PSYCHOLOGICAL DISORDERS

"To study the abnormal is the best way of understanding the normal."

- William James (1842-1910)


This new study shows that 5 out of 4 people have a multiple personality disorder.
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06-23-07

PSYCHOLOGICAL DISORDERS

"Paradox: Antonyms such as mental health and mental illness suggest a sharp distinction between those who are normal and those who are not, but it's often difficult to draw a line that clearly separates normality from abnormality."

HISTORICAL AND CONTEMPORARY APPROACHES TO PSYCHOLOGICAL DISORDERS

HISTORICAL APPROACHES

- Prospectives on psychological disorders have changed through the centuries.
- Historically mental illnesses have been regarded as having supernatural or religious origins:
- Demonic possession.
- Punishment for sin.
- Trephination: drilling a hole in the skull in order to “release” demons thought to possess someone
- Also used exorcism, beatings, castration, mutilation even execution as early “treatments”.

“THE EXTRACTION OF THE STONE OF MADNESS” (C. 1500)


Fig. 1.

REFORMERS MAKE AN IMPACT

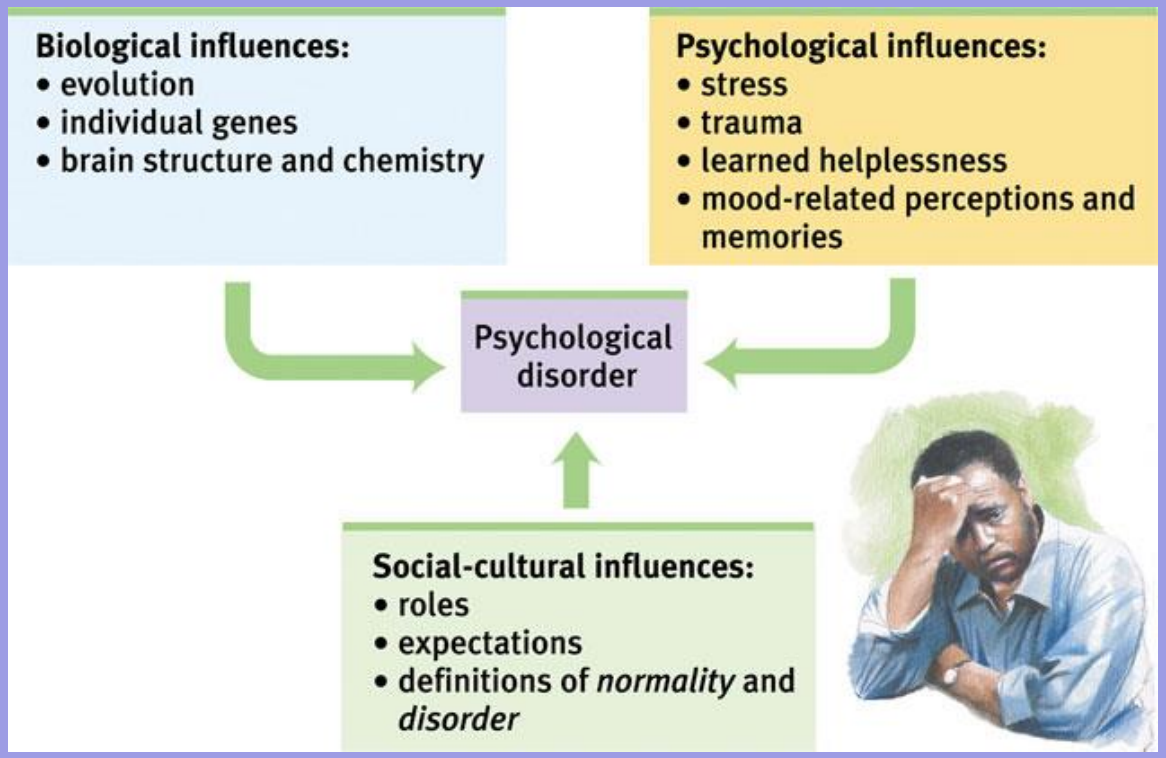
- In the 18th century, the systematic treatment of psychological disorders began to transform.
- Conditions had improved but the mentally ill were often chained up in filthy institutions.
- Philippe Pinel: French physician who sought to eliminate the institutionalized brutality of mental institutions.
- Later, Dorothea Dix would bring the reform movement for the mentally insane to the United States.

THE MEDICAL MODEL

- During the 1800s, scientist discovered the physical effects of the *syphilis* germ.
- If the dementia that accompanied syphilis had a physical cause, might it be that ALL mental disorders could be traced to diseases of the body?
- Medical Model: belief that abnormal behavior should be thought of as a disease; with physical causes and a subsequent cure
- Key Terms:
- Diagnosis: distinguishing one illness from another
- Etiology: apparent cause and developmental history of an illness
- Prognosis: forecast about the probable course of an illness

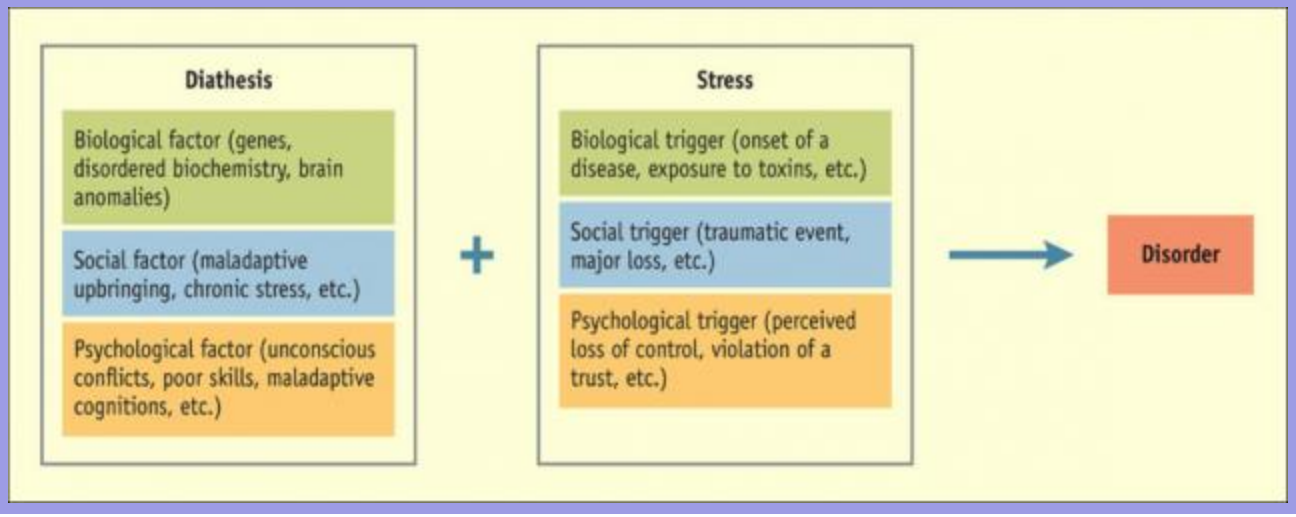
THE BIO-PSYCHO-SOCIAL APPROACH

- Bio-psycho-social approach: studies of how biological, psychological and social-cultural factors interact to produce specific psychological disorders



DIATHESIS-STRESS MODEL

- The diathesis-stress model is psychology's attempt to explain abnormal behavior as both:
  - 1. a predispositional vulnerability
  - 2. and a reaction to the stress from life experiences
- The D-S Model attempts to determine which individuals are at the highest risk of developing psychological disorders.
- "Why does Person A develop schizophrenia while Person B does not even when all other life factors are similar?"



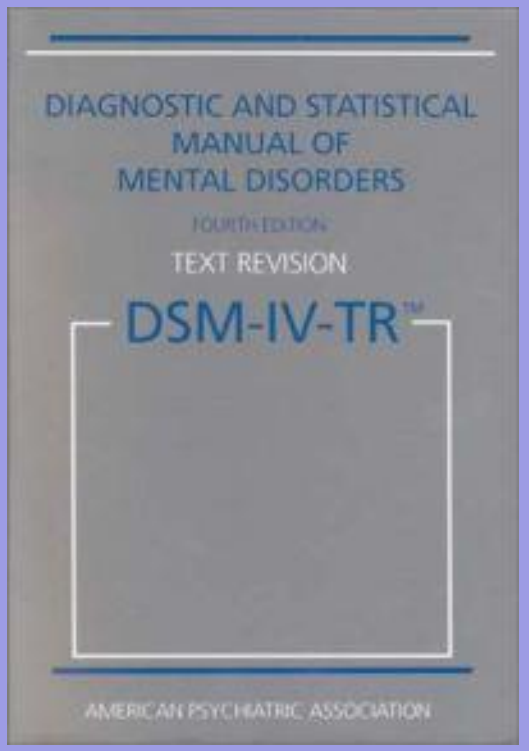
CRITERIA OF ABNORMAL BEHAVIOR

- In making diagnoses of mental disorders, clinicians rely on a variety of criteria.
- The foremost of these criteria include:
- 1. Deviance: the behavior deviates from what their society considers acceptable.
- 2. Dysfunctional: when one's everyday adaptive behavior becomes impaired.
- 3. Distress: subjective feelings of pain and suffering

- People are judged to have a psychological disorder only when their behavior becomes extremely deviant, dysfunctional or distressing.
- Thus, normality and abnormality exist on a continuum, not an either-or proposition.

THE CLASSIFICATION OF DISORDERS

- In order to facilitate empirical research and enhance communication among clinicians, psychologists devised a system for classifying psychological disorders.
- This system is outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- The DSM is currently in its 4th edition (DSM-IV-TR); revised in 2000.
- The DSM-5 is set to be released in 2013.
- Over the years many disorders have been added (anorexia), while others have been dropped (homosexuality).
- Recall that what constitutes "abnormal" varies not only from culture to culture, but over time as well.



THE CLASSIFICATION OF DISORDERS

- The DSM employs a multi-axial system of classification.
- It asks for a clinician's judgments about individuals on five separate axes.
- Axis I: Clinical Syndromes
- Axis II: Personality Disorders or Mental Retardation
- Numbers 3 -5 are used to record supplemental information:
- Axis III: General Physical Disorders
- Axis IV: List of psychosocial and/or environmental problems
- Axis V: Global Assessment of Functioning Scale (GAF)
- Rate the capability of normal functioning (social and occupational) within society on a continuum.

TABLE 16.1

HOW ARE PSYCHOLOGICAL DISORDERS DIAGNOSED?

Based on assessments, interviews, and observations, many clinicians diagnose by answering the following questions from the five levels, or *axes,* of the DSM-IV-TR. (Parenthetical page references refer to this text.)

Axis I Is a *Clinical Syndrome* present?
Using specifically defined criteria, clinicians may select none, one, or more syndromes from the following list:

- Disorders usually first diagnosed in infancy, childhood, and adolescence
- Delirium, dementia, amnesia, and other cognitive disorders
- Mental disorders due to a general medical condition
- Substance-related disorders (Chapter 7)
- Schizophrenia and other psychotic disorders (page 669)
- Mood disorders (page 658)
- Anxiety disorders (page 649)
- Somatoform disorders
- Factitious disorders (intentionally feigned)
- Dissociative disorders (page 656)
- Eating disorders (Chapter 12)
- Sexual disorders and gender identity disorder
- Sleep disorders (Chapter 7)
- Impulse-control disorders not classified elsewhere
- Adjustment disorders
- Other conditions that may be a focus of clinical attention

Axis II Is a *Personality Disorder* (page 667) or *Mental Retardation* (See Chapter 11) present?
Clinicians may or may not also select one of these two conditions.

Axis III Is a *General Medical Condition,* such as diabetes, hypertension, or arthritis, also present?

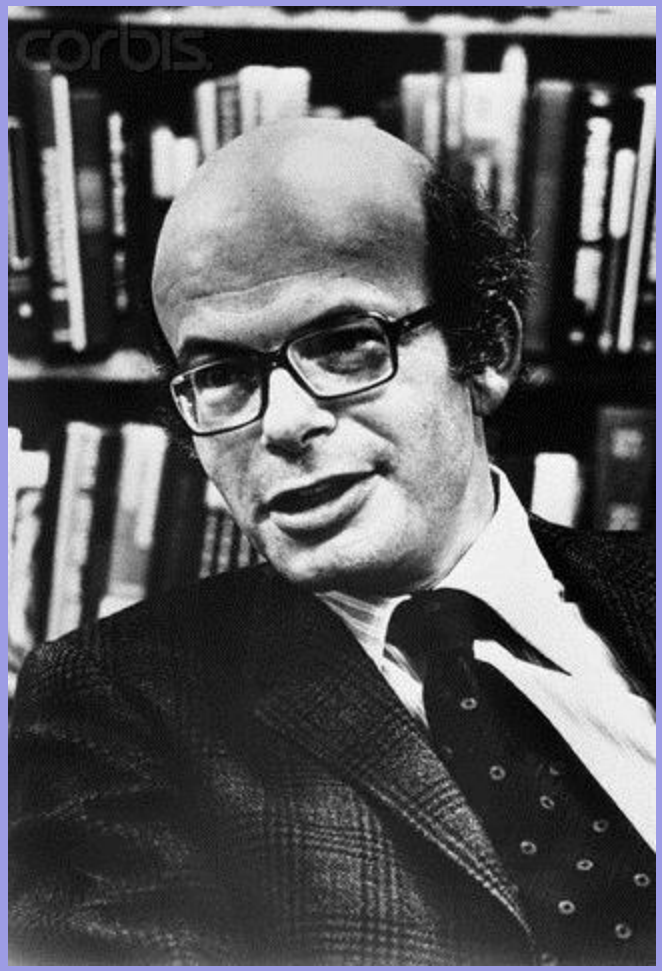
Axis IV Are *Psychosocial or Environmental Problems,* such as school or housing issues, also present?

Axis V What is the *Global Assessment* of this person's functioning?
Clinicians assign a code from 0–100. For example:

91–100 Superior functioning in a wide range of activities; life's problems never seem to get out of hand; is sought out by others because of his or her many positive qualities. No symptoms.
51–60 Moderate symptoms (for example, flat affect or occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (for example, few friends, or conflicts with peers or co-workers).
1–10 Persistent danger of severely hurting self or others (for example, recurrent violence) or persistent inability to maintain minimal personal hygiene or serious suicidal act with clear expectation of death.

DANGERS OF PSYCHOLOGICAL LABELING

- In the 1960s, many psychologists began to question to validity of classifying psychological disorders.
- These "anti-psychiatrists" believed that the current system of psychiatric diagnosis was too vague, self-opinionated and subjective; not scientific.
- Labels create preconceptions that guide our perceptions and our interpretations.
- To highlight the dangers of these diagnoses, psychologist David Rosenhan conducted his famous "*On Being Sane In Insane Places*" study in the early 1970s.



THE ROSENHAN STUDY

- Rosenhan and 7 other “pseudopatients” sought admission to various mental hospitals by faking hallucinations.
- They claimed the voices spoke the following words: “empty”, “hollow” and “thud”; sometimes called “The Thud Experiment”
- All were admitted to the psychiatric hospitals; most diagnosed as schizophrenic.
- Once inside, the pseudopatients were told to behave normally.
- Their stays in these hospitals ranged from 7 to 52 days; average was 19 days.
- Clinicians even perceived abnormal behavior in very normal acts, such as note-taking done by one pseudopatient.
- Patients were dismissed with a diagnosis of schizophrenia “in remission” only after admitting to their doctors that they were mentally ill.

IMPACTS OF THE ROSENHAN STUDY

- Many psychologists were shocked at the results of Rosenhan's study when he published the results in 1973.
- Study highlighted the dangers of labeling; what constitutes "sane" and what constitutes "insane"?
- Showed the extent to which mental patients were *dehumanized* and stigmatized by hospital doctors and staff.
- Compared the differences in quality of care between state-run and privately operated facilities.
- Led to the deinstitutionalization movement of the 1970s which released many from the confines of mental institutions.

SPECIFIC TYPES OF PSYCHOLOGICAL DISORDERS

Anxiety
Somatoform
Mood
Dissociative
Schizophrenia
Personality

ANXIETY DISORDERS

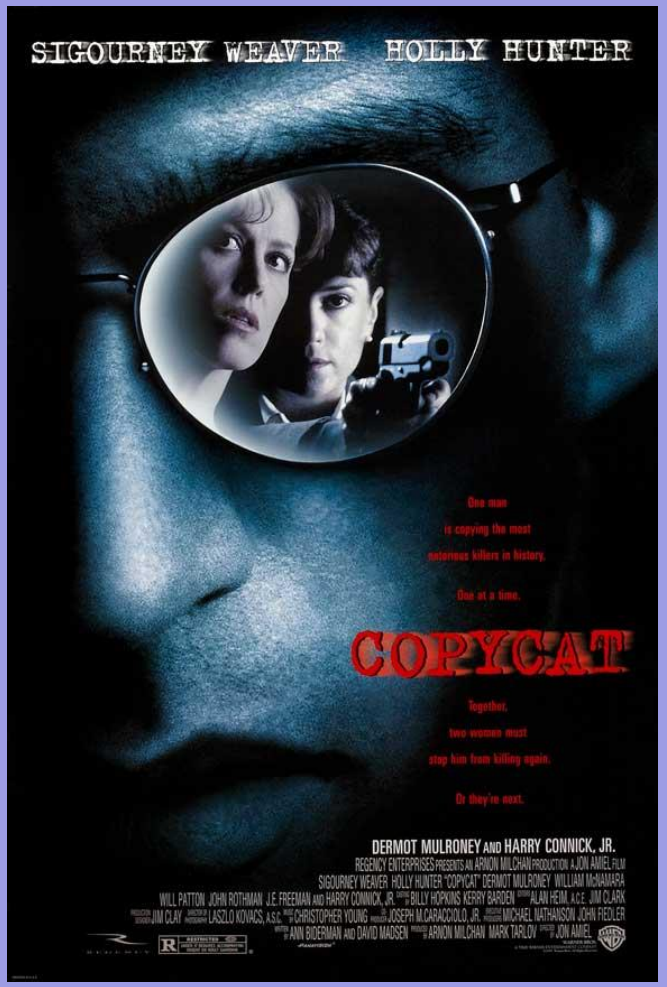
- Anxiety disorders: class of disorders marked by feelings of excessive apprehension and anxiety.
- Generalized anxiety disorder: marked by a *chronic*, high level of anxiety that is not tied to any specific threat
- "Worry about yesterday's mistakes and tomorrow's problems."
- Accompanied by physical symptoms:
- Trembling
- Muscle tension
- Dizziness
- Faintness
- Sweating
- Heart palpitations

ANXIETY DISORDERS

- Panic disorders: recurrent attacks of overwhelming anxiety that usually occur suddenly and unexpectedly.
- "Panic attacks" have similar symptoms of generalized anxiety disorder, but their effects are more intense and their occurrence is unpredictable.

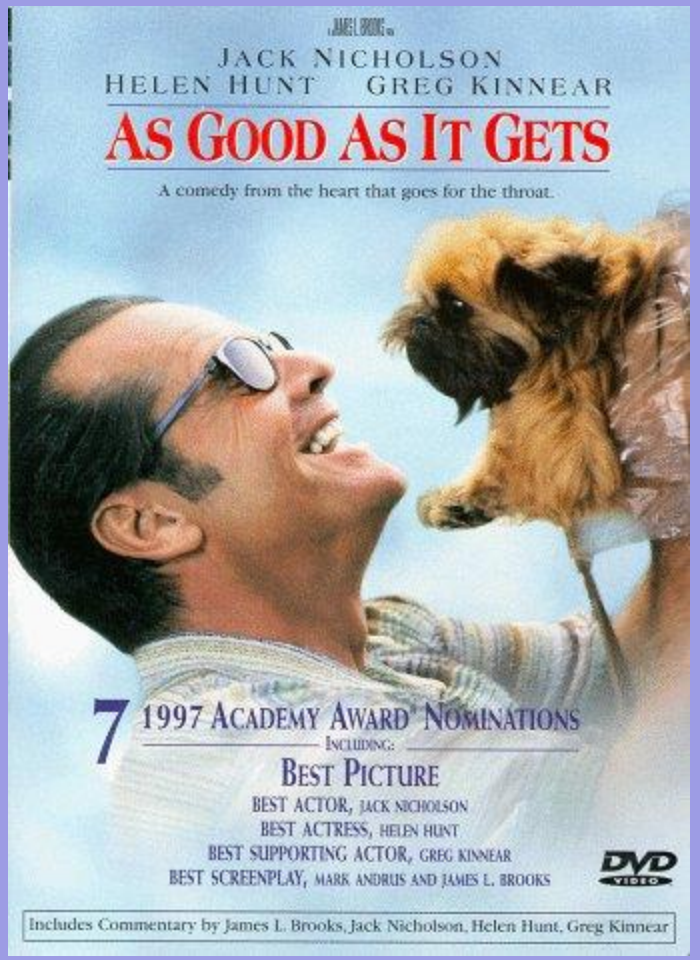
ANXIETY DISORDERS

- Phobic disorders: persistent and irrational fear of an object of situation that presents no realistic danger.
- Common phobias include fears of specific animals, heights, blood, flying, enclosed spaces, etc.
- Agoraphobia: fear of open places; seen more today as a complication of panic disorder than an independent phobia
  - Individual concerns about exhibiting panic in public may escalate to the point where one is afraid to leave home.



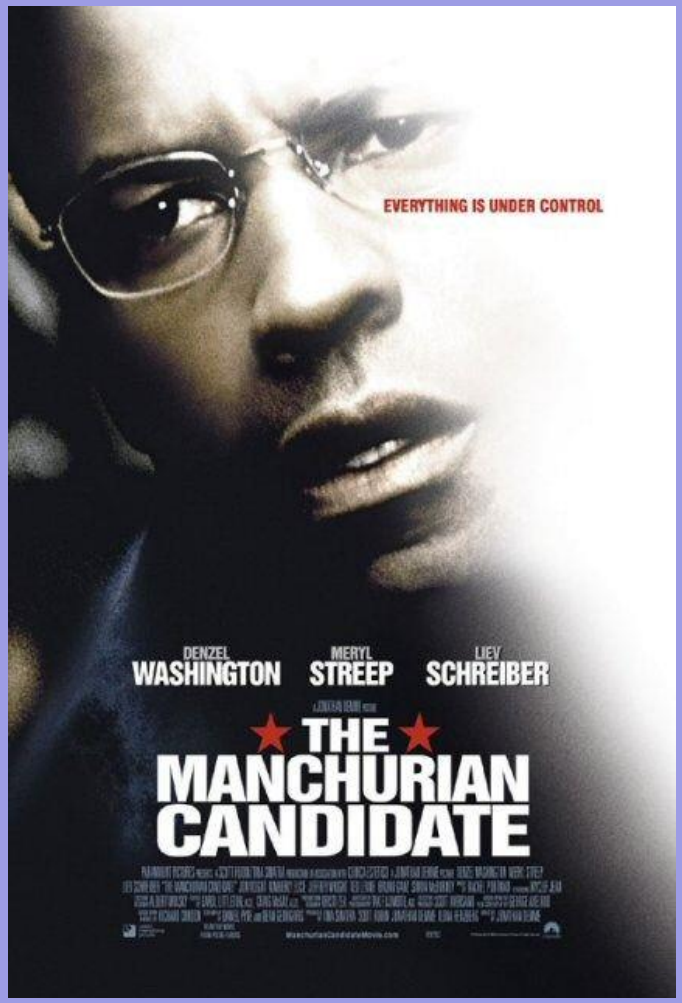
ANXIETY DISORDERS

- Obsessive-Compulsive Disorder (OCD): marked by persistent, uncontrollable intrusions of unwanted thoughts (obsessions) and urges to engage in senseless rituals (compulsions)
- Obsessions often center on inflicting harm on others, personal failures, suicide or sexual acts.
- Compulsions usually involve stereotyped rituals that temporarily relieve anxiety.
- Constant hand washing
- Repetitive cleaning
- Endless rechecking of locks, faucets, etc.



ANXIETY DISORDERS

- Posttraumatic Stress Disorder (PTSD): involves enduring psychological disturbance attributed to the experience of a major traumatic event.
- Symptoms include haunting memories, recurrent nightmares, social withdrawal, anxiety and insomnia
- Often seen following:
- Combat experience
- Rape or assault
- Automobile accidents
- Natural disasters
- Witnessing violent death



SOMATOFORM DISORDERS

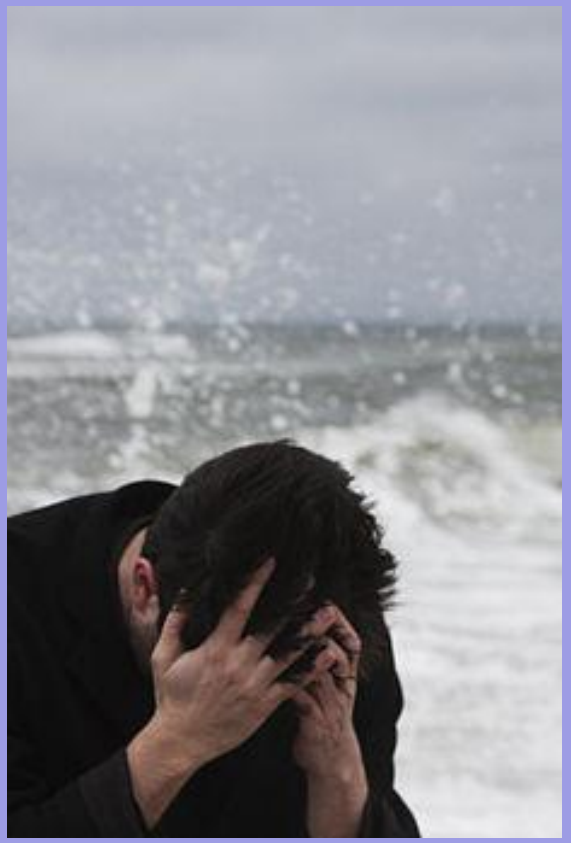
- Somatoform disorders: psychological disorder characterized by physical symptoms with no apparent physical cause
- Patients often become worried about their health because doctors are unable to find a cause for their problems.
- Specific types of somatoform disorders include:
- Conversion disorder: involves the actual loss of bodily function such as blindness, paralysis and numbness due to excessive anxiety.
- Hypochondria: involves persistent and excessive worry about developing or having a serious illness
- Body dysmorphic disorder: excessive concern about body image and preoccupation with a perceived defect of physical features
- Pain disorder: chronic pain thought to be caused by psychological stress

MOOD DISORDERS

- Mood disorders: marked by emotional disturbances of varied kinds that may spill over to disrupt physical, perceptual, social and thought processes.
- Two basic types of mood disorders: unipolar and bipolar.

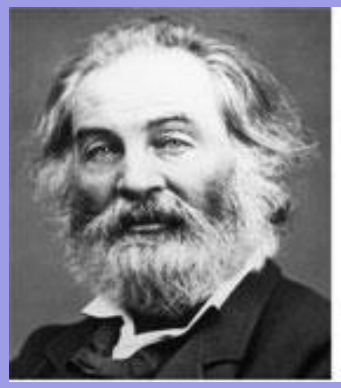
MOOD DISORDERS

- Major Depressive Disorder: unipolar condition in which people show persistent feelings of sadness and despair and a loss of interest in previous sources of pleasure
- Anhedonia: diminished ability to experience pleasure; common side effect of MDD
- MDD can be *episodic* or *chronic*.
- Most common of the psychological disorders.
- About twice as common in women; postpartum and postmenopausal depression
- Seasonal Affective Disorder: tendency to become depressed during the fall and winter seasons

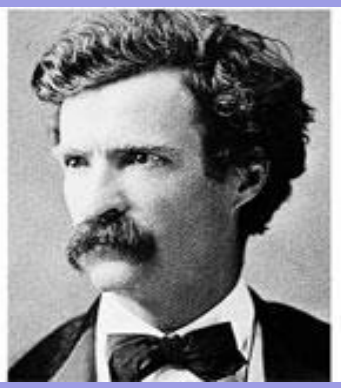


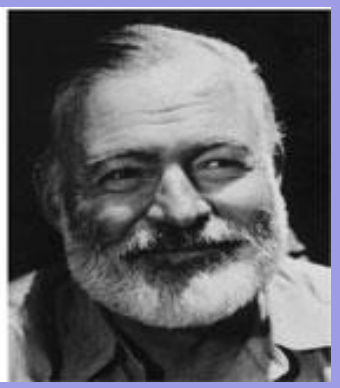
MOOD DISORDERS

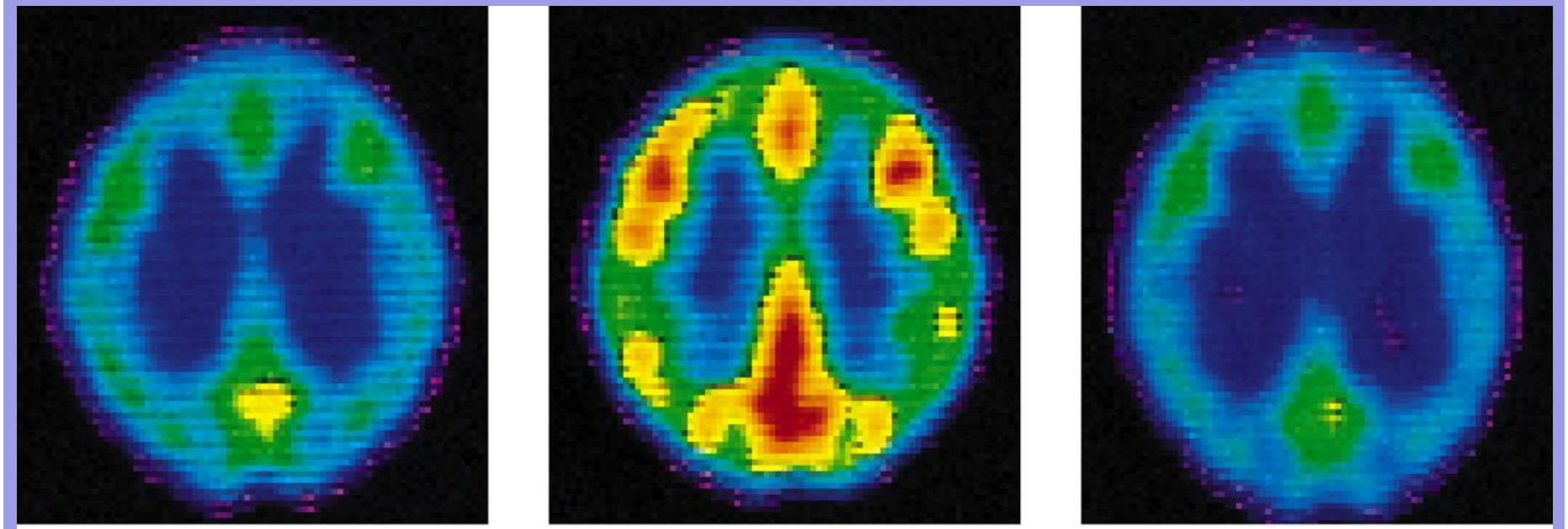
- Bipolar Disorder: (formerly manic-depressive disorder) characterized by the experience of one or more manic episodes and well as periods of depression
- Mania: hyperactive, wildly optimistic state
- People afflicted with bipolar disorder experience periods of extreme highs (mania) and extreme lows (depression) usually lasting weeks at a time.
- Roughly affects about 1% of the population; unlike MDD equally affects men and women.


Whitman


Wolfe


Clemens


Hemingway



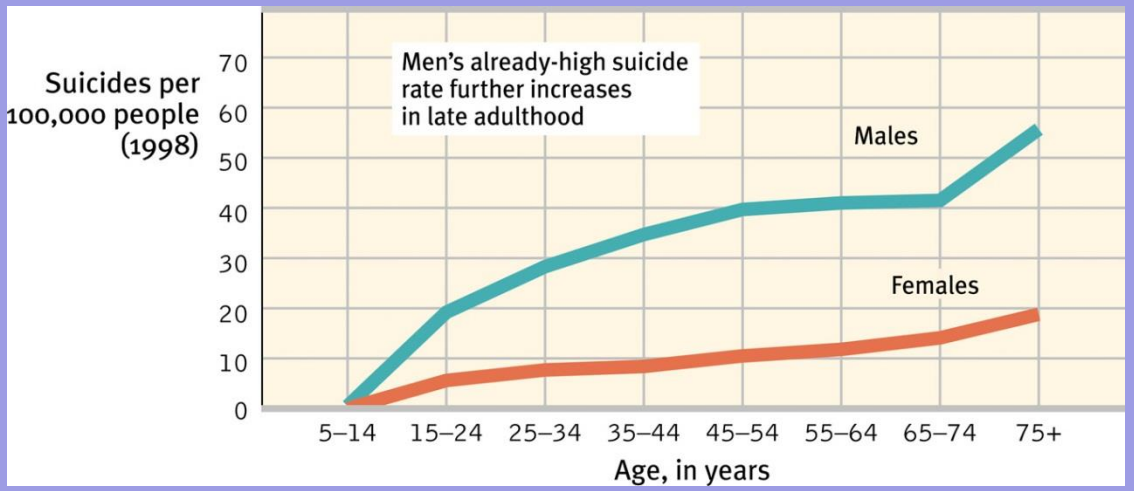
Depressed state
(May 17)

Manic state
(May 18)

Depressed state
(May 27)

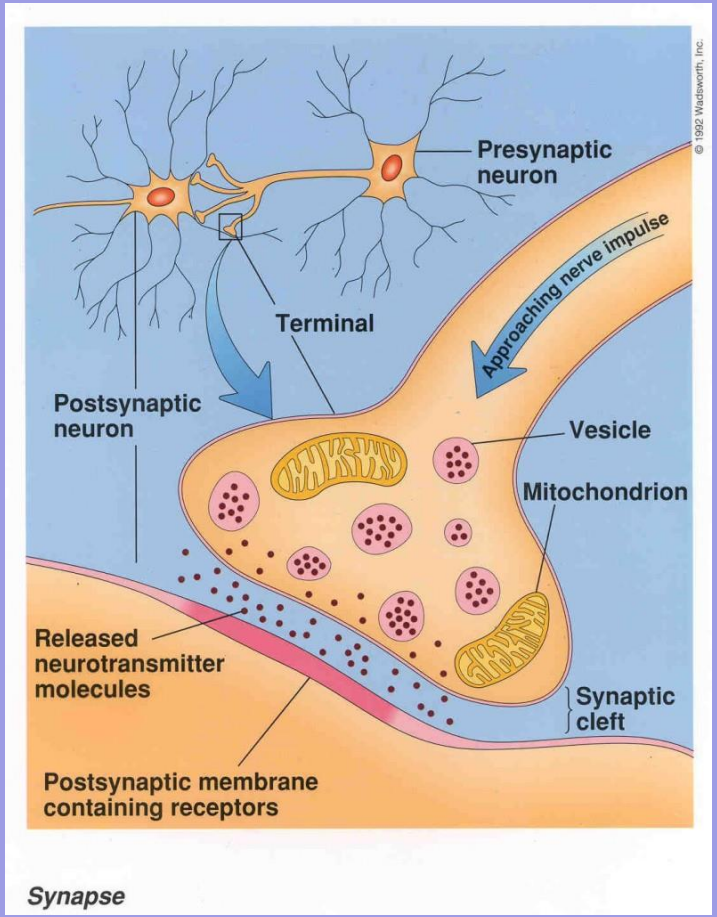
SUICIDE AND MOOD DISORDERS

- One tragic side effect of mood disorders is suicide.
- 11th leading cause of death in the United States.
- Estimate that suicide attempts and suicide completions are at about a 10:1 ratio.
- Women *attempt* suicide more often than men; men *complete* suicide four times more often than women.
- Completed suicides are highest amongst adults over the age of 75.

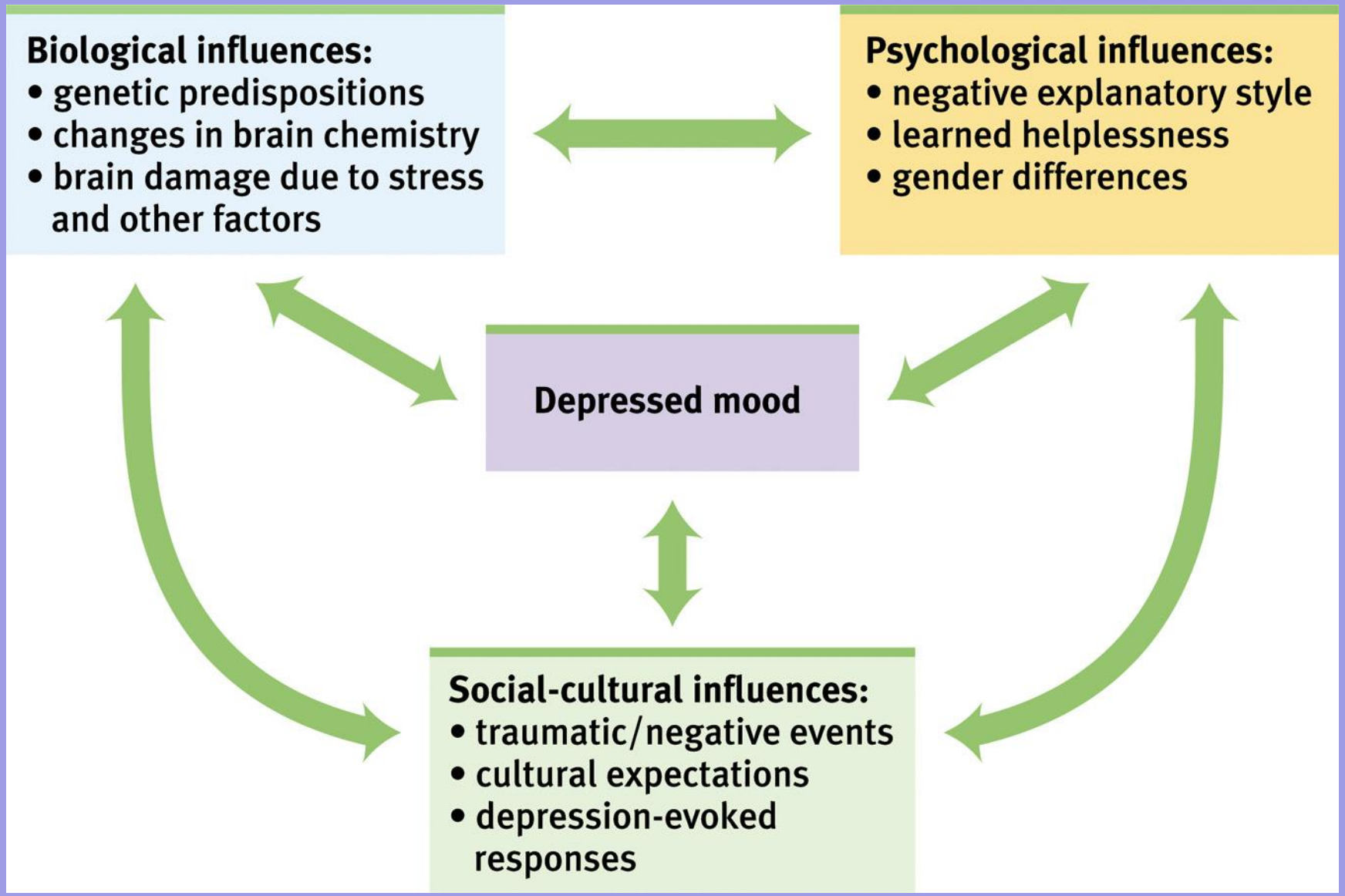


ETIOLOGY OF MOOD DISORDERS

- As with most psychological disorders, twin studies have suggested that heredity can create a *predisposition* to mood disorders.
- Correlations have been found between mood disorders and two key neurotransmitters:
  - Serotonin: low levels underlie many instances of depression
  - Norepinephrine: overabundant during mania but scarce during depression
- Depressed patients also tend to show an elevated level of *cortisol*, a hormone released during times of stress.



Synapse

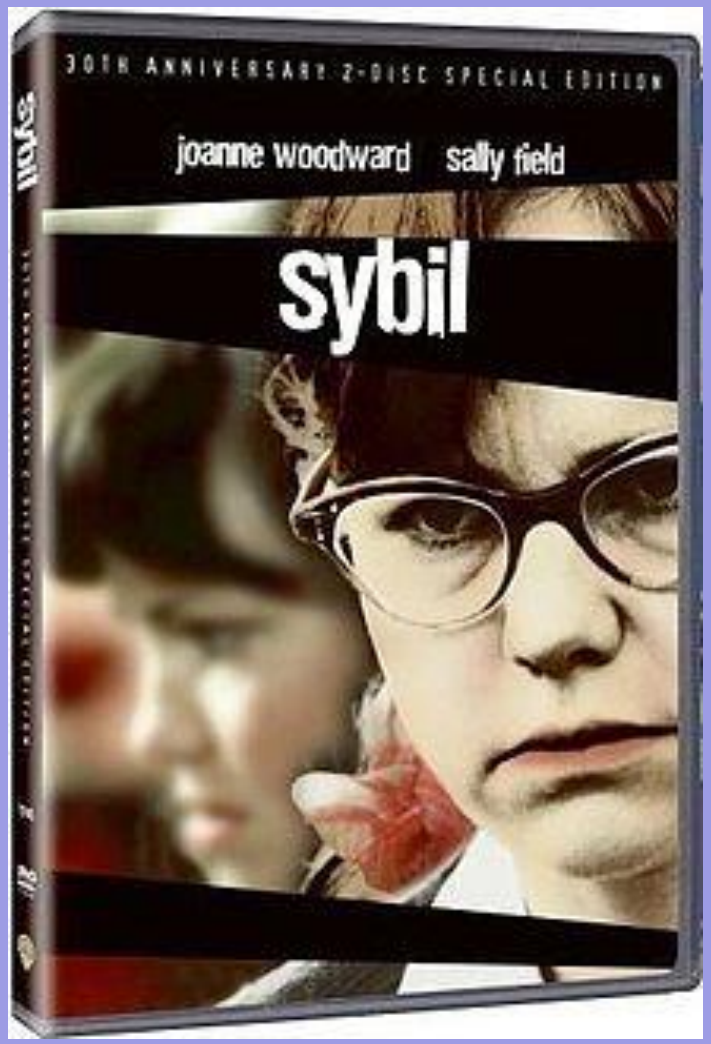

Biological influences:
• genetic predispositions
• changes in brain chemistry
• brain damage due to stress and other factors
Psychological influences:
• negative explanatory style
• learned helplessness
• gender differences
Depressed mood
Social-cultural influences:
• traumatic/negative events
• cultural expectations
• depression-evoked responses

DISSOCIATIVE DISORDERS

- Dissociative Disorders: class of disorders in which people lose contact with portions of consciousness or memory, resulting in the disruption of their sense of identity.
- Three main types of dissociative disorders:
- 1. Dissociative amnesia: sudden loss of memory for important personal information that is too extensive to be due to normal forgetting; normally occurs after a single, traumatic event
- 2. Dissociative fugue: involves the loss of memory for ones entire life along with their sense of personal identity; typically rebuild their lives in another location with a different identity
- 3. Dissociative Identity Disorder: coexistence in one person of two or more largely complete and usually different personalities; formerly called *multiple personality disorder*

DISSOCIATIVE IDENTITY: A CLOSER LOOK

- Each personality has his or her own name, memories, traits and physical mannerisms.
- The various personalities tend to be unaware of each other.
- Transitions between identities often occur suddenly.


30TH ANNIVERSARY 2-DISC SPECIAL EDITION
joanne woodward
sally field
sybil


JIM CARREY
RENÉE ZELLWEGER
FROM GENTLE TO MENTAL
Me, Myself & Irene
JUNE 23

DISSOCIATIVE IDENTITY: DOES IT EXIST?

D.I.D. Does Not Exist

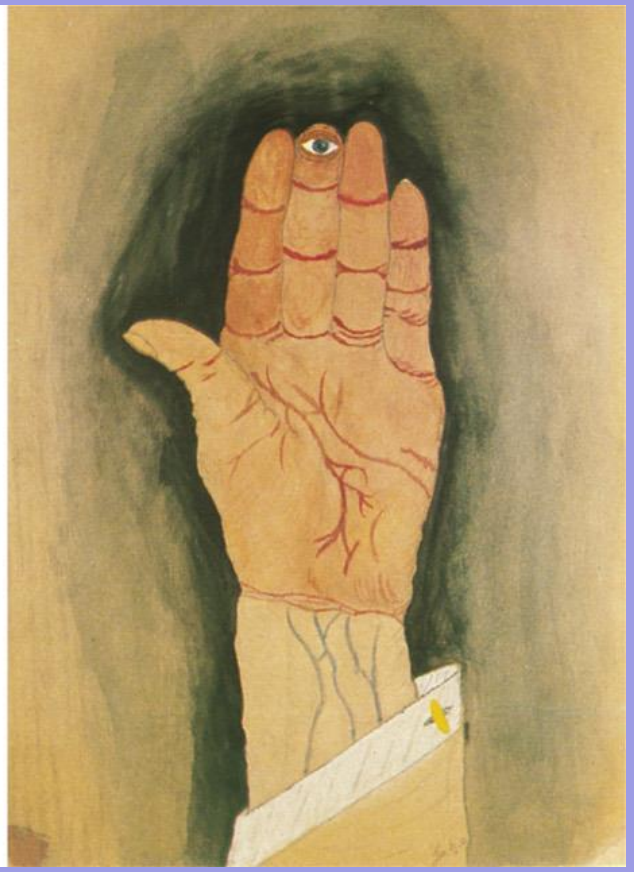
- People with DID are engaging in intentional role playing to use mental illness as an excuse for personal failings.
- DID is a “creation” of modern North American culture.
- Since the publication of “Sybil” in 1973, the number of average personalities has increased from 2 or 3 to about 15.
- Therapists subtly encourage creation of different personalities in their patients.

DID Does Exist

- Believe that DID has been historically under-diagnosed.
- No incentive exists for patients or therapists to manufacture cases of DID.
- DID is actually rooted in severe emotional trauma that occurred during childhood.

SCHIZOPHRENIA

- Schizophrenia: class of disorders marked by delusions, hallucinations, disorganized speech and deterioration of adaptive behavior
- At the core of schizophrenia lie disturbed *thoughts*.
- It is a severe, debilitating disorder that tends to have an early onset (adolescence or early adulthood) and often requires lengthy hospital care.
- The financial impact of schizophrenia is estimated to exceed the costs of ALL types of cancer combined.

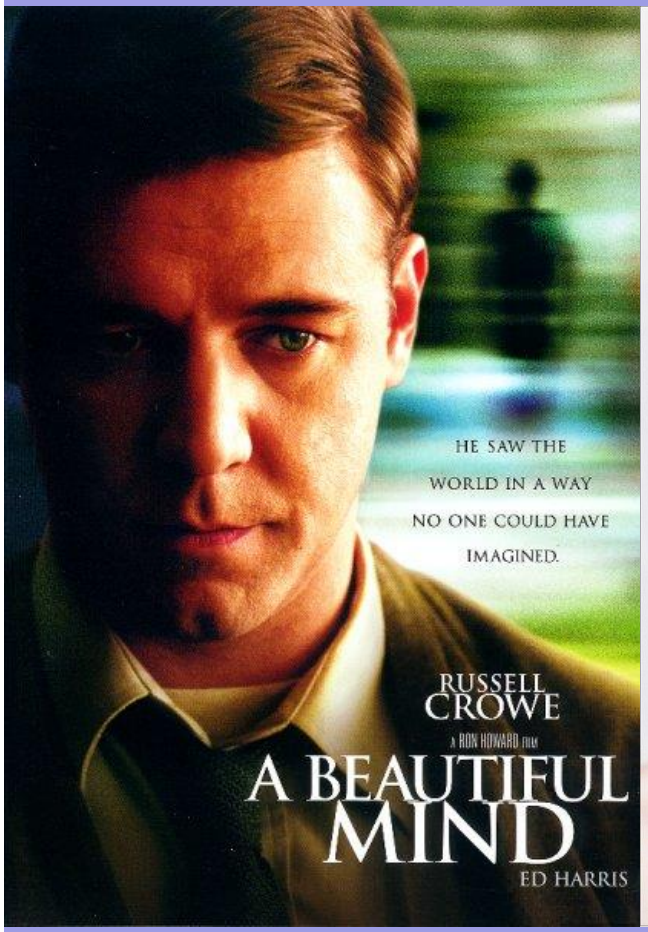


SCHIZOPHRENIA: GENERAL SYMPTOMS

- Delusions: false beliefs that are maintained even though they clearly are out of touch with reality
  - Believe private thoughts are being broadcast to others.
  - Thoughts are being injected into their minds against their will.
  - Their thoughts are being controlled by some external force.
- Delusions of grandeur: maintaining that they are famous or important (i.e. “Napoleon” or “God”)
- Thinking becomes chaotic rather than logical or linear.
- Hallucinations: sensory perceptions that occur in the absence of real, external stimuli or gross distortions of perceptual input.
- Auditory: hearing things that don’t exist (most common)
- Visual, Tactile, Olfactory and Gustatory hallucinations

SUBTYPES OF SCHIZOPHRENIA

- 1.Paranoid: dominated by delusions of persecution and delusions of grandeur
  - Convinced they are being watched and manipulated in malicious ways.
- 2.Catatonic: marked by striking disturbances, ranging from muscular rigidity to random motor activity
  - May remain motionless for long periods of time.
  - Other times they become hyperactive and incoherent.
- 3.Disorganized: severe deterioration of adaptive behavior
  - Emotionally indifferent, incoherent and complete social withdrawal
  - Aimless babbling and giggling are common.
- 4.Undifferentiated: patients whose symptoms cannot be placed in the before-mentioned categories are said to have undifferentiated schizophrenia


HE SAW THE
WORLD IN A WAY
NO ONE COULD HAVE
IMAGINED.
RUSSELL
CROWE
A RON HOWARD FILM
A BEAUTIFUL
MIND
ED HARRIS


OPENING NIGHT SELECTION
VENICE 2010
INTERNATIONAL FILM FESTIVAL
OFFICIAL SELECTION
TORONTO 2010
INTERNATIONAL FILM FESTIVAL
ACADEMY AWARD® NOMINEE
NATALIE PORTMAN
VINCENT CASSEL
MILA KUNIS
BLACK SWAN
A FILM BY DARREN ARONOFSKY
THE DIRECTOR OF THE WRESTLER AND REQUIEM FOR A DREAM
FOX SEARCHLIGHT PICTURES PRESENTS IN ASSOCIATION WITH CROSS CREEK PICTURES
A PROTOZOA PICTURES AND PHOENIX PICTURES PRODUCTION A FILM BY DARREN ARONOFSKY
NATALIE PORTMAN VINCENT CASSEL MILA KUNIS "BLACK SWAN" BARBARA HERSHEY AND WINONA RYDER
JIM BLACK AND GABE HILFER CLINT MANSELL ANDREW WEISBLUM, A.C.E. THERESE DEPREZ
MATTHEW LIBATIQUE, ASC MIKE MEDAVOY ARNOLD W. MESSER BRIAN OLIVER SCOTT FRANKLIN
ANDRES HEINZ MARK HEYMAN AND ANDRES HEINZ AND JOHN McLAUGHLIN DARREN ARONOFSKY
DECEMBER
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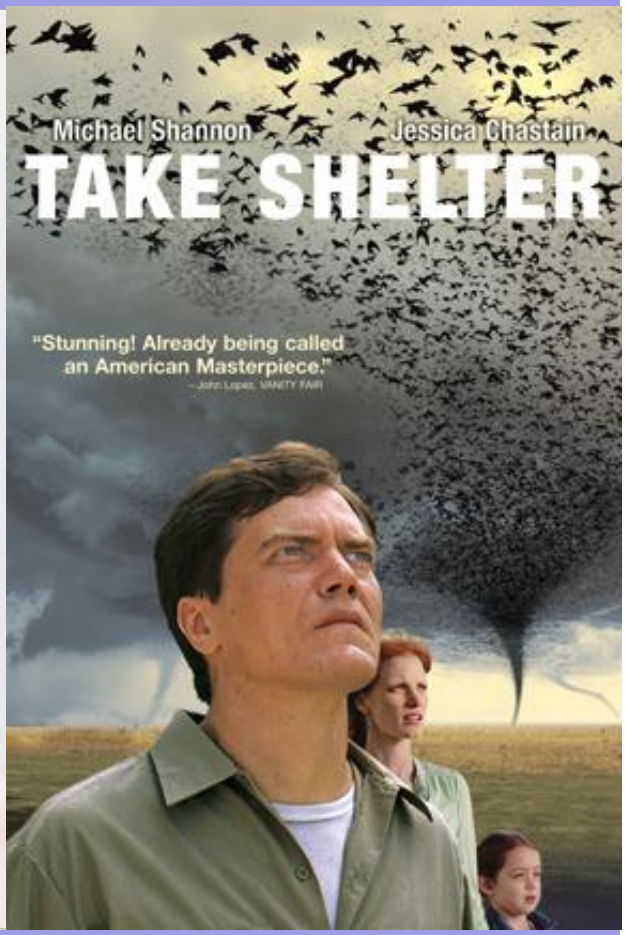
Michael Shannon
Jessica Chastain
TAKE SHELTER
"Stunning! Already being called
an American Masterpiece."
–John Lopez, VANITY FAIR

MODERN ORGANIZATION OF SCHIZOPHRENIA

Positive Symptoms

- Involve behavioral *excesses* or peculiarities.
- Hallucinations
- Delusions
- Bizarre behavior
- Wild flights of ideas
- "Word Salad"
- Thought blocking

Negative Symptoms

- Involve behavioral *deficits*.
- Flattened emotions; "flat effect"
- Social withdrawal
- Apathy
- Inability to maintain motivation; "avolition"
- "Alogia", or poverty of speech

ETIOLOGY OF SCHIZOPHRENIA

- Identical twins and children of parents who BOTH have schizophrenia roughly have a 50-50 chance of developing the disease as well.
- The neurotransmitter dopamine in ***excess*** could be the neurochemical basis for schizophrenia.
- THC (active ingredient in marijuana) has been linked to onset of schizophrenia in those with a predisposition to the disease.
- Reductions of both gray and white matter; impair the brain's neural communication.
- Disruptions in normal maturational processes during gestation:
  - Viral infection of the mother (particularly influenza)
  - Malnutrition (i.e. "Dutch Winter" famine victims)
  - Severe maternal stress

PERSONALITY DISORDERS

- Personality disorders: marked by extreme, inflexible personality traits that cause subjective distress or impaired social and occupational functioning.
- Most are *milder* disturbances in comparison to most of the Axis I disorders.
- DSM-IV lists ten different types of personality disorders.
- Grouped into three related clusters:
- 1. anxious-fearful: avoidant, dependent and obsessive-compulsive
- 2. odd-eccentric: schizoid, schizotypal, paranoid
- 3. dramatic-impulsive: histrionic, narcissistic, borderline, antisocial

ANTISOCIAL PERSONALITY DISORDER

- Antisocial personality disorder: marked by impulsive, callous, aggressive and irresponsible behavior that fails to accept social norms; formerly called *sociopaths* or *psychopaths*
- Individuals with APD chronically violate the rights of others yet feel little guilt about their transgressions.
- Rarely experience affection for others
- Irresponsible and impulsive.
- Sexually predatory and promiscuous; pursue immediate gratification.