

# Basics of Clinical Psychology

## Aims and Objectives

- What is Clinical Psychology?
- Classification
  - Why do we classify mental disorders?
  - How do we classify mental disorders?
  - Issues of classification
- Approaches to clinical psychology
  - Psychodynamic
  - Medical
  - Behavioural
  - Cognitive

## Introduction

Within this lecture theatre (containing about 100 people), there are approximately:

- 1-3 people who suffer persistent panic attacks.
- 3-4 people who have/will have GAD in a given 6-month period.
- 2-3 people who have/will have OCD (Robins *et al.*, 1984)
- 12% of males and 20% of females with a lifetime risk of depression (which may be short-lived or develop to chronic levels).
- 30-40% of males and 15% of females who will suffer from some kind of orgasmic disorder.

The incidence of psychological disorders is relatively high. This handout introduces clinical psychology — the application of scientific psychology to the understanding and resolution of human psychological problems. We'll look at ways in which mental disorders can be classified and the issues that are raised by classifying people. Finally we'll overview the major historical approaches to psychopathology.

## Classifying Psychological Disorders

Classification is a system by which entities are divided into subclasses. So, one example of this is dividing humans into males and females. We're taking a set of entities (humans) and dividing into two subclasses (males and females). If we were a group of aliens who had just landed on planet earth and we wanted to classify the genders, what would we need to know?

There are two things:

- Attributes of a given entity (what characteristics do males and females possess?)
- Defining characteristics of each subclass (what characteristics *define* a male and a female).

The problem is, how do we decide what characteristics define a male or female. If we took a biological approach then we could look at sex chromosomes and we could define genders in

this way (e.g. males have an XY sex chromosome pair but female have an XX sex chromosome pair). There is a problem with using this characteristic as a defining feature: this condition is neither necessary nor sufficient because there are chromosome disorders (XO, XXX, YYY etc.). So, on what attributes should we base classification? Should we base it on physical attributes (men have beer bellies, Women have larger hips); behavioural attributes (men drink beer and beat each other up, women don't), or cognitive (women are capable of expressing emotion, men are not)? Even something as seemingly black-and-white as gender is hard to classify (e.g. Imperato-McGuinley *et al.* 1979, studied males with a deficiency of the enzyme 5 $\alpha$ -reductase which meant they were born with ambiguous genitalia and raised as females, but at puberty had a normal increase in testosterone and developed male genitalia, these children were raised and classified as girls for 12 years before 'becoming' male at puberty). If we have these problems classifying something as fundamental as gender, imagine how difficult it is to find the defining attributes for a complex psychological disorder.

Even assuming we can decide on the necessary and sufficient conditions for a subclass we have to be able to measure these attributes. With something physical we can measure it (we can, for example, measure hip size) but with psychological constructs we're reliant on less objective and reliable measures (so, can we really reliably measure if a person has persistent and distressing intrusive thoughts?). These most basic issues are hugely problematic. So, why do we bother classifying disorders if it is so problematic?

### **Why Classify Disorders?**

*"What's the use of their having names" the Gnat said "If they won't answer to them?"*

*"No use to them" said Alice, "but it's useful to the people that name them, I suppose"*

[Lewis Carroll, Through the Looking Glass]

The quote from 'Through the Looking glass' asks the question of whether it useful to name things. Alice has just told the gnat that where she comes from insects do not answer to their names and the gnat's response is to question the purpose of them having names to which they do not answer. Alice responds that it is useful to the namer even if not to the insects themselves. In clinical psychology we classify disorders in the hope that it allows us a basis upon which to understand and treat disorders.

In simple terms clinical psychology is the application of scientific methods to understand and resolve human problems. Classification helps us to do this. First, imagine trying to develop a theory of why people are suicidal without having first decided what it is to be suicidal. Classification enforces some homogeneity upon the groups we study. This allows us to develop theories of how disorders develop, which in turn informs us about how these disorders might be treated. Without some agreement about what constitutes a particular disorder, we would be unlikely to unearth common underlying processes (because we'd be studying a heterogeneous group of people), and we'd be unable to communicate with other scientists about the theories we develop (because our understanding of a disorder would differ from someone else's).

### **How should we classify?**

A good classification system needs to do a number of things (as we've seen):

- *Divide into mutually exclusive and collectively exhaustive subclasses*: disorders should be distinct (i.e. if something belongs to one subclass it cannot belong to another: so, in the case of gender you are either male or female not both). Collectively exhaustive means that all entities can be classified (i.e. all people who are in reality male, should be categorised as male by our definitions). In psychological terms it is important that our system classifies people with the correct disorder, and that all people with a disorder can be classified as having a disorder based on the system we use.
- *Necessary & Sufficient Conditions*: There must be characteristics that are necessary for classification into a subclass (i.e. to define someone as having OCD it may be necessary that they have intrusive thoughts). There must also be a set of sufficient

conditions to belong to a subclass (for example, there may be many people without OCD who have intrusive thoughts, so this condition alone is not sufficient to have OCD, you may perhaps need to have intrusive thoughts AND a heightened belief that you'll act upon these thoughts).

- *Concept*: Once the conditions of membership have been defined, the subclass must be described by some kind of concept that reflects the nature of the conditions. For example, OCD as a concept reflects the persistent and uncontrollable nature of the thoughts and actions associated with the conditions that define the disorder).
- *Extend the Concept*: Once we have a concept, it must be possible to generalise this concept and extend it to new exemplars. So, if a new entity is encountered that has not previously been classified, it must be possible to classify this new exemplar based on our concept.

### ***Are disorders discrete or continuous?***

The next problem is whether mental disorders are discrete or continuous. We can loosely think of this distinction in terms of whether people with disorders can be neatly placed within a diagnostic 'box' or not. So, does someone with a mental disorder have attributes not experienced at all by 'normal' people, or does having a mental disorder mean that some of your 'normal' attributes are experienced in some qualitatively distinct way?

Think about something like OCD, if we're to define it in terms of having intrusive thoughts (such as 'I want to kill my father'). Is it the case that people with OCD experience intrusive thoughts and 'normal' people do not? Or is it the case that intrusive thoughts are part of normal life (e.g. how many people have been at a train station and had the thought they should jump in front of a train?) but that people with OCD experience these thoughts in a qualitatively distinct way (i.e. with an exaggerated sense that they might act upon the thought, or they experience these thoughts more frequently)? Is there a continuum underlying disorders?

<ul style="list-style-type: none"><li>• You cry when you watch Casablanca</li><li>• You go to bed for an afternoon mope</li><li>• You're too lethargic to go clubbing</li><li>• You phone round your friends asking for 3 of your good points</li><li>• It takes a good episode of the Simpsons to make you smile</li><li>• You eat a box of peppermint Matchsticks for comfort and enjoy them</li><li>• You go off sex, but only because you think no-one wants to do it with a misery guts</li></ul>	<ul style="list-style-type: none"><li>• You cry at nothing, sometimes for ages and afterwards you don't feel any better</li><li>• You go to bed for a week at a time</li><li>• You feel useless, helpless and hopeless</li><li>• You find it hard to make decisions</li><li>• You wake up earlier than usual</li><li>• You have difficulty sleeping</li><li>• You lose appetite or weight (or the reverse)</li><li>• You go off sex</li><li>• You avoid other people</li><li>• You think of suicide</li></ul>
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The boxes above are examples from the Guardian Newspaper highlighting the difference between sadness (red) and depression (blue). Now in some sense they've trivialised sadness and used slightly fatuous examples. However, it illustrates the issue nicely. For example, if we use 'inability to get up in the morning' as a defining attribute of depression we're talking about something that everyone experiences. At what point does it become part of depression. Is it when we can't get out of bed for 2 hours, 3 hours, or a week? There are other examples that hint towards a discrete classification system (thoughts of suicide): This 'symptom' is a biggie

diagnostically, if you go to a GP and say you've thought about suicide you'll be on Prozac before you can say 'antidepressant', do non depressed people never think about suicide?

The vast majority of diagnostic criteria reflect everyday experiences to which we can all relate. In fact, throughout this course, as you listen to the diagnostic criteria for the various disorders, most of you will at some point convince yourself that you're phobic, depressed, social phobic, have panic disorder or some kind of sexual dysfunction. The chances are you haven't got any of these disorders, so, at what point do any one of these attributes become severe enough to indicate a mental disorder?

### ***How do we classify: DSM-IV?***

Kraepelin was one of the first to distinguish distinct syndromes. He made the distinction between *dementia praecox* and *manic-depressive psychosis*. Much of the modern classification systems owe their origin to Kraepelin who defined two discrete disorders both having necessary and sufficient attributes for classification. The World Health Organisation (WHO) publish diagnostic manuals for medicine, and the American Psychiatric Association (APA) developed a similar set of diagnostic manuals based on the WHO's system of classification, which again depends on defining necessary and sufficient criteria for diagnosis. This manual is known as the Diagnostic and Statistical Manual (DSM) and has been revised over the years: DSM (1952), DSM II (1969), DSM III (1980), DSM III-R (1987), DSM IV (1994). DSM IV is probably the most widely used diagnostic manual for psychiatric problems and is based on a multiaxial Classification:

- Axis I: Diagnostic Categories (except II)
- Axis II: Personality disorders/mental retardation
- Axis III: General medical conditions
- Axis IV: Psychosocial & environmental problems
- Axis V: Level of adaptive functioning (GAFS)

All of the disorders we cover on this course are found on Axis I, with the remaining axes used to identify other contributing factors (medical conditions, environmental factors etc.). Axis I contains the following disorders:

- Disorders usually first diagnosed in infancy, childhood or adolescence
- Delirium, dementia, amnesic & other cognitive disorders
- Substance related disorders
- Schizophrenia and other psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Sexual and gender identity disorders
- Eating disorders
- Sleeping disorders
- Impulse control disorders not elsewhere classified
- Adjustment disorders

### **Assessing a classification system**

A good classification system needs to be both reliable and valid.

- *Reliability*: A classification must be reliable in that if different clinicians diagnosed the same person, that person should always be classified in the same way (i.e. a system is not reliable if one clinician classifies someone as obsessive-compulsive whereas another classifies the same person as schizophrenic). Reliability is necessary for validity, but it is not sufficient. The use of standardized interview techniques and more explicit criteria has improved the reliability of DSM classification.
- *Validity*: First and foremost a valid system must be reliable. Validity comes also from many sources. Can we isolate causal factors for a given disorder (etiological validity), can we predict future outcomes based on what we know about the disorder (predictive validity), does the classification correlate with other measures (e.g. questionnaires that measure OCD), and does the construct itself have an intuitive validity?

### **Criticisms of DSM**

A number of criticisms have been levelled at DSM. Historically, it has been a very unreliable measure with the original manual leading to only 54% agreement between therapists in diagnosis (Beck *et al.*, 1962) and recent manuals (DSM III and III-R) improving this value to only 70% (Kirk & Kutchins, 1992).

- *Specificity*: There is considerable overlap between disorders (e.g. 30-50% of people with agoraphobia are diagnosed as having panic disorder). Also, looking at the symptoms of Borderline Personality Disorder (out-of-control emotions that cannot be smoothed, hypersensitivity to abandonment, self-harm, emptiness) are also benchmarks of depression and the vast majority of sufferers are also diagnosed as being depressed, having GAD, PTSD, Panic or some other anxiety disorder.
- *Biases*: Szasz (1961) argues that abnormality does not exist and that DSM reflects a societal desire to suppress individuals whose behaviour does not conform to our socially constructed norms. For example, anthropologists have noted culturally endorsed behaviours (e.g. the wild man of Borneo) that would be deemed antisocial or abnormal in the Western world. DSM has also been criticised for adopting a male-dominated perspective on disorders. For example, 'Dependent Personality Disorder' (characterised by fear of abandonment and indecisiveness) is said to pathologize normal female behaviour because it doesn't conform to male perceptions of normality (Caplan & Gans, 1991).
- *Stigma*: diagnostic labels change perceptions of the person. Rosenhan (1973) reports a study in which 8 'normal' people reported to 12 psychiatric hospitals (over a period of time) reporting hearing voices saying 'empty', 'hollow' and 'thud'. All were diagnosed as Schizophrenic. Rosenhan reported that doctors and staff treated these pseudopatients differently from the minute this label was attached (for example, staff would ignore the pseudopatients' attempts at conversation, their normal histories were distorted into tales of ambivalent relationships and outbursts were attributed to the pathology and not the behaviour of staff etc.).
- *Political influence*: Some of the disorders included (and excluded) in DSM are the result of political agendas. For example, PTSD was included after Vietnam soldiers protested for its inclusion so that they could receive sickness benefit. Homosexuality was dropped as a disorder in 1973 due to pressure from Gay rights groups (which demonstrates how cultural and historical perceptions of 'abnormality' influence what we consider to be abnormal. There are far fewer of our generation who would consider homosexuality a mental disorder, but two generations ago in Victorian Britain it would have been considered just that. Masochistic Personality Disorder was a recent controversial example (it was going to be included and then was dropped because of pressure from psychologists who felt it would serve to pathologize women in abusive relationships

(and the solution to have an equivalent Sadistic Personality Disorder was dropped because it would allow abusers legal protection through diminished responsibility.

- *Homogeneity of sufferers*: classification imposes homogeneity within disorders and encourages therapists to ignore the individual characteristics of a particular patient.

## Approaches to Clinical Psychology

There are a number of different approaches to theory and therapeutic practice in clinical psychology. This course is based heavily on medical, behavioural and cognitive models (usually in combination). This course has very little to say about psychodynamic theories and therapies.

I admit that this is largely because as an empirical researcher studying experimental psychopathology, the non-scientific nature of psychodynamic therapies sits uncomfortably with me. I'll get this personal bias out into the open now, but you should feel free to ignore it.

### *Psychodynamic*

Freud's basic premise was that there was a conflict between unconscious desires/drives and conscious behaviours and actions. In essence he conceptualised these in a number of ways.

Freud's Thanatos and Eros were basic drives towards death and life. These are in conflict.

There was the Id (unconscious primitive desires – eat, drink, procreate, please), Super-ego (conscience and morality) and the ego (reality principle). Characterized as "A sex crazed monkey (id) locked in mortal combat with a puritanical matron aunt (super-ego) refereed by a timid nervous clerk (ego)".

Freud also proposed the psychosexual stages: Oral (0-1 years), Anal (1-2 years), and Phallic (3-6) years. Failure to resolve any one of these stages would lead to trauma. I.e. Anal fixation (obsession), oral fixation (eating disorders), and the Oedipal complex (phobias: male is attracted to mother and fears castration from a jealous father, anxiety is transferred to a more socially appropriate target, in females penis envy).

Therapeutically, Freud looked to hypnosis (regression to an early state), dream analysis and the talking cure to unearth the cause of trauma. However, all of this was incredibly subjective and led to an amazing array of ridiculous case studies (I.e. little Hans). The theory is unfalsifiable because it offers no predictions about behaviour, is based on single case studies (non-scientific) and reflects Freud's own ambivalent parental relationships (which, ironically, he projected (to use his terminology) onto any poor sod who entered his office!).

### *Medical (Biological)*

The medical model is basically what is applied in medicine: all disorders can be attributed to some biological cause. This cause can take many forms:

- *Structural abnormalities*. The brain consists of a huge array of complex matter and liquid-filled ventricles. Psychopathology could be attributed to unusually large or small ventricles, or structural abnormalities of key areas such as the hypothalamus or amygdala.
- *Hormones*: Disorders could be due to abnormal levels of certain hormones (for example the secretion of cortisol during stress).
- *Neurology*: neurons communicate by releasing neurotransmitters into the gap between them (the synaptic gap). Reuptake (when the 'sending' neuron releases a neurotransmitter into the synaptic gap and then re-absorbs some of that neurotransmitter reducing the amount left in the synaptic gap) and degradation (when the 'receiving' neuron releases an enzyme to break down the neurotransmitter. Too much or too little reuptake and degradation can lead to high or low levels of neurotransmitters in the synaptic gap).

- *Genetics*: Any of the above may result from genetic factors (inherited structural abnormalities, hormone imbalances or neurological factors).

For therapy, the solution is drugs to act on the biological problems (I.e. increase production of a neurotransmitter, prevent reuptake or a neurotransmitter, encourage production of a neurotransmitter, redress hormonal imbalances etc.)

### **Behavioural**

The behavioural model basically suggests that mental illness results from maladaptive learning processes (emphasis is on environment and not behaviour). These responses are not cognitively mediated (I.e. out of conscious control). The model simply assumes that by treating the learnt behaviour, you treat the underlying cause (I.e. by re-learning about the environment you over-write the maladaptive learning).

In its radical form, behaviourists believed that we have no free will; we are simply a product of a set of learnt responses over which we have no conscious control.

Therapy hinges on re-learning: for example exposure to a threat (so you can re-learn that it is not actually threatening) and counter-conditioning (where a new and non anxious response is learnt to a threatening situation (e.g. relaxation while encountering a threatening situation). Unlike the medical model it emphasises social/environmental aspects.

### **Cognitive**

The cognitive model is in a sense the complete opposite to the behavioural one in that it emphasises the role of consciously controlled processes. The basic premise is that biased thought processes lead to maladaptive behaviour (for example someone is spider phobic because they perceive spiders as being huge – for whatever reason).

Little is hypothesised about how this maladaptive thinking is caused – however it seems likely that biology and learning have a role to play (and hence these three models are by no means mutually exclusive).

Therapy hinges on challenging thought biases (I.e. get rid of the maladaptive thoughts and the maladaptive behaviours will go).

When we study simple phobias we'll look in more detail at the behavioural and cognitive models and how they differ.

## **Key References**

### *Approaches to Psychopathology:*

Gelder, M. (1997). The scientific foundations of cognitive behaviour therapy. In D. M. Clark and C. G. Fairburn (Eds.), *Science and practice of cognitive behaviour therapy*. Oxford: Oxford University Press (pp 3–26). (Main/Short RC489.C63 Sci)\*

Ledwidge, B. (1978). Cognitive behaviour modification: a step in the wrong direction? *Psychological Bulletin*, 85, 353–375. (QZ10 Psy)\*\*

Rachman, S. J. (1997). The evolution of cognitive behaviour therapy. In D. M. Clark and C. G. Fairburn (Eds.), *Science and practice of cognitive behaviour therapy*. Oxford: Oxford University Press (pp 3–26). (Main/Short RC489.C63 Sci)\*\*

Salkovskis, P. M. (1986). The cognitive revolution: new way forward, backward somersault or full circle? *Behavioural Psychotherapy*, 14, 278–282.\*\* [in reserve]

### *Classification and Diagnosis:*

Rosenhan, D. L. (1973). On being sane in insane places. *Science*, 179, 250–258. (Q 1 Sci)\*\*

Spitzer, R. L. (1975). On pseudoscience in science, logic in remission and psychiatric diagnosis: a critique of 'on being sane in insane places'. *Journal of Abnormal Psychology*, 84, 442–452. (QZ10 Jou)\*\*

The two articles above are an informative debate of the issue of whether diagnostic labels hinder treatment.

American Psychiatric Association (1994). *DSM-IV*. Washington D.C.: APA (Main RC 454.4 Dia)  
(Not really for reading; but skimming will give you some sense of how classification really 'works')