Ch. 15 – psychological disorders

Introduction to Psychological Disorders15-1 How should we draw the line between normality and disorder? According to psychologists and psychiatrists, psychological disorders are marked by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior. ONCH. 15 – PSYCHOLOGICAL DISORDERS SPECIFICALLY FOR YOUFOR ONLY$13. 90/PAGEOrder Now15-2 How do the medical model and the biopsychosocial approach influence our understanding of psychological disorders? The medical model assumes that psychological disorders are mental illnesses with physical causes that can be diagnosed, treated, and, in most cases, cured through therapy, sometimes in a hospital.

The biopsychosocial perspective assumes that three sets of influences.....
- biological (evolution, genetics, brain structure and chemistry),
- psychological (stress, trauma, learned helplessness, mood-related perceptions and memories),
- social and cultural circumstances (roles, expectations, definitions of " normality" and " disorder"
..... interact to produce specific psychological disorders.

Epigenetics also informs our understanding of disorders.

15-3 How and why do clinicians classify psychological disorders, and why do some psychologists criticize the use of diagnostic labels? The American Psychiatric Association's DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) contains diagnostic labels and descriptions that provide a common language and shared concepts for communication and research.

Most U. S. health insurance organizations require a DSM diagnosis before paying for treatment.

Some critics believe the DSM editions have become too detailed and extensive.

Others view DSM diagnoses as arbitrary labels that create preconceptions, which bias perceptions of the labeled person's past and present behavior.

15-4 Why is there controversy over attention-deficit/hyperactivity disorder? A child (or, less commonly, an adult) who displays extreme inattention and/or hyper-activity and impulsivity may be diagnosed with attention-deficit/hyperactivity disorder (ADHD) and treated with medication and other therapy.

The controversy centers on whether the growing number of ADHD cases reflects overdiagnosis or increased awareness of the disorder.

Long-term effects of stimulant-drug treatment for ADHD are not yet known.

15-5 Do psychological disorders predict violent behavior? Mental disorders seldom lead to violence, but when they do, they raise moral and ethical questions about whether society should hold people with disorders responsible for their violent actions.

Most people with disorders are nonviolent and are more likely to be victims than attackers.

15-6 How many people have, or have had, a psychological disorder? Is poverty a risk factor? Psychological disorder rates vary, depending on the time and place of the survey.

In one multinational survey, rates for any disorder ranged from less than 5 percent (Shanghai) to more than 25 percent (the United States).

Poverty is a risk factor: Conditions and experiences associated with poverty contribute to the development of psychological disorders.
But some disorders, such as schizophrenia, can drive people into poverty.

Anxiety Disorders, OCD, and PTSD15-7 How do generalized anxiety disorder, panic disorder, and phobias differ? Anxious feelings and behaviors are classified as an anxiety disorder only when they form a pattern of distressing, persistent anxiety or maladaptive behaviors that reduce anxiety.

People with generalized anxiety disorder feel persistently and uncontrollably tense and apprehensive, for no apparent reason.

In the more extreme panic disorder, anxiety escalates into periodic episodes of intense dread.

Those with a phobia may be irrationally afraid of a specific object, activity, or situation.

Two other disorders (OCD and PTSD) involve anxiety but are classified separately from the anxiety disorders.

15-8 What is OCD? Persistent and repetitive thoughts (obsessions), actions (compulsions), or both characterize obsessive-compulsive disorder (OCD).

15-9 What is PTSD? Symptoms of posttraumatic stress disorder (PTSD) include ....

- four or more weeks of haunting memories, nightmares,
- social withdrawal,
- jumpy anxiety,
- numbness of feeling,
- and/or sleep problems

..... following some traumatic experience. 15-10 How do conditioning, cognition, and biology contribute to the feelings and thoughts that mark anxiety disorders, OCD, and PTSD? The learning perspective views anxiety disorders, OCD, and PTSD as products of

- fear conditioning,
- stimulus generalization,
- fearful-behavior reinforcement, and
- observational learning of others' fears and cognitions (interpretations, irrational beliefs, and hypervigilance).

The biological perspective:

- considers the role that fears of life-threatening animals, objects, or situations played in natural selection and evolution;

- genetic predispositions for high levels of emotional reactivity and neurotransmitter production; and

- abnormal responses in the brain's fear circuits.

Depressive Disorders and Bipolar Disorder15-11 How do major depressive disorder, persistent depressive disorder, and bipolar disorder differ? A person with major depressive disorder experiences two or more weeks with five or more symptoms, at least one of which must be either
(1) depressed mood or
(2) loss of interest or pleasure.

Persistent depressive disorder includes a mildly depressed mood more often than not for at least two years, along with at least two other symptoms.

A person with the less common condition of bipolar disorder experiences not only depression but also mania—episodes of hyperactive and wildly optimistic, impulsive behavior.

15-12 How can the biological and social-cognitive perspectives help us understand depressive disorders and bipolar disorder? The biological perspective on depressive disorders and bipolar disorder focuses on genetic predispositions and on abnormalities in brain structures and function (including those found in neurotransmitter systems).

The social-cognitive perspective views depression as an ongoing cycle of stressful experiences (interpreted through negative beliefs, attributions, and memories) leading to negative moods and actions and fueling new stressful experiences.

15-13 What factors increase the risk of suicide, and what do we know about nonsuicidal self-injury? Suicide rates differ by nation, race, gender, age

group, income, religious involvement, marital status, and (for gay and lesbian youth, for example) social support structure.

Those with depression are more at risk for suicide than others are, but social suggestion, health status, and economic and social frustration are also contributing factors.

Environmental barriers (such as jump barriers) are effective in preventing suicides.

Forewarnings of suicide may include:
- verbal hints,
- giving away possessions,
- withdrawal,
- preoccupation with death, and
- discussing one's own suicide.

Nonsuicidal self-injury (NSSI) does not usually lead to suicide but may escalate to suicidal thoughts and acts if untreated.

People who engage in NSSI do not tolerate stress well and tend to be self-critical, with poor communication and problem- solving skills.

Schizophrenia15-14 What patterns of perceiving, thinking, and feeling characterize schizophrenia? Symptoms of schizophrenia include
- disturbed perceptions,
- disorganized thinking and speech, and
- diminished, inappropriate emotions.

Delusions are false beliefs;

Hallucinations are sensory experiences without sensory stimulation

Schizophrenia symptoms may be
- positive (the presence of inappropriate behaviors) or
- negative (the absence of appropriate behaviors).

15-15 How do chronic and acute schizophrenia differ? Schizophrenia typically strikes during late adolescence, affects men slightly more than women, and seems to occur in all cultures.
In chronic (or process) schizophrenia, the disorder develops gradually and recovery is doubtful.
In acute (or reactive) schizophrenia, the onset is sudden, in reaction to stress, and the prospects for recovery are brighter. 15-16 What brain abnormalities are associated with schizophrenia? People with schizophrenia have increased dopamine receptors, which may intensify brain signals, creating positive symptoms such as hallucinations and paranoia.

Brain abnormalities associated with schizophrenia include enlarged, fluid-filled cerebral cavities and corresponding decreases in the cortex.

Brain scans reveal abnormal activity in the frontal lobes, thalamus, and amygdala.

Interacting malfunctions in multiple brain regions and their connections may produce schizophrenia's symptoms.

15-17 What prenatal events are associated with increased risk of developing schizophrenia? Possible contributing factors include

- viral infections or famine conditions during the mother's pregnancy;
- low weight or oxygen deprivation at birth; and
- maternal diabetes or
- older paternal age15-18 Do genes influence schizophrenia? What factors may be early warning signs of schizophrenia in children? Twin and adoption studies indicate that the predisposition to schizophrenia is inherited.

Multiple genes probably interact to produce schizophrenia.

No environmental causes invariably produce schizophrenia, but environmental events (such as prenatal viruses or maternal stress) may " turn on" genes for this disorder in those who are predisposed to it.

Possible early warning signs of later development of schizophrenia include both:

- biological factors (a mother with severe and long-lasting schizophrenia; oxygen deprivation and low weight at birth; separation from parents; short attention span and poor muscle coordination) and

- psychological factors (disruptive or withdrawn behavior; emotional unpredictability; poor peer relations and solo play).

Dissociative, Personality, and Eating Disorders15-19 What are dissociative disorders, and why are they controversial? Dissociative disorders are conditions in which conscious awareness seems to become separated from previous memories, thoughts, and feelings.

Skeptics note that dissociative identity disorder, formerly known as multiple personality disorder, increased dramatically in the late twentieth century; is rarely found outside North America; and may reflect role playing by people who are vulnerable to therapists' suggestions.

Others view this disorder as a manifestation of feelings of anxiety, or as a response learned when behaviors are reinforced by anxiety-reduction.

15-20 What are the three clusters of personality disorders? What behaviors and brain activity characterize the antisocial personality? Personality disorders are disruptive, inflexible, and enduring behavior patterns that impair social functioning.

This disorder forms three clusters, characterized by
(1) anxiety,
(2) eccentric or odd behaviors, and
(3) dramatic or impulsive behaviors.

Antisocial personality disorder (one of those in the third cluster) is characterized by a lack of conscience and, sometimes, by aggressive and fearless behavior.

Genetic predispositions may interact with the environment to produce the altered brain activity associated with antisocial personality disorder.

15-21 What are the three main eating disorders, and how do biological, psychological, and social-cultural influences make people more vulnerable to them? In those with eating disorders (most often women or gay men),

psychological factors can overwhelm the body's tendency to maintain a normal weight.

Despite being significantly underweight, people with anorexia nervosa (usually adolescent females) continue to diet and exercise excessively because they view themselves as fat.

Those with bulimia nervosa (usually females in their teens and twenties) secretly binge and then compensate by purging, fasting, or excessive exercise.

Those with binge-eating disorder binge but do not follow with purging, fasting, and exercise.

Cultural pressures, low self-esteem, and negative emotions interact with stressful life experiences and genetics to produce eating disorders.