busy working on his part in the Sixth form play.

irrational beliefs
Alex believes that the essay grade shows that he is not really any good at psychology, and should think about giving up the course. There is no reason why he should do any better next time.

C: Consequences of B
desirable emotions
Alex is disappointed with his grade.

undesirable emotions
Alex feels he is no good at psychology.

desirable behaviour
He decides to spend more time on psychology assignments once the play is over, and in the meantime put time aside for psychology to make sure he keeps up with new work.

undesirable behaviour
He decides to give up psychology
ABC Activity

• Read the handout scenarios, identify the irrational beliefs and fill in an alternative way of thinking, feeling and behaving.
• Make up an ABC scenario of your own.
COGNITIVE TREATMENTS:
KEY STUDY: Beck et al (1978); Comparing Pharmacotherapy & cognitive therapy

- **Aim:** Compare effectiveness of cognitive therapy & drug therapy
- **Method:** controlled experiment (using self-reports)
- **Participants:** 44 patients diagnosed with depression
- **Procedure:** Patients assessed with 3 self-reports before & after treatment:
  - Beck Depression Inventory
  - Hamilton Rating scale
  - Rasking Scale

Two conditions: 12 weeks of cognitive therapy sessions twice a week, or 100 Imipramine capsules from doctor (20 mins each week). Observations
Beck et al (1978) continued

**Findings:** Both groups significant decrease in depression symptoms on all 3 scales

- Cognitive therapy group - greater improvements on self-reports & observer ratings (79% compared to 20%)

**Drop-out rate:** 5% on cognitive group & 32% on drug treatment

**Conclusions:** Cognitive therapy is better treatment for depression
  - Fewer symptoms
  - Better adherence