TYPES OF DISORDERS

1. Anxiety Disorders and Somatoform Disorders

I. Anxiety disorders in general

A. A diagnosis of anxiety disorder occurs when overwhelming anxiety disrupts social or occupational functioning or produces significant distress.

B. Manifestations/Symptoms of anxiety

1. Cognitive: Thought processes range from generalized worry to overwhelming fear and often focus on various possibilities of impending doom.

2. Behavioral: The avoidance of an anxiety-provoking situation may be practiced. For example, persons may be unwilling to leave home.

3. Somatic: Numerous physiological complaints are experienced due to activation of the sympathetic nervous system. Examples include stomach aches, headaches, shakiness and so forth.

II. Specific anxiety disorders

A. Panic disorder

1. Recurrent and unexpected panic attacks are severe and involve feelings of terror and physiological involvement, such as a pounding heart and difficulty breathing. 2. These attacks lead to concern about future attacks or losing control, which may result in the individual being fearful of having a panic attack in public or of leaving home.

B. Generalized anxiety disorder

1. This is characterized by persistent high levels of anxiety and excessive worry with symptoms present for at least 6 months. 2. The physiological responses are similar to, although not as severe as, those experienced in panic disorder, but they are more persistent/long lasting.
C. Phobia

1. A persistent, irrational, unrealistic fear of specific objects or situations.

2. Exposure to a feared stimulus produces intense fear or panic. The anxiety dissipates when the phobic situation is not being confronted.

3. Three subcategories include:

   a. Simple phobias, such as fear of closed spaces (claustrophobia) or spiders (arachnophobia).
   
   b. Agoraphobia, which is the irrational fear of open spaces, leading to a fear of leaving home or other safe havens.
   
   c. Social phobias involving social situations, such as public speaking.

D. Obsessive-compulsive disorder (OCD)

1. This involves both patterns of obsessions (thoughts, images or impulses that recur or persist despite a person's efforts to suppress them) and compulsions (repetitive, purposeful, but undesired acts performed in a ritualized manner in response to an obsession).

2. Persons with the disorder acknowledge the senselessness of their behavior; however, when anxiety rises, the ritualized behavior to relieve the tension cannot be resisted.

III. Explaining anxiety disorders

A. The learning perspective 1. Generalized anxiety has been linked with a classical conditioning of fear and the attendant stimulus. 2. Avoidance relieves fear through negative reinforcement.

B. The cognitive perspective 1. Observational learning can produce fear which results in anxiety. 2. For example, if a parent fears dogs, the child may learn this fear through observation.

C. The biological perspective 1. Fears that represent age-old threats, such as heights or spiders, may have contributed to our survival and have an
evolutionary basis. 2. Some people are genetically predisposed to fears and high anxiety. These disorders tend to run in families.

D. The biopsychosocial perspective views anxiety as having a biological involvement and learning component, both of which are influenced by culture.

IV. Somatoform disorders

A. These disorders are characterized by complaints of physical symptoms that have no organic or physiological explanation — they are psychologically based. The symptoms are not considered voluntary or under conscious control.

B. Specific somatoform disorders

1. Somatization disorder is characterized by multiple physical complaints with no organic explanation and an onset before age 30.
2. Conversion disorder is characterized by a specific physical complaint, such as paralysis of the legs, or blindness. Patients strongly believe there is impairment, but may show less distress than with a real loss.
3. Hypochondriasis is characterized by persistent preoccupation with one's health and physical condition, despite the fact that genuine symptoms of a disorder are lacking.

V. Explaining somatoform disorders

A. These disorders now constitute only 5 percent of all disorders treated. Decreasing incidence seems linked to our growing understanding of physiological and psychological disorders.

B. The behavioral perspective suggests that avoidance behavior (becoming ill to avoid or reduce anxiety-arousing stress) is reinforced in two ways:

2. Dissociative and Personality Disorders

I. Dissociative disorders are characterized by disturbances or changes in memory, consciousness or identity due to psychological factors.
A. Specific dissociative disorders

1. Dissociative amnesia involves partial or total loss of important personal information that may occur after a stressful or psychologically traumatic event. There is no organic cause.

2. Dissociative fugue occurs when the individual suffers confusion over personal identity and often assumes a partial or complete new identity. It is accompanied by unexpected travel away from home.

3. Depersonalization disorder is the most common dissociative disorder and is characterized by feelings of unreality concerning the self and the environment. It is characterized by the intensity of the symptoms and anxiety provoked by the symptoms. Most young adults have experienced some symptoms of this disorder.

4. Dissociative identity disorder (formerly called multiple personality disorder) is a rare, dramatic and controversial disorder characterized by the existence of two or more distinct personalities within one person.

   a. The original personality is unaware of other personalities, but they are conscious of the original personality and often of each other. b. Each personality maintains its own identity, name and distinctive behavior pattern. c. The diagnosis of this disorder is controversial. Even research showing different brain wave patterns for personalities is now suspect since others have shown an ability to produce different brain waves on demand.

B. Explaining dissociative disorders

1. Dissociation is a relatively common response to traumatic experience. People report feeling detached from their surroundings and their own bodies. 2. In those persons with dissociative disorders the dissociative experiences are more extreme and frequent, and the symptoms severely disrupt everyday functioning.

3. The learning perspective views dissociation as rewarding and thus highly reinforcing. 4. Some psychologists suggest that dissociative identity disorder is a diagnostic fad.
II. Personality disorders

A. In general, personality disorders are

1. Characterized by long-standing chronic, inflexible, maladaptive patterns of perception, thought and behavior that seriously impair an individual's ability to function personally or socially. 2. Usually recognizable by the time the person reaches adolescence. 3. As a group, among the least reliably judged and are questioned as to their existence independent of the social and cultural factors in which they develop.

B. Examples of specific personality disorders

1. Narcissistic personality disorder is marked by a grandiose sense of self-importance and is preoccupied with fantasies of success or power. Additionally, the individual feels a need for constant attention or admiration, has inappropriate reactions to criticism, may be indifferent or over-reacting, and feels entitled to favors without reciprocation.

2. Antisocial personality disorder is marked by a long-standing pattern of irresponsible behavior that hurts others without causing feelings of guilt for oneself. The individual often does not experience shame or intense emotion of any kind. The violation of social norms begins early in life and may involve various criminal acts, often committed impulsively.

C. Explaining antisocial personality disorders

1. The biological perspective suggests that a genetic vulnerability may contribute to the antisocial personality disorder. This is correlated with a fearless approach to life. 2. The biopsychosocial perspective suggests that, in the case of antisocial personality disorder, if fearlessness is channeled in productive directions, heroism or adventurism may result. Lacking a sense of social responsibility, the same disposition produces, for example, a con artist or killer. 3. Some studies have detected early signs of antisocial behavior in children as young as 3 to 6 years old.
3. Mood (Affective) Disorders

I. Mood disorders in general

A. This category of mental disorders has significant and chronic disruption in mood as the predominant symptom. This causes impaired cognitive, behavioral and physical functioning.

B. Mood disorders are differentiated from normal moods on the basis of duration, intensity and absence of cause. For example, two weeks of continued symptoms with high levels of intensity and with no precipitating cause indicates a major depressive episode.

C. Prevalence of mood disorders

1. Mood disorders are among the most common of all psychological disorders. 2. Mood disorders are more common in women than in men. 3. The greatest risk of developing major depression occurs between the ages of 15-24 and 35-44. 4. Episodes recur in one half of all cases and last at least two weeks.

II. Major depression characteristics

A. Emotional symptoms involve feelings of sadness, hopelessness and guilt. They also involve feeling emotionally disconnected from other people. B. Behavioral symptoms include a dejected, unsmiling, downcast demeanor; slowed movements and speech; tearfulness and spontaneous crying; and a loss of interest or pleasure in one's usual activities, including sex and eating. C. Cognitive symptoms involve difficulty thinking, concentrating and remembering; global negativity and pessimism; and suicidal thoughts or preoccupation with death. D. Physical symptoms include changes in appetite resulting in weight gain or loss; constipation; sleep disturbances, such as insomnia, oversleeping or early waking; chronic, vague aches and pains; and loss of energy, or restless, fidgety activity.

III. Other depressed mood disorders

A. Dysthymic disorder involves chronic, low-grade feelings of depression that produce subjective discomfort but, unlike major depression, does
not seriously impair one's ability to function. B. Seasonal affective disorder (SAD) involves episodes of depression which typically recur in fall and winter and remit during spring and summer.

IV. Bipolar disorder is characterized by alternating episodes of major depression and mania.

A. Characteristics of mania include

1. Emotional symptoms, such as euphoria, expansiveness and excitement (feeling "on top of the world"). 2. Behavioral symptoms, such as out-of-character energy or activity, frenzied, disorganized goal-directed activity, rapid-fire speech, spending sprees and illegal acts, and severely disrupted sleep patterns often resulting in little or no sleep over a number of days. 3. Cognitive symptoms, such as wildly inflated self-esteem, grandiosity (sometimes involving delusional beliefs), easy distractibility leading to a flight of ideas in which thoughts rapidly and loosely shift, irritability and verbal abusiveness if grandiose ideas are questioned.

B. Prevalence and course

1. 1% of Canadians suffer from bipolar disorder. 2. Onset typically occurs in the early twenties. 3. The disorder affects men and women at the same rate. 4. It is a recurring, chronic disorder that generally responds favorably to drug therapy.

C. Cyclothymic disorder, a milder, but chronic form of bipolar disorder, involves moderate but frequent mood swings. People with the disorder are perceived as extremely moody, unpredictable, and inconsistent.

V. Explaining affective disorders

A. The biopsychological perspective

1. Family, twin and adoption studies indicate that some people inherit a genetic predisposition for mood disorders. 2. Indirect evidence indicates that two neurotransmitters, serotonin and
norepinephrine, are implicated in major depression. 3. Symptoms of major depression are alleviated in about 80 percent of people for whom antidepressant medication is prescribed. These medications increase the availability of serotonin and norepinephrine in the brain. 4. Continued use of antidepressants can prevent recurrences of major depression.

B. The behavioral perspective stresses the role of reinforcement.

1. Depressed people may lack the social skills needed to gain normal social reinforcement from others. 2. Thus, a vicious cycle develops in which reduced social reinforcement leads to depression, and depressed behavior further reduces social reinforcement.

C. The cognitive perspective stresses that the way people think can result in depression.

1. Perfectionists set themselves up for depression through irrational self-demands they may not be able to meet. 2. Paying attention to negative information, being highly self-critical, being pessimistic about the future and focusing on the cause of the negative mood all contribute to depression. 3. Making attributions that are internal ("it's all my fault"), stable ("nothing can change to improve the situation") and global ("it is a major, all-encompassing problem") may cause depression.

D. The biopsychosocial perspective recognizes the roles played by an individual's biochemistry, behavior and mood (along with environmental stress factors), thus acknowledging that depression is an ailing mind in an ailing body. It also acknowledges that altering any one of the components of the chemistry-cognition-mood circuit can affect the others.
4. Schizophrenia

I. Description and symptoms of schizophrenia

A. Schizophrenia is a group of severe disorders characterized by the breakdown of personality functioning, withdrawal from reality, distorted emotions and disturbed thought.

B. DSM-IV indicates that the following symptoms must be manifested:

1. Delusions (false beliefs inconsistent with evidence or logic, e.g., "I am Queen Elizabeth")

2. Auditory hallucinations (false or distorted perceptions of hearing that seem vividly real to the person experiencing them)

3. Marked disturbance of speech, affect or thinking

4. Deterioration from former functioning level

5. Symptoms that last at least 6 months and are currently present for 1 month

D. The symptoms of schizophrenia

1. "Positive" symptoms (meaning an excess or distortion of normal functioning)

   a. Delusions  
   b. Hallucinations  
   c. Severely disorganized thought processes, speech and behavior  
   d. Disturbances involving extremely high or low activity levels of motor activity or odd movements and gestures.

2. Negative symptoms (meaning restriction or reduction of normal functioning)

   a. Flat affect, showing little emotion  
   b. Inability to feel pleasure  
   c. Lack of motivation  
   d. Lack of meaningful speech  
   e. Cessation of personal hygiene
II. Types of schizophrenia

A. Paranoid schizophrenia involves strongly held delusions of persecution or grandeur.

1. The onset of symptoms tends to occur later in life (in the 30s) than in other types of schizophrenia. 2. The individual rarely displays obviously disorganized behavior, but may act upon the delusions. This may result in behavior that seems reasonable to the individual, but not to others.

B. Disorganized schizophrenia involves inappropriate behavior and affect including odd movements and disconnected emotional states. It also involves incoherent language which may be "word salad" (words and ideas that jump from one subject to another with little coherence).

C. Catatonic schizophrenia involves frozen, rigid or excitable motor behavior. For example, patients can maintain postures with their arms raised for hours.

D. Undifferentiated schizophrenia has a mixed (undifferentiated) set of symptoms. It involves thought disorders and features from other types of schizophrenia.

III. The course of schizophrenia

A. Onset

1. The disorder typically occurs in men younger than 25 and in women between 25 and 45 years of age.

   a. Men and women are equally affected.  

   b. Schizophrenia occurs in approximately 1 percent of the world’s population and is seen in all cultures.

2. Gradual onset

   a. Some changes in previous behavior may be noted by others, especially social withdrawal.
b. The promodal phase (preceding the active phase) involves increased withdrawal with peculiar actions or talk.

c. During the active phase, full-blown symptoms are present.

d. Residual phase

(1) The symptoms are no longer prominent. (2) There is some remaining impairment in functioning.

e. Generally, one-third of patients recover, one-third are helped with medication, but retain some symptoms, and one-third are not helped by drug therapy. This is sometimes referred to as the "Rule of Thirds."

3. Sudden onset in a previously symptom-free individual usually occurs early in life (in the 20s) and presents a better prognosis for recovery with no recurrence. This is not true for gradual onset schizophrenia.

IV. Long-term outcome studies regarding schizophrenia indicate that recovery may be more rapid in developing countries than in the U.S., Europe or Russia. This may be due to greater acceptance or work opportunities available in third world communities. This has important implications for social policy.

V. Explaining schizophrenia: a biopsychological perspective

A. Studies of families, twins and adopted individuals have firmly established that genetic factors play a role in many cases.

B. Abnormal brain chemistry

1. One theory implicates an excess of the neurotransmitter dopamine.

2. Dopamine blocking drugs often reduce symptoms of schizophrenia, particularly positive ones.

C. In some patients there is evidence of a prenatal viral infection-based cause.
D. Abnormalities in brain structures and functioning are present in some patients with schizophrenia.

1. MRI studies have found abnormalities in the frontal lobes, temporal lobes and basal ganglia.

2. The fluid-filled ventricles are enlarged in some brains of schizophrenic patients.

E. Schizophrenia may be viewed as a complex, chronic medical illness, similar to diabetes or cancer, affecting different people in different ways.

F. Researchers have been unable to find a single psychological factor that emerges consistently as causing schizophrenia. Rather, it seems that those who are genetically predisposed to developing schizophrenia may be more vulnerable to such factors as disturbed family environments and stress.