Psychological or Mental Disorder

• Prolonged or recurring psychological problem seriously interfering with a person’s ability to live a satisfying personal life & function adequately within society.
• About 20-30% of adults have suffered from a mental disorder in the last year; 51% will sometime in their life. All of us will have friends, family, or colleagues with mental disorders.

How do psychologists distinguish normal from abnormal/disordered?

• Not just that the behavior is rare or different from norm
• Is ability to function impaired?
• Is the behavior causing distress?
• Often the degree & duration of disruption will distinguish “normal range” from “abnormal range”

Ways of Viewing Disorders

• Medical Model - mental disorders are seen as similar to physical disorders, with “symptoms” that can be “diagnosed” & “treated”
• Psychological models – focus on different kinds of psych causes for the abnormal behavior
  • Psychodynamic – unconscious processes
  • Behavioral – inappropriate learned responses
  • Humanistic – problems of self concept & actualization
• In truth multiple factors involved in most disorders – biological, psychological and social/environmental.

Clinical Assessment of Disorders

• Clinical Interview
• Psychological tests (e.g. MMPI)
• Neurological/physical assessment
• Problems: individual may not be cooperative, symptoms can be complex & hard to understand, even professionals may not always agree on the clinical diagnosis.

DSM IV and DSM 5

• Diagnostic & Statistical Manual of Mental Disorders – regularly revised
• American Psychiatric Association’s guide to diagnosing & classifying mental disorders based on input from clinical professionals, organizations, and research
• Provides a common “professional language” and diagnostic guidelines or criteria
• Switch from 4th to 5th revision is just underway so there will be a little confusion in our book, videos and web resources. (you can skip p.514-515)
• http://psychcentral.com/dsm-5/
Major Clinical Syndromes We’ll Talk About (DSM 5)

- Anxiety disorders
- Obsessive-Compulsive Disorders
- Trauma-related disorders
- Dissociative disorders
- Somatic symptom disorders
- Depressive Disorders
- Bipolar Disorder
- Schizophrenia spectrum

Generalized Anxiety Disorder

- Excessively nervous, tense, worrying more than necessary on most days for at least 6 months
- Impairs functioning; sleep problems & anxiety–related physical complaints are common
- Used to be called “free-floating anxiety”
- Affects about 1 in 20 adults (5%), is more common in women, & may be associated with substance abuse or depression

Panic Disorder - >3,000,000 in US

- Recurrent unpredictable attacks of intense physical terror plus continual worry about having the next attack
- Attacks include 4 or more of these: pounding heart, sweating, trembling, breathless, choking feelings, nausea, chest pain, dizzy, feeling out of control or that you might die, terror
- Limits person’s activities
- 4% of adults, 2-3 X as many women

Agoraphobia

- Fear of going out (away from your safe place), especially into situations that may be difficult to escape from or where help may be unavailable. Fear that going out may cause panic attacks.
- Person may avoid particular situations (shopping, public transportation, large crowds) or may be totally house-bound
  - http://www.youtube.com/watch?v=u0dpgmwETcg&feature=related
Theories About What Causes Panic Disorder

- Biological differences in body responses and/or sensitivity to body responses (Artificially causing body changes (e.g. with caffeine or lactate) can trigger a panic attack)

- Social cognitive approach - panic is due to differences in cognitive interpretation of bodily signs

Phobias

- Persistent intense irrational fear of particular situations or things
- Fear leads to avoidance that interferes with normal activities
- 75% are linked to traumatic experiences; all 3 types of learning can be involved
- Most common is social phobia (fear of humiliation or embarrassment in social situations) (13%)
- Others (7-11%) have "specific phobias"

Some Specific Phobias (11%)

- acrophobia - fear of heights
- claustrophobia - fear of closed spaces
- brontophobia – fear of storms
- zoophobia - fear of animals
- xenophobia - fear strangers/unfamiliar
- Some phobias may have a biological basis - we may be biologically prepared to fear things that were dangerous to us in our evolutionary past

Obsessive-Compulsive Disorder (3%)

- Repetitive intrusive thoughts (”obsessions”) + repetitive behavioral rituals (”compulsions”)
- Feel driven to engage in those behaviors - otherwise experience intense anxiety.
- Common compulsions: hand-washing/cleaning, checking things, counting things, putting things in order
- [http://www.youtube.com/watch?v=tPFQMRx2l3Y](http://www.youtube.com/watch?v=tPFQMRx2l3Y)
Obsessive-Compulsive Disorders

• *OCD (used to be grouped with anxiety disorders)
• Hoarding disorder
• Hair-pulling disorder (trichotillomania)
• Skin-picking disorder (excoriation)
• Body dysmorphic disorder

Trauma-Related Disorder:
Post-Traumatic Stress Disorder (PTSD)
(used to be grouped with anxiety disorders)

• Anxiety & feelings of helplessness after an extreme trauma - keep thinking about trauma, may have recurring nightmares or flashbacks, over-response to associated cues, avoidance of associated situations, and numbing of emotional responses
• Anxiety causes difficulty concentrating, irritability, memory problems, sleep problems, physical symptoms, exaggerated startle response
• May be delayed; persists at least a month

Somatic Symptom Disorders

• *Conversion Disorder
• Illness Anxiety Disorder
• Factitious Disorder

• Major Depression ~17% overall (21% in women 13% in men)
• sadness, feel helpless, hopeless, worthless
• no energy, apathetic, nothing matters
• can’t make decisions, complete tasks
• have selective memory for negative events
• lose appetite for food & sex, disordered sleep, may move & talk slowly
• suicidal thoughts or actions; ~15% kill themselves

Mood Changes Across Time

Causes of Depression

• Biological factors (genetic, brain chemistry)
• Linked to underactivity of serotonin and/or NE ("monoamines")
• Cognitive factors (pessimism, negative thinking or rumination, learned helplessness)
• Psychological factors (personality, stresses, lack of coping skills or social support, life events)
Brain Changes in Depression

- Bipolar I Disorder (1.3%, no sex diff) (aka Manic Depressive disorder)
  - Periods of mania + depressive periods
  - Symptoms during the manic phase:
    - Euphoria and extreme confidence/self-esteem
    - Rapid, racing thoughts & speech
    - Unrealistic view of capabilities, may be delusional
    - Increased energy & activity; agitation
    - Impulsive, distractible
    - Decreased need for sleep; may be irritable
  - Bipolar II – hypomania (milder) + depression

Mania

Genetics

- Twin studies:
  - If identical twin is bipolar, ~80% chance other twin will also develop bipolar disorder (only 16% of fraternal twins match)
  - Major depression also runs in families
    - If identical twin depressed, ~60% chance other twin will also suffer from depression

- Mood Changes Across Time

  - Bipolar I Disorder
  - Bipolar II Disorder

- Persistent Depressive Disorder (mild) - (what used to be called Dysthymic Disorder (6%))

  - Chronic low-level depression for 2 yrs or more, with intervals of normal mood not lasting longer than a few weeks or months.
  - Symptoms like depression but not as debilitating.
  - Individuals tend to accept being “down in the dumps” as just a fact of life.
Seasonal Affective Disorder (SAD) (see sleep chap)

- Depression that typically occurs in the fall/winter and disappears when days get longer in the spring.
- Characterized by lack of energy, oversleeping, overeating as well as depressed, irritable mood
- Artificially lengthening the day with full-spectrum lights can relieve this depression
- [http://www.cbsnews.com/video/watch/?id=2357916n](http://www.cbsnews.com/video/watch/?id=2357916n)

Schizophrenia (~1%)

- Serious mental disorder lasting >6 months with at least 2 of these interfering with their functioning:
  - Delusions (irrational beliefs)
  - Hallucinations (most often hearing voices)
  - Disorganized thought & speech
  - Grossly disorganized behavior OR catatonia
  - Decreased normal emotional expression, speech, social interactions

Schizophrenia Symptoms

- “Positive (+) symptoms”
  - Hallucinations
  - Delusions
  - Disorganized thought & speech
  - Inappropriate emotion
  - Disorganized or catatonic behavior

- “Negative (-) symptoms”
  - Normal emotions lost
  - Decreased social interaction
  - Speech often decreased

Some Subcategories from DSM IV

- Paranoid- delusions of being plotted against/persecuted; delusions of grandeur; hear voices
- Disorganized- childish behavior, bizarre ideas (often about their body), inappropriate & changeable emotions, neglect of personal hygiene; very disorganized speech
- Catatonic- periods of prolonged immobility alternating with wild motor activity; may echo or imitate others
- Some don’t neatly fall in a single category (“undifferentiated”)

Other Ways of Catagorizing

- Type I- those with just positive (+) symptoms have a better chance of responding to meds & showing some recovery
- Type II- those with negative (-) symptoms are less likely to respond to meds & show recovery
- Acute vs chronic schizophrenia

http://www.youtube.com/watch?v=gGnl8dqEoPQ&feature=channel
Causative Factors

- Inherited predisposition
- Overactive DA theory
- Brain changes (larger ventricles, smaller thalamus, less activity in the frontal lobe)

PET Scans – Less Prefrontal Activity in Schizophrenics

Diathesis-Stress Theory -

- Genetic vulnerability ("diathesis") interacts with environmental stress to determine whether you reach threshold for the disorder

Dissociation

- A breakdown of the normal integrated self; the splitting off of mental processes into separate states of awareness; a dividing of consciousness
- Some dissociation is a normal part of daily life (e.g., being temporarily unaware of the outside world when daydreaming or realizing you don’t remember anything about your drive home) or processes like hypnosis.

Dissociative Amnesia

- Amnesia for personal information and events that does not have an organic basis. Usually no loss of procedural or other semantic memories.
- Associated with stressful or traumatic events
- Recovery possible (unlike most organic cases)
Dissociative Fugue  
(now a subtype of Dissociative Amnesia)  
• Psychogenic amnesia or confusion about identity paired with sudden, unexpected travel or fleeing to a new location  
• May start up a new life with no recollection of past  

Dissociative Identity Disorder (multiple personality disorder)  
• Individual shows 2 or more distinct personality states, each with its own manner of thinking & behaving, and appearing at different times.  
• 90% of cases are females  

Why is DID Controversial?  
• Huge recent increase in reported cases  
• Increase mostly limited to the USA  
• Majority of recent cases had a wide range of chronic psychiatric problems or were using insanity defense  
• Certain therapists may over-diagnose or “suggest” DID  
• DID symptoms can be intentionally induced under hypnosis  

Opposing Views of DID/MPD  
• 1. Mental “splitting” was a way of coping with severe childhood abuse.  
• 2. Public awareness of cases of DID led to some people assuming this pattern of behavior and some therapists encouraging this diagnosis.  

Somatic Symptom Disorders  
• Disorders in which the symptoms take a bodily form without an apparent physical basis  
• Disorder usually allows individual to escape from a distressing situation or get attention  
• Patients with these disorders often seek medical attention – may take MDs a while to discover there is nothing physically wrong  
• Severe cases fairly rare but experiencing some somatic symptoms much more common  

Conversion Disorder  
• Psychological distress/anxiety is “converted” into some specific physical symptom (blindness, paralysis, loss of sensation, etc.)  
• No organic or physical basis for medical problems can be found  
• Recovery is likely  
• Person is not consciously “faking it” - not under voluntary control
Personality Disorders

- Excessive, inflexible, long-standing maladaptive personality traits that impair social functioning and/or cause distress
- DSM 5 now has 6 varieties, but we'll just cover 2 examples

Antisocial Personality Disorder

- Pervasive pattern of disregard for or violation of others’ rights for your own benefit with no feelings of remorse or conscience
- Symptoms:
  - Repeated unlawful behavior
  - Aggressiveness
  - Impulsiveness
  - Deceitful and manipulative
  - Recklessness
  - Consistent irresponsibility

Borderline Personality Disorder

- Pervasive instability in relationships, mood, self-image
  - Impulsive self-damaging acts or others
  - Unstable and intense emotional erratic relationships