



### Abnormal Behavior

- The **medical model** proposes that it is useful to think of abnormal behavior as a disease
- Previous models had proposed these behaviors were caused by demonic possession, being a witch, or offending God
- **Diagnosis**: distinguishing one illness from another
- **Etiology**: the apparent causation and developmental history of an illness
- **Prognosis**: a forecast about the probable course of an illness

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### Theoretical Approaches to Psychological Disorders

- Biological approach (evident in the medical model)
  - Brain structure, biochemical problems, genetics
- Psychological approach
  - Psychodynamic, behavioral, social cognitive, trait, humanistic
- Sociocultural approach
  - Emphasis is placed largely on social context
- Interactionist (biopsychosocial) approach
  - Blends the other three approaches

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### Stereotypes of Psychological Disorders

- Three common stereotypes:
  - **Psychological disorders are incurable**
    - **TRUTH**: The vast majority of individuals improve with treatment
  - **People with psychological disorders are often violent and dangerous**
    - **TRUTH**: There is only a weak relationship between violence and mental illness
  - **People with psychological disorders behave in bizarre ways and are very different from normal people**
    - **TRUTH**: It is actually difficult to identify most individuals with a psychological disorder

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Psychodiagnosis:  
The Classification of Disorders

- *Diagnostic and Statistical Manual of Mental Disorders* – 4th ed. (DSM-IV-TR; American Psychiatric Association, 2000)
  - **Axis I: Clinical Syndromes** (e.g., mood disorder)
  - **Axis II: Personality Disorders or Mental Retardation** (e.g., borderline personality disorder)
  - **Axis III: General Medical Conditions** (e.g., cancer)
  - **Axis IV: Psychosocial and Environmental Problems** (e.g., recently divorced)
  - **Axis V: Global Assessment of Functioning** (e.g., 50 indicates “serious symptoms or impairment in social, occupational, or school functioning”)

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Prevalence of Psychological Disorders

- How common are psychological disorders?
- **Epidemiology** is the study of the distribution of mental or physical disorders in a population
- **Prevalence** refers to the percentage of a population that exhibits a disorder during a specified time period (e.g., lifetime prevalence)
  - Recent estimates are around 40%
  - However, these high estimates include individuals with mild problems

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Axis I Clinical Syndromes

- These are the types of disorders we are going to focus on:
  - Anxiety Disorders
  - Somatoform Disorders
  - Dissociative Disorders
  - Mood Disorders
  - Schizophrenia and Other Psychotic Disorders

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## Anxiety Disorders

- **Generalized anxiety disorder** is marked by a chronic, high level of anxiety that is not tied to any specific threat
- **Phobic disorder** refers to a persistent and irrational fear of an object or situation that presents no realistic danger
- **Panic disorder** is characterized by recurrent attacks of overwhelming anxiety that occur suddenly and unexpectedly
  - May lead to **agoraphobia** which is a fear of going out to public places
- **Obsessive compulsive disorder (OCD)** is marked by persistent, uncontrollable intrusions of unwanted thoughts (obsessions) and urges to engage in senseless rituals (compulsions)
- **Posttraumatic Stress Disorder (PTSD)** involves enduring psychological disturbance attributed to the experience of a major traumatic event

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## Etiology of Anxiety Disorders

- Biological factors
  - Genetic predisposition
  - Anxiety sensitivity
  - Neurotransmitters (serotonin, GABA)
- Conditioning and learning
  - Acquired through classical conditioning or observational learning
  - Maintained through operant conditioning
  - However, we acquire some fears (e.g., snakes) more easily than others (e.g., broken glass)
- Cognitive factors
  - Judgments of perceived threat
- Stress serves as a precipitator

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## Somatoform Disorders

- **Somatoform disorders** are physical ailments that cannot be fully explained by organic conditions and are largely due to psychological factors
- **Somatization Disorder** is marked by a history of diverse physical complaints that appear to be psychological in origin
- **Conversion Disorder** is characterized by a significant loss of physical function (with no apparent organic basis), usually in a single organ system (ex. glove anesthesia)
- **Hypochondriasis** is characterized by excessive preoccupation with health concerns and incessant worry about developing physical illness

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### Etiology of Somatoform Disorders

- Personality factors
  - Histrionic personality characteristics: tend to be self-centered, suggestible, excitable, highly emotional, and overly dramatic
  - Neuroticism
  - Insecure attachment style (e.g., anxious-ambivalent)
- Cognitive factors
  - Pay more attention to physical processes
  - Catastrophic conclusions about minor symptoms
  - Equate good health with complete absence of symptoms and discomfort
- The sick role may be reinforcing
  - Greater attention
  - Escape from problems and responsibilities

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### 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** is a sudden loss of memory for important personal information that is too extensive to be due to normal forgetting
- **Dissociative fugue** is a loss of memory for their entire lives along with their sense of personal identity
- **Dissociative identity disorder (DID)** involves the coexistence in one person of two or more largely complete – and usually very different – personalities
  - Formerly known as “multiple personality disorder”

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### Etiology of Dissociative Disorders

- Stress
  - Appears to play a role in amnesia and fugue
- Personality
  - Fantasy proneness and a tendency to become absorbed in personal experiences may be related
- It is unclear whether Dissociative Identity Disorder really exists
  - May be an excuse for personal failings
  - Therapists may accidentally “suggest” that clients have multiple personalities

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## Mood Disorders

- **Mood disorders** are a class of disorders marked by emotional disturbances of varied kinds that may spill over to disrupt physical, perceptual, social, and thought processes
- **Major depressive disorder** refers to persistent feelings of sadness and despair along with a loss of interest in previous sources of pleasure
  - Around 7%-18% experience this disorder
  - **Dysthymic disorder** is a less severe form of depression
- **Bipolar disorder** is characterized by the experience of one or more manic episodes as well as periods of depression
  - About 1%-2.5% experience this disorder
  - Formerly known as "manic-depressive disorder"
  - **Cyclothymic disorder** is a less severe form of bipolar disorder

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### Comparison of Common Symptoms in Manic and Depressive Episodes

Characteristics	Manic Episode	Depressive Episode
Emotional	Elated, euphoric, very sociable, impatient at any hindrance	Gloomy, hopeless, socially withdrawn, irritable

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Motor	Hyperactive, tireless, requires less sleep than usual, increased sex drive, variable appetite	Less active, tired, difficulty sleeping, decreased sex drive, difficulty with appetite

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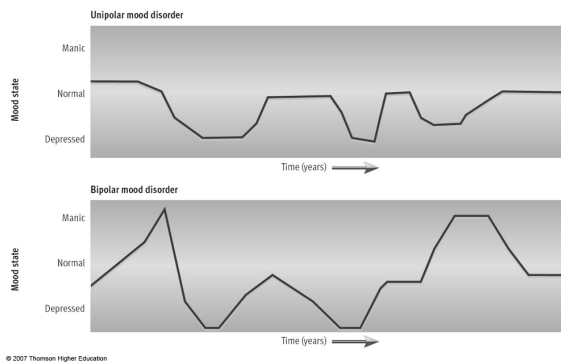
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### Episodic Patterns in Mood Disorders




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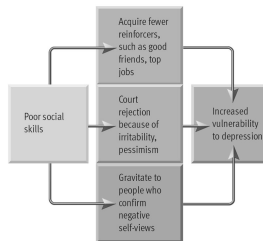
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### Etiology of Mood Disorders

- **Biological factors**
  - Genetic vulnerability
  - Neurochemical factors: abnormal levels of norepinephrine and serotonin
  - Neuroanatomical factors: small hippocampus (used for memory consolidation) and may be related to the creation of new neurons
- **Cognitive factors**
  - Learned helplessness
  - Rumination
- **Precipitating stress**
- **Interpersonal roots**




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## Schizophrenia

- **Schizophrenia** means “split mind”...but this is not the same thing as Dissociative Identity Disorder
- General symptoms
  - Delusions (false beliefs) and irrational thoughts
  - Deterioration of adaptive behavior (e.g., poor hygiene)
  - Hallucinations (false sensory experiences)
  - Disturbed emotions: blunted, inappropriate, or overreactive

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## Subtyping of Schizophrenia

- Subtypes of Schizophrenia
  - **Paranoid type**: dominated by delusions of persecution, along with delusions of grandeur
  - **Catatonic type**: marked by motor disturbances, ranging from muscular rigidity to random motor activity (decreasing prevalence)
  - **Disorganized type**: a particularly severe deterioration of adaptive behavior
    - emotional indifference, frequent incoherence, and social withdrawal
  - **Undifferentiated type**: marked by idiosyncratic mixtures of schizophrenic symptoms

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## Schizophrenia: Positive vs. Negative Symptoms

- New model for classification
  - **Positive symptoms** involve behavioral excesses or peculiarities such as hallucinations, delusions, bizarre behavior, and wild flights of ideas
  - **Negative symptoms** involve behavioral deficits, such as flattened emotions, social withdrawal, apathy, impaired attention, and poverty of speech
  - Most patients report both types of symptoms
    - But those with predominantly positive symptoms usually have a better response to treatment

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## Schizophrenia: Course and Outcome

- Schizophrenia usually emerges during adolescence or early adulthood
  - Individual usually has a history of odd behavior and deficits in cognitive or social functioning
- Occurs in about 1% of people
  - About 15%-20% experience a full recovery
- Relatively favorable prognosis when:
  - Sudden onset
  - Later onset
  - Social and work adjustment were good before onset
  - Proportion of negative symptoms is low
  - Cognitive functioning is relatively preserved
  - Good adherence to treatment interventions
  - Healthy, supportive family situation

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## Etiology of Schizophrenia

- Biological factors
  - Genetic vulnerability
  - Neurochemical factors: excessive dopamine
  - Structural abnormalities of the brain: enlarged ventricles; smaller and less active prefrontal cortex
  - Neurodevelopmental hypothesis refers to problems during prenatal development that lead to subtle neurological damage
    - Prenatal viral infection, prenatal malnutrition, obstetrical complications, and other brain insults
- Precipitating stress may trigger onset of symptoms or exacerbation of symptoms

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## Personality Disorders

Cluster	Disorder	Description	% Male/% Female
Anxious/fearful	Avoidant personality disorder	Excessively sensitive to potential rejection, humiliation, or shame; socially withdrawn in spite of desire for acceptance from others	50/50
	Dependent personality disorder	Excessively lacking in self-reliance and self-esteem; passively allowing others to make all decisions; constantly subordinating own needs to others' needs	31/69
	Obsessive-compulsive personality disorder	Preoccupied with organization, rules, schedules, lists, trivial details; extremely conventional, serious, and formal; unable to express warm emotions	50/50

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## Culture and Pathology

- Do these psychological disorders exist in other cultures?
- Are the symptom patterns the same across cultures?
- **Relativistic view**: the criteria for mental disorders vary greatly across cultures and that there are no universal standards for normality/abnormality
- **Pancultural view**: the criteria for mental illness is similar around the world and that basic standards of normality/abnormality are universal
- The principle categories of disorders (e.g., mood disorders) do appear to exist in all cultures
- Culture bound disorders
  - **Koro**: fear that one's penis will withdraw into one's abdomen (southern Asia)
  - **Windigo**: intense craving for human flesh and the fear that one will turn into a cannibal (Algonquin Indian cultures)
  - **Anorexia nervosa**: restriction of food intake (affluent Western cultures)

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