Chapter 11: Psychological Disorders

I. What Is Abnormal?

A. Defining Abnormality

1. Abnormal physiology can affect mental functioning.
2. Culture and context are important in defining abnormality.
3. Difficult to give exact definition mental disorders can encompass so many aspects of functioning.
4. A good working definition is that a **psychological disorder** is a constellation of symptoms that create significant distress or impairment in work, school, family, relationships, or daily living.
    a. Up to 48% of Americans have experienced a psychological disorder at some point in their lives, and up to 20% have a diagnosable disorder in any given year.

B. Explaining abnormality

1. In ancient Greece, Hippocrates attributed mental illness to imbalances in 4 fluids.
2. In the Middle Ages and up through 17th century New England, mental illness was attributed to demonic possession or other work of the devil.
3. In the early and middle 20th century, Freud's psychodynamic model was the standard for understanding abnormality.
4. Currently, many psychologists embrace the *biopsychosocial model*, which focuses on the levels of the brain, the person, and the group.
    a. The level of the brain
        (1) The **diathesis-stress model** may be the best explanation for many psychological disorders.
    b. The level of the person
        (1) Classical and operant conditioning, observational learning, and thought patterns can all play a role in psychological disorders.
    c. The level of the group
        (1) In the 1960s, Szasz argued that mental illness is a myth, and reflects nothing more than a label that is applied to social nonconformists
        (2) Rosenhan's study proved that labels can powerfully affect how people are treated, but do not mean that psychological disorders do not exist.
        (3) Culture differ in what they consider abnormal,, but some disorders are recognized worldwide.
        (4) Since diagnoses involves making judgments, errors do occur.
    d. Events at all three levels, and their interactions, must be considered when trying to understand psychological disorders.

C. Categorizing disorders.

a. The *DSM-IV* has five axes for categorizing disorders:
    (1) Axis I: Clinical Disorders
    (2) Axis II: Personality Disorders and Mental Retardation

(3) Axis III: General Medical Conditions

(4) Axis IV: Psychosocial and environmental problems.

(5) Axis V: Global Assessment of Functioning

b. An appendix outlines cultural factors that should be considered in diagnosis.

c. It defines 17 categories of problems and almost 300 mental disorders

d. It has been criticized on several grounds:

(1) It has introduced categories that define medical problems as psychological disorders.

(2) It does not provide discrete boundaries for separating normality from abnormality.

(3) Many of the disorders are not clearly distinct from each other.

D. **Personality disorders** involve relatively stable personality traits that are inflexible and maladaptive, causing distress or difficulty in daily functioning.

1. There are 10 Axis II personality disorders:

a. **Antisocial personality disorder** involves a pattern of disregard or violation of the rights of others.

b. **Avoidant personality disorder** involves a pattern of social discomfort, feelings of inadequacy, and hypersensitivity to negative evaluation.

c. **Borderline personality disorder** involves a pattern of instability in self-image, feelings, and relationships and pronounced impulsivity.

d. **Dependent personality disorder** involves a pattern of clingy, submissive behavior due to an extreme need to be taken care of.

e. **Histrionic personality disorder** involves a pattern of excessive attention seeking and expression of emotion.

f. **Narcissistic personality disorder** involves an exaggerated sense of self-importance, need for admiration, and lack of empathy.

g. **Obsessive-compulsive personality disorder** involves a pattern of preoccupation with perfectionism, orderliness, and control.

h. **Paranoid personality disorder** involves a pattern of suspiciousness and distrust of others.

i. **Schizoid personality disorder** involves a pattern of detachment from social relationships and a narrow range of displayed emotions.

j. **Schizotypal personality disorder** involves a pattern of extreme discomfort in close relationships, odd or quirky behavior, and cognitive or perceptual distortions.

II. Anxiety and mood disorders

A. **Anxiety disorders** are characterized by intense and pervasive anxiety and fear, and/or extreme efforts to avoid these feelings.

1. **Panic disorder** is characterized by repeated **panic attacks**.

a. People with this disorder constantly fear having more attacks.

b. They may start avoiding places associated with past attacks, leading to **agoraphobia**.

c. At the level of the brain:
   (1) People who develop this disorder may be born with a biological vulnerability involving oversensitivity of the locus coeruleus (a biological "alarm system).
   (2) They may also be more sensitive to high carbon dioxide levels (caused from hyperventilation).
d. At the level of the person:
   (1) Many sufferers have *anxiety oversensitivity* that may increase sympathetic nervous system activity, leading to panic.
   (2) They may become hypervigilant for signals that have led to panic in the past.
e. At the level of the group, 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.

B. **Phobias** a fear and avoidance of objects or situations extreme enough to interfere with everyday life.
   a. **Social phobias** involve fear of public humiliation or embarrassment and the ensuing avoidance of situations likely to arouse this fear. About 13% of Americans experience social phobias.
   b. **Specific phobias** involve persistent and excessive or unreasonable fears triggered by a specific object or situation, along with attempts to avoid the feared stimulus.
   c. At the level of the brain:
      (1) Phobias have a genetic component that results in hyperactivity of the amygdala and other fear-related brain structures.
      (2) Humans appear to be biologically prepared to develop phobias about certain stimuli (such as snakes) and not others (such as teddy bears).
   d. Classical and operant conditioning may be involved in learning many specific phobias.

2. **Posttraumatic stress disorder (PTSD)** is experienced by some people after a traumatic event, and is characterized by unwanted re-experiencing of the trauma, avoidance of anything related to the trauma, and heightened arousal.
   a. Three conditions must be met for diagnosis of this disorder:
      (1) The person experiences or witnesses an event that involves actual or threatened serious injury or death.
      (2) The traumatized person responds to the situation with fear and helplessness.
      (3) The traumatized person experiences three sets of symptoms:
         (a) Persistent re-experiencing of the traumatic event
         (b) Persistent avoidance of anything associated with the trauma, and a general emotional numbing
         (c) Heightened arousal.
   b. Symptoms may not appear immediately, but may last for months or years, once they do appear.
   c. Most people who experience a traumatic event do not develop PTSD.
   d. Women more likely to develop PTSD when trauma resulted from crimes not natural disasters.

e. At the level of the 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.

f. At the level of the person:

(1) Risk is increased by a history of depression, social withdrawal, and lack of control of stressors.

(2) Classical and operant conditioning may be linked to the avoidance symptoms.

g. At the level of the group, risk is decreased by support from family, friends, or counselors, immediately after the traumatic event.

3. **Obsessive-compulsive disorder (OCD)** is characterized by the presence of obsessions, and sometimes compulsions.

a. About 2 to 3% of Americans suffer from obsessive-compulsive disorder at some point.

b. Culture does not affect rates, but does affect the way some symptoms are displayed.

c. **Obsessions** are recurrent and persistent thoughts, impulses, or images that feel intrusive and inappropriate, and are difficult to suppress or ignore.

d. **Compulsions** are repetitive behaviors or mental acts that an individual feels compelled to perform in response to an obsession.

e. At the level of the brain:

(1) If one member of a family has OCD, other members are more likely to have an anxiety disorder of some type.

(2) 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.

(3) Serotonin is involved in OCD symptoms, but the mechanism is unknown.

(4) Serotonin-based medications such as Prozac can reduce OCD symptoms.

f. At the level of the person, operant conditioning may increase compulsive behaviors because they temporarily relieve anxiety.

g. At the level of the group, people with severe OCD tend to have experienced more family stress and have had families more rejecting of them.

B. **Mood disorders** are marked by persistent or episodic disturbances in affect that interfere with normal functioning in at least one realm of life.

1. **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.

a. Up to 20% of Americans experience this disorder at some point in their lifetimes.

b. By the year 2020, it will be the second most debilitating disease in America, after heart disease.

c. It is the most common psychological disorder in the United States

d. There are cultural differences in the types of symptoms associated with this disorder.
e. Most suicides seem to be motivated by the hopelessness associated with depression.
    (1) 30% of people with depression attempt suicide
    (2) One-half of them succeed (over 19,000 per year)
    (3) Common misconceptions of suicide:
        (a) *If you talk about suicide, you won't really do it*.
        (b) *People who attempt suicide are "crazy*."
        (c) *Someone determined to commit suicide can't be stopped*.
        (d) *People who commit suicide weren't willing to seek help*
        (e) *Talking about suicide could give someone the idea, so don't talk or ask about it.*

2. **Dysthymia** is similar to major depression, but is less intense and longer lasting.
    a. About 6% of Americans experience this disorder.
3. **Bipolar disorder** is marked by one or more episodes of either mania or hypomania.
    a. Cycling between manic/hypomanic episodes and depression can take years.
    b. If left untreated, mood swings become more frequent over time, linked to a poorer prognosis.
4. At the level of the brain:
    a. There is evidence of genetic involvement in mood disorders:
        (1) Depressed people have lower brain activity in an area of the frontal lobe directly connected to brain areas involved in emotion.
        (2) The amygdala is enlarged in people with bipolar disorder.
            (a) There are shifts in temporal lobe activity during manic episodes that are not present in other mood states.
            (b) If one twin has bipolar disorder, the other twin has an 80% chance of developing some type of mood disorder.
        (3) The neurotransmitters serotonin, norepinephrine, and *substance P* are involved in depression.
        (4) Lithium, used to treat bipolar disorder, lowers norepinephrine in the brain.
5. At the level of the person:
    a. Depressed people make less eye contact, more negative comments, are less responsive to others, speak more softly, and in shorter sentences.
    b. Beck has identified a "negative triad" of depression composed of:
        (1) A negative view of the world
        (2) A negative view of the self
        (3) A negative view of the future

c. People with negative triad make cognitive distortions - perpetuate depressing feelings and beliefs.
d. A person's **attributional style** affects his or her risk of depression.

6. At the level of the group:
   a. Life stresses occurring before the onset of depression can influence its severity.
   b. Decreased activity & contact with other people increases likelihood of more depressive symptoms.
   c. The family environment can affect recovery from depression and bipolar disorder.
   d. Culture can play a role in facilitating depression, particularly among Western women.
   e. Social stressors that affect biological rhythms can increase severity of bipolar disorder.

III. **Schizophrenia** is a psychotic disorder in which patient's affect, behavior, and thoughts are profoundly altered.

A. Symptoms of schizophrenia.
   1. Usually divided into **positive symptoms** and **negative symptoms**.
      a. Positive symptoms: *hallucinations*, *delusions*, *disorganized behavior*, and *disorganized speech*.
      b. Positive symptoms usually respond more than negative symptoms to antipsychotic medication.
      c. Negative symptoms include *flat affect*, *alogia*, and *avolition*.
   2. Not all symptoms are present in all schizophrenics.
   3. Average age of onset is in the twenties.
   4. Symptoms often appear gradually.

B. Types of schizophrenia.
   1. There are four subtypes of schizophrenia:
      a. **Paranoid** Schizophrenia, which has best prognosis for recovery, but also the highest suicide rate
      b. **Disorganized** schizophrenia, which involves disorganized speech and behavior and flat or inappropriate affect.
      c. **Catatonic** schizophrenia, which involves bizarre motor behaviors.
      d. **Undifferentiated** schizophrenia, which involves symptoms that do not clearly fall into any of the other three subtypes.

C. Causes of schizophrenia
   1. Schizophrenia has a 1% occurrence rate worldwide, but recovery rates are lower in Western nations.
   2. At the level of the brain:
      a. Genetic factors are clearly involved in the development of schizophrenia.
         (1) Having relatives with schizophrenia increase the risk of developing it.
      b. People with schizophrenia have enlarged brain *ventricles*.
      c. Frontal lobe problems involving too few dopamine receptors are linked to schizophrenia.
      d. Smaller than normal temporal lobes are linked to schizophrenia.
      e. Risk heightened by genetic vulnerability & prenatal complications (diathesis-stress model).
      f. Higher risk have higher baseline levels of cortisol, which may affect dopamine activity.
      g. The *dopamine hypothesis*s too simplistic; other neurotransmitters are also involved.

3. At the level of the person:
    a. As children, schizophrenics exhibit fewer expressions of joy, and do worse at activities requiring motor coordination.
4. At the level of the group:
    a. Emotional expression in the family can affect the likelihood of a recurrence of schizophrenic episodes (high **expressed emotion** increases risk).
    b. **Social selection** and **social causation** may be why rates of schizophrenia are higher among those from urban areas and lower socioeconomic classes.

IV. Dissociative and eating disorders

A. **Dissociative disorders** are characterized by a disruption in the usually integrated functions of consciousness, memory, or identity.
    1. Symptoms include *identity confusion, identity alteration, derealization,* and *depersonalization.*
    2. About 10% of Americans have been diagnosed with a dissociative disorder.
    3. **Dissociative amnesia** involves an inability to remember important information.
    4. **Dissociative fugue** involves an abrupt, unexpected departure from work, combined with an inability to remember some or all of the past.
    5. **Dissociative identity disorder** (formerly multiple personality disorder) is characterized by a person having two or more distinct personalities that take control of the individual's behavior.
        a. Most sufferers experienced severe and repeated physical or sexual abuse as young children.
        b. Most sufferers have very high hypnotizability and dissociative capacity.
        c. Sufferers may dissociate as a defense against the abuse.
        d. Some researcher believe DID is nothing more than elaborate role-playing.
        e. Others believe it is a subtype of posttraumatic stress disorder.

B. **Eating disorders** involve severe disturbances in eating behavior.
    1. More than 90% of those diagnosed with eating disorders are female.
    2. **Anorexia nervosa** is characterized by a refusal to maintain even a low normal weight.
        a. Sufferers have a distorted body image
        b. 10% of those hospitalized for the disorder will die.
        c. There are two types of anorexia:
            (1) The *binge-eating-purging type*
            (2) The classic *restricting type*
    3. **Bulimia nervosa** is characterized by recurrent episodes of binge eating followed by attempts to prevent weight gain.
            (1) The *purging type*
            (2) The *nonpurging type*

4. At the level of the brain:
    a. There is evidence of a genetic predisposition for anorexia.
    b. Obsessive personality traits in a family may increase the risk for anorexia.
    c. Environment is the major predictor of bulimia nervosa.
    d. Dieting may disrupt serotonin levels in bulimics, triggering binge eating episodes.
5. At the level of the person:
    a. Higher risk for anorexia is linked to being perfectionistic, having a negative self-image, and engaging in dichotomous, black-or-white thinking.
    b. Dieting may increase sense of control, purging may relieve anxiety caused from overeating
6. At the level of the group:
    a. Family and culture may enhance risk by encouraging a preoccupation with weight and appearance.