Unit 12: Abnormal Psychology

Section 1: Abnormal Behaviour

The Medical Model
- The medical model proposes that it is useful to understand abnormal behaviour as a disease.
- Previous to the medical model, mental illness and psychological disorders were understood in the context of superstition (e.g., demonic possession).
- Some psychologists, like Thomas Szasz, oppose the medical model.
  - Diagnosis involves distinguishing one illness from another.
  - Etiology refers to the causes of an illness.
  - Prognosis is the forecast of the course of an illness.

What Is Abnormal Behaviour?
- Criteria
  1. Deviance
  2. Maladaptive Behaviour, i.e., impairment of everyday behaviour
  3. Personal Distress, e.g., depression, anxiety

Psychodiagnosis
- The guidelines for psychodiagnosis is the Diagnosis and Statistical Manual of Mental Disorders (DSM-IV).
- DSM-IV requires judgements on five axes or dimensions of a disorder.
  1. Clinical Syndromes
  2. Personality Disorders and Mental Retardation
  3. General Medical Conditions
  4. Psychosocial and Environmental Problems
  5. Global Assessment of Functioning Scale (GAF)

How Prevalent Are Psychological Disorders?
- **Epidemiology** is the study of the distribution of a disorder in a population.
- **Prevalence** refers to the percentage of a population that exhibits a disorder during a specific period of time.
- The lifetime prevalence of psychological disorders involves up to 1/3 of the population. The most common disorders are anxiety disorders and substance abuse.

Section 2: Anxiety Disorders

**Anxiety disorders** are a class of disorders marked by feelings of excessive apprehension and anxiety.

**Generalized Anxiety Disorder**
- *Generalized anxiety disorder* (GAD) is marked by a chronic, high level of anxiety that is not tied to any specific threat.
- This is sometimes called **free-floating anxiety disorder**.
- People with this disorder tend to worry about everything, especially yesterday's mistakes and tomorrow's problems.

**Phobic Disorder**
- A *phobic disorder* is marked by persistent and irrational fear of an object or situation that presents no realistic danger.
- Though many people have phobias (e.g., fear of public speaking or fear of mice), a phobic disorder is only diagnosed when the fear seriously disrupts everyday behaviour.

**Panic Disorder & Agoraphobia**
- A *panic disorder* is characterized by recurrent attacks of overwhelming anxiety (i.e., panic attacks) that usually occur unexpectedly.
- *Agoraphobia* is a fear of going to public places. Though traditionally understood as a phobic disorder, this is now considered a type of panic disorder.

**Obsessive-Compulsive Disorder**
- An *obsessive-compulsive disorder* (OCD) is marked by persistent, uncontrollable intrusions of unwanted thoughts (obsessions) and urges to engage in senseless rituals (compulsions).
- Obsessions (e.g., failure, sex, aggression, suicide) lead to anxiety which is temporarily relieved by rituals (e.g., washing hands, checking locks).

**Post-Traumatic Stress Disorder** is classed as an anxiety disorder.

**Etiology of Anxiety Disorders**

**Biological Factors**
- Twin studies have revealed a slight genetic predisposition to anxiety disorders.
- Anxiety sensitivity may make people predisposed to anxiety disorders.
- Some neurotransmitters have been linked to anxiety disorder
Behavioural Factors

- Many phobias are acquired through classical conditioning. Many can be traced to a single traumatic event.
- Because phobias cause anxiety, avoiding these situations strengthens the phobia through operant conditioning.
- People are biologically predisposed to develop certain fears.
- Observational learning can condition fears and phobias.

Cognitive Factors: Certain patterns of thinking (e.g., selective recall or focusing attention) can misinterpret harmless situations as dangerous, thus contributing to an anxiety disorder.

Personality: People who are neurotic (self-conscious, nervous, insecure) are prone to anxiety disorders.

Stress: There is a correlation between anxiety disorders and stress.

Section 3: Somatoform Disorders

- A somatoform disorder is a physical ailment that cannot be fully explained by organic conditions and which are largely due to psychological factors.
- Do not confuse somatoform disorders with psychosomatic diseases

Somatization Disorder

- A somatization disorder is marked by a history of diverse physical ailments that appears to be psychological in origin.
- The intensity of the disorder is correlated with the level of stress the individual is experiencing.
- This disorder occurs mostly in women and often occurs with anxiety and depression.

Conversion Disorder

- A conversion disorder is characterized by a significant loss of physical function with no organic cause.

Hypochondria

- Hypochondria (aka hypochondriasis) is characterized by a preoccupation with health concerns and worry about developing physical illness.
- Hypochondria often occurs with anxiety disorders and depression.

Etiology of Somatoform Disorders

- Biology: a highly sensitive ANS may predispose an individual to somatoform disorders.
- Personality: somatoform disorders are associated with certain personality traits, especially histrionic personalities (self-centered, dramatic, emotional) and neurotic personalities.
- Cognition: people with somatoform disorders tend to use catastrophic thinking and focus excessively on health concerns.
• **The Sick Role**: some people like being sick. The illness behaviour can be reinforced by society.

**Section 4: Dissociative Disorders**

**Dissociative disorders** are a class of disorders in which people lose contact with portions of their consciousness or memory, resulting in disruptions in their sense of identity.

**Dissociative Amnesia**
- *Dissociative amnesia* is a sudden loss of important personal information.
- Memory losses may be centered around a single traumatic event (disaster, rape, combat, etc.).
- In *dissociative fugue*, an individual loses memory as well as personal identity (name, home, job, etc.).

**Dissociative Identity Disorder**
- *Dissociative identity disorder (DID)*, formerly *multiple personality disorder*, involves the co-existence of two or more complete and different personalities in the same individual.
- Do not confuse this with schizophrenia.
- Independent personalities may be unaware of each other and not share memories.
- This is an extremely rare condition. Some psychologists question its existence and propose that it is really a form of social role playing.

**Etiology of Dissociative Disorders**
- **Stress** can be a major factor in dissociative disorders, especially severe childhood emotional trauma (e.g., sexual abuse).
- **Personality** may be a factor, especially fantasy prone personalities

**Section 5: Mood Disorders**

**Mood disorders** are a class of disorder marked by emotional disturbances which disrupt social, physical, perceptual, and thought processes.

**Major Depressive Disorder**
- In *major depressive disorder* people show persistent feelings of sadness and despair and a loss of interest in previous sources of pleasure.
- People suffering from depression are often irritable, anxious, brooding, and lack energy. Changes in sleeping patterns and appetite are common. Feelings of worthlessness, dejection, guilt, and hopelessness characterize depression.
- Depression often coexists with anxiety disorders
- Women are more likely to suffer depression.
- Other types of depression include
  - **dysthymic disorder**: lesser severe than a major depressive disorder
  - **post-partum depression**: a depressive disorder occurring after giving birth
o seasonal affective disorder (SAD): a depressive disorder affected by the time of year

Bipolar Disorder
- Bipolar disorder, formerly manic-depressive disorder, is characterized by alternating manic periods and depression.
- During manic episodes, a person's self-esteem and energy are very high.
- Cyclothymic disorder is a less severe form of bipolar disorder.
- If a person with bipolar or cyclothymic disorder experience more than four periods of mania and depression, they are exhibiting a rapid-cycling pattern.

Etiology of Mood Disorders
- Genetic Factors: Twin studies indicate that heredity predisposes individuals to mood disorders.
- Neurochemical Factors: There is a correlation between abnormal levels of norepinephrine and serotonin and mood disorders.
- Cognitive Factors: Learned helplessness and a pessimistic explanatory style contribute to depression, particularly when combined with stress and low self-esteem. This is the basis of Martin Seligman's hopelessness theory. People who ruminate about their depression stay depressed longer.
- Interpersonal Factors: Poor social skills is correlated with depression. It may be that people who fail to develop strong social support networks make themselves more susceptible to depression. As well, depressed people are depressing—they're no fun to be around. Thus depression itself can lead to social rejection and reduced social support.
- Stress: There is a correlation between stress levels and the onset of depression.

Section 6: Schizophrenic Disorders

Schizophrenic disorders are a class of disorders marked by delusions, hallucinations, disorganized speech, and deterioration of adaptive behaviour.

General Symptoms
- Delusions and irrational Thought
  o This may include beliefs that one's thoughts are broadcast to others or that thoughts are being injected into one's mind.
  o This may include delusions of grandeur, i.e., people believe they are famous.
- Deterioration of Adaptive Behaviour
- Hallucinations, which are often auditory (e.g., hearing voices).
- Disturbed emotion, both in terms of under-reacting and over-reacting to emotional stimuli.

Subtypes of Schizophrenia
- Paranoid schizophrenia is characterized by delusions of persecution and delusions of grandeur.
- Catatonic schizophrenia is characterized by withdrawal of physical activity, e.g., a person may become motionless and never speak.
- **Disorganized schizophrenia** is characterized by severe maladaptive behaviour. This may include complete social withdrawal, incoherence, and emotional indifference.
- **Undifferentiated schizophrenia** is a term for all other types of schizophrenia.
- Some psychologists do not use these four types. Instead, they focus on determining **negative symptoms** (e.g., behavioural deficits or flattened emotions) and **positive symptoms** (e.g., behavioural excesses or hallucinations).
- Generally, people suffering from schizophrenia experience a full recovery, recover sufficiently to lead a normal life, or do not recover sufficiently to lead a normal life.

**Etiology of Schizophrenic Disorders**
- There is a genetic vulnerability to schizophrenia.
- Excessive dopamine levels are correlated with schizophrenia.
- There is evidence that structural abnormalities in the brain (especially the ventricles and the thalamus) may be a factor in the onset of schizophrenia.
- The **neurodevelopmental hypothesis** holds that schizophrenia is caused by disruption to either prenatal or postnatal development.
- **Expressed emotion**, which refers to how families of patients treat the patient, can influence the course of the disorder. Families who are critical rather than supportive tend to increase the severity of the disorder.
- **Stress** may play a key role in triggering schizophrenic disorder.

**Section 7: Personality Disorders**

- **Personality disorders** are marked by extreme and inflexible personality traits that cause a person distress or impair social functioning.
- Most psychologists class personality disorders as **anxious/fearful**, **odd/eccentric**, or **dramatic/impulsive**.
- **Dimensional Approach**: Some psychologists prefer not to categorize the personality disorder and instead describe the characteristics or dimensions of the individual cases.

**Antisocial Personality Disorder**
- **Antisocial personality disorder** is marked by impulsive, aggressive behaviour that ignores social norms. The terms **psychopathic** and **sociopathic** are often used to describe people with this disorder.
- People with this disorder are predatory, chronically violate the rights of others, and display no sense of loyalty, guilt, or respect for rules or laws.
- About 3% of the population may have this disorder. People with this disorder rarely seek treatment (unless court ordered) and usually do not accept that there is anything wrong with them.
- **Etiological Factors**
  - People with this disorder often come from homes where discipline is ineffective or abusive. As well, the parents often make no effort to teach children responsibility, respect, or honesty.
- Eysenck has theorized that an insensitive ANS may diminish classical conditioning and thus reduce the acquisition of normal social inhibitions.

**Other Personality Disorders**
- **Borderline personality disorder**, instability in relationships, self-image, and mood.
- **Narcissistic personality disorder**, need for admiration and lack of empathy
- **Histrionic personality disorder**, excessive emotionality and attention seeking.
- **Paranoid personality disorder**, marked by patterns of distrust and paranoia.
- **Schizoid personality disorder**, marked by detachment from social relationships.

**Section 8: Eating Disorders**
- **Eating disorders** are marked by severely disturbed eating behaviour and an unhealthy preoccupation with weight.
- 95% of people with eating disorders are women.
- Eating disorders are usually developed in adolescence.

**Anorexia Nervosa**
- *Anorexia nervosa* involves intense fear of gaining weight, disturbed body image, and dangerous measures to lose weight.
- People with anorexia typically drastically reduce their intake of food, though some also have a binge-purge (eat-puke) pattern.
- People with anorexia usually refuse to acknowledge their behaviour is abnormal.

**Bulimia Nervosa**
- *Bulimia nervosa* involves the binge-purge pattern. People with bulimia regularly overeat then vomit.
- People with bulimia tend to maintain a normal weight and usually recognize the maladaptive characteristics of their behaviour.

**Etiology of Eating Disorders**
- There may be a slight genetic predisposition for eating disorders.
- People with anorexia tend to be obsessive, rigid, neurotic, and restrained.
- People with bulimia tend to be impulsive, sensitive, and have low self-esteem.
- There is a large cultural influence on eating disorders.
- Family environments may influence the onset of eating disorders.

**Section 9: Other Psychological Disorders**

**Substance Abuse Disorders**
- Alcoholism.
- Drug addiction, especially cocaine and heroin.
Sexual Disorders
- Sexual dysfunction.
- Paraphilia is an inappropriate sexual interest. This includes pedophilia, the sexual attraction to children.

Sleep Disorders
- Sleep apnea, narcolepsy, insomnia, and others

Organic Mental Disorders
- Any mental disorder which has a clearly biological cause, e.g., Alzheimer's disease.
- These disorders are usually marked by dementia.

Disorders Which Develop in Childhood
- Autism.
  - Children with autism show no signs of emotional or social attachment.
  - Language and cognitive development are usually impaired.
  - Often these children rock repetitively, repeat the same phrases over and over, or focus intensely on simple objects.
  - Autism is a Pervasive Developmental Disorder (PDD), as is Rett's and Asperger's.
- Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).
  - Children with ADD display an abnormal lack of ability to concentrate or focus attention.
  - Children with ADHD also display an abnormal inability to control their physical activity and often engage in immature behaviour.
- Learning Disabilities. These are usually process problems, e.g., dyslexia, a reading problem. Children with learning disabilities are usually of at least average intelligence.

Section 10: Psychological Disorders and the Law
- Insanity is a legal status in which a person is not responsible for his or her actions because of a mental illness.
- Note that insanity is a legal term, not a psychological term. Courts decide who is insane, not psychologists or psychiatrists.
- The M'naghten Rule is that insanity exists when a mental disorder makes a person unable to distinguish right from wrong.
- People with mental disorders who present a danger to themselves or others may be involuntarily committed to a hospital or psychiatric facility.