

Chapter 16:

Psychological Disorders

The Scope and Nature of Psychological Disorders

What is “Abnormal”?

- Defining what normal and abnormal is takes into account many measures such as:
 - Personal values of a given diagnostician
 - Expectations of the culture in which a person lives
 - Expectations of the person’s culture of origin
 - General assumptions about human nature
 - Statistical deviation from the norm
 - Harmfulness, suffering and impairment
- **Abnormal behaviour** can be defined as behaviour that is personally dysfunctional, and/or so culturally deviant that other people **judge** it to be inappropriate or maladaptive

Historical Perspectives on Deviant Behaviour

- According to the **vulnerability-stress model**, each of us has some degree of vulnerability for developing a psychological disorder, given sufficient stress
- In most instances, a predisposition creates a disorder only when a stressor – some recent or current event that requires a person to cope – combines with vulnerability to trigger the disorder

Diagnosing Psychological Disorders

- **Reliability** – in psychological testing, the consistency with which a measure assess a given characteristic, or different observers agree on a given score; the degree to which clinicians show high levels of agreement in their diagnostic decisions
- **Validity** – the extent to which a test measures what it is supposed to; the degree to which a diagnostic system’s categories contain the core features of the behaviour disorders and permit differentiation among the disorders
- DSM-IV-TR – most widely used diagnostic classification system in North America
 - Contains detailed lists of observable behaviours that must be present in order for a diagnosis to be made
 - Allows diagnostic information to be represented along five dimensions, or axes, that take both the person and his or her life situation into account
 - Axis I – the primary diagnosis/primary clinical symptoms
 - Axis II – reflects long-standing personality or developmental disorders
 - Axis III – notes relevant physical disorders
 - Axis IV – rates intensity of environmental stressors
 - Axis V – global assessment of level of functioning

DSM-V: Integrating Categorical and Dimensional Approaches

- Current classification system is a categorical system, in which people are placed within specific diagnostic categories
 - However, criteria is so detailed and specific that many people don't fit neatly into the categories
 - Also does not provide a way of capturing the severity of the person's disorder, nor can it capture symptoms that are adaptively important but not severe enough to meet the behavioural criteria for the disorder
- An alternative to the categorical system is a dimensional system, in which relevant behaviours are rated along a severity measure

Critical Issues in Diagnostic Labelling

- **Social and personal implication** – once a diagnostic label is attached to a person, it becomes easy to accept the label as an accurate description of the individual rather than of the behaviour
- **Legal consequences** – psychiatric diagnoses also have important legal consequences
 - **Competency** refers to a defendant's state of mind at the time of a judicial hearing (not at the time the crime was committed)
 - **Insanity** relates to the presumed state of mind of the defendant at the time the crime was committed

Anxiety Disorders

- Anxiety – state of tension and apprehension that is a natural response to perceived threat
- In **anxiety disorders**, the frequency and intensity of anxiety responses are out of proportion to the situations that trigger them, and the anxiety differs with daily life
- Anxiety responses have four components:
 - a **subjective-emotional** component – includes feelings of tension and apprehension
 - a **cognitive** component – includes subjective feelings of apprehension, a sense of impending danger, and a feeling of inability to cope
 - **physiological** responses – includes increased heart rate and blood pressure, muscle tension, rapid breathing, nausea, dry mouth, diarrhea, and frequent urination
 - **behavioural** responses – includes avoidance of certain situations and impaired task performance
- Anxiety disorders take a number of different forms, including phobic disorders, generalized anxiety disorders, panic disorders, post-traumatic stress disorders, and obsessive-compulsive disorders
- Two statistics are commonly used in epidemiological research:
 - **Incidence** refers to the number of new cases that occur during a given period
 - **Prevalence** refers to the number of people who have a disorder during a specified period of time

Phobic Disorder

- **Phobias** are strong and irrational fears of certain objects or situations
- Can develop at any point in life, but many of them develop during childhood, adolescence and early adulthood
- Once developed, they rarely go away on their own, and may broaden or intensify over time

Generalized Anxiety Disorder

- **Generalized anxiety disorder** is a chronic state of diffuse or “free-floating” anxiety that is not attached to specific situations or objects
- Can interfere with daily functioning – hard to concentrate, make decisions, and remember commitments

Panic Disorder

- **Panic disorders** occur suddenly and unpredictably, and are much more intense
- In most cases, they occur out of the blue and in the absence of any identifiable stimulus
- Formal diagnosis requires recurrent attacks that do not seem tied to environmental stimuli, followed by psychological or behavioural problems

Obsessive-Compulsive Disorder (OCD)

- **Obsessive-compulsive disorders** usually consist of two components – one cognitive and one behavioural – although either one can occur alone
- **Obsessions** are repetitive and unwelcome thoughts, images, or impulses that invade consciousness, are often abhorrent to the person, and are very difficult to dismiss or control
- **Compulsions** are repetitive behavioural responses that can be resisted only with great difficulty – often responses to obsessive thoughts and function to reduce the anxiety associated with the thoughts

Causal Factors in Anxiety Disorders

- Biological factors:
 - Genetic factors may create a vulnerability to anxiety disorders
 - Hereditary factors may cause overreactivity of neurotransmitter systems involved in emotional responses
 - Low levels of the inhibitory neurotransmitter, GABA, activity in arousal areas may cause some people to have highly reactive nervous systems that quickly produce anxiety responses in response to stressors
 - Sex differences – women exhibit anxiety disorders more often than men do
- Psychological factors:
 - According to Freud, **neurotic anxiety** occurs when unacceptable impulses threaten to overwhelm the ego’s defenses and explode into action
 - Cognitive theorists stress the role of maladaptive thought patterns and beliefs in anxiety disorders – anxiety-disordered people “catastrophize” about demands and magnify them into threats
 - From the behavioural perspective, anxiety disorders result from emotional conditioning – once anxiety is learned (through classical conditioning or observational learning), it may be triggered either by cues from the environment or by internal cues, such as thoughts and images
 - In the case of phobic reactions, the cues tend to be external ones, relating to the feared object or situation
 - In panic disorders, the anxiety-arousing cues tend to be internal ones, such as bodily sensations or mental images
- Sociocultural factors:
 - Role of culture is most dramatically shown in **culture-bound disorders** that occur only in certain places (e.g. anorexia nervosa is a culture-bound anxiety-based disorder that occurs in the United States)

Eating Disorders

- Victims of **anorexia nervosa** have an intense fear of being fat and severely restrict their food intake to the point of self-starvation
- People who suffer from **bulimia nervosa** are overly concerned with becoming fat, but instead of self-starvation, they binge eat and then purge the food, usually by inducing vomiting or using laxatives
- Causes of Anorexia and Bulimia:
 - Variations in beauty norms among different ethnic groups
 - Personality factors – anorexics are often perfectionists who often strive to live up to lofty self-standards and bulimics tend to be depressed and anxious, and exhibit low impulse control
 - Genetic factors may create a predisposition toward eating disorders

Mood (Affective) Disorders

- Another set of emotion-based disorders are **mood disorders**, which involve depression and mania (excessive excitement)

Depression

- **Major depression** is a mood disorder characterized by intense depression that interferes markedly with functioning
- Others exhibit a less intense form of depression called **dysthymia** that has less dramatic effects on personal and occupational functioning
- The negative mood state is the core feature of depression – sadness, misery, and loneliness
- There are three types of symptoms of depression: cognitive symptoms, motivational symptoms, and somatic (physical) symptoms
 - **Cognitive symptoms** – difficult concentrating and making decisions; usually have low-self esteem, belief that they are inferior, inadequate, and incompetent; view future with great pessimism and hopelessness
 - **Motivational symptoms** – inability to get started and perform behaviours that might produce pleasure or accomplishment
 - **Somatic (bodily) symptoms** – include loss of appetite and weight loss; sleep disturbances, particularly insomnia, occur; loss of sexual desire and responsiveness

Bipolar Disorder

- In a **bipolar disorder**, depression (usually the dominant state) alternates with periods of **mania**, a state of highly excited mood and behaviour that is quite the opposite of depression
- In a manic state, mood is euphoric and cognitions are flamboyant; at a motivational level, manic behaviour is hyperactive

Prevalence and Course of Mood Disorders

- The prevalence of depressive disorders is similar across socioeconomic and ethnic groups, but there is a major sex difference in our culture – women appear to be about twice as likely as men to suffer depression
 - Biological theories suggest that genetic factors, biochemical differences in the nervous system, or the monthly premenstrual depression that many women experience could increase vulnerability to depressive disorders

- Environmental theories focus on possible cultural causes, such as the traditional sex role expectation for females
- After the initial episode, depression typically lasts an average of 5 – 10 months when untreated
- Once a depressive episode has occurred, one of three patterns may follow:
 - In perhaps half of all cases, depression will never recur
 - Many other cases, recovery with recurrence
 - About ten percent of people will not recover and will remain chronically depressed

Causal Factors in Mood Disorders

- Biological factors:
 - Both genetic and neurochemical factors have been linked to depression
 - One prominent biochemical theory links depression to an underactivity of neurotransmitters (norepinephrine, dopamine, and serotonin) that activate brain areas involved in pleasure and positive motivation
 - Drugs that relieve depression increase the activity of these transmitters
 - Manic disorders may stem from an overproduction of the same neurotransmitters that are underactive in depression
- Psychological factors:
 - Psychoanalysts Abraham (1911) and Freud (1917) believed that early traumatic losses or rejections create vulnerability for later depression by triggering a grieving and rage process that becomes part of the individual's personality
 - According to Aaron Beck (1976), depressed people victimize themselves through their own beliefs that they are defective, worthless, and inadequate
 - This **depressive cognitive triad** of negative thoughts concerning the world, oneself, and the future seems to pop into consciousness automatically, and many depressed people report that they cannot control or suppress the negative thoughts
 - The **depressive attributional pattern** of taking no credit for successes but blaming themselves for failures maintains depressed people's low self-esteem and their belief that they are worthless failures
 - Another prominent cognitive account of depression, **learned helplessness theory**, holds that depression occurs when people expect that bad events will occur and there is nothing they can do to prevent or cope with them
 - Peter Lewinsohn (1985) believed that depression is usually triggered by a loss, some other punishing event, or by a drastic decrease in the amount of positive reinforcement that the person receives from her or his environment

Somatoform Disorders

- **Somatoform disorders** involve physical complaints or disabilities that suggest a medical problem, but which have no known biological cause are not produced voluntarily by the person
- In **hypochondriasis**, people become unduly alarmed about any physical symptom they detect are convinced that they have or are about to have a serious illness
- People with pain disorder experience intense pain that either is out of proportion to whatever medical condition they have or for which no physical basis can be found

- The most fascinating of the somatoform disorders is **conversion disorder**, in which serious neurological symptoms, such as paralysis, loss of sensation, or blindness suddenly occur
- Somatoform disorders tend to run in families, though it is not clear whether this reflects the role of genetic factors or environmental learning and social reinforcement for bodily symptoms, or both
- The incidence of somatoform disorders tend to be much higher in cultures that discourage open discussion of emotions or that stigmatize psychological disorders

Dissociative Disorders

- **Dissociative disorders** are disorders which involve a major dissociation of personal identity or memory
- Three forms that such disorders can take are psychogenic amnesia, psychogenic fugue, and dissociative personality disorder:
 - In **psychogenic amnesia**, a person responds to a stressful event with extensive but selective memory loss – some remember nothing about their past, others can no longer recall specific memories
 - **Psychogenic fugue** is a more profound dissociative disorder in which a person loses all sense of personal identity, give up his or her customary life, wanders to a new faraway location, and establishes a new identity
 - Usually triggered by a highly stressful event or trauma
 - May last from a few hours or days to several years
 - In **dissociative identity disorders (DID)**, formerly known as multiple personality disorder, two or more separate personalities coexist in the same person
 - A primary, or host personality, appears more often than the others (called alters), but each personality has its own integrated set of memories and behaviours
 - Personalities may differ in age and gender, and may differ not only mentally and behaviorally, but also physiologically

What Causes Dissociative Identity Disorder?

- According to Frank Putnam's **trauma-dissociation theory**, the development of new personalities occurs in response to severe stress – for many patients, this begins in early childhood, frequently in response to physical or sexual abuse
- Putnam believes that in response to the trauma and their helplessness to resist it, children may engage in something akin to self-hypnosis and dissociate from reality – they create an alternative identity to detach themselves from the trauma, to transfer what is happening to someone else who can handle it, and to blunt the pain
- However, other theorists have challenged this theory as they believe that multiple personalities result from role immersion and therapist suggestion

Schizophrenia

- **Schizophrenia** is a psychotic disorder that involves severe disturbances in thinking, speech, perception, emotion and behaviour

Characteristics of Schizophrenia

- Individual misinterprets reality and exhibits disordered attention, thought or perception
- Withdrawal from social interaction is common, communication is strange or inappropriate, personal grooming may be neglected, and behaviours may become disorganized

- Schizophrenic thought disorder sometimes includes **delusions**, which are false beliefs that are sustained in the face of evidence that normally would be sufficient to destroy them
- Some experience **hallucinations**, false perceptions that have a compelling sense of reality – auditory hallucinations (typically voices speaking to the patient) are most common, although visual and tactile hallucinations may occur
- Many people with schizophrenia have **blunted affect**, manifesting less sadness, joy and anger than most people; others have **flat affect**, showing almost no emotion at all – their voices are monotonous, their faces impassive

Subtypes of Schizophrenia

- **Paranoid type:** most prominent features in paranoid schizophrenics are delusions of persecution, in which people believe that others mean to harm them, and delusions of grandeur, in which they believe they are enormously important; suspicion, anxiety, or anger may accompany the delusions, and hallucinations may occur
- **Disorganized type:** central features are confusion and incoherence, together with severe deterioration of adaptive behaviour; behaviour often appears silly and childlike, emotional responses are highly inappropriate and are often unable to function on their own
- **Catatonic type:** shows striking motor disturbances, ranging from muscular rigidity to random or repetitive movements; alternate between stuporous states in which they seem oblivious to reality and agitated excitement during which they can be dangerous to others
- **Undifferentiated type:** people who exhibit some of the symptoms and thought disorders of the above categories but do not have enough of the specific criteria to be diagnosed in those categories
- Schizophrenic reactions are categorized into two main categories on the basis of two classes of symptoms:
 - **Type I schizophrenia** is characterized by a predominance of **positive symptoms**, such as delusions, hallucinations, and disordered speech and thinking – symptoms are called positive because they represent pathological extremes of normal processes
 - **Type II schizophrenia** features **negative symptoms**, an absence of normal reactions, such as lack of emotional expression, loss of motivation, and an absence of normal speech

Causal Factors in Schizophrenia

- Biological factors:
 - Strong evidence of genetic predisposition to schizophrenia
 - Indication of a number of structural abnormalities in the brains of schizophrenic patients, such as destruction of neural tissue, loss or deterioration of neurons in the cerebral cortex and limbic system, and abnormalities in the thalamus
 - **Dopamine hypothesis** states that the symptoms of schizophrenia (particularly positive) are produced by overactivity of the dopamine system in areas of the brain that regulate emotional expression, motivation behaviour and cognitive functioning
- Psychological factors:
 - For Freud, schizophrenia represented an extreme example of the defense mechanism of **regression**, in which a person retreats to an earlier and more secure (even infantile) stage of psychosocial development in the face of overwhelming anxiety
 - Other psychodynamic thinkers view the disorder as a retreat from an interpersonal world that has become too stressful to deal with
 - Some cognitive theorists believe that schizophrenics have a defect in the attentional mechanism that filters out irrelevant stimuli, so that they are overwhelmed by both internal and external stimuli – sensory inputs become a chaotic flood and irrelevant thoughts and images flash into consciousness

- Environmental factors:
 - Stressful life events seem to interact with biological or personality vulnerability factors
 - Previously hospitalized schizophrenics are more likely to relapse if they return to a home environment that is high in a factor called **expressed emotion**, which involves high levels of criticism, hostility, and overinvolvement – thus high expressed emotion may be either a cause of or a response to patients’ disordered behaviour
- Sociocultural factors:
 - Prevalence of schizophrenia is highest in lower socioeconomic populations
 - The social causation hypothesis attributes the high prevalence of schizophrenia to the higher levels of stress that low-income people experience, particularly within urban environments
 - The social drift hypothesis proposes that as people develop schizophrenia, their personal and occupational functioning deteriorates, so that they drift down the socioeconomic ladder into poverty and migrate to low-cost urban environments

Personality Disorders

- People diagnosed with **personality disorders** exhibit stable, ingrained, inflexible, and maladaptive ways of thinking, feeling, and behaving
- Three clusters that capture important commonalities among such disorders include: dramatic and impulsive behaviour, anxiety and fearfulness, or odd and eccentric behaviours
- Among the personality disorders, the most destructive to society is the antisocial personality disorder and the borderline personality disorder

Antisocial Personality Disorder

- People with **antisocial personality disorder** seem to lack a conscience – exhibit little anxiety or guilt, and tend to be impulsive and unable to delay gratification of their needs
- Research shows that there are two behavioural clusters of behaviours associated with psychopathy:
 - The first cluster consists of selfishness, callousness, and interpersonal manipulation
 - The second represents impulsivity, instability and social deviance
- Also display failure to respond to punishment

Causal Factors of Antisocial Personality Disorder

- Biological factors:
 - Genetic predisposition – physiological basis for the disorder might be some dysfunction in brain structures that govern emotional arousal and behavioural self-control, particularly the amygdala and the prefrontal cortex
 - Dysfunction in these areas would result in behavioural impulsiveness and a chronically underaroused state that impairs avoidance learning, causes boredom, and encourages a search for excitement
 - Antisocial individuals also have subtle neurological deficits in the prefrontal lobes – functions of planning, reasoning and behavioural inhibition – that are associated with reduced autonomic activity
- Psychological and environmental factors:
 - Absence of a well-developed superego results in reduction of restraints on the id, causing impulsive and self-indulgent behaviour

- Cognitive theorists believe that an important feature in antisocial individuals is their consistent failure to think about or anticipate the long-term negative consequences of their acts – this causes them to act impulsively, thinking only of what they want at the moment
- Antisocial individuals often come from homes in which parents exhibit a great deal of aggression and are inattentive to needs of children
- Exposure to deviant peers – children who become antisocial often learn from peer groups that model antisocial behaviour and reinforce it with social approval

Borderline Personality Disorder

- **Borderline personality disorder (BPD)** refers to a collection of symptoms characterized primarily by serious instability in behaviour, emotion, identity, and interpersonal relationships
- Central feature is emotional dysregulation, an inability to control negative emotions in response to stressful life events, many of which borderline individuals themselves cause
- Have intense and unstable personal relationships, and experience chronic feelings of extreme anger, loneliness, and emptiness, as well as momentary losses of personal identity
- Engage in impulsive behaviour and repetitive self-destructive behaviours
- BPD is highly associated with a number of other disorders, including mood disorders, PTSD, and substance-abuse disorders

Causal Factors of Borderline Personality Disorder

- Chaotic personal histories marked by interpersonal strife, sexual and physical abuse, and inconsistent parenting – reflected in earliest memories
- Early lack of acceptance by parents may cripple self-esteem and lead to clinging dependency and an inability to cope with separation
- Exhibit sudden and harmful shifts from extreme love and clinging dependence to intense hatred or feelings of abandonment – reflects a cognitive process called **splitting**, the failure to integrate positive and negative aspects of another's behaviour into a coherent whole
- Emotional explosiveness and impulsivity of borderlines reflect biological abnormalities in the neurotransmitter systems or areas of the brain that contribute to emotional self-regulation
- Cases of BPD increase in unstable societies that are rapidly changing, leaving some members with a sense of emptiness, problems of identity and fears of abandonment

Disorders of Childhood and Old Age

Childhood Disorders

- **Attention deficit / hyperactivity disorder (ADHD)** – problems may take the form of inattention, hyperactivity/impulsivity, or a combination of the two
 - Most common childhood disorder
 - Occurs at least four times more frequently in boys than in girls
 - Boys are more likely to exhibit aggressive and impulsive behaviours, whereas girls are more likely to be primarily inattentive
 - Environmental factors such as inconsistent parenting, may play a role in combination with biological factors

- **Autistic disorder** – long-term disorder characterized by extreme unresponsiveness to others, poor communication skills, and highly repetitive and rigid behaviour patterns
 - Typically appearing in the first three years of life in the form of unresponsiveness and lack of interest in others, autism tends to be a lifelong disorder
 - Lack of social responsiveness to others is a central feature
 - Language and communication difficulties are also common – language involves repetition with little meaning, or engage in echolalia, the exact echoing of phrases spoken by others
 - Sameness and routine are important to autistic children
 - Have repetitive and stereotyped behaviour patterns and interests
 - Causal factors have a biological basis:
 - Abnormal development in the cerebellum, which coordinates movement and is involved in shifting attention
 - Genetic factors have also been linked

Dementia in Old Age

- **Dementia** – gradual loss of cognitive abilities that accompany brain deterioration and interferes with normal functioning
- Progressive degeneration of brain tissue occurs as a result of disease or injury
- More than a dozen types and causes of dementia exist, the most common being: Alzheimer’s disease, Parkinson’s disease, Huntington’s disease, and Creutzfeldt-Jakob disease
- When dementia begins after age 65, it is labeled senile dementia
- Memory impairment, poor judgment, confusion, language problems, and disorientation may appear gradually or periodically
- **Alzheimer’s disease** is the leading cause of dementia in the elderly (60%) – disorder is caused by deterioration in the frontal and temporal lobes of the brain, including the hippocampus, a subcortical structure involved in memory
 - A key to Alzheimer’s disease is the destruction of cells that produce acetylcholine, a neurotransmitter that is critically involved in the neural processes underlying memory