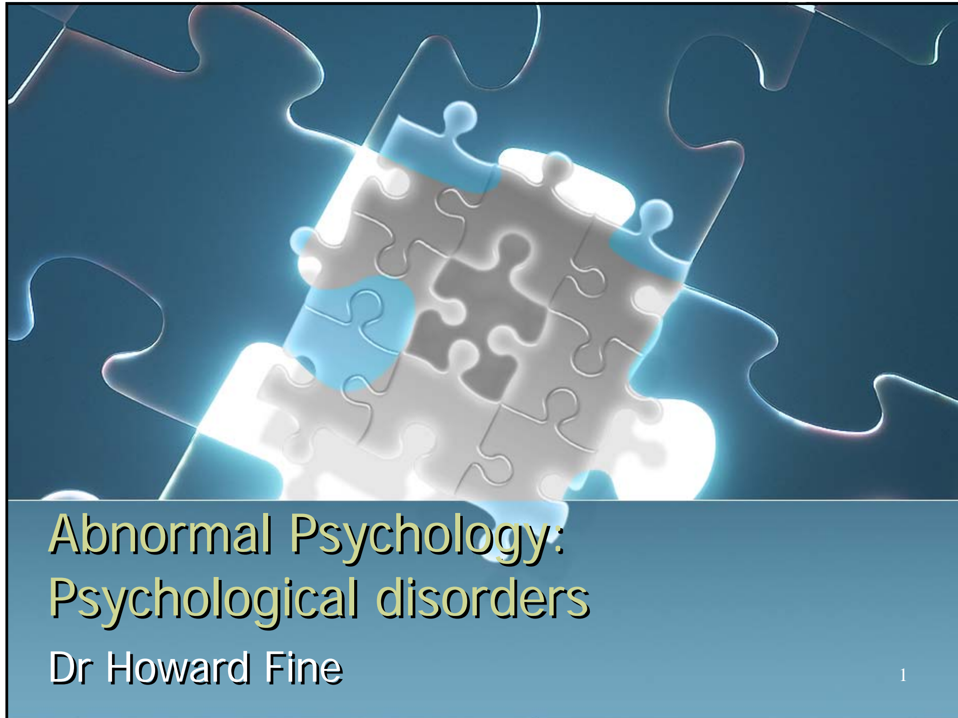
Abnormal Psychology:
Psychological disorders
Dr Howard Fine
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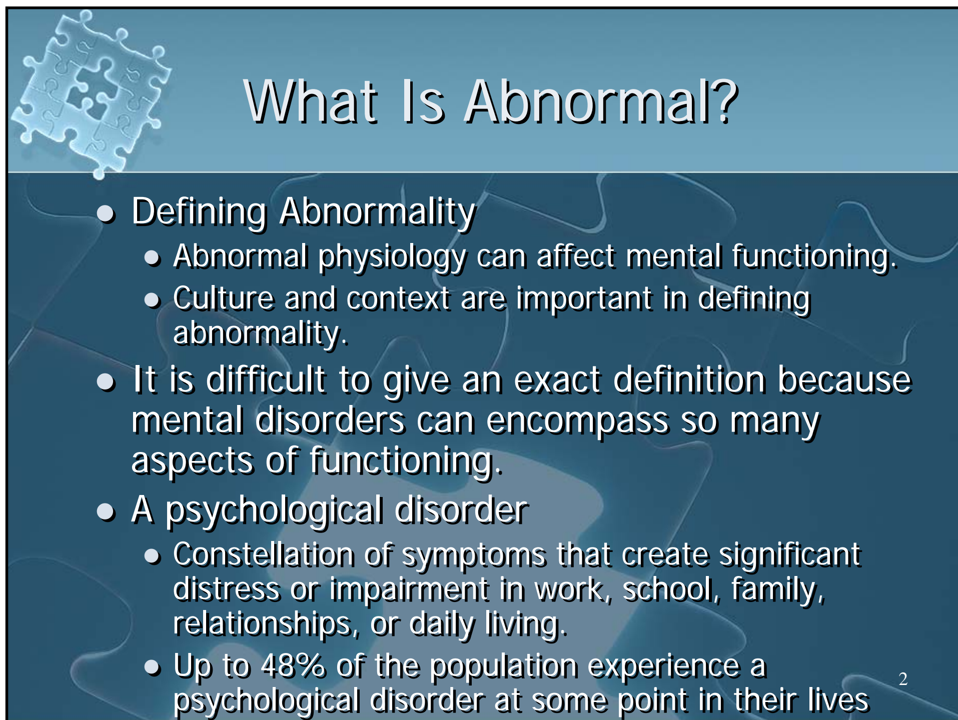
What Is Abnormal?
Defining Abnormality
Abnormal physiology can affect mental functioning.
Culture and context are important in defining abnormality.
It is difficult to give an exact definition because mental disorders can encompass so many aspects of functioning.
A psychological disorder
Constellation of symptoms that create significant distress or impairment in work, school, family, relationships, or daily living.
Up to 48% of the population experience a psychological disorder at some point in their lives
2

Psychological Disorders

A pattern of behavioral and psychological symptoms that causes significant personal distress, impairs the ability to function in one or more important areas of daily life, or both.

3

"Harmful Dysfunction" Jerome Wakefield, 1999

- A condition is a mental disorder only if:
  - The condition results from the failure of some internal mechanism to perform its natural function
  - The condition causes harm to the person as judged by the standards of that person's culture
  - "Only dysfunctions that are socially disvalued are disorders"

4

How often does abnormal behaviour occur? (More definitions)

- Epidemiology- study of the frequency and distribution of disorders within a population
- Comorbidity- more than one condition

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Prevalence

- The total number of *active* cases (old and new) present in the population at a given time
- This includes people who were diagnosed for the first time as well as people who have had the disorder for a longer period of time.
- For example: People diagnosed with depression this year + people who were diagnosed earlier but are still depressed

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Prevalence

- Approximately 48% of adults experienced symptoms at least once in their lives
- Approximately 80% who experienced symptoms in the last year did NOT seek treatment
- Most people seem to deal with symptoms without complete debilitation
- Women have higher prevalence of depression and anxiety
- Men have higher prevalence of substance abuse and antisocial personality disorder

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Lifetime Prevalence Rates of Selected Disorders (Kessler 1994)

- Anxiety Disorders 24.9%
- Mood Disorders 19.3%
- Schizophrenia & related disorders 0.7%
- Antisocial Personality 3.5%
- Substance Abuse 26.6%

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Defining Abnormality

- Abnormality is distinct from insanity, can be defined by events at the levels of the brain, by biological or structural abnormalities; of the person, by objective behaviours and subjective distress; and of the group, in which abnormality is defined by the culture and the context of the behaviours.
- Obvious symptoms of abnormality
  - Psychosis
    - Obvious impairment in ability to perceive and comprehend events accurately; Gross disorganization of behaviour
  - Hallucinations - Mental images so vivid they seem real
  - Delusions - Enriched false beliefs that are often bizarre
- Not so obvious
  - Depression / Anxiety / Repetitive thoughts/behaviours

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Explaining Abnormality

- In ancient Greece, Hippocrates attributed mental illness to imbalances in 4 fluids.
- In the Middle Ages and up through 17th century New England, mental illness was attributed to demonic possession or other work of the devil.
- In the early and middle 20th century, Freud's psychodynamic model was the standard for understanding abnormality.

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Explaining Abnormality

- Many Psychologists embrace the *biopsychosocial model*, focusing on the levels of the brain, the person, and the group.
- The level of the brain
  - The diathesis-stress model explains psychological disorders (that certain biological factors make some individuals more vulnerable to developing particular disorders) are then triggered by stressors.
  - Underlying biological vulnerability + stressor = Disorder
    - Schizophrenia, anxiety, alcoholism, depression

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Explaining Abnormality

- The level of the person
  - Classical & operant conditioning, observational learning, and cognitions play a role in psychological disorders.
- The level of the group
  - In the 1960s, Szasz argued that mental illness is a myth, and reflects a label that is applied to social nonconformists
    - Noted that mental illnesses are labels we attach to social nonconformists as a way of punishing and stigmatizing nonconformity.
- Cultures differ in what they consider abnormal
  - Since diagnoses involves making judgments, errors do occur.
  - Homosexuality was 'abnormal' according the DSM-III
- Events at all three levels, and their interactions, must be considered when trying to understand psychological disorders.

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Categorizing Disorders

- Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000)
  - Provides a common language to label disorders
  - Comprehensive guidelines to help diagnose disorders
- The first edition of the *DSM* published by the American Psychiatric Association in 1952, based on psychodynamic theory.
- The *DSM-IV* (1994) avoids relying a single theory.
- The *DSM-IV* has 5 axes for categorizing disorders
  - An appendix outlines cultural factors to be considered in diagnosis.
- It defines 17 categories of problems and almost 300 mental disorders

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Categorizing Disorders

- It has been criticized on several grounds:
  - It has introduced categories that define medical problems as psychological disorders.
  - It does not provide boundaries for separating normality & abnormality.
  - Many of the disorders are not clearly distinct from each other.
  - It is the predominant means of categorizing disorders in the United States, but may or may not work well in other countries

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DSM

- Axis I: Clinical Disorders
  - Consider more short-term or treatable(?)
  - Depression, ADHD, Anxiety
- Axis II: Personality Disorders and Mental Retardation
  - Longer lasting clinical disorders, more difficult to treat
- Axis III: General Medical Conditions
  - Head injury or substance use
- Axis IV: Psychosocial and environmental problems.
  - Divorce, family loss
- Axis V: Global Assessment of Functioning
  - 0-100 rating of how well person is doing

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Psychiatric Disorders

- Are placed on Axis I and Axis II
  - Impairment in functioning at work, in school, in relationships, or in daily living is necessary to merit a diagnosis of a disorder.
  - Personality disorders reflect relatively stable personality traits that have become inflexible and maladaptive, causing distress or difficulty with daily functioning in school, work, and other social spheres.

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Axis I and II Disorders

- Axis I
  - Disorders evident in childhood
  - Cognitive disorders
  - Substance Abuse
  - Schizophrenia
  - Mood disorder
  - Anxiety Disorders
  - Dissociative Disorder

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Axis I & II Disorders

- Sexual Disorders:
  - Sexual identity (transexualism), paedophilia
- Eating Disorders
  - Anorexia, Bulimia, BED
- Sleep Disorders
- Factitious Disorders
  - Malingering
  - Munchhausen's syndrome
- Impulse control disorders
  - Gambling, kleptomania
- Adjustment Disorders
  - Marital problems, child-parent relationship problems

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Axis I & II Disorders

- **Axis II**
  - **Personality Disorders:**
    - **Long-standing maladaptive patterns of behaviour that are immature &/or inappropriate ways of coping with stress or solving problems**

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10 Axis II personality disorders

- **Antisocial personality disorder** - a pattern of disregard/violation of the rights of others.
- **Avoidant personality disorder** - a pattern of social discomfort, feelings of inadequacy, and hypersensitivity to negative evaluation.
- **Borderline personality disorder** - a pattern of instability in self-image, feelings, and relationships and pronounced impulsivity.
- **Dependent personality disorder** - a pattern of clingy, submissive behaviour due to an extreme need to be taken care of.
- **Histrionic personality disorder** - a pattern of excessive attention seeking and expression of emotion.

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Personality Disorders cont..

- **Narcissistic personality disorder** - an exaggerated sense of self-importance, need for admiration, and lack of empathy.
- **Obsessive-compulsive personality disorder** - a pattern of preoccupation with perfectionism and control.
- **Paranoid personality disorder** - a pattern of suspiciousness and distrust of others.
- **Schizoid personality disorder** - a pattern of detachment from social relationships and a narrow range of displayed emotions.
- **Schizotypal personality disorder** – a pattern of extreme discomfort in close relationships, odd behaviour, and cognitive/perceptual distortions.

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Anxiety Disorders

- Primary disturbance is distressing, persistent anxiety or maladaptive behaviors that reduce anxiety
- Characterized by intense and pervasive anxiety and fear, and/or extreme efforts to avoid these feelings.
- The anxiety disorders include
  - panic disorder (with or without agoraphobia), specific and social phobias, posttraumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD).

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Generalized Anxiety Disorder (GAD)

- More or less constant worry about many issues
- The worry seriously interferes with functioning
- Physical symptoms
  - headaches
  - stomach aches
  - muscle tension
  - irritability

Model of Development of GAD

- GAD has some genetic component
- Related genetically to major depression
- Childhood trauma also related to GAD

Genetic predisposition or childhood trauma → Hypervigilance → GAD following life change or major event

Panic Disorders

- Panic disorder is characterized by repeated panic attacks.
  - Sudden episode of helpless terror with high physiological arousal
  - People with this disorder constantly fear having more attacks.
  - They may start avoiding places associated with past attacks, leading to agoraphobia.

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Panic Disorders

- Brain:
  - People who develop this disorder may be born with a biological vulnerability involving oversensitivity of the locus coeruleus (a biological "alarm system").
  - They may also be more sensitive to high carbon dioxide levels (caused from hyperventilation).
- Personal Factors:
  - Many sufferers have *anxiety oversensitivity* that may increase sympathetic nervous system activity, leading to panic.
  - They may become hypervigilant for signals that have led to panic in the past.
  - while most sufferers reported a stressful event prior to the onset of the disorder, it did not predict the severity of duration of the disorder

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Cognitive-behavioral Theory of Panic Disorder

- Sufferers tend to misinterpret the physical signs of arousal as catastrophic and dangerous
- This interpretation leads to further physical arousal, tending toward a vicious cycle
- After the attack the person is very apprehensive of another attack

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Phobias

- **Phobias** an intense, irrational fear and avoidance of objects or situations extreme enough to interfere with everyday life.
- At the level of the brain:
  - Phobias have a genetic component that results in hyperactivity of the amygdala and other fear-related brain structures.
  - Humans appear to be biologically prepared to develop phobias about certain stimuli (such as snakes) and not others (such as teddy bears).
  - Classical and operant conditioning may be involved in learning many specific phobias.

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Some Unusual Phobias

- Ailurophobia—fear of cats
- Algobphobia—fear of pain
- Anthropophobia—fear of men
- Monophobia—fear of being alone
- Pyrophobia—fear of fire

Phobias

- **Social phobias** involve fear of public humiliation or embarrassment and the ensuing avoidance of situations likely to arouse this fear.
  - public speaking (stage fright)
  - fear of crowds, strangers
  - meeting new people
  - eating in public
- Considered phobic if these fears interfere with normal behaviour
- About 13% of the population experience social phobias.
- Equally often in males and females

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Specific Phobias

- Involve persistent and excessive or unreasonable fears triggered by a specific object or situation, along with attempts to avoid the feared stimulus.

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PTSD

- Experienced by some people after a traumatic event. Characterized by unwanted re-experiencing of the trauma, avoidance, and heightened arousal.
- Three conditions must be met for diagnosis:
  - The person experiences or witnesses an event that involves actual or threatened serious injury or death.
  - The traumatized person responds to the situation with fear and helplessness.
  - The traumatized person experiences three sets of symptoms:
    - Persistent re-experiencing of the traumatic event
    - Persistent avoidance of anything associated with the trauma, and a general emotional numbing
    - Heightened arousal.

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PTSD

- Symptoms may not appear immediately, but may last for months or years, once they do appear.
- Most people who experience a traumatic event do not develop PTSD.
- Women were more likely to develop PTSD when their traumas resulted from crimes rather than natural disasters.

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PTSD

- **Brain** - Some people may be biologically predisposed to develop the disorder because of hypersensitivity of the locus coeruleus and easy activation of the limbic system by imagery of the traumatic event.
- **Person** - Risk is increased by a history of depression, social withdrawal, and lack of control of stressors.
- **Group** - Risk is decreased by support from family, friends, or counselors.

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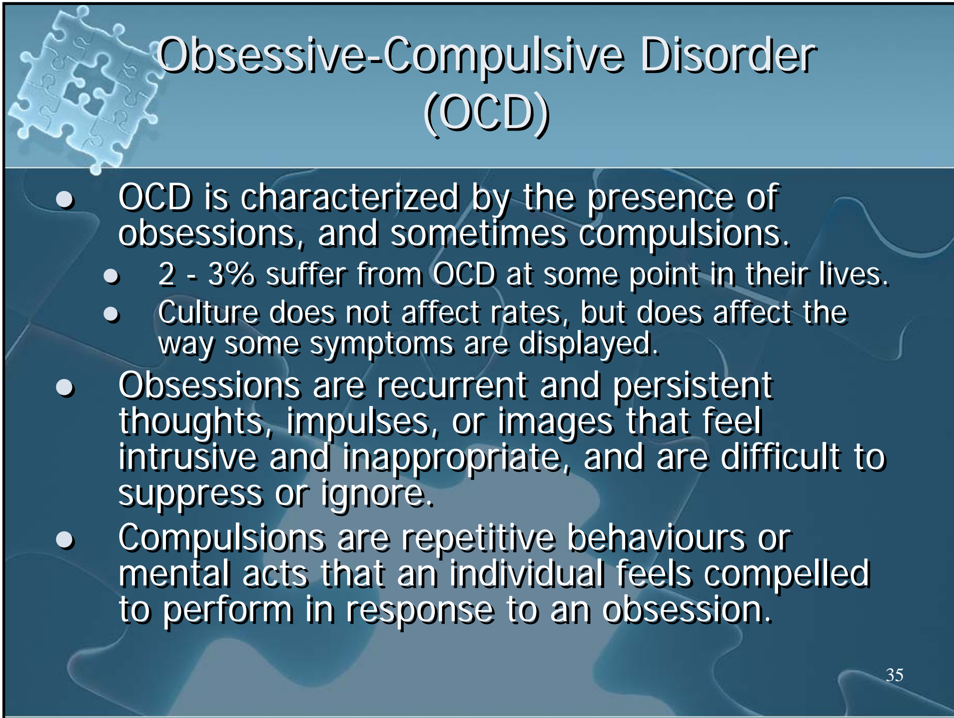
Obsessive-Compulsive Disorder (OCD)
OCD is characterized by the presence of obsessions, and sometimes compulsions.
2 - 3% suffer from OCD at some point in their lives.
Culture does not affect rates, but does affect the way some symptoms are displayed.
Obsessions are recurrent and persistent thoughts, impulses, or images that feel intrusive and inappropriate, and are difficult to suppress or ignore.
Compulsions are repetitive behaviours or mental acts that an individual feels compelled to perform in response to an obsession.
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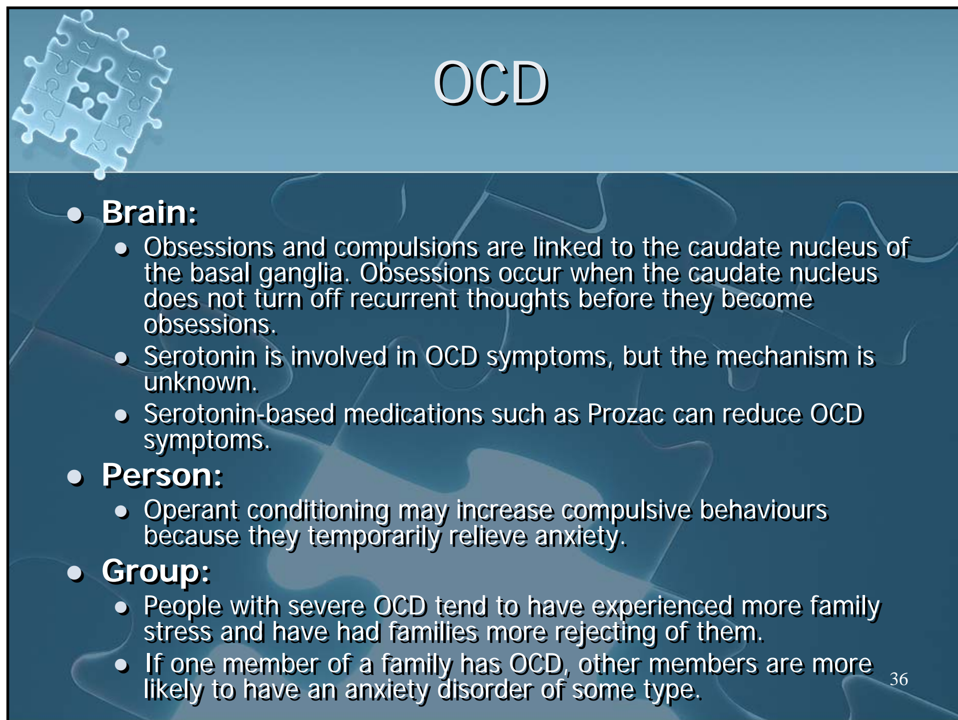
OCD
Brain:
Obsessions and compulsions are linked to the caudate nucleus of the basal ganglia. Obsessions occur when the caudate nucleus does not turn off recurrent thoughts before they become obsessions.
Serotonin is involved in OCD symptoms, but the mechanism is unknown.
Serotonin-based medications such as Prozac can reduce OCD symptoms.
Person:
Operant conditioning may increase compulsive behaviours because they temporarily relieve anxiety.
Group:
People with severe OCD tend to have experienced more family stress and have had families more rejecting of them.
If one member of a family has OCD, other members are more likely to have an anxiety disorder of some type.
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Mood Disorders

- Mood disorders are marked by persistent or episodic disturbances in affect that interfere with normal functioning in at least one realm of life.
- A category of mental disorders in which significant and chronic disruption in mood is the predominant symptom, causing impaired cognitive, behavioural, and physical functioning
  - Major depressive disorder (MDD) is characterized by at least 2 weeks of depressed mood or loss of interest in nearly all activities, along with sleep or eating disturbances, loss of energy, and feelings of hopelessness.

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Symptoms of Major Depression

- Emotional—sadness, hopelessness, guilt, turning away from others
- Behavioural—tearfulness, dejected facial expression, loss of interest in normal activities, slowed movements and gestures, withdrawal from social activities
- Cognitive—difficulty thinking and concentrating, global negativity, preoccupation with death/suicide
- Physical—appetite and weight changes, excess or diminished sleep, loss of energy, global anxiety, restlessness

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Emotional symptoms

- Feelings of sadness, hopelessness, helplessness, guilt, emptiness, or worthlessness
- Feeling emotionally disconnected from others
- Turning away from other people

Cognitive symptoms

- Difficulty thinking, concentrating, and remembering
- Global negativity and essimism
- Suicidal thoughts or preoccupation with death

Behavioral symptoms

- Dejected facial expression
- Makes less eye contact; eyes downcast
- Smiles less often
- Slowed movements, speech, and gestures
- Tearfulness or spontaneous episodes of crying
- Loss of interest or pleasure in usual activities, including sex
- Withdrawal from social activities

Physical symptoms

- Changes in appetite resulting in significant weight loss or gain
- Insomnia, early morning awakening or oversleeping
- Vague but chronic aches and pains
- Diminished sexual interest
- Loss of physical and mental energy
- Global feelings of anxiety
- Restlessness, fidgety activity

Dysthymic Disorder

- Chronic, low-grade depressed feelings that are not severe enough to be major depression
- May develop in response to trauma, but does not decrease with time
- Can have co-existing major depression

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Seasonal Affective Disorder

- Cyclic severe depression and elevated mood
- Seasonal regularity
- Unique cluster of symptoms
  - intense hunger
  - gain weight in winter
  - sleep more than usual
  - depressed more in evening than morning

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Prevalence and Course

- Most common of psychological disorders
- Women are twice as likely as men to be diagnosed with major depression
- Untreated episodes can become recurring and more serious
- Seasonal affective disorder (SAD)—onset with changing seasons

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Bipolar Disorders

- Cyclic disorder (manic-depressive disorder)
- Mood levels swing from severe depression to extreme euphoria (mania)
- No regular relationship to time of year
- Must have at least one manic episode
  - Supreme self-confidence
  - Grandiose ideas and movements
  - Flight of ideas

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Prevalence and Course

- Onset usually in young adulthood (early twenties)
- Mood changes more abrupt than in major depression
- No sex differences
- Commonly recurs every few years
- Can often be controlled by medication (lithium)

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Explaining mood disorders

- There is evidence of genetic involvement in mood disorders:
  - The neurotransmitters serotonin, norepinephrine, and dopamine are involved in depression.
  - Unipolar Depression
    - Lower brain activity in an area of the frontal lobe directly connected to brain areas involved in emotion
      - less left activity or increased right
  - Bipolar Depression
    - Enlarged amygdala
    - There are shifts in temporal lobe activity during manic episodes that are not present in other mood states.
    - If one twin has bipolar disorder, the other twin has an 80% chance of developing some type of mood disorder.

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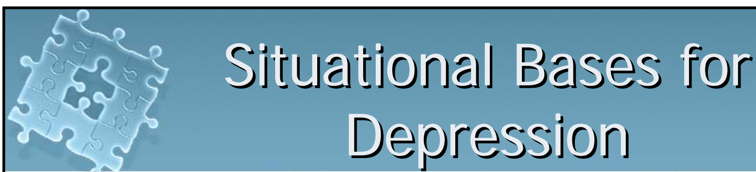

Situational Bases for Depression

- Positive correlation between stressful life events and onset of depression
  - Does life stress cause depression?
- Culture can play a role in facilitating depression, particularly among Western women.
- Most depressogenic life events are losses
  - spouse or companion
  - long-term job
  - health
  - income

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Cognitive Bases for Depression

- A.T. Beck: depressed people hold pessimistic views of
  - themselves
  - the world
  - the future
- Depressed people distort their experiences in negative ways
  - exaggerate bad experiences
  - minimize good experiences

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Cognitive Bases for Depression

- Hopelessness theory
  - depression results from a pattern of thinking
  - person loses hope that life will get better
  - negative experiences are due to stable, global reasons
    - e.g., "I didn't get the job because I'm stupid and inept" vs. "I didn't get the job because the interview didn't go well"

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What is Schizophrenia?

- Comes from Greek meaning "split" and "mind"
  - 'split' refers to loss of touch with reality
  - not dissociative state
  - not 'split personality'
- Equally split between genders, males have earlier onset
  - 18 to 25 for men
  - 26 to 45 for women

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Symptoms of Schizophrenia

- Delusions of persecution
  - 'they're out to get me'
  - paranoia
- Delusions of grandeur
  - "God" complex
- Delusions of being controlled
  - MI6 is controlling my brain with a radio signal

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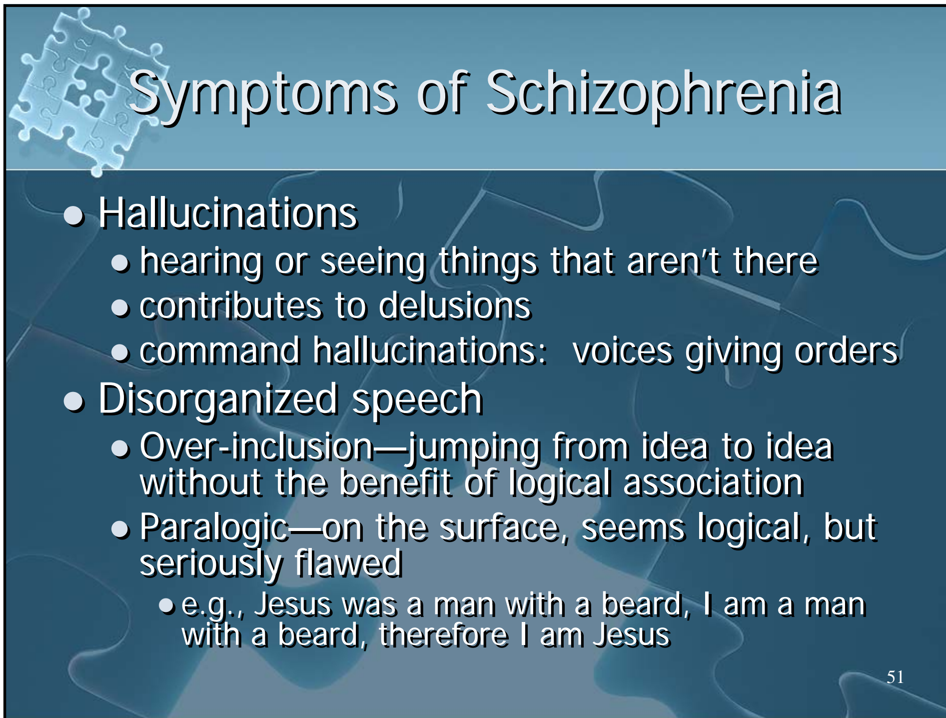
Symptoms of Schizophrenia
Hallucinations
hearing or seeing things that aren't there
contributes to delusions
command hallucinations: voices giving orders
Disorganized speech
Over-inclusion—jumping from idea to idea without the benefit of logical association
Paralogic—on the surface, seems logical, but seriously flawed
e.g., Jesus was a man with a beard, I am a man with a beard, therefore I am Jesus
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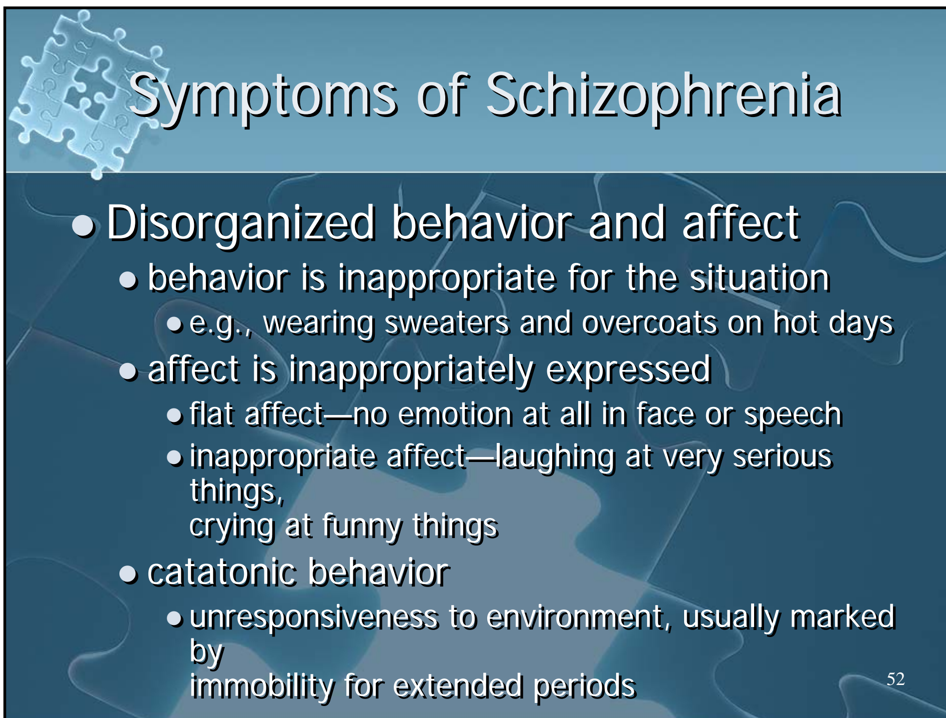
Symptoms of Schizophrenia
Disorganized behavior and affect
behavior is inappropriate for the situation
e.g., wearing sweaters and overcoats on hot days
affect is inappropriately expressed
flat affect—no emotion at all in face or speech
inappropriate affect—laughing at very serious things,
crying at funny things
catatonic behavior
unresponsiveness to environment, usually marked by
immobility for extended periods
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Schizophrenia

- Symptoms of schizophrenia: Usually divided into positive symptoms and negative symptoms.
  - Positive symptoms include
    - hallucinations, delusions, disorganized behaviour, and disorganized speech.
    - Positive symptoms usually respond to antipsychotic medication.
    - Thought to be result of dopamine dysfunction
    - Those that only show positive symptoms are called Type 1
      - show periods of clarity, tended to have normal functioning before

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Schizophrenia

- Negative symptoms include
  - flat affect: don't show emotions, blunted emotional response
  - Alogia: poverty of speech
  - Avolition: lack of goal directed behaviour
  - Impaired attention, social isolation.
  - Unresponsive to anti-psychotic medication
  - Believed to be due to structural brain abnormalities
  - Those that only show negative symptoms tend to have poorer social and educational functioning before episode

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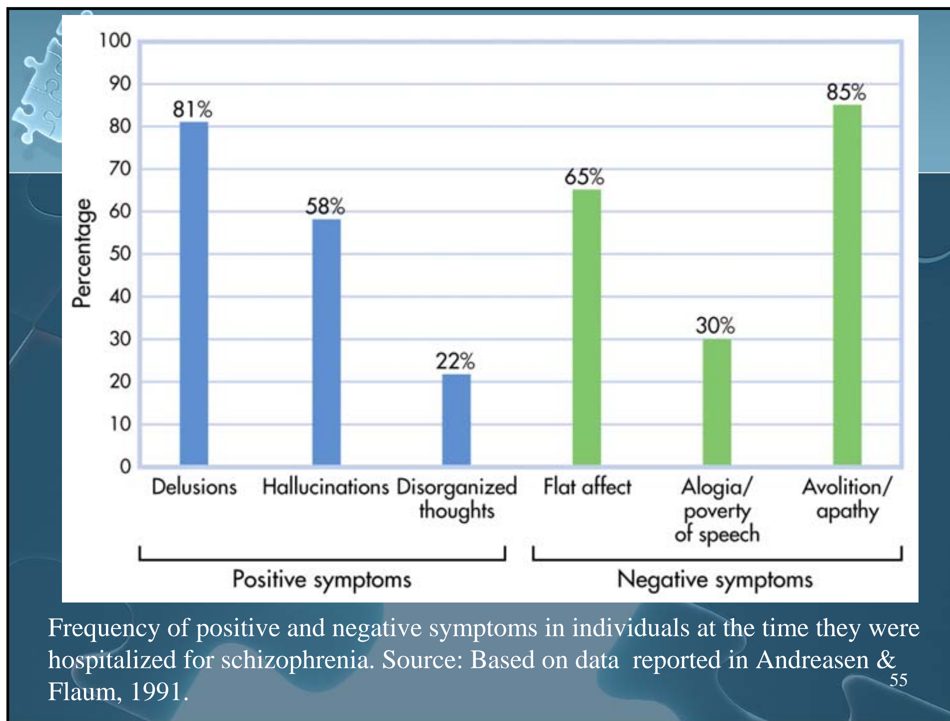

Frequency of positive and negative symptoms in individuals at the time they were hospitalized for schizophrenia. Source: Based on data reported in Andreasen & Flaum, 1991.

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Subtypes of Schizophrenia

- Paranoid type
  - delusions of persecution
    - believes others are spying and plotting
  - delusions of grandeur
    - believes others are jealous, inferior, subservient
- Catatonic type—unresponsive to surroundings, purposeless movement, parrot-like speech
- Disorganized type
  - delusions and hallucinations with little meaning
  - disorganized speech, behaviour, and flat affect

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Causes of schizophrenia

- Schizophrenia has a 1% occurrence rate worldwide, but recovery rates are lower in Western nations.
- Brain factors:
  - Genetic factors are clearly involved in the development of schizophrenia.
  - Having relatives with schizophrenia increase the risk of developing It
    - As well as had father hospitalized for psychological disorders

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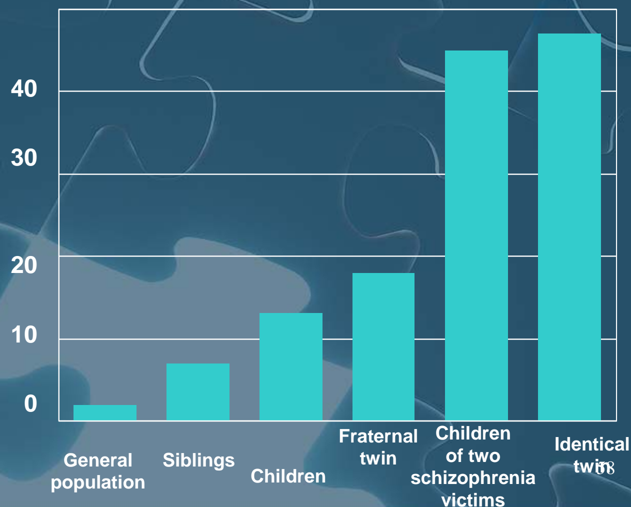
Schizophrenia and Genetics

Risk increases with genetic similarity

Lifetime risk of developing schizophrenia for relatives of a schizophrenic



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Biological Bases of Schizophrenia

- Other congenital influences
  - difficult birth (e.g., oxygen deprivation)
  - prenatal viral infection
- Brain chemistry
  - neurotransmitter excesses or deficits
  - dopamine theory

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Other Biological Factors

- Brain structure and function
  - enlarged cerebral ventricles and reduced neural tissue around the ventricles
  - PET scans show reduced frontal lobe activity
- Early warning signs
  - nothing very reliable has been found yet
  - certain attention deficits can be found in children who are at risk for the disorder
- Father's age—older men are at higher risk for fathering a child with schizophrenia

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The Dopamine Theory

- Drugs that reduce dopamine reduce symptoms
- Drugs that increase dopamine produce symptoms even in people without the disorder
- Theory: Schizophrenia is caused by excess dopamine
- Dopamine theory not enough; other neurotransmitters involved as well

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SCHIZOPHRENIA

- CAT & MRI SCANS:
  - Structural abnormality
    - Abnormalities in structures involved in thinking, concentration, memory and perception
      - Frontal and Temporal lobes, hippocampus.
- PET SCANS:
  - Abnormalities in structures involved in thinking/concentration and memory
    - Show reduced metabolism in frontal lobes

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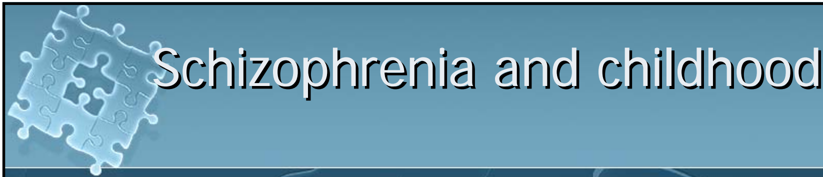

Schizophrenia and childhood

- As children:
  - Exhibit fewer expressions of joy
  - More likely to show inappropriate behaviour at school
  - Have less impulse control and more likely to be socially isolated
- May show an atypical pattern of infant development involving lags and spurts (more extreme than expected) in maturation of visual and motor abilities.

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Schizophrenia and the family

- Family and social influences :
  - Emotional expression in the family can affect the likelihood of a recurrence of schizophrenic episodes (high expressed emotion increases risk)
  - Higher expressed emotion in family, the higher the risk for relapse and more meds required to treat disorder.
  - Parental communication that is disorganized, hard-to-follow, or highly emotional
  - Expressed emotion
    - highly critical, over-enmeshed families
  - More likely to have been removed from mom at early age
    - Why?

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Cultural Differences in Schizophrenia

- Prevalence of symptoms is similar no matter what the culture
- Less industrialized countries have better rates of recovery than industrialized countries
  - families tend to be less critical of the patients
  - less use of antipsychotic medications, which may impair full recovery
  - think of it as transient, rather than chronic and lasting disorder

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Summary of Schizophrenia

- Many biological factors seem involved
  - heredity
  - neurotransmitters
  - brain structure abnormalities
- Family and cultural factors also important
- Combined model of schizophrenia
  - biological predisposition combined with psychosocial stressors leads to disorder
  - Is schizophrenia the maladaptive coping behavior of a biologically vulnerable person?

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Dissociative Disorders

- What is dissociation?
  - literally a dis-association of memory
  - person suddenly becomes unaware of some aspect of their identity or history
  - unable to recall except under special circumstances (e.g., hypnosis)
- Three types are recognized
  - dissociative amnesia
  - dissociative fugue
  - dissociative identity disorder

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Dissociative Amnesia

- Margie and her brother were recently victims of a robbery. Margie was not injured, but her brother was killed when he resisted the robbers. Margie was unable to recall any details from the time of the accident until four days later.

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Dissociative Amnesia

- Also known as psychogenic amnesia
- Memory loss the only symptom
- Often selective loss surrounding traumatic events
  - person still knows identity and most of their past
- Can also be global
  - loss of identity without replacement with a new one

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Dissociative Fugue

- Thom, a school physics teacher from London, disappeared three days after his wife unexpectedly left him. Six months later, he was discovered tending bar in Manchester. Calling himself Martin, he claimed to have no recollection of his past life and insisted that he had never been married.

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Dissociative Fugue

- Also known as psychogenic fugue
- Global amnesia with identity replacement
  - leaves home
  - develops a new identity
  - apparently no recollection of former life
  - called a 'fugue state'
- If fugue wears off
  - old identity recovers
  - new identity is totally forgotten

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Dissociative Identity Disorder (DID)

Norma has frequent memory gaps and cannot account for her whereabouts during certain periods of time. While being interviewed by a Clinical Psychologist, she began speaking in a childlike voice. She claimed that her name was Donna and that she was only six years old. Moments later, she seemed to revert to her adult voice and had no recollection of speaking in a childlike voice or claiming that her name was Donna.

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Dissociative Identity Disorder

- Originally known as “multiple personality disorder”
  - 2 or more distinct personalities manifested by the same person at different times
  - VERY rare and controversial disorder
- Most sufferers experienced severe and repeated physical or sexual abuse as young children.
  - Sufferers may dissociate as a defence against the abuse.
- Most sufferers have very high hypnotizability and dissociative capacity.
- Some researcher believe DID is nothing more than elaborate role-playing, others believe it is a subtype of PTSD

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Causes of Dissociative Disorders?

- Repeated, severe sexual or physical abuse
- However, many abused people do not develop DID
- Combine abuse with biological predisposition toward dissociation?
  - people with DID are easier to hypnotize than others
  - may begin as series of hypnotic trances to cope with abusive situations

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The DID Controversy

- Some curious statistics
  - 1930–60: 2 cases per decade in USA
  - 1980s: 20,000 cases reported
  - many more cases in US than elsewhere
  - varies by therapist—some see none, others see a lot
- Is DID the result of suggestion by therapist and acting by patient?

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Practice Questions

1. Discuss the usefulness of the concept of 'abnormality' in psychology.
2. 'Depression is largely caused by social factors'. Discuss.
3. 'Schizophrenia is a multi-faceted group of disorders and thus requires multi-faceted approaches to treatment. Discuss.
4. Discuss some of the applications of behaviour therapy to the treatment of anxiety disorders.
5. 'Those who were abused as children are significantly more likely to experience mental health problems in adult life'. Discuss.
6. 'To what extent do life events play a part in the development of mental illness?
7. When is the compulsory treatment of mentally ill people justified?

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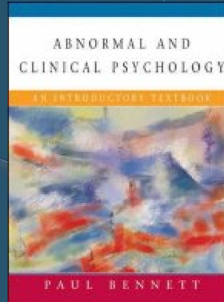
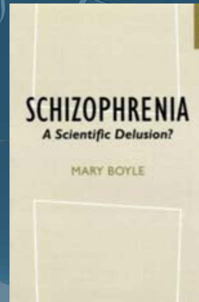
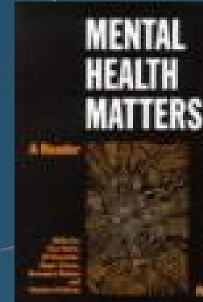
Useful resources







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