Psychological Disorders

SUBTITLE

Defining Abnormality

- Abnormality as deviation from the average.
- Abnormality as deviation from the ideal.
- Abnormality as a sense of personal discomfort
- Abnormality as the inability to function effectively
- Abnormality as a legal concept.

Defining Abnormality

abnormal behavior is behavior that causes people to experience distress and prevents them from functioning in their daily lives

Behavior should be evaluated in terms of gradations that range from fully normal functioning to extremely abnormal behavior. Behavior typically falls somewhere between those extremes.

Perspectives on Abnormality: From Superstition to Science
I) MEDICAL PERSPECTIVE

When an individual displays symptoms of a psychological disorder, the fundamental cause will be found through a physical examination of the individual, which may reveal a hormonal imbalance, a chemical deficiency, or a brain injury. Indeed, when we speak of mental “illness,” “symptoms” of psychological disorders, and mental “hospitals,” we are using terminology associated with the medical perspective.

Perspectives on Abnormality: From Superstition to Science
II) PSYCHOANALYTIC PERSPECTIVE

holds that abnormal behavior stems from childhood conflicts over opposing wishes regarding sex and aggression. According to Freud, children pass through a series of stages in which sexual and aggressive impulses take different forms and produce conflicts that require resolution. If these childhood conflicts are not dealt with successfully, they remain unresolved in the unconscious and eventually bring about abnormal behavior during adulthood.

Perspectives on Abnormality: From Superstition to Science
III) BEHAVIORAL PERSPECTIVE

looks at the rewards and punishments in the environment that determine abnormal behavior. behavioral theorists see both normal and abnormal behaviors as responses to various stimuli—responses that have been learned through past experience and are guided in the present by stimuli in the individual's environment. To explain why abnormal behavior occurs, we must analyze how an individual has learned it and observe the circumstances in which it is displayed.

Perspectives on Abnormality: From Superstition to Science
IV) COGNITIVE PERSPECTIVE

the cognitive approach assumes that cognitions (people's thoughts and beliefs) are central to a person's abnormal behavior. A primary goal of treatment using the cognitive perspective is to explicitly teach new, more adaptive ways of thinking.

For instance, suppose that you develop the erroneous belief that "doing well on this exam is crucial to my entire future" whenever you take an exam. Through therapy, you might learn to hold the more realistic and less anxiety-producing thought, "my entire future is not dependent on this one exam." By changing cognitions in this way, psychologists working within a cognitive framework help people free themselves from thoughts and behaviors that are potentially maladaptive

Perspectives on Abnormality: From Superstition to Science
V) HUMANISTIC PERSPECTIVE

emphasize the responsibility people have for their own behavior even when their behavior is considered abnormal. The humanistic perspective concentrates on what is uniquely human—that is, it views people as basically rational, oriented toward a social world, and motivated to seek self-actualization. Humanistic views people as having an awareness of life and of themselves that leads them to search for meaning and self-worth.

Rather than assuming that individuals require a “cure,” the humanistic perspective suggests that they can, by and large, set their own limits of what is acceptable behavior. As long as they are not hurting others and do not feel personal distress, people should be free to choose the behaviors in which they engage.

Perspectives on Abnormality: From Superstition to Science
VI) SOCIOCULTURAL PERSPECTIVE

assumes that people's behavior—both normal and abnormal—is shaped by the society and culture in which they live. According to this view, societal and cultural factors such as poverty and prejudice may be at the root of abnormal behavior. Specifically, the kinds of stresses and conflicts people experience in their daily lives can promote and maintain abnormal behavior.

This perspective is supported by research showing that some kinds of psychological disorders are far more prevalent among particular social classes, races, and ethnicities, than they are in others.

Classifying Abnormal Behavior: The ABCs of DSM

Crazy. Whacked. Mental. Loony. Insane. Neurotic. Psycho. Strange. Demented. Odd. Possessed

Psychologists and other careproviders need to classify abnormal behavior in order to diagnose it and ultimately treat it.

DSM-5: DETERMINING DIAGNOSTIC DISTINCTIONS

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the most widely used system to classify and define psychological disorders (American Psychiatric Association, 2013). The DSM-5, most recently revised in 2013, provides comprehensive and relatively precise definitions for more than 200 disorders.

The Major Psychological Disorders

Anxiety Disorders

a feeling of apprehension or tension, in reaction to stressful situations. There is nothing “wrong” with such anxiety. It is a normal reaction to stress that often helps rather than hinders our daily functioning. Without some anxiety, for instance, most of us probably would not have much motivation to study hard, undergo physical exams, or spend long hours at our jobs.

But some people experience anxiety in situations in which there is no apparent reason or cause for such distress. Anxiety disorders occur when anxiety arises without external justification and begins to affect people’s daily functioning.

Anxiety Disorders: Phobic Disorder

specific phobia, an intense, irrational fear of a specific object or situation. For example, claustrophobia is a fear of enclosed places, acrophobia is a fear of high places, xenophobia is a fear of strangers, social phobia is the fear of being judged or embarrassed by others.

Phobic Disorder	Description	Example
Agoraphobia	Fear of places, such as unfamiliar or crowded spaces, where help might not be available in case of emergency	Person becomes housebound because any place other than the person's home arouses extreme anxiety symptoms.
Specific phobias	Fear of specific objects, places, or situations	
Animal type	Specific animals or insects	Specific animals or insects
Natural environment type	Events or situations in the natural environment	Person has extreme fear of storms, heights, or water.
Situational type	Public transportation, tunnels, bridges, elevators, flying, driving	Person becomes extremely claustrophobic in elevators.
Blood injection injury type	Blood, injury, injections	Person panics when viewing a child's scraped knee.
Social phobia	Fear of being judged or embarrassed by others	Person avoids all social situations and becomes a recluse for fear of encountering others' judgment

Anxiety Disorders: Panic Disorder

panic attacks occur that last from a few seconds to several hours. Panic disorders do not have any identifiable, specific triggers (unlike phobias, which are triggered by specific objects or situations). During an attack, and an individual feels a sense of impending, unavoidable doom.

Although the physical symptoms of a panic attack differ from person to person, they may include heart palpitations, shortness of breath, unusual amounts of sweating, faintness and dizziness, gastric sensations, and sometimes a sense of imminent death. Panic attacks seemingly come out of nowhere and are unconnected to any specific stimulus. Because they don't know what triggers their feelings of panic, victims of panic attacks may become fearful of going places.

Anxiety Disorders: Panic Disorder

panic attacks occur that last from a few seconds to several hours. Panic disorders do not have any identifiable, specific triggers (unlike phobias, which are triggered by specific objects or situations). During an attack, and an individual feels a sense of impending, unavoidable doom.

Although the physical symptoms of a panic attack differ from person to person, they may include heart palpitations, shortness of breath, unusual amounts of sweating, faintness and dizziness, gastric sensations, and sometimes a sense of imminent death. Panic attacks seemingly come out of nowhere and are unconnected to any specific stimulus. Because they don't know what triggers their feelings of panic, victims of panic attacks may become fearful of going places.

Anxiety Disorders: Generalized Anxiety Disorder

People experience long-term, persistent anxiety and uncontrollable worry. Sometimes their concerns are about identifiable issues involving family, money, work, or health. In other cases, though, people with the disorder feel that something dreadful is about to happen but can't identify the reason and thus experience "free-floating" anxiety.

Because of persistent anxiety, people with generalized anxiety disorder cannot concentrate or set their worry and fears aside; their lives become centered on their worry. Furthermore, their anxiety is often accompanied by physiological symptoms, such as muscle tension, headaches, dizziness, heart palpitations, or insomnia.

Obsessive-Compulsive Disorder

People are plagued by unwanted thoughts, called obsessions, or feel that they must carry out behaviors, termed compulsions, which they feel driven to perform. An **obsession** is a persistent, unwanted thought or idea that keeps recurring. For example, a student may be unable to stop thinking that she has neglected to put her name on a test and may think about it constantly for the 2 weeks it takes to get the paper back. A man may go on vacation and wonder the whole time whether he locked his house. A woman may hear the same tune running through her head over and over.

In each case, the thought or idea is unwanted and difficult to put out of mind. For people with serious obsessions, the thoughts persist for days or months and may consist of bizarre, troubling images.

Obsessive-Compulsive Disorder

As part of an obsessive-compulsive disorder, people may also experience **compulsions**, irresistible urges to repeatedly carry out some act that seems strange and unreasonable even to them. Whatever the compulsive behavior is, people experience extreme anxiety if they cannot carry it out even if it is something they want to stop. The acts may be relatively trivial, such as repeatedly checking the stove to make sure all the burners are turned off, or more unusual, such as washing one's hands so much that they bleed.

Somatic Symptom Disorders

Are psychological difficulties that take on a physical (somatic) form but for which there is no medical cause. Even though an individual with a somatic symptom disorder reports physical symptoms, no biological cause exists, or if there is a medical problem, the person's reaction is greatly exaggerated.

One relatively common type of somatic symptom disorder is **illness anxiety disorder**, in which people have a constant fear of illness and a preoccupation with their health and believe that everyday aches and pains are symptoms of a dread disease. The "symptoms" are not faked; rather, they are misinterpreted as evidence of some serious illness—often in the face of inarguable medical evidence to the contrary.

Somatic Symptom Disorders

Conversion disorder is another somatic symptom disorder and involve an apparent physical disturbance, such as the inability to see or hear or to move an arm or leg. However, the cause of the physical disturbance is purely psychological; there is no biological reason for the problem.

Conversion disorders often begin suddenly. Previously normal people wake up one day blind or deaf, or they experience numbness that is restricted to a certain part of the body. A hand, for example, may become entirely numb, while an area above the wrist, controlled by the same nerves, remains sensitive to touch—something that is physiologically implausible.

Dissociative Disorders

characterized by separation (or dissociation) of different facets of a person's personality that are normally integrated & work together. By dissociating key parts of who they are, people are able to keep disturbing memories or perceptions from reaching conscious awareness & thereby reduce their anxiety.

A person with a **dissociative identity disorder (DID)** (once called multiple personality disorder) displays characteristics of two or more distinct personalities, identities, or personality fragments. Individual personalities often have a unique set of likes and dislikes and their own reactions to situations. Some people with multiple personalities even carry several pairs of glasses because their vision changes with each personality. Moreover, each individual personality can be well adjusted when considered on its own

Dissociative Disorders

Dissociative amnesia is another dissociative disorder in which a significant, selective memory loss occurs. Dissociative amnesia is unlike simple amnesia, which involves an actual loss of information from memory and typically results from a physiological cause. In contrast, in cases of dissociative amnesia, the “forgotten” material is still present in memory—it simply cannot be recalled. The term repressed memories is sometimes used to describe the lost memories of people with dissociative amnesia.

Dissociative Disorders

Dissociative fugue is a form of amnesia in which a person leaves home suddenly and assumes a new identity. In this unusual and rare state, people take sudden, impulsive trips and adopt a new identity. After a period of time—days, months, or sometimes even years—they suddenly realize that they are in a strange place and completely forget the time they have spent wandering. Their last memories are those from the time just before they entered the fugue state.

The common thread among dissociative disorders is that they allow people to escape from some anxiety-producing situation. Either the person produces a new personality to deal with stress, or the individual forgets or leaves behind the situation that caused the stress as he or she journeys to some new—and perhaps less anxiety-ridden— environment.

Mood Disorders

are disturbances in emotional experience that are strong enough to intrude on everyday living. In extreme cases, a mood may become life threatening; in other cases, it may cause the person to lose touch with reality.

Mood Disorders: Major Depressive Disorder

a severe form of depression that interferes with concentration, decision making, and sociability. Women are twice as likely to experience major depression as men.

The rate of depression is going up throughout the world. Results of in-depth interviews conducted in the United States, Puerto Rico, Taiwan, Lebanon, Canada, Italy, Germany, and France indicate that the incidence of depression has increased significantly over previous rates in every area. In fact, in some countries, the likelihood that individuals will have major depression at some point in their lives is three times higher than it was for earlier generations. In addition, people are developing major depression at increasingly younger ages.

Mood Disorders: Major Depressive Disorder

People who suffer from major depression experience similar feelings, but the severity tends to be considerably greater. They may feel useless, worthless, and lonely, and they may think the future is hopeless and no one can help them. They may lose their appetite and have no energy. Moreover, they may experience such feelings for months or even years. They may cry uncontrollably, have sleep disturbances, and be at risk for suicide. The depth and duration of such behavior are the hallmarks of major depression.

Mood Disorders: Mania And Bipolar Disorder

Mania is an extended state of intense, wild elation. People experiencing mania feel intense happiness, power, invulnerability, and energy. Believing they will succeed at anything they attempt, they may become involved in wild schemes.

Some people sequentially experience periods of mania and depression. This alternation of mania and depression is called bipolar disorder (a condition previously known as manic-depressive disorder). The swings between highs and lows may occur a few days apart or may alternate over a period of years. In addition, in bipolar disorder, periods of depression are usually longer than periods of mania.

Schizophrenia

refers to a class of disorders in which severe distortion of reality occurs. Thinking, perception, and emotion may deteriorate; the individual may withdraw from social interaction; and the person may display bizarre behavior. The symptoms displayed by persons with schizophrenia may vary considerably over time.

Characteristics of schizophrenia disorder include the following:

- **Decline from a previous level of functioning**. An individual can no longer carry out activities he or she was once able to do.
- **Disturbances of thought and speech**. People with schizophrenia use logic and language in a peculiar way. Their thinking often does not make sense, and their logic is frequently faulty, which is referred to as a formal thought disorder. They also do not follow conventional linguistic rules.

Schizophrenia

- **Delusions**. People with schizophrenia often have delusions—firmly held, unshakable beliefs with no basis in reality. Among the common delusions people with schizophrenia experience are the beliefs that they are being controlled by someone else, they are being persecuted by others, and their thoughts are being broadcast so that others know what they are thinking.

- **Hallucinations and perceptual disorders**. People with schizophrenia sometimes do not perceive the world as most other people do. They may see, hear, or smell things differently from others. In fact, they may not even have a sense of their bodies in the way that others do, having difficulty determining where their bodies stop and the rest of the world begins.

Schizophrenia

- **Inappropriate emotional displays**. People with schizophrenia sometimes show a lack of emotion in which even the most dramatic events produce little or no emotional response. Alternately, they may display strong bursts of emotion that is inappropriate to a situation. For example, a person with schizophrenia may laugh uproariously at a funeral or react with anger when being helped by someone.

- **Withdrawal**. People with schizophrenia tend to have little interest in others. They tend not to socialize or hold real conversations with others, although they may talk at another person. In the most extreme cases, they do not even acknowledge the presence of other people and appear to be in their own isolated worlds.

Onset of schizophrenia occurs in early adulthood, and symptoms follow one of two primary courses. In **process schizophrenia**, the symptoms develop slowly and subtly and in **reactive schizophrenia**, the onset of symptoms is sudden and conspicuous.

Personality Disorders

is characterized by a set of inflexible, maladaptive behavior patterns that keep a person from functioning appropriately in society. People with personality disorders frequently lead seemingly normal lives. However, just below the surface lies a set of inflexible, maladaptive personality traits that prevent them from functioning effectively as members of society

Antisocial personality disorder Individuals with this disturbance show no regard for the moral and ethical rules of society or the rights of others. Although they can appear quite intelligent and likable (at least at first), upon closer examination they turn out to be manipulative and deceptive. Moreover, they lack any guilt or anxiety about their wrongdoing. When those with antisocial personality disorder behave in a way that injures someone else, they understand intellectually that they have caused harm but feel no remorse.

Personality Disorders

People with antisocial personality disorder are often impulsive and lack the ability to withstand frustration. They can be extremely manipulative. They also may have excellent social skills; they can be charming, engaging, and highly persuasive. Some of the best con artists have antisocial personalities.

A variety of factors have been suggested ranging from an inability to experience emotions appropriately to problems in family relationships. For example, in many cases of antisocial behavior, the individual has come from a home in which a parent has died or left or one in which there is a lack of affection, a lack of consistency in discipline, or outright rejection. Other explanations concentrate on sociocultural factors, because an unusually high proportion of people with antisocial personalities come from lower socioeconomic groups.

Personality Disorders

People with **borderline personality disorder** have problems regulating emotions and thoughts, display impulsive and reckless behavior, and have unstable relationships with others. They also have difficulty in developing a secure sense of who they are. As a consequence, they tend to rely on relationships with others to define their identity. The problem with this strategy is that rejections are devastating. People with this disorder distrust others and have difficulty controlling their anger. Their emotional volatility leads to impulsive and self-destructive behavior.

Individuals with borderline personality disorder often feel empty and alone, and they have difficulty cooperating with others. They may form intense, sudden, one-sided relationships in which they demand the attention of another person and then feel angry when they don't receive it. One reason for this behavior is that they may have a background in which others discounted or criticized their emotional reactions, and they may not have learned to regulate their emotions effectively.

Personality Disorders

The **narcissistic personality disorder** is another type of personality disorder. The narcissistic personality disorder is characterized by an exaggerated sense of self-importance. Those with the disorder expect special treatment from others while at the same time disregarding others' feelings. In some ways, in fact, the main attribute of the narcissistic personality is an inability to experience empathy for other people.

Treatment of Psychological Disorders

Treating psychological disorders fall into two main categories: psychologically based and biologically based therapies. **Psychologically based therapy**, or psychotherapy, is treatment in which a trained professional—a therapist—uses psychological techniques to help someone overcome psychological difficulties and disorders, resolve problems in living, or bring about personal growth. In psychotherapy, the goal is to produce psychological change in a person (called a "client" or "patient") through discussions and interactions with the therapist. In contrast, **biomedical therapy** relies on drugs and medical procedures, to improve psychological functioning.

Many therapists today take an eclectic approach to therapy; they use a variety of methods with an individual patient. Assuming that psychological as well as biological processes often produce psychological disorders, eclectic therapists may draw from several perspectives simultaneously to address the psychological as well as the biological aspects of a person's problems.

Approaches to Treatment

There are about 400 varieties of psychotherapy. Although the methods are diverse, all psychological approaches have a common perspective: They seek to solve psychological problems by modifying people's behavior and helping them obtain a better understanding of themselves and their past, present, and future

Psychodynamic Approaches to Therapy

Psychodynamic therapy seeks to bring unresolved past conflicts and unacceptable impulses from the unconscious into the conscious, where patients may deal with the problems more effectively.

Psychoanalysis is Freud's version of psychotherapy. The goal of psychoanalysis is to release hidden thoughts and feelings from the unconscious part of our mind in order to reduce their power in controlling behavior. In psychoanalysis, which tends to be a lengthy and expensive process, patients may meet with a therapist with considerable frequency, sometimes as much as 50 minutes a day, 4 to 5 days a week, for several years. In their sessions, they often use a technique developed by Freud called **free association**. Psychoanalysts using this technique tell patients to say aloud whatever comes to mind, regardless of its apparent irrelevance or senselessness, and the analysts attempt to recognize and label the connections between what a patient says and the patient's unconscious.

Psychodynamic Approaches to Therapy

Therapists also use **dream interpretation**, examining dreams to find clues to unconscious conflicts and problems. Moving beyond the surface description of a dream (called the manifest content), therapists seek its underlying meaning (the latent content), which thereby reveals the true unconscious meaning of the dream. The same unconscious forces that initially produced repression may keep past difficulties out of the conscious mind, which produces resistance. **Resistance** is an inability or unwillingness to discuss or reveal particular memories, thoughts, or motivations. It is the therapist's job to discern instances of resistance and interpret their meaning.

Because of the close, almost intimate interaction between patient and psychoanalyst, the relationship between the two often becomes emotionally charged and takes on a complexity unlike most other relationships. Patients may eventually think of the analyst as a symbol of a significant other in their past, perhaps a parent or a lover, and apply some of their feelings for that person to the analyst—a phenomenon known as **transference**.

Psychodynamic Approaches to Therapy

Transference is the transfer of feelings to a psychoanalyst of love or anger that had been originally directed to a patient's parents or other authority figures. A therapist can use transference to help a patient recreate past relationships that were psychologically difficult.

Sandy: My father . . . never took any interest in any of us . . . It was my mother—rest her soul—who loved us, not our father. He worked her to death. Lord, I miss her. . . . I must sound angry at my father. Don't you think I have a right to be angry? Therapist: Do you think you have a right to be angry? Sandy: Of course, I do! Why are you questioning me? You don't believe me, do you? Therapist: You want me to believe you. Sandy: I don't care whether you believe me or not. . . . I know what you're thinking— you think I'm crazy—you must be laughing at me—I'll probably be a case in your next book! You're just sitting there—smirking—making me feel like a bad person— thinking I'm wrong for being mad, that I have no right to be mad. Therapist: Just like your father. Sandy: Yes, you're just like my father.—Oh my God! Just now—I—I—thought I was talking to him.