Chapter 13: Psychological Disorders

•**Psychopathology**—scientific study of the origins, symptoms, and development of psychological disorders

•**Psychological disorder** or **mental disorder**—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

Diagnosis

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)—describes specific symptoms and diagnostic guidelines for psychological disorders.

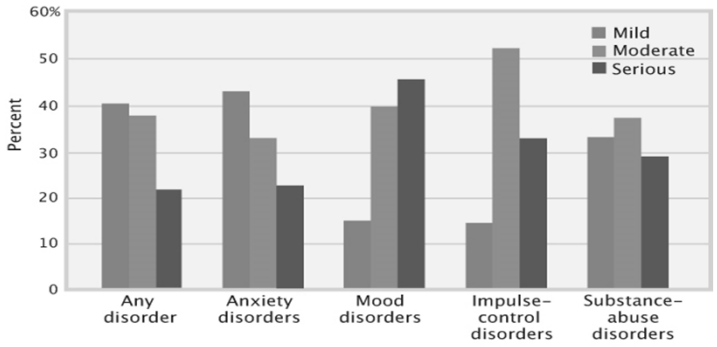
- Provides a common language to label mental disorders.
- Comprehensive guidelines to help diagnose mental disorders.

Some DSM-IV-TR Categories

Category	Features	Examples
Infancy,Childhood, or adolescent	Symptoms usually diagnosed in childhood	Autistic Disorder Tourette's Disorder
Substance-related	Effects of seeking or using drugs	Substance abuse
Eating disorders	Disturbances in body image, eating	Anorexia nervosa Bulimia nervosa
Impulse-control disorders	Inability to resist actions that may be harmful	Kleptomania, pyromania

Prevalence of Psychological Disorders

- Approximately 50% of adults experienced symptoms at least once in their lives (Kessler research).
- 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 a higher prevalence of depression and anxiety.
- Men have a higher prevalence of substance abuse and antisocial personality disorder.



Anxiety Disorders

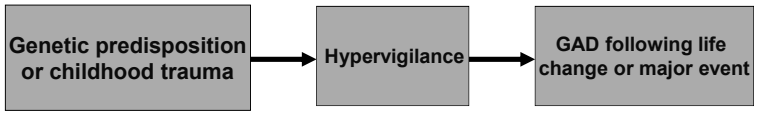
- Primary disturbance is distressing, persistent anxiety or maladaptive behaviors that reduce anxiety
- Anxiety—diffuse, vague feelings of fear and apprehension

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



Panic Disorder

- Panic attacks—sudden episode of helpless terror with high physiological arousal
- Very frightening—sufferers live in fear of having them
- Agoraphobia often develops as a result

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.

Phobias

- Intense, irrational fears that may focus on:
- Natural environment—heights, water, lightening
- Situation—flying, tunnels, crowds, social gathering
- Injury—needles, blood, dentist, doctor
- Animals or insects—insects, snakes, bats, dogs

Some Unusual Phobias

- Anemophobia: fear of wind
- Aphephobia: fear of being touched by another person
- Catotrophobia: fear of breaking a mirror
- Gamophobia: fear of marriage
- Phonophobia: fear of the sound of your own voice

Agoraphobia

- Fear of panic attacks in public places
- Avoid situations that might provoke a panic attack or where there may be no escape or help if a panic attack were to come.
- Not everyone with panic disorder develops agoraphobia.

Social Phobias

- Social phobias—fear of social situations. Also called social anxiety disorder. Stems from irrational fear of being embarrassed or judged by others in public
  - public speaking (stage fright)
  - fear of crowds, strangers
  - meeting new people
  - eating in public
- Considered phobic if these fears interfere with normal behavior
- More prevalent among women than men

Development of Phobias

Classical conditioning model

- problems:
  - often no memory of a traumatic experience
  - traumatic experience may not produce phobia

Preparedness theory—phobia serves to enhance survival

Posttraumatic Stress Disorder (PTSD)

- Follows events that produce intense horror or helplessness (traumatic episodes)
- Core symptoms include:
  - Frequent recollection of traumatic event, often intrusive and interfering with normal thoughts
  - Avoidance of situations that trigger recall of the event
  - Increased physical arousal associated with stress

Obsessive-Compulsive Disorder (OCD)

- Obsessions—irrational, disturbing thoughts that intrude into consciousness
- Compulsions—repetitive actions performed to alleviate obsessions
- Often accompanied by an irrational belief that failure to perform ritual action will lead to catastrophe
- Checking and washing most common compulsions
- Deficiency in serotonin implicated and heightened neural activity in caudate nucleus

Mood Disorders

- A category of mental disorders in which significant and chronic disruption in mood is the predominant symptom, causing impaired cognitive, behavioral, and physical functioning.
  - Major depression
  - Dysthymic disorder
  - Bipolar disorder
  - Cyclothymic disorder

Major Depression

- A mood disorder characterized by extreme and persistent feelings of despondency, worthlessness, and hopelessness
  - Prolonged, very severe symptoms
  - Passes without remission for at least 2 weeks
  - Global negativity and pessimism
  - Very low self-esteem

Symptoms of Major Depression

•Emotional—sadness, hopelessness, guilt, turning away from others

•Behavioral—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

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

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

Prevalence and Course of Major Depression

- 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

Bipolar Disorders

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

Cyclothymic Disorder

- Cyclothymic—mood disorder characterized by moderate but frequent mood swings that are not severe enough to qualify as bipolar disorder

Prevalence and Course

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

Explaining Mood Disorders

Neurotransmitter theories
- dopamine
- norepinephrine
- serotonin

Genetic component
- more closely related people show similar histories of mood disorders

Eating Disorders

•Involve serious and maladaptive disturbances in eating behavior, including reducing food intake, severe overeating, obsessive concerns about body shape or weight

Two Main Types

•Anorexia Nervosa-characterized by excessive weight loss, irrational fear of gaining weight, and distorted body self-perception

•Bulimia Nervosa-characterized by binges of extreme overeating followed by self-induced vomiting, misuse of laxatives, or other methods to purge

Causes of Eating Disorders

•Perfectionism, rigid thinking, poor peer relations, social isolation, low self-esteem associated with anorexia

•Genetic factors implicated in both

•Both involve decrease in serotonin

Personality Disorders

•Inflexible, maladaptive pattern of thoughts, emotions, behaviors, and interpersonal functioning that are stable over time and across situations, and deviate from the expectations of the individual's culture.

Paranoid Personality Disorder

•Pervasive mistrust and suspiciousness of others are the main characteristics
•Distrustful even of close family and friends
•Reluctant to form close relationships
•Tend to blame others for their own shortcomings
•Occurs in about 3 percent of population, more frequent in men
•Pathological jealousy seen in intimate relationships

Antisocial Personality Disorder

•Used to be called psychopath or sociopath
•Evidence often seen in childhood (conduct disorder)
•Manipulative, can be charming, can be cruel and destructive
•Seems to lack "conscience"
•More prevalent in men than women

Borderline Personality Disorder

•Chronic instability of emotions, self-image, relationships
•Self-destructive behaviors
•Intense fear of abandonment and emptiness
•Possible history of childhood physical, emotional, or sexual abuse
•Diagnosis more prevalent among women

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

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 incident until four days later.

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

Dissociative Fugue

•Jay, a high school physics teacher in New York City, disappeared three days after his wife unexpectedly left him for another man. Six months later, he was discovered tending bar in Miami Beach. Calling himself Martin, he claimed to have no recollection of his past life and insisted that he had never been married.

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

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.

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

•Examples include Sybil, Trudy Chase, Chris Sizemore ("Eve")

•Has been used as a criminal defense

Dissociative Identity Disorder

•Pattern typically starts prior to age 10 (childhood)

•Most people with disorder are women

•Most report recall of torture or sexual abuse as children and show symptoms of PTSD

Causes of Dissociative Disorders?

- Repeated, severe sexual or physical abuse
- However, many abused people do not develop DID
- Becomes a pathological defense mechanism to cope with intense feelings of rage and anger

The DID Controversy

- Some curious statistics
  - 1930–1960: 2 cases per decade in USA
  - 1980s: 20,000 cases reported
  - many more cases in U.S. than elsewhere
  - varies by therapist—some see none, others see a lot
- Is DID the result of suggestion by therapist and acting by patient?

What is Schizophrenia?

- Comes from Greek meaning "split" and "mind"
  - 'split' refers to loss of touch with reality
  - not dissociative state
  - not 'split personality'

Symptoms of Schizophrenia

- Positive symptoms
  - hallucinations
  - delusions
- Negative symptoms
  - absence of normal cognition or affect (e.g., flat affect, poverty of speech)
- Disorganized symptoms
  - disorganized speech (e.g., word salad)
  - disorganized behaviors

Symptoms of Schizophrenia

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

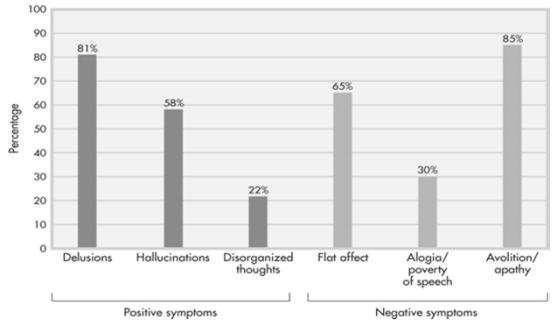
Symptoms of Schizophrenia

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.

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

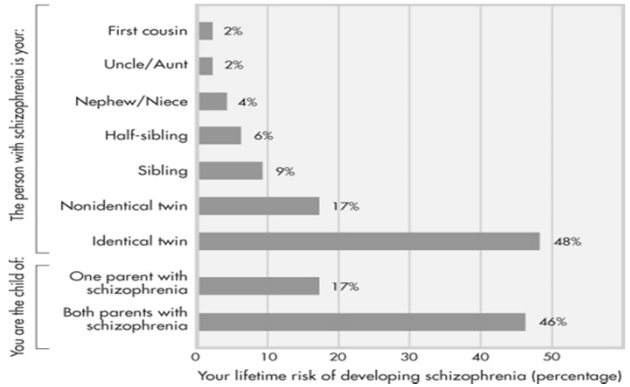


Frequency of positive and negative symptoms in individuals at the time they were hospitalized for schizophrenia. Source: Based on data reported in Andreasen & Flaum, 1991.

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, behavior, and flat affect

Schizophrenia and Genetics



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

Biological Bases of Schizophrenia

Other congenital influences
- difficult birth (e.g., oxygen deprivation)
- prenatal viral infection

Brain chemistry
- neurotransmitter excesses or deficits
- dopamine theory

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

Family Influences on Schizophrenia

Family variables
- parental communication that is disorganized, hard-to-follow, or highly emotional
- expressed emotion
  - highly critical, over-enmeshed families

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?

Understanding Suicide

- Suicide prevalence rates
  - About 30,000 per year take their own lives
  - 500,000 people require emergency room treatment for suicide attempt
  - Twice as many die from suicide as from homicide
- Gender differences
  - Women outnumber men for suicide attempts
  - Men outnumber women in suicide deaths
  - Higher suicides during the winter holidays a myth

Helping to Prevent Suicide

- Guidelines:
  - Active listening to feelings
  - Not minimizing the person's intentions
  - Identify other possible solutions
  - Ask the person to delay the decision
  - Encourage professional help