Cognitive-Behavioral Model

General

- This model integrates **behavioral** and **cognitive** perspectives to explain abnormal behavior.

Causes of Psychological Disorders

1. **Behavioral Perspective**
    - Views abnormal behavior as learned through **classical and operant conditioning**.
    - Problems are seen as direct behavioral issues rather than symptoms of underlying conditions.
2. **Cognitive Perspective**
    - Based on the philosophy of **Epictetus (84 AD)**:
        - "Men are not disturbed by things, but by the way they think of them."
    - Maladaptive thinking leads to disorders, including:
        - Short-term thoughts: **Expectations, appraisals, attributions**
        - Long-term beliefs: **Core philosophies, cognitive distortions**
3. **Social Cognitive Perspective**
    - Based on **Bandura's observational learning and social cognitive theory**.
    - Behavior is shaped by:
        - **Environment** (external stimuli)
        - **Behavior itself** (reinforcement, conditioning)
        - **Personal cognition** (self-efficacy, self-regulation)
    - Emphasizes **reciprocal determinism** (behavior, cognition, and environment influence one another).

Treatment Approaches

1. **Behavioral Therapy**
    - Uses **conditioning techniques** to eliminate unwanted behaviors.
    - Reinforces adaptive behaviors through **classical and operant conditioning**.

2. **Cognitive Therapy**
    - Identifies and challenges **maladaptive thought patterns**.
    - Replaces irrational thinking with **logical, evidence-based reasoning** (Ellis, Harper, & Powers, 1975).
3. **Social Cognitive Therapy**
    - Uses **modeling techniques** to reshape behavior.
    - Focuses on **self-efficacy** and **self-regulation strategies** to improve mental health.

VI. Meta-Theoretical Models

A. General

Meta-theoretical models integrate research from various theoretical approaches to enhance the understanding and treatment of psychological abnormalities. Given the complexity of psychological disorders and the valuable insights provided by different models, these overarching frameworks are gaining popularity. Two of the most prominent meta-theoretical models are the **biopsychosocial model** and the **diathesis-stress model**.

B. The Biopsychosocial Model

The **biopsychosocial model** emphasizes the interaction between biological, psychological, and sociocultural factors in the development and maintenance of psychological disorders. The relative influence of each factor varies depending on the individual and the specific condition. However, a comprehensive understanding of a person's psychological difficulties requires considering all three dimensions.

C. The Diathesis-Stress Model

The **diathesis-stress model** proposes that biological predispositions (diathesis) create vulnerabilities to various psychological disorders. These disorders develop when environmental stressors exceed an individual's threshold of vulnerability, triggering symptoms of abnormality.

VII. Stigma and Abnormal Behavior

Stigma occurs when individuals are discredited or rejected by society due to a particular characteristic or attribute. When behaviors are classified as "mental disorders," those affected may be perceived negatively, leading to societal rejection.

A. The Relationship Between Stigma and Psychological Problems

The label of “mental illness” or terms like “crazy” can shape both how an individual is perceived by others and their own self-concept. Stigmatization influences how people experience their condition and whether they seek help. Cultural and ethnic backgrounds also play a role in how mental illness is stigmatized, particularly in **African American, Latino/a, and Asian communities**.

B. Consequences of Diagnostic Labels

Being diagnosed with a mental disorder affects self-perception and how others view an individual. Social cognitive biases reinforce stigma:

- **Confirmation bias** (Wason, 1960): People interpret information in ways that confirm pre-existing beliefs.
- **Self-serving bias** (Miller & Ross, 1975): Individuals attribute successes to internal factors and failures to external causes.
- **Self-fulfilling prophecy** (Merton, 1957): Expectations about an individual influence their behavior, making the label become reality.

C. Addressing and Overcoming Stigma

1. **Rosenhan’s (1973) study, "On Being Sane in Insane Places"**, demonstrated how even mental health professionals reinforce stigma through misdiagnosis and bias.
2. **Criticism of the DSM (Diagnostic and Statistical Manual)** argues that its categorical classification system encourages labeling, reinforcing stigma.
3. **Efforts to counteract stigma** have emerged throughout history:
    - Some perspectives view **all individuals as "mad" in some way** (Porter, 2003).
    - The **“wise fool” concept** reframed madness as wisdom (Porter, 2003).
    - Modern movements like **Mad Pride** advocate for reclaiming "madness" as a source of strength and identity, challenging stigma.

VIII. Prevalence of Mental Disorders

A. Global and Regional Prevalence

1. According to the **World Health Organization (WHO)**, over **450 million** people worldwide experience some form of mental disorder.
2. The **12-month prevalence rate** of mental disorders:
    - **Adults in the U.S.:** 26.2%

- **Adults in Europe:** 27%
- **Children in the U.S.:** 13.1% (with **8.6% classified as ADHD**)

B. Suicide Statistics

- In **2007**, approximately **35,000 suicides** occurred in the U.S.
- **95% of these suicides** were committed by individuals aged **19 and over** (**CDC statistics**).

IX. Financial Impact of Mental Disorders

A. Disability and Mental Illness

1. **Mental illness** is the **leading cause of disability in children** (**Whitaker, 2010**).
2. Mental disorders account for **28% of the burden of disability** in the **U.S. and Canada** (**WHO statistics**).

B. Economic Costs

1. Mental health expenditures make up **6.2% of total healthcare costs** (**$100 billion in 2002**, **NIMH statistics**).
2. The **average per-person spending** on mental health care in the U.S. is approximately **$1,500** (**NIMH statistics**).

X. Classification of Psychological Disorders

A. Classification Systems

1. The **DSM-5** (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*) (**American Psychiatric Association, 2013**) is the most widely used classification system for mental disorders in the U.S.
2. The **International Classification of Diseases (ICD-10)** (**World Health Organization, 1992**) is used globally, with a chapter dedicated to **mental and behavioral disorders**.

B. Contents of the DSM-5

1. The **DSM-5** includes diagnostic criteria and codes for **19 categories** of mental disorders.

2. Additional **V-codes** cover conditions affecting mental health but not classified as disorders (e.g., sibling relational problems, religious/spiritual concerns, extreme poverty).

C. Organization of the DSM-5

1. The DSM-5 follows a **developmental structure**, with disorders appearing earlier in life listed first, followed by those emerging later.
2. Disorders within categories are also organized in a **developmental sequence**.

D. The International Classification of Diseases (ICD)

1. The **ICD**, published by the **WHO**, is the primary system for classifying all diseases, including mental disorders.
2. The **DSM-5** aligns its coding system with **ICD-9-CM** and **ICD-10-CM** while anticipating **ICD-11** (expected in **2017**).
3. Though **DSM and ICD** have differences in structure, they maintain significant **correspondence** for consistency.

II. Understanding Classification

The classification of psychological disorders is complex because human experiences and expressions of distress are vast and varied. Classification systems aim to describe the most common patterns of psychological problems. These descriptions function as **prototypes**, or ideal examples, rather than rigid definitions.

III. Criticisms of the DSM

A. Biomedical Orientation

One of the primary criticisms of the **DSM** is its reliance on a **biomedical model**, which frames psychological disorders in medical terms (e.g., the use of "diagnosis"). This approach may overlook psychological, social, and environmental factors.

B. Categorical vs. Dimensional Classification

Another major criticism concerns the **categorical nature** of the DSM:

- In reality, psychological disorders exist on a **spectrum** rather than as clear-cut categories (**Markon, Chmielewski, & Miller, 2011**).
- The **DSM remains categorical** ("in or out") because categorical classification is **traditional in medicine** and is easier for **clinicians** to use (**APA, 2013; Widiger & Shea, 1991**).

Issues with Categorical Classification:

- **Increases inter-rater reliability** (agreement between professionals) but raises concerns about **validity**.
- **Reification of categories**: Labels may be perceived as fixed conditions rather than descriptions of symptoms.
- **Stigma and secondary labeling**: Diagnoses can influence **self-perception** and how others view an individual.
- **Description vs. Explanation**: A diagnosis describes a condition but does not explain **why** a person exhibits certain behaviors (e.g., **bulimia nervosa** describes binge eating but does not explain its cause).

C. Modifications in the DSM-5

The **DSM-5** has introduced **more dimensional elements** to address these concerns:

- **Broadening categories** (e.g., **Autism Spectrum Disorder** instead of separate subtypes).
- **Severity coding** for many disorders.
- **Specifiers** to better capture variations within disorders (e.g., **major depressive disorder** with anxious distress).

Despite these changes, the DSM remains **primarily categorical** (**APA, 2013**).

IV. Key Considerations in Classifying Psychological Disorders

A. Clinical Significance

- A psychological disorder is diagnosed **only if it significantly interferes** with an individual's life (**APA, 2013**).
- Clinical significance is determined by **mental health professionals**, who assess suffering and functional impairment.

B. Complexity of Psychological Disorders

- Psychological problems have **biological, psychological, and sociocultural influences**.
- Oversimplified questions (e.g., *"Is schizophrenia genetic?"*) fail to capture the **multifactorial** nature of disorders.

C. Variability in Disorder Expression

- Disorders exist on a **spectrum of severity**.
- Different individuals may develop similar disorders due to **different contributing factors**.

D. Cultural and Individual Influences on Psychological Disorders

1. **Cultural Context**
    - Psychological disorders are defined in relation to **cultural, social, and familial norms** (**APA, 2013**).
    - Understanding an individual's **cultural background** is crucial in assessing mental health (**Matsumoto & van de Vijver, 2011**).
2. **Demographic Considerations**
    - **Age, cultural/ethnic background, and sexual orientation** all influence how mental health issues manifest and how individuals experience psychological disorders.

Psychological Disorders: Classification, Causes, and Examples

I. Influence of Culture, Gender, and Social Support

- Culture and gender impact how individuals experience and express psychological disorders.
- Certain disorders, such as **dissociative identity disorder, eating disorders, and ADHD**, are more prevalent in specific cultures (**Hacking, 1999; Toro et al., 2005**).
- Some disorders are culture-specific, e.g., **susto**, an anxiety disorder in Central and South America, linked to supernatural experiences (**Tan, 1980**).
- Culture and gender are **not direct causes** but influence the development and manifestation of disorders (**APA, 2013**).
- **Social support** is a protective factor in preventing and treating mental disorders (**Cobb, 1976; Bryant, 2010**).

II. Anxiety Disorders

Anxiety disorders involve an **exaggerated fear response** that disrupts daily life. Individuals often recognize their fears as irrational but struggle to control them.

A. Types of Anxiety Disorders

1. **Specific Phobia** – Irrational fear of an object or situation.

2. **Agoraphobia** – Fear of open or public spaces where escape seems difficult.
3. **Social Anxiety Disorder** – Fear of humiliation in social settings.
4. **Panic Disorder** – Sudden, intense panic attacks without real danger.
5. **Generalized Anxiety Disorder (GAD)** – Persistent and excessive worry about various aspects of life.

B. Causes of Anxiety Disorders

1. **Psychological Factors:**
    - **Classical conditioning** (learned fear responses).
    - **Negative reinforcement** (avoiding fear-inducing situations).
    - **Cognitive biases** (fear of negative evaluation).
    - **Unresolved unconscious conflicts**.
2. **Biological Factors:**
    - **GABA dysfunction** (neurotransmitter imbalance).
    - **Amygdala-hypothalamus-locus coeruleus dysfunction** (**Comer, 2014**).

III. Obsessive-Compulsive and Related Disorders

These disorders involve **intrusive thoughts (obsessions) and repetitive behaviors (compulsions)** that cause distress.

A. Types of Obsessive-Compulsive and Related Disorders

1. **Obsessive-Compulsive Disorder (OCD)** – Unwanted, anxiety-inducing thoughts with compulsive behaviors to reduce distress.
2. **Hoarding Disorder** – Persistent difficulty discarding items, leading to excessive accumulation.
3. **Body Dysmorphic Disorder** – Preoccupation with perceived physical flaws, leading to compulsive behaviors.

B. Causes of Obsessive-Compulsive and Related Disorders

1. **Psychological Factors:**
    - **Negative reinforcement** (compulsions reduce anxiety).
    - **Cognitive distortions** (irrational thinking about intrusive thoughts).
2. **Biological Factors:**

- **Overactive orbitofrontal cortex-caudate nuclei-thalamic circuit**.
- **Dysregulation of serotonin, glutamate, and dopamine**.

IV. Depressive Disorders

Depressive disorders are characterized by **persistent sadness, loss of pleasure, and cognitive or physical changes**.

A. Types of Depressive Disorders

1. **Major Depressive Disorder (MDD)** – Depressed mood, loss of interest, sleep disturbances, and lack of motivation lasting at least **two weeks**.
2. **Persistent Depressive Disorder (PDD)** – Chronic depressive symptoms lasting at least **two years**.
3. **Premenstrual Dysphoric Disorder (PMDD)** – Severe mood swings before menstruation, resolving afterward.

B. Causes of Depressive Disorders

1. **Psychological Factors:**
   - **Cognitive Triad** (negative beliefs about self, world, and future).
   - **Lack of reinforcement**.
   - **Unresolved grief or symbolic loss**.
2. **Biological Factors:**
   - **Dysfunction in the prefrontal cortex, amygdala, hippocampus, and Brodmann Area 25**.
   - **Serotonin imbalances** (genetic predisposition).

V. Bipolar and Related Disorders

Bipolar disorders involve **mood fluctuations between mania and depression**.

A. Types of Bipolar Disorders

1. **Bipolar Disorder** – At least **one manic episode** with possible depressive episodes.
   - **Manic Episode**: Elevated or irritable mood, decreased need for sleep, rapid thoughts, impulsivity, and possible delusions.

- **Depressive Episode**: Periods of low mood, lack of energy, and negative thoughts (not always present).

Psychological Disorders: Causes and Examples

I. Bipolar and Related Disorders

A. Causes of Bipolar Disorder

1. **Psychological Factors:**
   - **Manic-defense hypothesis**: Suggests that underlying depressive processes are denied and countered with manic behavior, possibly due to a need for external approval.
2. **Biological Factors:**
   - Possible links to **norepinephrine, serotonin, or GABA**.
   - Abnormal **ion activity within neurons**.
   - Structural abnormalities in **basal ganglia and cerebellum**.
   - Genetic predispositions may contribute to vulnerability.

II. Schizophrenia Spectrum and Other Psychotic Disorders

A. Examples

1. **Schizophrenia:** Characterized by delusions, hallucinations, disorganized speech, disorganized behavior, and negative symptoms. Symptoms must persist for at least **six months** and significantly impact daily functioning.
2. **Delusional Disorder:** The presence of one or more **false beliefs** despite contradictory evidence. These can be categorized as **erotomanic, grandiose, jealous, persecutory, or somatic**.

B. Causes

1. **Psychological Factors:**
   - External-personal attributions for negative events.
   - Operant conditioning reinforcing peculiar behaviors.
   - Efforts to make sense of **peculiar perceptual experiences**.
   - Family stress and dysfunction.
2. **Biological Factors:**

- **Dopamine and serotonin imbalances**.
- Abnormalities in the **frontal and temporal lobes**.
- Structural differences in **hippocampus, amygdala, and thalamus**.

III. Personality Disorders

A. Examples

1. **Antisocial Personality Disorder:** Includes traits of **psychopathy and sociopathy**, such as deceitfulness, impulsivity, aggression, recklessness, irresponsibility, and lack of conscience.
2. **Borderline Personality Disorder:** Marked by **instability** in identity, mood, and relationships. Symptoms may include **impulsivity, feelings of emptiness, suicidal ideation, and self-harming behaviors**.

B. Causes

1. **Psychological Factors:**
   - Childhood mistreatment and trauma.
   - Lack of empathy, failure to learn from punishment.
   - Operant and classical conditioning, irrational beliefs.
2. **Biological Factors:**
   - **Genetic predispositions** for maladaptive personality traits.
   - Slow autonomic arousal.
   - Abnormal **frontal lobe activity**.

IV. Trauma and Stressor-Related Disorders

A. Examples

1. **Post-Traumatic Stress Disorder (PTSD):** A reaction to severe trauma, characterized by **intrusive memories, flashbacks, avoidance of trauma-related stimuli, mood disturbances, and heightened arousal**.
2. **Adjustment Disorder:** Emotional or behavioral problems **within three months** of experiencing a stressful event.

B. Causes

1. **Psychological Factors:**
    - Negative appraisals, fatalistic beliefs.
    - Childhood trauma, lack of social support.
    - Poor coping skills, low self-efficacy.
2. **Biological Factors:**
    - Abnormal activity of **cortisol and norepinephrine**.
    - Dysfunction in the **hypothalamus-amygdala circuit**.

V. Dissociative and Somatic Symptom Disorders

A. Examples

1. **Dissociative Identity Disorder:** Presence of **two or more distinct personalities**, each with unique cognition, affect, and behavior.
2. **Somatic Symptom Disorder:** Distressing somatic symptoms that interfere with daily life.
3. **Illness Anxiety Disorder:** Preoccupation with having or acquiring an illness, despite the absence of significant symptoms.
4. **Conversion Disorder:** Physical symptoms causing **loss of function**, not due to physical causes.
5. **Factitious Disorder (Munchausen's Syndrome):** Fabrication of medical issues for attention.

B. Causes

1. **Psychological Factors:**
    - Unconscious defense mechanisms.
    - Secondary gains (escaping responsibilities).
    - Suggestion, self-hypnosis, repression.
2. **Biological Factors:**
    - Some unspecified neurological predispositions.

VI. Feeding and Eating Disorders

A. Examples

1. **Anorexia Nervosa: Refusal to maintain normal body weight** due to intense fear of gaining weight.
2. **Bulimia Nervosa:** Binge eating followed by compensatory behaviors (purging or excessive exercise).
3. **Binge-Eating Disorder:** Binge eating without compensatory behaviors.

B. Causes

1. **Psychological Factors:**
    - **Ego deficiencies, perceptual disturbances**.
    - **Cognitive distortions and irrational beliefs**.
2. **Biological Factors:**
    - **Dysfunction of the hypothalamus**.
3. **Sociocultural Factors:**
    - Unrealistic societal beauty standards.
    - Family environment and communication patterns.

VII. Neurodevelopmental Disorders

A. Examples

1. **Intellectual Disability:** Deficits in **intellectual and adaptive functioning**.
2. **Autism Spectrum Disorder:** Challenges in **social communication, restricted interests, and repetitive behaviors**.
3. **Attention-Deficit/Hyperactivity Disorder (ADHD):** Persistent **inattention and/or hyperactivity-impulsivity**.

B. Causes

1. **Psychological Factors:**
    - Failure in self-regulation.
    - High stress, family dysfunction.
    - Delays in theory of mind development.
2. **Biological Factors:**
    - **Dopamine dysfunction in ADHD**.

- Abnormalities in **frontal-striatal brain areas**.
- Genetic predisposition and prenatal complications.

VIII. Substance-Related and Addictive Disorders

A. Examples

1. **Alcohol Use Disorder:** Excessive drinking causing **cravings, social problems, and physical harm**.
2. **Gambling Disorder:** Persistent and problematic gambling behavior.

B. Causes

1. **Psychological Factors:**
   - **Conditioning, modeling, trauma, stress, impulsivity**.
   - Poor coping mechanisms and low self-efficacy.
2. **Biological Factors:**
   - **Genetic predisposition, reward-deficiency syndrome**.
   - Abnormal **GABA receptor activity**.
3. **Sociocultural Factors:**
   - Poverty, unemployment, dysfunctional family environments.
   - Social normalization of substance use.