Psychological Disorders

Psychopathology - the study of mental disorders
“Abnormal” psychology

Psychological 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 behavior maladaptive, impairing ability to function optimally?
– 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 illnesses” are seen as similar to physical disorders, with “symptoms” that can be “diagnosed” & “treated”
• But it may not always be appropriate or useful to consider all disordered behaviors as “illnesses”
• For example – some disordered patterns of behavior may simply be learned maladaptive behaviors.

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-TR

• Diagnostic & Statistical Manual of Mental Disorders – IV TR
• 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 criteria”
Major Clinical Syndromes

(We’ll concentrate on disorders that make up what is known as “Axis I” of the DSM but won’t get to all categories)

- Anxiety disorders
- Mood disorders
- Schizophrenic disorders
- Somatoform disorders
- Dissociative disorders

Generalized Anxiety Disorder

- Excessively nervous, tense, worrying about multiple things more than necessary on most days for at least 6 months
- Impairs functioning; sleep problems & anxiety-related physical complaints are very 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

Phobic Disorder

- 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

Panic Disorder

- 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

Agoraphobia (5.5%)

- 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
Obsessive-Compulsive Disorder (3%)
- Repetitive intrusive thoughts ("obsessions")
- 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=tPFQM Rx2I3Y](http://www.youtube.com/watch?v=tPFQM Rx2I3Y)

Post-Traumatic Stress Disorder (PTSD)
- Anxiety & feelings of helplessness after an extreme trauma
  - keep thinking about trauma, may have recurring nightmares or flashbacks, over-respond to associated cues, avoid associated situations, and show 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

Etiology of Anxiety Disorders
- Multiple factors seem to affect your risk of suffering an anxiety disorder:
  - Biological (genetics, transmitters, sensitivity to bodily symptoms)
  - Conditioning and learning
  - Cognitive factors – attention to and interpretation of threats
  - Stress and trauma in one's life

Mood Disorders
- Major depression ("unipolar depression")
- Bipolar Disorder ("manic-depressive 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
- [Graph showing mood changes over time](image)
• Bipolar Disorder (1.3%, no sex diff) (aka Manic Depressive disorder)
  • Periods of abnormally elevated mood (excited, irrationally optimistic) + 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

• Mood Changes Across Time

Etiology 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 (interpersonal interactions, personality factors, life stresses, lack of coping skills or social support)

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

Brain Changes in Depression

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
- Disordered thought & speech
- Inappropriate emotion
- Disorganized or catatonic behavior

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

Some Subcategories

- 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 Categorizing

- 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

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

Somatoform Disorders
- A separate DSM category from “Anxiety Disorders”, yet still can be tied to anxiety/psychological distress
- Disorders in which the symptoms take a bodily form without an apparent physical basis
- Disorder allows individual to escape from a distressing situation
- Patients with these disorders seek medical attention – may take MDs a while to discover there is nothing physically wrong
- Severe cases fairly rare but experiencing some somatoform symptoms much more common

Somatization Disorder
- Years of diverse physical complaints (gastrointestinal, neurological, sexual, pain) beginning before age 30 for which no physical basis can be found, and which appear to be associated with psychological distress & need for attention. May have many doctors, many exploratory tests.

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

Hypochondriasis
- Misinterpretation of bodily symptoms and preoccupation with the idea that one has a serious medical illness despite getting a clean bill of health and medical reassurance. Causes clinically significant distress and/or impairment of functioning for at least 6 months.

Etiology of Somatoform Disorders
- Certain cognitive characteristics (excess attention to bodily processes; very negative interpretations of minor symptoms
- Personality factors (emotional reactivity or “neuroticism”, insecurity)
- Learning (being “sick” is reinforced by attention and care from others, is a good excuse for underperformance)
**Dissociative Disorders**

- A DSM category of disorders characterized by an extreme degree of dissociation which seems to be caused by stress/psychological trauma
  - Dissociative amnesia
  - Dissociative fugue
  - Dissociative identity 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 because you were thinking about something else) or occurs in 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 or amnesia)

**Dissociative Fugue**

- 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.

**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