

**Psychology 105  
Psychological Disorders  
Chapter 13**

**Term Papers Due May 8**  
**Final Exam Take-home essay**  
- Handed out May 8  
- Due May 15 at Final Exam  
**Final Exam in-classroom**  
- May 8 6-8 PM  
- Room 606

Spring 2008

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**Psychological Disorders: Outline**

- What is a Psychological Disorder?
    - Insanity
    - Models of Psychopathology
    - Prevalence of Psychological Disorders
  - Types of Psychological Disorders - a sampling
    - DSM-IV - classification and symptoms
      - Mood Disorders
      - Anxiety Disorders
      - Schizophrenic Disorders
      - Somatoform Disorders\*
      - Eating Disorders\*
      - Dissociative Disorders\*
      - Personality Disorders\*
  - Diagnosis, Culture
- \* See Supplementary Information at end of slides

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**Warning: Medical Student's Syndrome**

- Many symptoms of psychological disorders are exaggerations of normal behaviors, which you may experience. You will see yourself in some of the disorders we discuss.
- Don't worry - seeing some 'symptoms' does not mean that you have the disorder. [But if you are seriously concerned, contact a counselor]
- Don't go around diagnosing friends and family - you'll seriously annoy them!

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### Some Synonyms

- These terms are used interchangeably
  - Psychological Disorder
  - Mental Disorder
  - Mental Illness
  - Psychopathology
    - Also, used to describe the branch of psychology that studies psychological disorders
  
- But NOT Insanity

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### What is a Psychological Disorder?

What is "normal"? And how do we distinguish it from the "abnormal" thoughts, behaviors and emotions seen in psychological disorders?

- So-called "normals" have more in common with folks who have a psychological disorder than they differ from them
- Diagnosis of psychological disorder: a matter of degree, context and judgment about the symptoms
- Some key characteristics: Relative to context, culture and environment of individual, psychological disorders are characterized by frequent, persistent patterns of:
  - **DISRUPTED THOUGHTS AND PERCEPTIONS**
    - Hallucinations
    - Delusions
    - Irrational, illogical, nonsensical patterns of thought

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### What is a Psychological Disorder, Cont.

- **DISRUPTED EMOTIONS**
  - Persistently & frequently distressed emotions
  - Flat emotions, or absence of emotion
  - Emotions inappropriate to situation (socially or culturally defined), rapidly changing emotions
- **DISRUPTED BEHAVIOR**
  - Impaired functioning
  - Maladaptive, self-defeating, inability to achieve realistic goals
  - Deviant: unconventional, undesirable, inappropriate to situation (socially or culturally defined)
  - Erratic or unpredictable
  - Associated with health, social, occupational problems
- Person poses a **DANGER TO SELF OR OTHERS**  
**Seung-Hui Cho**: an example of a disordered mind

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### Insanity

- "Insanity" is a legal term, not a psychological or psychiatric term
  - An insanity defense\* requires that, *at the time of the crime*,
    - the crime is the result of a severe mental disease or defect, and
    - the defendant does not have the ability to appreciate the nature and quality or the wrongfulness of his acts.
  - Insanity plea is rare, about 2/1000 felony cases, and successful about 26% of those
- **Guilty But Mentally Ill** - verdict entitles convict to treatment for mental disorder while incarcerated - by 2000, had been adopted by 20 states

\* 1984 federal law; this definition varies by state. 1984 law eliminated the 'irresistible impulse' component of the defense.

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### Models of Psychological Disorders

*What are the causes of psychological disorders?*

- **Pre-medical model:** it is due to supernatural forces, possession by evil spirits, demons, witches, which must be driven out
- **Medical model:** it is due to organic illness (e.g. brain damage, genetic disorder, disease, imbalances), expressed in psychological symptoms, with specific symptoms and causes that require specific treatments
- **Psychological models:** it arises from internal conflict, distorted emotions or thought processes
- **Sociocultural model:** it has more to do with ills of society and culture than problems within the individual
- **SYNTHESIS: Biopsychosocial models:** it arises from an interaction of biological/medical, social, cultural, cognitive, and other environmental factors
  - **Diathesis-stress model** - disorders result from a predisposition (diathesis) and exposure to stressful environmental events or life circumstances

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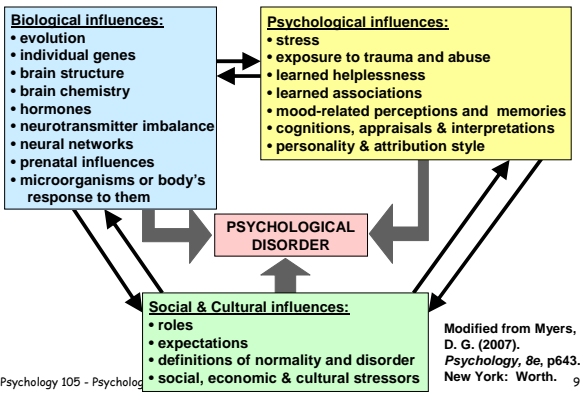
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### Bio-psycho-social Models of Psychological Disorder



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### Prevalence of Psychological Disorders in US

According to a recent study (2005)\*,

- > 26% of US population reported symptoms in past 12 months that meet criteria for psychological disorder; 60% of these "serious" or "moderate"
- > Nearly half of Americans will suffer from a psychological disorder at some point in their lifetime
- > Half of all lifetime cases begin by age 14; three quarters have begun by age 24

*Are the disorders too broadly defined so as to include the ups and downs of life, or do this many people suffer from psychological disorder?*

\* <http://archpsyc.ama-assn.org/cgi/content/full/62/6/593>

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### Prevalence of Psychological Disorder: some US stats

Disorder	% *	Disorder	% *
(* % of adults over 18 in any given year)			
<b>Mood Disorders</b>	<b>9.5</b>	<b>Anxiety Disorders</b>	<b>18.1</b>
-Major Depressive	6.7	-Panic disorder	2.7
-Bipolar	2.6	-Obsessive-Compulsive disorder	1.0
-Dysthymic	1.5	-Post-traumatic stress disorder	3.5
		-- in Vietnam vets, since 1965	~30
Schizophrenia	1.1	-Generalized anxiety disorder	3.1
ADHD	4.1	-Agoraphobia	0.8
Autism Spectrum Disorders	0.6	-Specific phobias	8.7
Alzheimer's Disease		<b>Personality Disorders</b>	<b>14.8</b>
age >65	10%	- Antisocial (~3%M, 1%F)	~4
age >85	50%		

\*Sources: <http://www.nimh.nih.gov/publicat/numbers.cfm>  
<http://pn.psychiatryonline.org/cgi/content/full/39/17/12>

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### Classifying Psychological Disorders

- > *Diagnostic and Statistical Manual of Mental Disorders - IV*\* (pub. by American Psychiatric Association) is the most commonly used classification and diagnostic system in the US
  - Usually referred to as "DSM-IV"
  - Compiled by Psychiatrists and Psychologists
  - Use mandated by insurance companies
  - Controversial because
    - Model is primarily medical, less social/psychological influence acknowledged
    - Many psychological disorders span more than one category
    - Treatment is not covered
    - Categorization can depersonalize patient
    - Many experts involved in compilation receive research funds from pharmaceutical companies

\* Current Edition is DSM-IV-TR™ (Text Revision)

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**Mood (affective) Disorders**

**Mood Disorder:** abnormal, extreme, prolonged disturbances in emotion or mood

- **Unipolar Disorders** (aka Depressive Disorders) involve the 'low' end of moods
- **Major Depressive Disorder:** Depression lasting for weeks or months, including some of these symptoms:
  - Persistent depressed mood (some of: feeling sad, anxious, hopeless, pessimistic, guilty, worthless, empty)
  - Restlessness, irritability
  - reduced interest in formerly enjoyable activities
  - reduced energy, fatigue, sleep disturbances (too much or insomnia)
  - appetite loss, or overeating
  - difficulty concentrating, holding a conversation, or making ordinary decisions
  - suicidal thoughts or intentions - ~15% commit suicide

Video clip: [Depression](#)

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**Unipolar Disorder (Mood)**

- Depression is the "Common Cold" of psychological disorder (Seligman) - in any year, affects about 5.8% of men and 9.5% of women worldwide
- Periods of moderate to high stress frequently precede onset of depression
- Major depression costs Americans ~ \$43 billion per year in treatment, hospitalization, lost productivity & work
- Most major depressive episodes eventually self-terminate (recover) without therapy; and depression may recur
- Cross culturally: also prevalent across the globe; incidence varies among countries, and expression of symptoms may differ

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**Unipolar Disorder (Mood)**

**Some other forms of Unipolar Disorder**

- **Seasonal Affective Disorder (SAD)** - depression during winter months, evidently related to insufficient sunlight
  - Treated successfully by exposure to bright light (several hours/day) during winter months
- **Dysthymia (Dysthymic Disorder)** - long-term, chronic mild depression
  - "Dumps and grumps" - persistent low mood, irritability
  - Symptoms similar to major depressive disorder, but less severe
  - Patients at risk for episodes of major depressive disorder
- **Post-partum depression** - severe depression in first year (usually first 4 weeks) after a woman gives birth
  - Symptoms similar to major depressive disorder

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### Unipolar Disorder (Mood)

**Unipolar Disorders - biological markers**

- > **Genetic:** if identical twin is diagnosed with major depressive disorder, other twin has about 50-60% chance of becoming depressed (fraternal - 20-30%)
- > **Biochemical imbalance:** Relief (not cure) is frequently obtained from drugs that increase availability of some mood-influencing neurotransmitters, especially serotonin and norepinephrine
  - Insufficient serotonin or norepinephrine at critical synapses?
  - Insensitivity to serotonin or norepinephrine?
- > **Different brain activity pattern:**
  - Relatively lower brain activity seen in left frontal lobe; overall, generally lower brain activity
  - Shrinking of hippocampus found with prolonged depression
- > **Excessive inflammatory response?** Recently observed correlations between higher levels of inflammation markers and depression

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### Unipolar Disorder (Mood)

**Unipolar Disorder: Psychosocial contributors**

- > **Negative events** sometime triggers situational depression, but recovery is usually spontaneous
- > **Major stressor and stress response** often precedes a depressive episode
- > **Pessimism and predominantly negative outlook** are correlated with increased risk for depression (Seligman)
- > **Cognitive distortions** increase vulnerability to depression, and when corrected, reduce its intensity (Beck, Burns, Ellis)

Depression cycle of **learned helplessness** (Seligman, Burns)

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graph TD
    A[Negative Life Events  
Inescapable Stress] --> B[Social rejection, loneliness,  
failure at task]
    A --> C[Self-defeating beliefs  
Negative attributions]
    B --> D[Withdrawal, negative or  
Self-defeating behaviors]
    C --> E[Depressed mood]
    D --> E
    E --> D
  
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### Unipolar Disorder (Mood)

- > **What are some of the risk factors for major depressive disorder?**
  - Women more at risk than men - ruminative mood (tendency to focus on problems rather than dismissing them)
  - **Age:** Teenagers and adults under age 44
  - **Culture:** living in more individualistic cultures (as opposed to group-focused, collectivistic cultures)
  - Family member who has had a mood disorder
  - Stress early in life, recent experience of major stress in life lives\*
- > The incidence of depression appears to be increasing worldwide, cause unknown; not just attributable to better diagnosis, greater social acceptability

\*currently controversial: should depressed people who have recently experienced loss, grief, or major stress response be categorized and treated in the same way as others considered to have major depression?

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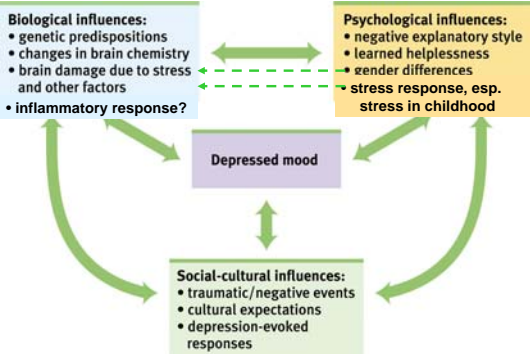
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### Depression: Biological, Psychological & Social Influences



Psychology 105 - Psychological Disorders After Myers, D. G. (2007) *Psychology*, 8e, p665. 19  
New York: Worth.

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### Bipolar Disorder (Mood)

- Formerly called **manic-depressive disorder**
- Has two phases, depressive and manic, which tend to alternate or cycle, sometimes with normal mood in between
- Depressive phase symptoms similar to unipolar, but it does not respond in the same way to the same drugs
- Manic phase is characterized by
  - Hyperactive, euphoric state
  - Talkative, energetic, feeling great, need little sleep
  - Tendencies towards grandiosity, risk-taking, hypersexuality, ignorance of consequences, irrational & delusional thinking
  - Denial that there is any problem
- Patients may be stable much of the time, oscillate between phases, or stay predominantly in one phase or the other
- Age of onset typically late teens to early 20s, sometimes in childhood

Video: [Bipolar Disorder](#)

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### Bipolar Disorder (Mood)

#### Forms of Bipolar Disorder

- Subcategories of Bipolar Disorder:
  - **Bipolar I** - full-strength cycling between manic and depressive phases
  - **Bipolar II** - manic phase is less intense; termed *hypomanic* (low manic)
    - Difficult to differentiate from unipolar disorder
- **cyclothymic disorder** - a mild form of bipolar disorder in which one's mood cycles periodically between moderate highs and moderate lows (analogous to dysthymia and unipolar disorder)
- Severity of bipolar symptoms varies, from none (between cycles) to mild to psychotic in some extreme phases of mania and depression

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### Bipolar Disorder (Mood)

Who is at risk for bipolar disorder?

- ~1% of US population over age 18
- Usually first diagnosed in people in late teens - early 20s; also seen in children (but clear diagnosis is even more difficult in children than adults)
- Strong genetic component: if identical twin is bipolar, risk of other twin having a mood disorder is at least 80% (concordance rate)
- Emerging evidence of tie to inflammation

Bipolar disorder usually responds well to medication (with some unpleasant side effects), and most medications differ from those used to treat unipolar disorder

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### Anxiety Disorders

**Anxiety Disorders:** Mental problems characterized mainly by high, persistent anxiety (irrational apprehension, fearfulness, worry) or maladaptive behaviors that reduce anxiety

- *Post Traumatic Stress Disorder* - See Ch. 15 notes
- *Panic Disorder:* Sudden "out of the blue" attacks of intense fear or anxiety,
  - usually associated with physical symptoms like heart palpitations, rapid breathing, shortness of breath, dizziness, racing thoughts
  - belief: it's a heart attack
  - Anxiety comes from "nowhere" - no events in person's present experience explain it

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### Panic Disorder, continued (Anxiety disorder)

- Genetic influence seen in panic disorder
- Brain mechanism in limbic system, especially amygdala, participates (learned fear)
- *Agoraphobia* (fear of public and open spaces) may develop in people who have experienced panic attacks, especially in public
  - Inability to escape public situation, fear of embarrassment
  - Cues from public place associated with panic attack (classical conditioning);
  - Sometimes fear generalizes to all public situations
- Treated with anti-anxiety drugs and cognitive-behavioral therapy

Video Clip - [Panic Disorder](#)

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### Specific Phobias (anxiety disorder)

**Phobia:** Anxiety disorder involving a pathological fear and avoidance of a **specific object or situation**

- **Specific phobias** usually one of four types
  - Animals (insects, spiders, snakes, dogs, mice)
  - Natural environmental events (heights, thunderstorms, water)
  - Blood, injections, injury
  - Specific situations (flying, closed-in places, dentists)
    - **Social phobias** - intense fear of social situations or interactions
- **Agoraphobia** - fear of open places, going out in public
- We may be "biologically prepared" for some phobias more than others (Seligman)
- Phobias are usually treated using exposure therapy and systematic desensitization

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### Generalized Anxiety Disorder

- **Persistent anxiety not tied to any specific object or situation** - "worrywarts"
  - Exaggerated concerns and apprehensions of doom - focus on future, what might happen
  - Tension, difficulty relaxing, insomnia
  - Physical symptoms include breathlessness, fatigue, headaches, muscle tension, muscle aches, difficulty swallowing, trembling, twitching, sweating, nausea, lightheadedness, urinary urge
  - Risk highest between childhood and middle age
  - Moderate genetic component suspected (20-40% concordance rate for MZ twins)

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### Obsessive-Compulsive Disorder (anxiety)

➤ **OCD is characterized by obsessions and compulsions**

- **Obsessions:** repetitive, persistent, uncontrollable thoughts, which tend to focus on fears, doubts and impulses
- **Compulsion: behaviors:** performing repetitive acts or rituals (doing so reduces anxiety)

➤ **Genetic:** tends to run in families (concordance rate in MZ twins ~65-80%).

- People with OCD sometimes have tics, oddities in motor control areas of brain;
- SSRIs reduce problem, in both humans and dogs (yes, some dogs have symptoms of OCD!)

➤ **Changing behavior** (cognitive/behavioral therapy) results in changes in OCD patient's brain



Compulsive Hoarding

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### Explanations of Anxiety Disorders

- **Learning: Phobias**
  - Classically conditioned fear responses
    - that generalize beyond original trigger situation
    - that are maintained by reinforcement (escape or avoidance reduces the anxiety)
  - Sometimes learned by observation
- **Cognitive: Panic attacks**
  - Misinterpretation of physical sensations, associations with external cues
- **Biological:**
  - Some genetic components; higher risk if identical twin has an anxiety disorder
  - Pts with OCD have elevated activity in anterior cingulate cortex (monitors actions for errors)
  - Brain changes observed in amygdala after intense fear-provoking experience
  - Drugs (tranquilizers, SSRIs) sometimes help Pts overcome the disorders

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### Schizophrenic Disorders

- **Schizophrenia:** Psychotic disorders involving severe distortions of thought, perceptions, emotions and/or behaviors
- Person lives in a different world
  - Seriously disordered thinking
  - Delusions
  - Hallucinations
  - Blunted emotions
- Probably more than one disorder

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### Schizophrenic Disorders

- About 0.8 - 1.2% of population over age 18 has a schizophrenic disorder, worldwide (estimates vary)
- Account for about 40% of mental hospital admissions in US
- Risk of suicide is high
- Usually first seen in men before age 25, women age 25-45, with variation
- Course of disease is often more severe in men
- Diagnostic symptoms: must last for significant period of time, cause social/job distress, not due to general medical condition or use of drug or medication; there are usually some low-level signs long before it is diagnosed

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### Schizophrenic Disorders

**Positive** Diagnostic symptoms (observable expressions of abnormal behavior) - some of:

- Distorted thinking: Delusions (grandeur, persecution), irrational conclusions, "thought blocking"
- Distorted perceptions of world: objects change shape or size
  - Hallucinations, especially auditory; voices giving "orders," fingers touching them, odors no one else can smell
- Disorders of movement: clumsiness, repetitive movements, tics, catatonia (postural rigidity)
- Disorganized speech - "word salad"
- Cognitive deficits, including poor working memory, short attention span, poor 'executive function'
- Inappropriate emotions

Video Clip: [Disorganized Schizophrenia](#)

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### Schizophrenic Disorders

**Negative** Diagnostic symptoms (deficits in behavior, absence of normal behavior) - some of:

- Inability to express emotion (flat affect)
- Anhedonia (inability to find or experience pleasure)
- Refusal to engage in everyday activities, such as bathing, eating, dressing; apathy
- Diminished ability to initiate and sustain planned activity
- Social withdrawal
- Absence/terseness of speech
- Can be mistaken for major depression

Negative symptoms often persist after an acute episode with positive symptoms.

Schizophrenics may show positive only, negative only or mix of symptoms

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### Schizophrenic Disorders

Major types of schizophrenia

Disorganized	Hallucinations, incoherent speech, bizarre behavior, inappropriate emotion, disorganized delusions
Catatonic	Stupor, motor dysfunctions, rigid posture, repetitive movement, negativism
Paranoid	Delusions, hallucinations, disordered thinking; themes of persecution, grandeur, jealousy
Undifferentiated	Catchall category for symptoms that don't fit neatly elsewhere or overlap categories
Residual	Have had episodes in past, some symptoms remain (esp. hallucinations, flat affect)

**Chronic:** Schizophrenia develops slowly, recovery doubtful

**Acute:** Schizophrenia develops in response to major stressor; recovery more likely

Video clips [Paranoid Schizophrenia 1](#) [Paranoid Schiz. 2](#)

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**Biology of Schizophrenia**

- Former view: caused by defective parenting (“Schizophrenogenic Mother”)
- Present view: primarily a brain disorder
- Involvement of dopamine
  - Excessive # of dopamine receptors, or sensitive dopamine receptors, in brains
  - Dopamine antagonist (blocking) drugs reduces positive symptoms (but not so much negative symptoms)
  - Drugs that increase dopamine levels (amphetamines, cocaine, L-Dopa) can produce schizophrenic-like symptoms
- Involvement of glutamate - increasing glutamate can help alleviate negative symptoms
- Low activity in frontal lobes, prefrontal cortex and abnormal activity in the limbic system
- Smaller brains, larger ventricles

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**Possible Causes of Schizophrenia**

- **Neurological damage:** shrinkage of frontal cortex, thalamus, enlarged ventricles
- **Prenatal factors**
  - Low birth weight, oxygen deprivation at birth
  - Prenatal virus (respiratory, flu) in mother in 2<sup>nd</sup> trimester - or immune response to virus
  - Age of father - higher incidence with older fathers (when mother's age and other correlated variables are controlled)
- **Genetics:** having schizophrenic blood relative increases risk of a person having schizophrenia:
  - ~50-65% for identical twin sharing placenta,
  - ~45% for two parents,
  - ~10% for one sibling or parent.
  - (general population: ~1%)
  - Several candidate genes have been identified; multiple mutations in several genes have been observed in schiz. pts.
- **Inflammation-related markers** correlate with schizophrenia

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**Possible Causes of Schizophrenia - 2**

- **But:** genetics doesn't control 100%, since *concordance rate* is well below 100%. There is evidence for involvement of multiple genes.
- **Psychological triggers:**
  - Not effective if no genetic predispositions
  - Childhood stressors very likely to contribute
- **Apparently both biological disposition plus environmental event(s) or stress required to “turn on” hereditary tendency**

**Prognosis for Schizophrenia**

- ~25% recover fully from 1<sup>st</sup> episode and have no recurrences
- ~50% have recurrent episodes, with periods of remission
- ~25% have a severe course, worsening over time, with no recovery

P<sub>2</sub> Video Clip: [A treated schizophrenic](#) 16

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### Diagnosis and Labeling of Mental Disorders

- Accurate diagnosis can lead to effective treatment. Misused, it can lead to labels that can depersonalize, restrict freedom, and ignore social and cultural context.
- Labels: Whether it's mad, maniac, insane, crazy, loon, wacko, nutcase, fruitcake ... or OCD, psychopath, depressive, agoraphobic, schizophrenic - the label can have effect of hiding the person behind the label and attaching a stigma
- There is a trend towards looking at not just problems but also the benefits mental disorders may confer: e.g.,
  - autism (concentration, enhanced abilities in some areas [savant])
  - bipolar and ADHD (creative energy),

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### Cultural and other Contexts

Behaviors must be evaluated in context:

- Szasz: The Myth of Mental Illness - symptoms are really deviant behaviors violating social norms; label them as "mental illness" and you can now "treat" people who have become inconvenient [extreme position]
- Behaviors may be seen as normal or abnormal, depending on context
- Cultural variability seen in
  - Expression of symptoms
  - Tendency to diagnose a particular illness; may also have to do with socioeconomic status
- Where do you draw the line between eccentricity, violation of social norms, and a psychological disorder needing treatment?

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### SUPPLEMENT: ADDITIONAL DISORDERS DSM-IV - Dimensions (Axes)

Disorders classified on five major axes:

- Clinical Disorders (where our focus is)
- Personality Disorders and Mental Retardation
- General Medical Conditions
- Psychosocial and Environmental Problems
- General Assessment of Functioning

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**DSM-IV - Clinical Disorders  
(Axis 1 - Examples)**

- Substance-related disorders
- Mood disorders
- Anxiety Disorders
- Dissociative Disorders
- Somatoform Disorders
- Schizophrenia, psychotic disorders
- Sexual and gender identity Disorders
- Sleep Disorders

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**DSM-IV Personality Disorders and Mental  
Retardation  
(Axis 2 - Examples)**

- Paranoid personality disorder
- Schizotypal personality disorder
- Antisocial personality disorder
- Narcissistic personality disorder
- Borderline personality disorder
- Dependent personality disorder
- Mental Retardation

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**More disorders**

- Personality Disorders
- Somatoform Disorders
- Dissociative Disorders
- Eating Disorders
- Adjustment Disorders

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### Personality Disorders

- Conditions involving chronic, pervasive, inflexible and maladaptive patterns of thinking, emotion, social relationships, and impulse control, which lead to impairments in social functioning
- Are these disorders or simply people with extremes on basic (e.g., Big 5) personality characteristics?

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### Narcissistic PD (Personality Disorder)

- Exaggerated sense of self-importance, preoccupation with fantasies of success or power, need for constant attention and admiration ("center of universe")
- Overreact to criticism or defeat
- Feel entitled to favors w/out obligation
- Exploit others
- Have difficulty understanding how others feel - little empathy
- Frequently depressed when not treated as they'd like to be, or if fantasies of success/power don't come to fruition

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### Antisocial PD (Personality Disorder)

- Long-standing pattern of irresponsible behavior indicating lack of conscience and diminished sense of responsibility to others (AKA psychopath, sociopath\*)
  - Chronic lying, stealing, fighting
  - Cunning, manipulative, con-artists
  - Glibness/superficial charm
  - Need for stimulation/lack of fear
  - Found among criminals, businesspeople, politicians
  - Not psychotic, often intelligent and charming
  - Higher incidence in men (3-6%) than women (1%)

\*Psychologists disagree as to whether "sociopath" and "psychopath" should be lumped into a single diagnostic category or separated

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## Somatoform Disorders

*Psychological disorders appearing in the form of bodily symptoms or physical complaints*

- **Conversion Disorder** (aka Hysteria): Real physical or neurological impairment, with no discoverable physical cause
  - If effective psychological treatment found, the symptoms disappear



### **Glove anesthesia (conversion disorder)**

B indicates numbness pattern if there is nerve damage. A indicates reported numbness if no nerve damage, and is typical of a **conversion disorder**

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## Hypochondriasis (Somatoform)

Excessive concern about health and disease

- Involves misinterpretation of normal bodily responses, twinges, etc.
- Tend to persist for months, drive patient from doctor to doctor, cause significant distress and impaired function
- Often associated with excessive anxiety

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## Dissociative Disorders

*Fragmentation of personality - some parts of personality detached from others, loss of memory for some aspects of life, sometimes entire sense of identity*

- **Dissociative Amnesia**: inability to remember important personal information - identity, family history, specific traumatic event or experience, that cannot be traced to a physical cause
  - Can last for hours or years, often disappearing spontaneously

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### Dissociative Disorders

- **Dissociative Fugue** - like dissociative amnesia, with the addition that the person usually leaves home, family, job, and lands in a new place with no memories of past
- May last weeks or years
- Recovery often spontaneous, but typically affected/recovered people claim they have no memory for activities during blackout period
- Causes: high stress, alcohol
- Movie: "Unknown White Male"

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### Dissociative Disorders

- **Depersonalization Disorder**: Sensation that mind and body have separated.
- "Out of body" experience, feelings of observing own body, "near death experience"
- Common following severe physical trauma, following surgery; usually short-lived
- May be due to anoxia or shock-induced changes in brain

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### Dissociative Identity Disorder

*Individual alternates between two or more distinct personalities or identities; aka Multiple Personality Disorder*

- Personalities appear to control person's thoughts and actions, one at a time
- Each personality has own distinctive and sometimes conflicting traits
- Interpersonality amnesia is common; original personality often unaware of other personalities, others may be aware of original and each other
- Rheta-Schreiber, F. (1973) Sybil (book and movie)

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### Dissociative Identity Disorder, cont.

- Personalities may have distinguishing characteristics in terms of expressions, manner of speaking, handwriting, even EEG
- Personalities often differ in terms of key dimensions - shyness, assertiveness, anxiety, extraversion
- Cause thought to be repeated and inescapable abuse in childhood, particularly sexual abuse
- Easy to fake if physiological measures not taken; role of social learning brings reality of symptoms into question
- Some psychologists think the disorder is very rare; others doubt its existence
- NOT the same as schizophrenia

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### Eating Disorders

- Outward signs of inner emotional or psychological problems, expressed in food choices and how food is eaten; involve serious distortion of body image
- Frequent and persistent thoughts and behaviors about body, foods, and eating that do lead to health, social, school, and work problems
- May result in serious medical problems
- Most prevalent in Western culture
- Most likely to develop in girls and teens, starting as early as 9 or 10

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### Anorexia Nervosa (eating disorder)

Early stage anorexia      Profound anorexia



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### Anorexia Nervosa (eating disorder)

- **Characteristics:** noticeable weight loss, isolation, excessive exercise, obsession with food, calories, diets, skipping meals or eating tiny portions, complaining about being too fat when actually too thin, deteriorating health
- **Risk factors:** female; perfectionist; obedient, "good girl", good student; history of obesity or depression; distorted body image; performance in competitive sports; history of abuse, teasing, harassment
- Some young women report that eating seems to be the only thing in their lives that is solely under their control

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### Bulimia (Eating Disorder)

- "Binge and purge" syndrome in which person overeats (without control) and then attempts to get rid of calories or lose weight by vomiting, laxatives, enemas, diuretics or fasting.
- Eating accompanied by feelings of shame and guilt; food often not enjoyed
- Leads to series of medical complications
- Risk factors similar to anorexia nervosa
- Often socially supported, even though bulimic individuals rarely take joy in their slimness

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### Adjustment Disorders

- Miscellaneous disorders, often not as clinically serious, but more prevalent, than others: "life sucks" and there is difficulty in dealing with the vagaries of life. Counseling often helps.
- Mild depression
  - Marital Problems
  - Academic and job problems
  - Bereavement, Grief
  - Parent-child problems

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