

# Psychological Disorders

## Chapter 16

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# Psychological Disorders

- I. What Is Abnormal Behavior?
- II. What Are Anxiety Disorders?
- III. What Are Mood Disorders?
- IV. What Are Dissociative Disorders?
- V. What Is Schizophrenia?
- VI. What Are Personality Disorders?
- VII. Eating Disorders
- VIII. How Are Violence and Mental Disorders Related?

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# I. What Is Abnormal Behavior?

- Not typical
- Socially unacceptable
- Distressing to the person or others
- Maladaptive
- Result of distorted cognitions

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## Abnormal Psychology

Concerned with the assessment, treatment, and prevention of maladaptive behavior.

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## Abnormality Models

- Set of related concepts that help scientists organize data and predict behavior
- Form the basis of abnormal psychology
  - Assessment, treatment, and prevention of maladaptive behavior

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## Models

Religious or Supernatural: Person is abnormal because of sinful or demonic possession, temptation by the devil

Statistical Disease: Person is abnormal because he or she deviates too far from the norm.

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## Models

Medical/Disease: Person is abnormal because of some physical malfunction in the body

Psychological: Abnormality is due to defective strategies or coping with stressful circumstances and sociocultural conditions

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## Models

### Psychodynamic:

- Based on Freud's theory of personality
- Abnormal behavior caused by anxiety from unresolved conflicts

### Humanistic:

- Abnormal behavior caused when people's needs are not met
  - Due to external circumstances or internal factors

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## Models

### Behavioral

- Abnormal behavior is learned
- Thus, it can also be unlearned
  - Using traditional learning principles
  - Replaced with more appropriate behaviors

### Cognitive

- Thought processes lead to abnormal behavior
  - E.g., false assumptions, unrealistic coping
  - Changing thoughts changes behavior

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## Models

Sociocultural: Abnormal behavior develops within and because of context

- Some disorders are expressed differently in different cultures
- Some disorders are not expressed at all in some cultures
- Once labeled as abnormal, a person may start to act that way
  - **Self-fulfilling prophecy**

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## Models

Evolutionary: Abnormal behavior may once have been normal and adaptive

- Maladaptiveness is crucial for being considered abnormal

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## Which Model is Best?

Some psychologists adhere to one model  
Many use different models

- **Eclectic Approach**
  - Different models for different disorders
- **Biopsychosocial Approach**
  - Acknowledges biological, psychological and social factors
  - Combines models

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## Diagnosing Psychopathology

### The Diagnostic and Statistical Manual of Mental Disorders

- Current version is a text revision of the 4<sup>th</sup> edition (DSM-IV-TR)
- Designed to diagnose disorders, improve reliability, and be consistent with research and experience, insurance/billing purposes
- 17 categories of disorders

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## The DSM-IV-TR

### Five dimensions (**Axes**) of diagnostic information

- Axis I: Clinical Disorders
- Axis II: Personality Disorders and Mental Retardation
- Axis III: Current Medical Conditions
- Axis IV: Psychosocial or Environmental Problems
- Axis V: Global Assessment of Functioning

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## II. What Are Anxiety Disorders?

- Generalized feeling of fear and apprehension
- May be associated with a specific object or situation
- Often accompanied by physiological arousal
- Must occur for a 6 month period

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## Generalized Anxiety Disorder

Persistent anxiety not due to a specific stressor

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## Panic Disorder

Characterized by panic attacks

- Intense anxiety and autonomic arousal
- Shortness of Breath, increased heart rate, sweating
- Also occur in other anxiety disorders
- No identifiable trigger for the panic attacks

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## Phobic Disorders

- Excessive, irrational fear **and** avoidance of a specific object or situation
- May be maintained by the relief of escaping the feared situation

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## Agoraphobia

- Fear and avoidance of being alone in a place from which escape would be difficult or embarrassing
- In severe cases, the person may not even leave the house
- May occur with or without panic attacks
- Difficult to treat
  - Cognitive behavioral therapy and / or drug therapy may help

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## Social Phobia

- Fear and avoidance of situations where one might be evaluated or embarrassed
- Fear of public speaking, parties
- Very common, though often untreated

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## Specific Phobia

- Irrational, persistent fear and avoidance of a specific object or situation
- Behavior therapy is usually effective

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## Obsessive–Compulsive Disorder (OCD)

- Persistent and uncontrollable thoughts and irrational beliefs (obsessions)
  - Obsessions often focused on maintaining order and control
- Rituals that interfere with daily life (compulsions)
  - Compulsions reduce anxiety from the obsessions
  - E.g., compulsive hand-washing to relieve obsessive thoughts about germs

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## Post Traumatic Stress Disorder (PTSD):

Traumatic event is persistently re-experienced, persistent avoidance of stimuli associated with the trauma and numbing of general responses, persistent symptoms of increased arousal

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## III. What Are Mood Disorders?

- In mood disorders, disturbances of mood are intense and persistent enough to be clearly maladaptive
- Extreme & persistent sadness, despair, loss of interest in activities



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## What Are Mood Disorders?

- The two key moods involved are mania and depression
- In *unipolar disorders* the person experiences only severe depression
- In *bipolar disorders* the person experiences both manic and depressive episodes



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## The Prevalence of Mood Disorders

- Higher in industrialized than developing countries
    - May be due to higher rates of diagnosis
  - Twice as likely for women than men
    - In the U.S., 19–23% of women and 8–11% of men
    - May be due to differences in coping style
- The lifetime prevalence for bipolar disorder ranges from 0.4–1.6%

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## Onset and Duration

- First episode usually occurs before age 40
- Symptoms may last days, weeks, or months
- May be one or more repeated episodes
- Children and adolescents can be depressed
  - May also experience Anxiety and Loneliness

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## Depressive Symptoms



- Poor appetite and weight loss
- Sleep disturbance
- Loss of energy and interest
- Difficulty concentrating
- Feelings of worthlessness, guilt
- Thoughts of suicide
- Inability to experience pleasure

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## Unipolar Mood Disorders

- Two fairly common causes of depression that are generally not considered mood disorders are
  - Loss and the grieving process
  - Postpartum blues

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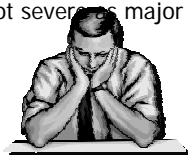
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## Unipolar Mood Disorders

- The two main categories of mild to moderate depressive disorders are
  - Adjustment Disorder with Depressed Mood
  - Dysthymic Disorder- Not severe as major depression - Chronic



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## Major Depressive Disorder

- Clinical Depression
- The diagnostic criteria for major depressive disorder require
  - That the person exhibit more symptoms than are required for dysthymia
  - That the symptoms be more persistent
- Subtypes of major depression include
  - Major depressive episode with melancholic features
  - Severe major depressive episode with psychotic features
  - Major depressive episode with atypical features

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## Depressive Symptoms

Sometimes include delusions

- False beliefs inconsistent with reality
- May induce feelings of guilt, shame, or persecution

Difficulty with **reality testing**

- Inability to judge demands accurately and respond appropriately

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## Major Depressive Disorder

- If major depression does not remit for more than two years, chronic major depressive disorder is diagnosed
- Some people who experience recurrent depressive episodes show a pattern commonly known as Seasonal Affective Disorder

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## Biological Bases of Mood Disorders

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## Biological Theories

### Neurotransmitters

#### Monoamine theory of major depression

- Depression results from problems with monoamine neurotransmitters
  - Dopamine, norepinephrine, epinephrine, serotonin
  - May be too few of these neurotransmitters
  - May not bind effectively to receptors
- Drugs that increase binding relieve depression
- Not effective for all cases of depression

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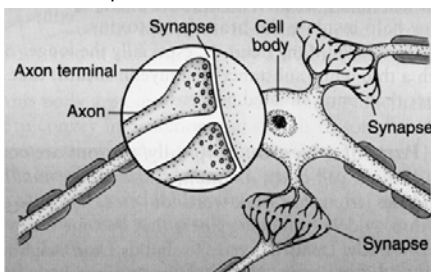
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## The Motor Neuron

### The Synapse

- Small space between neurons



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## Cellular Level

### The Functioning of Neurons

- Communication is an electrochemical process
  - Within neurons it is electrical
  - Between neurons it is chemical
  - A thin membrane around the neuron allows the process

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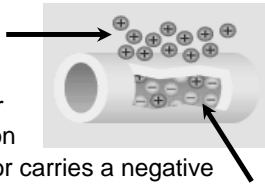
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## The Function of Neurons

- Partially permeable cell membrane
  - Traps charged particles inside or outside the neuron
  - At rest, the interior carries a negative electrical charge
  - The exterior carries a positive electrical charge
  - This difference in charges creates a state of **polarization**



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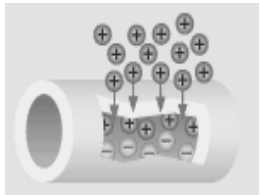
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## The Function of Neurons

- Each neuron has a **threshold**
  - Level of stimulation required for activation
- When the threshold is reached:
  - “Gates” open in cell membrane
  - Positive ions rush into cell
  - Neuron is **depolarized**
    - Relative charge is reversed
  - **Action potential** has formed



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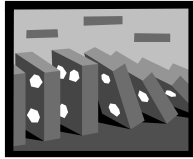
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## The Function of Neurons

- Action potential

- The “spike charge” is an electrical current that travels down an axon



- If the threshold is not reached, the neuron will not fire
- All-or-none Principle
  - Either the neuron fires or it doesn't
  - Action potential is always the same strength

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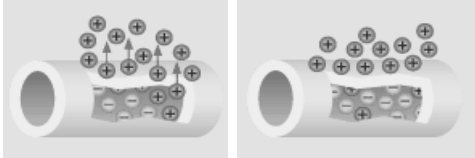
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## The Function of Neurons

- Neuron must recover between firings

- **Refractory Period**

- No action potentials can occur until resting state is re-established



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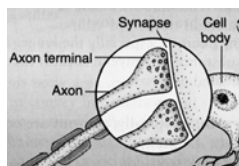
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## Neurotransmitters and Behavior

- Communication must cross the **synapse** between neurons



- Chemical signal
  - At the axon terminal, the action potential causes the release of **neurotransmitters**

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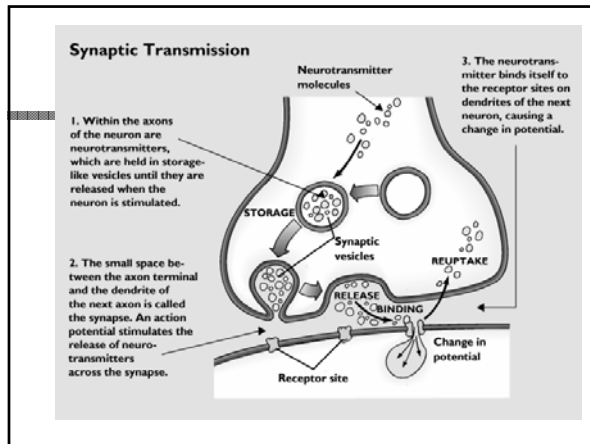
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### Neurotransmitters

- After binding with an adjacent neuron, one of two processes occurs
  - Breakdown by enzymes
  - **Reuptake** back into the releasing neuron
- Neurotransmitters have two effects
  - **Excitatory**: receiving neuron fires more easily
  - **Inhibitory**: receiving neuron fires less easily

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### Neurotransmitters

- There are at least 50 different neurotransmitters
- Examples:
  - **Acetylcholine (Ach)**
    - Excitatory
    - Receptors in skeletal muscles
    - Involved in memory and learning
    - Alzheimer's disease involves insufficient production of acetylcholine

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## Serotonin

- Inhibitory
- Involved in sleep regulation, appetite, anxiety, and depression
- Antidepressants affect serotonin
- A monoamine neurotransmitter

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## Dopamine

- Inhibitory
- Involved in movement, learning and memory, emotions, pleasure
- Also involved in Schizophrenia, ADHD, Parkinson's Disease

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## Norepinephrine

- Excitatory
- Involved in arousal, hunger, learning, memory, & mood disorders.

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## Neuropeptides

- Chemicals similar to neurotransmitters
  - Endorphins
  - Inhibitory, Painkillers. Occur naturally in the brain & bloodstream. Similar to morphine.

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## Selective Serotonin Reuptake Inhibitors (SSRIs)

- Alter levels of specific neurotransmitters in the brain
- Block reuptake of serotonin
  - Prolongs action of serotonin at synapse
  - Effects usually seen within about 4 week
  - Prozac, Zoloft, Paxil, Zyprexa, Luvox, Celexa, Effexor

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## Side Effects

- All Antidepressant drugs have some Side Effects
- Sexual side effects
  - Nausea, changes in appetite
  - Insomnia, headaches

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## Biological Causal Factors (Etiology) in Unipolar Disorder

- Family studies and twin studies suggest a moderate genetic contribution
- Altered neurotransmitter activity in several systems is clearly associated with major depression
- The hormone cortisol also plays a role
- Depression may be linked to low levels of activity in the left anterior or prefrontal cortex

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## Biological Causal Factors in Unipolar Disorder

- Disruptions of the following may also play a role:
  - Sleep
  - Circadian rhythms
  - Exposure to sunlight

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## Psychosocial Causal Factors in Unipolar Disorder

- Stressful life events are linked to depression
- Diathesis-Stress Models propose that some people have vulnerability factors that may increase the risk for depression

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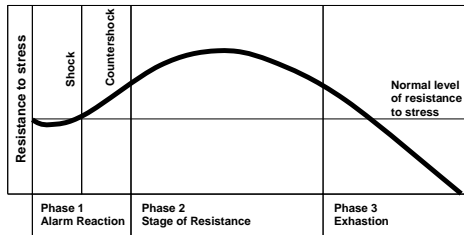
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## The Effects of Severe Stress: General Adaptation Syndrome



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## Psychosocial Causal Factors in Unipolar Disorder

- Freud believed that depression was anger turned inward
- Beck proposed a cognitive model of depression



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## Cognitive Theories

- Depression results from negative thinking
- Aaron Beck's approach
    - Negative views of self, environment and the future
    - Magnifies errors and misfortunes
    - Such cognitive distortions predict depression across ages and cultures

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## Psychosocial Causal Factors in Unipolar Disorder

- Reformulated Helplessness Theory: A pessimistic attributional style is a diathesis for depression
- Hopelessness Theory: A pessimistic attributional style and one or more negative life events will not produce depression unless one first experiences a state of hopelessness
- Seligman's Learned Helplessness: Repeated trying eventually lead to a person giving up

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## Bipolar Disorder

- Previously called manic–depressive disorder
- Alternating depression and **mania**
  - Excitement, euphoria, boundless energy
  - Rapid speech
  - Inflated self-esteem
  - Impulsivity
- Much less common than major depression
- No gender differences in prevalence
- Hypomania

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## Bipolar Disorder

- Usually appears in late adolescence/early adulthood
- Time in and between each phase varies widely from person to person
- Substantial genetic component
- Often treated successfully with drugs
  - Low compliance with drug treatment because manic phases are often pleasant for the individual
  - Untreated bipolar disorder is associated with suicide risk and other maladaptive behaviors

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## Bipolar Disorders

- Bipolar disorders are distinguished from unipolar disorders by the presence of manic or hypomanic symptoms
- Some people are subject to cyclical mood swings less severe than those of bipolar disorder; these are symptoms of cyclothymia

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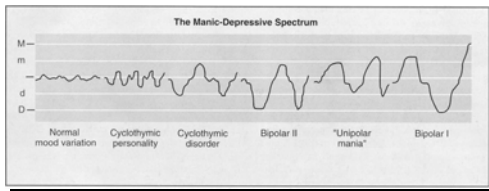
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## Bipolar Disorders: Features



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## Bipolar Disorders

- People may be diagnosed with Schizoaffective Disorder if they have a period of illness during which they:
  - Meet the criteria for a major mood disorder
  - Exhibit at least two major symptoms of schizophrenia

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## Biological Causal Factors in Bipolar Disorders

- There is a greater genetic contribution to bipolar disorder than to unipolar disorder
- Norepinephrine, serotonin, and dopamine all appear to be involved in regulating our mood states
- Bipolar patients may have abnormalities in the way ions are transported across the neural membranes

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## Biological Causal Factors in Bipolar Disorders

- Other biological influences may include
  - Cortisol levels
  - Disturbances in biological rhythms
  - Shifting patterns of blood flow to the left and right prefrontal cortex

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## Psychosocial Causal Factors in Bipolar Disorder

- Psychosocial causal factors include
  - Stressful life events
  - Personality variables (such as neuroticism and high levels of achievement striving)
- According to psychodynamic theorists, manic reactions are an extreme defense against or reaction to depression



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## Sociocultural Factors Affecting Unipolar and Bipolar Disorders

- The prevalence of mood disorders seems to vary considerably among different societies
  - The psychological symptoms of depression are low in China and Japan
  - Among several groups of Australian aborigines there appear to be no suicides
- In the United States, rates of unipolar depression are inversely related to socioeconomic status

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## Treatments and Outcomes

- Psychotherapy
  - Cognitive-behavioral therapy
  - Interpersonal therapy
  - Family and marital therapy

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## Treatments and Outcomes

- Many patients never seek treatment, and many of these patients will recover
- Antidepressant, mood-stabilizing, and antipsychotic drugs are all used in the treatment of unipolar and bipolar disorders

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## Treatments and Outcomes

- Antidepressant drugs usually require at least 3 to 4 weeks to take effect
- Discontinuing the drugs when symptoms have remitted may result in a relapse
- Lithium therapy has now become widely used as a mood stabilizer in the treatment of bipolar disorder
- Electroconvulsive therapy is often used with severely depressed patients

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## Electroconvulsive Therapy (ECT)

Electrical current applied to the head to produce a seizure

- Overused in the 1940s and 1950s
- Effective in short-term treatment of **Severe Depression** not responsive to antidepressants
- Drug treatment and talk therapy needed to maintain long-term change

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## Treatments and Outcomes

- The following forms of psychotherapy are also often effective:
  - Cognitive-behavioral therapy
  - Interpersonal therapy
  - Family and marital therapy

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## Suicide

## Suicide

Suicide is more likely than violence against others

- Suicide **attempters** are unsuccessful
  - More likely to be young, female, make less lethal attempts
- Suicide **completers** are successful
  - More likely to be White, male, older, and use more lethal means
- Substance abuse increases risk

## Suicide

- 60–70% of people with major depression think about suicide
- Those with antisocial personality disorder or bipolar disorder also at higher risk
- White men over age 75 at highest risk

## Suicide: Who Attempts and Who Commits Suicide?

- Rates of suicide among children seem to be increasing
- Rates of suicides for people 15–24 tripled between the mid-1950s and mid-1980s
- Conduct disorder and substance abuse are relatively more common among the completers of suicide
- Mood disorders are more common among nonfatal attempters

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## Suicide: Causal Factors

- Genetic factors may play a role in risk for suicide
- Reduced serotonergic activity appears to be associated with increased risk
- Whites have much higher rates of suicide than African Americans
- Rates of suicide vary across cultures and religions

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## Suicide: Suicidal Ambivalence

- Some people do not really wish to die but instead want to communicate a dramatic message concerning their distress
- Research has clearly disproved the tragic belief that those who threaten to take their lives seldom do so



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## Suicide: Prevention and Intervention

- Treatment of the person's current mental Disorder(s)
- Crisis intervention
- Preventive programs aimed at alleviating the problems of people who are in high-risk groups

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## IV. What Are Dissociative Disorders?

Sudden but temporary alteration in consciousness, identity, sensorimotor behavior, or memory  
Relatively rare, but very dramatic

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## Dissociative Disorders

- A group of conditions involving disruptions in a person's normally integrated functions of
  - Consciousness
  - Memory
  - Identity
  - Perception



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## Dissociative Disorders

- Derealization: One's sense of the reality of the outside world is temporarily lost
- Depersonalization: One's sense of one's self and one's reality is temporarily lost

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## Dissociative Disorders

- Dissociative Amnesia: Failure to recall previously stored personal information when that failure cannot be accounted for by ordinary forgetting. Not caused by head injury. Affects only certain types of memory. Often associated with a traumatic event. Memory may appear suddenly.
- Dissociative Fugue: Departs from home surroundings

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## Dissociative Disorders

- Dissociative Identity Disorder (DID): Person manifests two or more distinct identities or alters that alternate in some way in taking control of behavior
- Rare
- Usually starts in childhood



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## Dissociative Identity Disorder (DID)

- Formerly known as Multiple Personality Disorder
- The existence of two or more distinct alter within one individual
  - Each is dominant at different times
  - Often have different names and unique traits
  - Principal personality often can not remember what happens when alternates are in control
    - “Lost time”
  - Stress or crisis brings on shifts

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## Controversies

- Is the disorder real or faked?
- If the disorder is not faked, how does it develop?
- Are recovered memories of abuse in the disorder real or false?
- If abuse has occurred, did it play a causal role?

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## Treatment and Outcomes in Dissociative Disorders

- No systematic controlled research has been conducted
- Possible treatments include
  - Hypnosis
  - Integration of Separate Alters

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## V. What Is Schizophrenia?

Thought Disorder--NOT multiple personalities

Characterized by:

- Bizarre thinking
- Inappropriate emotional response
- Lack of reality testing
- Deterioration of social and intellectual functioning
- Symptoms must begin before age 45
- Must be present for at least 6 months
  - 1 month more or less continuously
- Impaired reality testing and disturbance in functioning makes schizophrenic disorder a type of **psychosis**

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## Schizophrenia

- Psychosis: Significant loss of contact with reality
- Symptoms:
  - Positive: Delusions and hallucinations
  - Negative: Inability to read others' emotions

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## Symptoms of Schizophrenia

Positive symptoms: Delusions and hallucinations

Negative symptoms: Inability to read others' emotions

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## Positive Symptoms in Schizophrenia

Reflect an excess or distortion in a normal repertoire of behavior and experience such as:

- Delusions
- Hallucinations
- Disorganized speech
- Disorganized behavior

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## Delusions

Thought Distortions: Disordered thinking

- **Grandeur:** Believe they are someone great (God, president)
- **Persecution:** People are out to get them.
- **Reference:** People are talking about them.
- **Thought Broadcasting:** People can read their minds.
- **Thought Insertion:** Others are putting bad thoughts into their minds.

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## Hallucinations

Perceptual Distortions

- Compelling perceptual experiences that occur without any physical stimulus
  - Auditory hallucinations (hearing voices) most common
  - Voices are perceived as coming from outside the person
  - Voices comment on or direct behavior

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## Hallucinations

- Visual: Seeing things (demons)
- Olfactory: Smelling things (smoke, decaying fish)
- Tactile: Sensation that something is crawling on or under the skin

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## Disorganized Speech

- Impaired language use: **Word salad**
- Memory deficits
  - Working and long-term memory
  - Attention problems

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## Negative Symptoms in Schizophrenia

- Reflect an absence or deficit of behaviors that are normally present
  - Flat or blunted emotional expressiveness
  - Alogia: Poverty of speech
  - Avolition: Lack of desire, motivation, persistence

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## Distortions in Emotional Reactions

### Inappropriate affect

- Emotional responses that are not appropriate for the situation
- Sometimes there is absence of affect
  - **Flat affect**
- Sometimes a range of emotions are experienced very quickly
  - **Ambivalent affect**

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## Subtypes of Schizophrenia

Paranoid Type  
Disorganized Type  
Catatonic Type  
Undifferentiated Type  
Residual Type

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## Paranoid Schizophrenia

- Delusions of grandeur and / or persecution
- Possibly hallucinations
- Both organized around a theme
  - E.g., "Aliens are stealing my thoughts."
- Often little cognitive or other impairments
- Higher rates of recovery than other types

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## Disorganized Schizophrenia

- Severely disturbed thought processes, disorganized behavior, incoherent, inappropriate affect
- Disintegration of normal personality
- Total lack of reality testing

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## Catatonic Schizophrenia

- Impairments in motor activity.
  - **Excited** catatonic schizophrenia
    - Bursts of violent or excited motor activity
    - Excessive talking and shouting
  - **Withdrawn** catatonic schizophrenia
    - Little to no motor or verbal activity at all (**stupor**)
    - Muscular rigidity
    - Waxy flexibility: molded into different positions

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## Residual Schizophrenia

- In touch with reality despite schizophrenic symptoms
- At least one previous episode of another type

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## Undifferentiated Schizophrenia

- All the essential features of a schizophrenic disorder
- Symptoms do not fit easily into one of the other types

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## Causes of Schizophrenia

### Biological Factors

- Concordance rates
  - Degree to which the disorder is shared by two or more individuals or groups
  - Higher for identical than fraternal twins
    - 86% versus 15%
- Neurotransmitters
  - Dopamine theory of schizophrenia
    - » Symptoms caused by too much dopamine

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## Environmental Factors

- Prenatal malnutrition and infection, birth injuries
- Exposure to lead, poverty, city life
- Family factors
  - Loss of a parent in childhood
  - Childhood depression or bipolar disorder

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## Psychosocial and Cultural Aspects

- Many theories about bad families causing schizophrenia have not stood the test of time including
  - The idea of the “**schizophrenic mother**”
  - The double-bind hypothesis
- Instead, communication problems may be the result of having a schizophrenic in the family
- Patients with schizophrenia are more likely to relapse if their families are high in expressed emotion

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## Treatment

- Antipsychotic Drugs: Block Dopamine receptors
- Two types of antipsychotics
  - Conventional (neuroleptics)
  - Novel
- Patients taking novel antipsychotics
  - Have fewer extrapyramidal (motor abnormality) side effects
  - Tend to do better overall

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## Psychosocial Approaches

- Case Management
- Social-Skills Training
- Cognitive-Behavioral Therapy
- Other forms of individual treatment
- Family Therapy

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## Family Therapy

- Provides families with communication skills
- Reduces high levels of expressed emotion

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## VI. What Are Personality Disorders?

Inflexible and long-standing maladaptive behaviors that cause distress and social/occupational impairment

Chronic interpersonal difficulties

Those diagnosed tend to fall into stereotypical gender and ethnic categories

Problems with one's identity or sense of self

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## Difficulties Doing Research on Personality Disorders

- Controversial
- Can be difficult to diagnose
- Those diagnosed tend to fall into stereotypical gender and ethnic categories



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## Cluster A: Personality Disorders

- Paranoid
- Schizoid
- Schizotypal

### Characteristics:

- Distrustful
- Suspicious
- Socially Detached

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## Personality Disorders: Cluster A

Disorder	Characteristics
Paranoid	Suspiciousness, mistrust, tendency to see self as blameless; on guard for perceived attacks by others; odd eccentric,
Schizoid	Impaired social relationships; inability and lack of desire to form attachments to others
Schizotypal	Peculiar thought patterns; oddities of perception and speech that interfere with communication and social interaction

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## Cluster B: Personality Disorders

- Histrionic
- Narcissistic
- Antisocial
- Borderline Personality Disorders

### Characteristics:

- Dramatic
- Emotional
- Erratic

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Personality Disorders: Cluster B	
Disorder	Characteristics
Histrionic	dramatic; overconcern with attractiveness; tendency of irritability and temper outbursts if attention seeking is frustrated, emotional
Narcissistic	Grandiosity; preoccupation with receiving attention; self-promoting; lack of empathy
Antisocial	Lack of moral or ethical development; inability to follow approved models of behavior; deceitfulness; shameless manipulation of others; history of conduct problems as a child
Borderline	Impulsiveness; inappropriate anger; drastic mood shifts; chronic feelings of boredom; attempts at self-mutilation or suicide

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Cluster C: Personality Disorders	
<ul style="list-style-type: none"> <li>• Avoidant</li> <li>• Dependent</li> <li>• Obsessive-Compulsive</li> </ul>	
Characteristics <ul style="list-style-type: none"> <li>• Anxious</li> <li>• Fearful</li> </ul>	

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Personality Disorders: Cluster C	
Disorder	Characteristics
Avoidant	Hypersensitivity to rejection or social derogation; shyness; insecurity in social interaction and initiating relationships
Dependent	Difficulty in separating in relationships; discomfort at being alone; subordination of needs in order to keep others involved in a relationship; indecisiveness
Obsessive-compulsive	Excessive concern with order, rules, and trivial details; perfectionism; lack of expressiveness and warmth; difficulty in relaxing and having fun

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## Provisional Categories

Passive-Aggressive  
Depressive



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## Personality Disorders: Provisional Categories

Disorder	Characteristics
Passive-aggressive	Negativistic attitudes and passive resistance to adequate performance expressed through indirect means such as complaining, being sullen and argumentative, expressing envy and resentment toward those who are more fortunate
Depressive	Pervasive depressive cognitions; persistent unhappiness or dejection; feeling of inadequacy, guilt, and self-criticism

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## Causal Factors in Antisocial Personality Disorder

- Genetic influences
- Learning of antisocial behavior
- Adverse environmental factors

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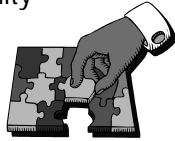
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## General Sociocultural Causal Factors for Personality Disorders

- Is our emphasis on impulse gratification, instant solutions, and pain-free benefits leading more people to develop the self-centered lifestyles that we see in more extreme forms in personality disorders?



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## Treatments and Outcomes

- Very difficult to treat (especially Cluster A)
- Treatment of the Cluster C disorders seems most promising
- Dialectical Behavior Therapy (DBT) shows promise for treating Borderline Personality Disorder (Cluster B)

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## Treatments and Outcomes in Psychopathic and ASPD

- Treatment of psychopaths is difficult
- Cognitive-behavioral treatments offer some promise



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## Eating Disorders

- Psychological disorders that are characterized by severe disturbances in eating behavior
- Anorexia Nervosa:
  - self starvation, refusal to maintain normal body
  - weight, fear of being overweight, life threatening,
  - distorted body image

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## Eating Disorders

- The two most common forms of eating disorders are
  - Anorexia nervosa
  - Bulimia nervosa
- At the heart of both disorders is
  - An intense and pathological fear of becoming overweight and fat
  - A pursuit of thinness that is relentless and sometimes deadly

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## Anorexia Nervosa

Characterized by:

- Self starvation
- Refusal to maintain normal body
- Fear of being overweight
- Distorted body image
- Life threatening

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## Anorexia Nervosa

- The mortality rate for females with anorexia nervosa is more than twelve times higher than the mortality rate for females aged 15–24 in the general population

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## Bulimia Nervosa

Characterized by:

- Frequent episodes of binge eating & purging
- Lack of control over eating
- Recurrent inappropriate behavior to prevent weight gain
- Typically of normal weight

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## Age of Onset and Gender Differences

- Anorexia nervosa is most likely to develop in 15- to 19-year-olds
- Bulimia nervosa is most likely to develop in women aged 20-24
- There are 10 females for every male with an eating disorder

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## Medical Complications

- Anorexia can lead to
  - Death from heart arrhythmias
  - Kidney damage
  - Renal failure
  - Amenorrhea
- Bulimia can lead to
  - Electrolyte imbalances
  - Hypokalemia (low potassium)
  - Damage to hands, throat, and teeth from induced vomiting

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## Comorbidity

Associated with:

- Clinical Depression
- Obsessive-Compulsive Disorder
- Substance Abuse Disorders
- Various Personality Disorders

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## Prevalence

- The lifetime prevalence of anorexia nervosa is around 0.5%
- The lifetime prevalence of bulimia is around 1–3%

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## Culture

- Eating disorders are becoming a problem worldwide
- The attitudes that lead to eating disorders are more common in Whites and Asians than African Americans

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## Etiology

- Multi-determined
- Runs in families
- Genetic influence has yet to be determined
- *Set-point theory* (the idea that our bodies resist marked variation) may play a role
- Serotonin levels may play a role

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## Sociocultural Factors

- Fashion magazines idealize extreme thinness
- Women often internalize the thin ideal

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## Risk and Causal Factors in Eating Disorders

- Nearly all instances of eating disorders begin with normal dieting
- Perfectionism
- Childhood sexual abuse may play a role

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## Treatment for Anorexia Nervosa

- Emergency procedures to restore weight
- Cognitive-behavioral therapy
- Antidepressants or other medications
- Family therapy



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## Treatment for Bulimia Nervosa

- Antidepressants or other medications
- Cognitive-behavioral therapy
- Little is known

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Obesity

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Obesity

- In the United States, 20% of men and 25% of women are morbidly obese
- Obesity is defined on the basis of the body mass index

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Calculating Body Mass Index

$$\frac{\text{weight (lbs.)}}{\text{height} \times \text{height (in.)}} \times 703 = \text{BMI}$$

	BMI
Healthy	18.5-24.9
Overweight	25-29.9
Obese	30-39.9
Morbidly obese	40+

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## Obesity

- Not an eating disorder
- Habit of overeating

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## Risk and Causal Factors in Obesity

- Genetic inheritance
- Hormones involved in appetite and weight regulation
- Sociocultural influences
- Family influences
- Stress and “comfort food”

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## Pathways to Obesity

- Binge eating is a predictor of later obesity
- Social pressure to conform to the thin ideal
- Depression
- Low self-esteem

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## Treatment of Obesity

- Methods used to treat obesity include:
  - Weight-loss groups
  - Medications
  - Gastric surgery
  - Behavioral management
- Difficult to lose weight and maintain their new low weight
- Prevention is important



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## VII. How Are Violence and Mental Disorders Related?

### Diagnoses Associated with Violence

- More serious disorders have more risk of violence
- Those with delusions at higher risk
- Manic phase of bipolar disorder
  - May be easily angered
- Paranoid schizophrenia
  - Violent actions are an attempt to protect the self in response to delusions

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## Schizophrenia & Homicide

- Schizophrenia plus alcohol abuse equals higher risk
- Those with substance problems alone more violent than those with schizophrenia alone
- Antisocial personality disorder
  - Violent and non-violent antisocial behavior make these individuals dangerous to others

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## Violence as Risk for Developing Mental Disorder

- Child abuse increases risk of a range of mental disorders
- Also increases risk of becoming an abuser
- Most abusers do not have a mental disorder
  - Poor parenting and environmental stress interact to create abusive parents

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## Domestic Violence

- Common throughout the world
- Married and unmarried partners
- Victims are at increased risk for PTSD, eating disorders, and depression
- May explain higher rates of these disorders among women

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## Rape

Women also more likely to be raped

- Date or acquaintance rape more common than stranger rape
- Experiences of male and female victims is similar
  - Increase risk for PTSD, anxiety disorders, depression, suicide, substance abuse
- Rapists unlikely to have a mental illness
  - Mental disorders less predictive of rape than social factors and attitudes

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