

Chapter 13. Defining Psychological Disorders

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When Minor Body Imperfections Lead to Suicide

“I think we probably noticed in his early teens that he became very conscious about aspects of his appearance...he began to brood over it quite a lot,” said Maria, as she called in to the talk radio program to describe her son Robert.

Maria described how Robert had begun to worry about his weight. A friend had commented that he had a “fat” stomach, and Robert began to cut down on eating. Then he began to worry that he wasn’t growing enough and devised an elaborate series of stretching techniques to help him get taller.

Robert scrutinized his face and body in the mirror for hours, finding a variety of imagined defects. He believed that his nose was crooked, and he was particularly concerned about a lump that he saw on it: “A small lump,” said his mother. “I should say it wasn’t very significant, but it was significant to him.”

Robert insisted that all his misery stemmed from this lump on his nose, that everybody noticed it. In his sophomore year of high school, he had cosmetic surgery to remove it.

Around this time, Robert had his first panic attack and began to worry that everybody could notice him sweating and blushing in public. He asked his parents for a \$10,000 loan, which he said was for overseas study. He used the money for a procedure designed to reduce sweating and blushing. Then, dissatisfied with the results, he had the procedure reversed.

Robert was diagnosed with *body dysmorphic disorder*. His mother told the radio host, “At the time we were really happy because we thought that finally we actually knew what we were trying to fight and to be quite honest, I must admit I thought well it sounds pretty trivial...things seemed to go quite well and he got a new girlfriend and he was getting excellent marks in his clinical work in hospital and he promised us that he wasn’t going to have any more surgery.”

However, a lighthearted comment from a friend about a noticeable vein in his forehead prompted a relapse. Robert had surgery to tie off the vein. When that didn’t solve all his problems as he had hoped, he attempted to have the procedure reversed but learned that it would require complicated microsurgery. He then used injections on himself to try opening the vein again, but he could never completely reverse the first surgery.

Robert committed suicide shortly afterward, in 2001 (Mitchell, 2002).

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13.1 Psychological Disorder: What Makes a Behaviour Abnormal?

Learning Objectives

1. Define “psychological disorder” and summarize the general causes of disorder.
2. Explain why it is so difficult to define disorder, and how the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is used to make diagnoses.
3. Describe the stigma of psychological disorders and their impact on those who suffer from them.

The focus of this chapter and the next is, to many people, the heart of psychology. This emphasis on **abnormal psychology** — *the application of psychological science to understanding and treating mental disorders* — is appropriate, as more psychologists are involved in the diagnosis and treatment of psychological disorder than in any other endeavour, and these are probably the most important tasks psychologists face. In 2012, approximately 2.8 million people, or 10.1% of Canadians aged 15 and older, reported symptoms consistent with at least one of six mental or substance use disorders in the past 12 months (Pearson, Janz, & Ali, 2013). At least a half billion people are affected worldwide. The six disorders measured by the Canadian Mental Health Survey were major depressive episode, bipolar disorder, generalized anxiety disorder, and abuse of or dependence on alcohol, cannabis, or other drugs. The impact of mental illness is particularly strong on people who are poorer, of lower socioeconomic class, and from disadvantaged ethnic groups.

People with psychological disorders are also stigmatized by the people around them, resulting in shame and embarrassment, as well as prejudice and discrimination against them. Thus the understanding and treatment of psychological disorder has broad implications for the everyday life of many people. Table 13.1, “Prevalence Rates for Psychological Disorders in Canada, 2012,” shows the **prevalence**, *the frequency of occurrence of a given condition in a population at a given time*, of some of the major psychological disorders in Canada.

	Lifetime	12-month
	percent	
Mental or substance disorders	33.1	10.1
Substance use disorder	21.6	4.4
Alcohol abuse or dependence	18.1	3.2
Cannabis abuse or dependence	6.8	1.3
Other drug abuse or dependence (excluding Cannabis)	4	0.7
Mood disorder	12.6	5.4
Major Depressive Episode	11.3	4.7
Bipolar Disorder	2.6	1.5
Generalized Anxiety Disorder	8.7	2.6

Table 13.1. Prevalence Rates for Psychological Disorders in Canada, 2012, adapted by J. Walinga from Statistics Canada 2013. [\[Long Description\]](#)

In this chapter our focus is on the disorders themselves. We will review the major psychological disorders and consider their causes and their impact on the people who suffer from them. Then in Chapter 14, “Treating Psychological Disorders,” we will turn to consider the treatment of these disorders through psychotherapy and drug therapy.

Defining Disorder

A **psychological disorder** is an ongoing dysfunctional pattern of thought, emotion, and behaviour that causes significant distress, and that is considered deviant in that person's culture or society (Butcher, Mineka, & Hooley, 2007). Psychological disorders have much in common with other medical disorders. They are out of the patient's control, they may in some cases be treated by drugs, and their treatment is often covered by medical insurance. Like medical problems, psychological disorders have both biological (nature) as well as environmental (nurture) influences. These causal influences are reflected in the bio-psycho-social model of illness (Engel, 1977).

The **bio-psycho-social model of illness** is a way of understanding disorder that assumes that disorder is caused by biological, psychological, and social factors (Figure 13.1, "The Bio-Psycho-Social Model"). The *biological component* of the bio-psycho-social model refers to the influences on disorder that come from the functioning of the individual's body. Particularly important are genetic characteristics that make some people more vulnerable to a disorder than others and the influence of neurotransmitters. The *psychological component* of the bio-psycho-social model refers to the influences that come from the individual, such as patterns of negative thinking and stress responses. The **social component** of the bio-psycho-social model refers to the influences on disorder due to social and cultural factors such as socioeconomic status, homelessness, abuse, and discrimination.

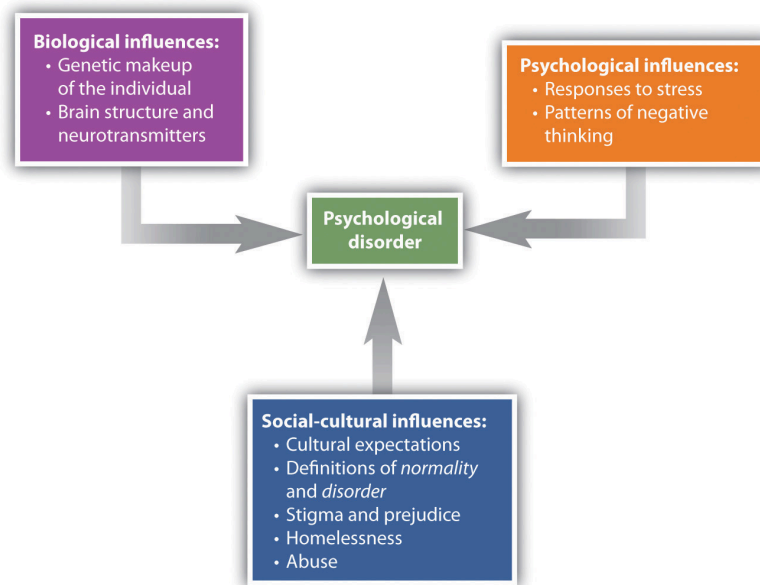


Figure 13.1 The Bio-Psycho-Social Model. The bio-psycho-social model of disorder proposes that disorders are caused by biological, psychological, and social-cultural factors.

To consider one example, the psychological disorder of schizophrenia has a biological cause because it is known that there are patterns of genes that make a person vulnerable to the disorder (Gejman, Sanders, & Duan, 2010). But whether or not the person with a biological vulnerability experiences the disorder depends in large part on psychological factors such as how the individual responds to the stress he or she experiences, as well as social factors such as whether or not the person is exposed to stressful environments in adolescence and whether or not the person has support from people who care about him or her (Sawa & Snyder, 2002; Walker, Kestler, Bollini, & Hochman, 2004). Similarly, mood and anxiety disorders are caused in part by genetic factors such as hormones and neurotransmitters, in part by the individual's particular thought patterns, and in part by the ways that other people in the social environment treat the person with the disorder. We will use the bio-psycho-social model as a framework for considering the causes and treatments of disorder.

Although they share many characteristics with them, psychological disorders are nevertheless different from medical conditions in important ways. For one, diagnosis of psychological disorders can be more difficult. Although a medical doctor can see cancer in the lungs using an MRI scan or see blocked arteries in the heart using cardiac catheterization, there is no corresponding test for psychological disorder. Current research is beginning to provide more evidence about the role of brain structures in psychological disorder, but for now the brains of people with severe mental disturbances often look identical to those of people without such disturbances.

Because there are no clear biological diagnoses, psychological disorders are instead diagnosed on the basis of clinical observations of the behaviours that the individual engages in. These observations find that emotional states and behaviours operate on a continuum, ranging from more normal and accepted to more deviant, abnormal, and unaccepted. The behaviours that are associated with disorder are in many cases the same behaviours that we engage in during our normal everyday life. Washing one's hands is a normal healthy activity, but it can be overdone by those with an *obsessive-compulsive disorder (OCD)*. It is not unusual to worry about and try to improve one's body image. The dancer in Figure 13.2, "How Thin Is Too Thin?" needs to be thin for her career, but when does her dieting turn into a psychological disorder? Psychologists believe this happens when the behaviour becomes distressing and dysfunctional to the person. Robert's struggle with his personal appearance, as discussed at the beginning of this chapter, was clearly unusual, unhealthy, and distressing to him.



Figure 13.2 How Thin Is Too Thin?

Whether a given behaviour is considered a psychological disorder is determined not only by whether a behaviour is unusual (e.g., whether it is mild anxiety versus extreme anxiety) but also by whether a behaviour is **maladaptive** — that is, the extent to which it causes distress (e.g., pain and suffering) and dysfunction (impairment in one or more important areas of functioning) to the individual (American Psychiatric Association, 2013). An intense fear of spiders, for example, would not be considered a psychological disorder unless it has a significant

negative impact on the sufferer’s life, for instance by causing him or her to be unable to step outside the house. The focus on distress and dysfunction means that behaviours that are simply unusual (such as some political, religious, or sexual practices) are not classified as disorders.

Put your psychology hat on for a moment and consider the behaviours of the people listed in Table 13.2, “Diagnosing Disorder.” For each, indicate whether you think the behaviour is or is not a psychological disorder. If you’re not sure, what other information would you need to know to be more certain of your diagnosis?

Table 13.2 Diagnosing Disorder.

[Skip Table]			
Yes	No	Need more information	Description
			Jackie frequently talks to herself while she is working out her math homework. Her roommate sometimes hears her and wonders if she is okay.
			Charlie believes that the noises made by cars and planes going by outside his house have secret meanings. He is convinced that he was involved in the start of a nuclear war and that the only way for him to survive is to find the answer to a difficult riddle.
			Harriet gets very depressed during the winter months when the light is low. She sometimes stays in her pajamas for the whole weekend, eating chocolate and watching TV.
			Frank seems to be afraid of a lot of things. He worries about driving on the highway and about severe weather that may come through his neighbourhood. But mostly he fears mice, checking under his bed frequently to see if any are present.
			A worshiper speaking in “tongues” at an Evangelical church views himself as “filled” with the Holy Spirit and is considered blessed with the gift to speak the “language of angels.”

A trained clinical psychologist would have checked off “need more information” for each of the examples in Table 13.2, “Diagnosing Disorder,” because although the behaviours may seem unusual, there is no clear evidence that they are distressing or dysfunctional for the person. Talking to ourselves out loud is unusual and can be a symptom of schizophrenia, but just because we do it once in a while does not mean that there is anything wrong with us. It is natural to be depressed, particularly in the long winter nights, but how severe should this depression be, and how long should it last? If the negative feelings last for an extended time and begin to lead the person to miss work or classes, then they may become symptoms of a mood disorder. It is normal to worry about things, but when does worry turn into a debilitating anxiety disorder? And what about thoughts that seem to be irrational, such as being able to speak the language of angels? Are they indicators of a severe psychological disorder, or part of a normal religious experience? Again, the answer lies in the extent to which they are (or are not) interfering with the individual’s functioning in society.

Another difficulty in diagnosing psychological disorders is that they frequently occur together. For instance, people diagnosed with anxiety disorders also often have mood disorders (Hunt, Slade, & Andrews, 2004), and people diagnosed with one personality disorder frequently suffer from other personality disorders as well. **Comorbidity occurs when people who suffer from one disorder also suffer at the same time from other disorders.** Because many psychological disorders are comorbid, most severe mental disorders are concentrated in a small group of people (about 6% of the population) who have more than three of them (Kessler, Chiu, Demler, & Walters, 2005).

Psychology in Everyday Life: Combating the Stigma of Abnormal Behaviour

Every culture and society has its own views on what constitutes abnormal behaviour and what causes it (Brothwell, 1981). The Old Testament Book of Samuel tells us that as a consequence of his sins, God sent King Saul an evil spirit to torment him (1 Samuel 16:14). Ancient Hindu tradition attributed psychological disorder to sorcery and witchcraft. During the Middle Ages it was believed that mental illness occurred when the body was infected by evil spirits, particularly the devil. Remedies included whipping, bloodletting, purges, and trepanation (cutting a hole in the skull, Figure 13.3) to release the demons.

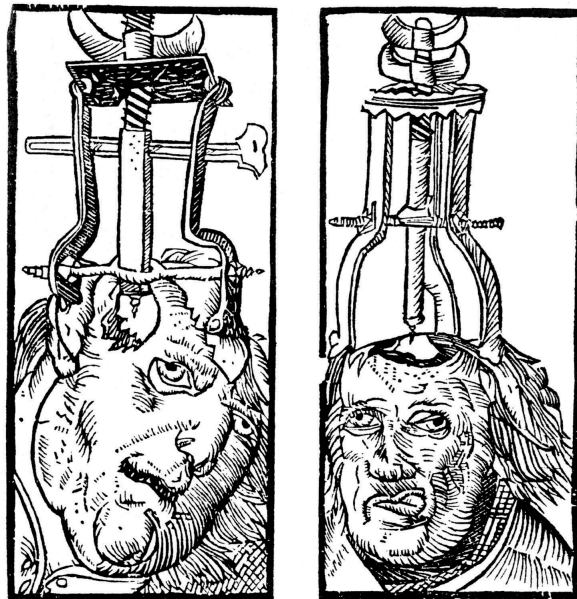


Figure 13.3 Trepanation. Trepanation (drilling holes in the skull) has been used since prehistoric times in attempts to cure epilepsy, schizophrenia, and other psychological disorders.

Until the 18th century, the most common treatment for the mentally ill was to incarcerate them in asylums or “madhouses.” During the 18th century, however, some reformers began to oppose this brutal treatment of the mentally ill, arguing that mental illness was a medical problem that had nothing to do with evil spirits or demons. In France, one of the key reformers was Philippe Pinel (1745-1826), who believed that mental illness was caused by a combination of physical and psychological stressors, exacerbated by inhumane conditions. Pinel advocated the introduction of exercise, fresh air, and daylight for the inmates, as well as treating them gently and talking with them.

Reformers such as Phillippe Pinel (1745-1826), Dorothea Dix (1802-1887), Richard M. Bucke (1837-1902), Charles K. Clarke (1857-1924), Clifford W. Beers (1876-1943), and Clarence M. Hincks (1885-1964) were instrumental in creating mental hospitals that treated patients humanely and attempted to cure them if possible (Figure 13.5). These reformers saw mental illness as an underlying psychological disorder, which was diagnosed according to its symptoms and which could be cured through treatment.

Dr Richard Bucke was appointed superintendent of the Asylum for the Insane in Hamilton in 1876 and a year later of the asylum in London, Ontario. He believed mental illness was a failure of the human biological adaptive process. In his attempts to reform the crude treatment of mentally ill patients he abandoned the practice of pacifying the inmates with alcohol or restraining them, and inaugurated regular cultural and sports events for patients.

Dr Charles Clarke was an assistant superintendent at the Hamilton asylum in the early 1880s, and later superintendent of the asylum at Kingston, Ontario. By 1887 he had changed the asylum from a jail to a hospital and was instructing nurses and attendants in the care of the mentally ill. By 1893 he was advocating that the term “asylum” be dropped and that special hospitals be constructed for the mentally ill.

Dr Clarence Hincks, born in St Mary’s, Ontario, was interested in mental health partly due to his own experiences with severe depression. In 1918, with Beers’s help, he organized the Canadian National Committee for Mental Hygiene, which later became the Canadian Mental Health Association.

Dix was a Massachusetts schoolteacher who wrote, lectured, and informed the public and legislators about the deplorable conditions in mental institutions like those shown in Figure 13.4. She was successful in influencing a number of state legislatures either to establish or improve their mental institutions, and because of her efforts a mental hospital was built in St. John’s, Newfoundland, in 1885. She also lobbied the Nova Scotia legislature and oversaw the building of a hospital for mental patients in that province.

Phillipe Pinel was a French physician who became intensely interested in mental health in the 1770s. He took a psychological approach as opposed to the prominent biological approach that was the custom and introduced new forms of treatments that involved close contact with and careful observation of patients. Pinel visited each patient up to several times a day, engaging them in lengthy conversations, and took careful notes in an effort to assemble a detailed case history and a natural history of the patient’s illness. At the time, his therapy was quite contrary to the usual practices of bleeding, purging, or blistering.



Figure 13.4 Asylums for People with Mental Disorders. Until the early 1900s people with mental disorders were often imprisoned in asylums such as these.

Despite the progress made since the 1800s in public attitudes about those who suffer from psychological disorders, people, including police, coworkers, and even friends and family members, still stigmatize people with psychological disorders. A **stigma** refers to *a disgrace or defect that indicates that person belongs to a culturally devalued social group*. In some cases the stigma of mental illness is accompanied by the use of disrespectful and dehumanizing labels, including names such as crazy, nuts, mental, schizo, and retard.

The stigma of mental disorder affects people while they are ill, while they are healing, and even after they have healed (Schefer, 2003). On a community level, stigma can affect the kinds of services social service agencies give to people with mental illness, and the treatment provided to them and their families by schools, workplaces, places of worship, and health-care providers. Stigma about mental illness also leads to employment discrimination, despite the fact that with appropriate support, even people with severe psychological disorders are able to hold a

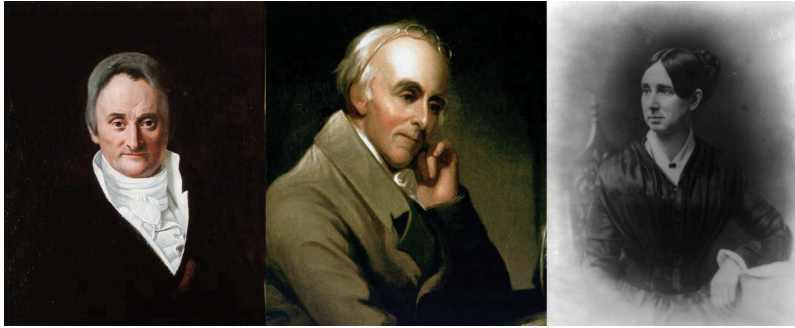


Figure 13.5 Portraits of Philippe Pine, Benjamin Rush, and Dorothea Dix. Reformers such as Philippe Pinel, Benjamin Rush, and Dorothea Dix fought the often brutal treatment of the mentally ill and were instrumental in changing perceptions and treatment of them.

job (Boardman, Grove, Perkins, & Shepherd, 2003; Leff & Warner, 2006; Ozawa & Yaeda, 2007; Pulido, Diaz, & Ramirez, 2004).

The mass media has a significant influence on society's attitude toward mental illness (Francis, Pirkis, Dunt, & Blood, 2001). While media portrayal of mental illness is often sympathetic, negative stereotypes still remain in newspapers, magazines, film, and television. (See the following video for an example.)

Television advertisements may perpetuate negative stereotypes about the mentally ill. For example, in 2010 Burger King ran an ad called "The King's Gone Crazy," in which the company's mascot runs around an office complex carrying out acts of violence and wreaking havoc.

Watch: "Burger King: The King's Gone Crazy" [YouTube]:
<http://www.youtube.com/watch?v=xYA7AnVwejo>



The most significant problem of the stigmatization of those with psychological disorder is that it slows their recovery. People with mental problems internalize societal attitudes about mental illness, often becoming so embarrassed or ashamed that they conceal their difficulties and fail to seek treatment. Stigma leads to lowered self-esteem, increased isolation, and hopelessness, and it may negatively influence the individual's family and professional life (Hayward & Bright, 1997).

Despite all of these challenges, however, many people overcome psychological disorders and go on to lead productive lives. It is up to all of us who are informed about the causes of psychological disorder and the impact of these conditions on people to understand, first, that mental illness is not a "fault" any more than is cancer. People do not choose to have a mental illness. Second, we must all work to help overcome the stigma associated with disorder. Organizations such as the Canadian Mental Health Association (CMHA) help by working to reduce the negative impact of stigma through education, community action, and individual support.

Diagnosing Disorder: The *DSM*

Psychologists have developed criteria that help them determine whether behaviour should be considered a psychological disorder and which of the many disorders particular behaviours indicate. These criteria are laid out in a 1,000-page manual known as the **Diagnostic and Statistical Manual of Mental Disorders (DSM)**, a document that provides a common language and standard criteria for the classification of mental disorders (American Psychiatric Association, 2013). The *DSM* is used by therapists, researchers, drug companies, health insurance

companies, and policymakers in Canada and the United States to determine what services are appropriately provided for treating patients with given symptoms.

The first edition of the *DSM* was published in 1952 on the basis of census data and psychiatric hospital statistics. Since then, the *DSM* has been revised five times. The last major revision was the fourth edition (*DSM-IV*), published in 1994, and an update of that document was produced in 2000 (*DSM-IV-TR*). The fifth edition (*DSM-5*) is the most recent edition and was published in 2013. The Medical Council of Canada transitioned to the *DSM-5* recently (MCC, 2013). The *DSM-IV-TR* was designed in conjunction with the World Health Organization's 10th version of the *International Classification of Diseases (ICD-10)*, which is used as a guide for mental disorders in Europe and other parts of the world.

The *DSM* does not attempt to specify the exact symptoms that are required for a diagnosis. Rather, the *DSM* uses categories, and patients whose symptoms are similar to the description of the category are said to have that disorder. The *DSM* frequently uses qualifiers to indicate different levels of severity within a category. For instance, the disorder of mental retardation can be classified as mild, moderate, or severe.

Each revision of the *DSM* takes into consideration new knowledge as well as changes in cultural norms about disorder. Homosexuality, for example, was listed as a mental disorder in the *DSM* until 1973, when it was removed in response to advocacy by politically active gay rights groups and changing social norms. The current version of the *DSM* lists about 400 disorders.

Although the *DSM* has been criticized regarding the nature of its categorization system (and it is frequently revised to attempt to address these criticisms), for the fact that it tends to classify more behaviours as disorders with every revision (even “academic problems” are now listed as a potential psychological disorder), and for the fact that it is primarily focused on Western illness, it is nevertheless a comprehensive, practical, and necessary tool that provides a common language to describe disorder. Most insurance companies will not pay for therapy unless the patient has a *DSM* diagnosis. The *DSM* approach allows a systematic assessment of the patient, taking into account the mental disorder in question, the patient's medical condition, psychological and cultural factors, and the way the patient functions in everyday life.

Diagnosis or Overdiagnosis? ADHD, Autistic Disorder, and Asperger's Disorder

Two common critiques of the *DSM* are that the categorization system leaves quite a bit of ambiguity in diagnosis and that it covers such a wide variety of behaviours. Let's take a closer look at three common disorders — *attention-deficit/hyperactivity disorder (ADHD)*, *autistic disorder*, and *Asperger's disorder* — that have recently raised controversy because they are being diagnosed significantly more frequently than they were in the past.

Attention-Deficit/Hyperactivity Disorder (ADHD)

Zack, aged seven years, has always had trouble settling down. He is easily bored and distracted. In school, he cannot stay in his seat for very long and he frequently does not follow instructions. He is constantly fidgeting or staring into space. Zack has poor social skills and may overreact when someone accidentally bumps into him or uses one of his toys. At home, he chatters constantly and rarely settles down to do a quiet activity, such as reading a book.

Symptoms such as Zack's are common among seven-year-olds, and particularly among boys. But what do the symptoms mean? Does Zack simply have a lot of energy and a short attention span? Boys mature more slowly than girls at this age, and perhaps Zack will catch up in the next few years. One possibility is for the parents and teachers to work with Zack to help him be more attentive, to put up with the behaviour, and to wait it out.

But many parents, often on the advice of the child's teacher, take their children to a psychologist for diagnosis. If Zack were taken for testing today, it is very likely that he would be diagnosed with a psychological disorder known as **attention-deficit/hyperactivity disorder (ADHD)**. *ADHD is a developmental behaviour disorder characterized by problems with focus, difficulty maintaining attention, and inability to concentrate, in which symptoms start before seven years of age* (Canadian Mental Health Association, 2014). Although it is usually first diagnosed in childhood, ADHD can remain problematic in adults, and up to 7% of university students are diagnosed with it (Weyandt & DuPaul, 2006). In adults the symptoms of ADHD include forgetfulness, difficulty paying attention to details, procrastination, disorganized work habits, and not listening to others. ADHD is about 70% more likely to occur in males than in females (Kessler, Chiu, Demler, & Walters, 2005), and is often comorbid with other behavioural and conduct disorders.

The diagnosis of ADHD has quadrupled over the past 20 years, and it is now diagnosed in about one out of every 37 Canadian children. It is the most common psychological disorder among children in the world (Olfson, Gameroff, Marcus, & Jensen, 2003). ADHD is also being diagnosed much more frequently in adolescents and adults (Barkley, 1998). You might wonder what this all means. Are the increases in the diagnosis of ADHD because today's children and adolescents are actually more distracted and hyperactive than their parents were, due to a greater awareness of ADHD among teachers and parents, or due to psychologists and psychiatrists' tendency to overdiagnose the problem? Perhaps drug companies are also involved, because ADHD is often treated with prescription medications, including stimulants such as Ritalin.

Although skeptics argue that ADHD is overdiagnosed and is a handy excuse for behavioural problems, most psychologists believe that ADHD is a real disorder that is caused by a combination of genetic and environmental factors. Twin studies have found that ADHD is heritable (National Institute of Mental Health, 2010), and neuroimaging studies have found that people with ADHD may have structural differences in areas of the brain that influence self-control and attention (Seidman, Valera, & Makris, 2005). Other studies have also pointed to environmental factors, such as a mother's smoking and drinking alcohol during pregnancy and the consumption of lead and food additives by those who are affected (Braun, Kahn, Froehlich, Auinger, & Lanphear, 2006; Linnet et al., 2003; McCann et al., 2007). Social factors, such as family stress and poverty, also contribute to ADHD (Burt, Krueger, McGue, & Iacono, 2001).

Autistic Disorder and Asperger's Disorder

Jared's kindergarten teacher has voiced her concern to Jared's parents about his difficulties with interacting with other children and his delay in developing normal language. Jared is able to maintain eye contact and enjoys mixing with other children, but he cannot communicate with them very well. He often responds to questions or comments with long-winded speeches about trucks or some other topic that interests him, and he seems to lack awareness of other children's wishes and needs.

Jared's concerned parents took him to a multidisciplinary child development centre for consultation. Here he was tested by a pediatric neurologist, a psychologist, and a child psychiatrist.

The pediatric neurologist found that Jared's hearing was normal, and there were no signs of any neurological disorder. He diagnosed Jared with a *pervasive developmental disorder*, because while his comprehension and expressive language was poor, he was still able to carry out nonverbal tasks, such as drawing a picture or doing a puzzle.

Based on her observation of Jared's difficulty interacting with his peers, and the fact that he did not respond warmly to his parents, the psychologist diagnosed Jared with **autistic disorder (autism)**, *a disorder of neural development characterized by impaired social interaction and communication and by restricted and repetitive behaviour, and in*

which symptoms begin before seven years of age. The psychologist believed that the autism diagnosis was correct because, like other children with autism, Jared, has a poorly developed ability to see the world from the perspective of others, engages in unusual behaviours such as talking about trucks for hours, and responds to stimuli, such as the sound of a car or an airplane, in unusual ways.

The child psychiatrist believed that Jared's language problems and social skills were not severe enough to warrant a diagnosis of autistic disorder and instead proposed a diagnosis of **Asperger's disorder**, *a developmental disorder that affects a child's ability to socialize and communicate effectively with others and in which symptoms begin before seven years of age.* The symptoms of Asperger's are almost identical to that of autism (with the exception of a delay in language development), and the child psychiatrist simply saw these problems as less extreme.

Imagine how Jared's parents must have felt at this point. Clearly there is something wrong with their child, but even the experts cannot agree on exactly what the problem is. Diagnosing problems such as Jared's is difficult, yet the number of children like him is increasing dramatically. Disorders related to autism and Asperger's disorder now affect 0.68% of Canadian children (Statistics Canada, 2003). The milder forms of autism, and particularly Asperger's, have accounted for most of this increase in diagnosis.

Although for many years autism was thought to be primarily a socially determined disorder, in which parents who were cold, distant, and rejecting created the problem, current research suggests that biological factors are most important. The heritability of autism has been estimated to be as high as 90% (Freitag, 2007). Scientists speculate that autism is caused by an unknown genetically determined brain abnormality that occurs early in development. It is likely that several different brain sites are affected (Moldin, 2003), and the search for these areas is being conducted in many scientific laboratories.

But does Jared have autism or Asperger's? The problem is that diagnosis is not exact (remember the idea of categories), and the experts themselves are often unsure how to classify behaviour. Furthermore, the appropriate classifications change with time and new knowledge. Under the *DSM-5*, released on May 18, 2013, Asperger's Syndrome is now subsumed under the category of Autism Spectrum Disorder (ASD).

Key Takeaways

- More psychologists are involved in the diagnosis and treatment of psychological disorder than in any other endeavour, and those tasks are probably the most important psychologists face.
- The impact on people with a psychological disorder comes both from the disease itself and from the stigma associated with disorder.
- A psychological disorder is an ongoing dysfunctional pattern of thought, emotion, and behaviour that causes significant distress and that is considered deviant in that person's culture or society.
- According to the bio-psycho-social model, psychological disorders have biological, psychological, and social causes.
- It is difficult to diagnose psychological disorders, although the *DSM* provides guidelines that are based on a category system. The *DSM* is frequently revised, taking into consideration new knowledge as well as changes in cultural norms about disorder.
- There is controversy about the diagnosis of disorders such as ADHD, autistic disorder, and Asperger's disorder.

Exercises and Critical Thinking

1. Do you or your friends hold stereotypes about the mentally ill? Can you think of or find clips from any films or other popular media that portray mental illness positively or negatively? Is it more or less acceptable to stereotype the mentally ill than to stereotype other social groups?
2. Consider the diagnosis of ADHD, autism, and Asperger's disorder from the biological, personal, and social-cultural perspectives. Do you think that these disorders are overdiagnosed? How might clinicians determine if ADHD is dysfunctional or distressing to the individual?

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Long Descriptions

Table 13.1 long description: Prevalence rates for psychological disorders in Canada, 2012.

Disorder		Lifetime	12-month
Substance use disorder	Alcohol abuse or dependence	18.1%	3.2%
	Cannabis abuse or dependence	6.8%	1.3%
	Other drug abuse or dependence (excluding Cannabis)	4%	0.7%
Total substance use disorders		21.6%	4.4%
Mood Disorder	Major Depressive Episode	11.3%	4.7%
	Bipolar disorder	2.6%	1.5%
	Generalized anxiety disorder	8.7%	2.6%
Total mood disorders		12.6%	5.4%
Total Mental/Substance disorders		33.1%	10.1%

[\[Return to Table 13.1\]](#)

13.2 Anxiety and Dissociative Disorders: Fearing the World Around Us

Learning Objectives

1. Outline and describe the different types of anxiety disorders.
2. Outline and describe the different types of dissociative disorders.
3. Explain the biological and environmental causes of anxiety and dissociative disorders.

Anxiety, *the nervousness or agitation that we sometimes experience, often about something that is going to happen*, is a natural part of life. We all feel anxious at times, maybe when we think about our upcoming visit to the dentist or the presentation we have to give to our class next week. Anxiety is an important and useful human emotion; it is associated with the activation of the sympathetic nervous system and the physiological and behavioural responses that help protect us from danger. But too much anxiety can be debilitating, and every year millions of people suffer from **anxiety disorders**, which are *psychological disturbances marked by irrational fears, often of everyday objects and situations* (Kessler, Chiu, Demler, & Walters, 2005).

Generalized Anxiety Disorder

Consider the following, in which Chase describes her feelings of a persistent and exaggerated sense of anxiety, even when there is little or nothing in her life to provoke it:

For a few months now I've had a really bad feeling inside of me. The best way to describe it is like a really bad feeling of negative inevitability, like something really bad is impending, but I don't know what. It's like I'm on trial for murder or I'm just waiting to be sent down for something. I have it all of the time but it gets worse in waves that come from nowhere with no apparent triggers. I used to get it before going out for nights out with friends, and it kinda stopped me from doing it as I'd rather not go out and stress about the feeling, but now I have it all the time so it doesn't really make a difference anymore (Chase, 2010).

Chase is probably suffering from a **generalized anxiety disorder (GAD)**, *a psychological disorder diagnosed in situations in which a person has been excessively worrying about money, health, work, family life, or relationships* for at least six months, even though he or she knows that the concerns are exaggerated, and when the anxiety causes significant distress and dysfunction.

In addition to their feelings of anxiety, people who suffer from GAD may also experience a variety of physical symptoms, including irritability, sleep troubles, difficulty concentrating, muscle aches, trembling, perspiration, and hot flashes. The sufferer cannot deal with what is causing the anxiety, nor avoid it, because there is no clear cause for anxiety. In fact, the sufferer frequently knows, at least cognitively, that there is really nothing to worry about.

About 3% of the general population suffer from GAD, and about two-thirds are women (Kessler, Chiu, Demler, &

Walters, 2005; Robins & Regier, 1991). Generalized anxiety disorder is most likely to develop between the ages of seven and 40 years, but its influence may in some cases lessen with age (Rubio & Lopez-Ibor, 2007).

Panic Disorder

When I was about 30 I had my first panic attack. I was driving home, my three little girls were in their car seats in the back, and all of a sudden I couldn't breathe, I broke out into a sweat, and my heart began racing and literally beating against my ribs! I thought I was going to die. I pulled off the road and put my head on the wheel. I remember songs playing on the CD for about 15 minutes and my kids' voices singing along. I was sure I'd never see them again. And then, it passed. I slowly got back on the road and drove home. I had no idea what it was (Ceejay, 2006).

Ceejay is experiencing **panic disorder**, *a psychological disorder characterized by sudden attacks of anxiety and terror that have led to significant behavioural changes in the person's life*. Symptoms of a panic attack include shortness of breath, heart palpitations, trembling, dizziness, choking sensations, nausea, and an intense feeling of dread or impending doom. Panic attacks can often be mistaken for heart attacks or other serious physical illnesses, and they may lead the person experiencing them to go to a hospital emergency room. Panic attacks may last as little as one or as much as 20 minutes, but they often peak and subside within about 10 minutes.

Sufferers are often anxious because they fear that they will have another attack. They focus their attention on the thoughts and images of their fears, becoming excessively sensitive to cues that signal the possibility of threat (MacLeod, Rutherford, Campbell, Ebsworthy, & Holker, 2002). They may also become unsure of the source of their arousal, misattributing it to situations that are not actually the cause. As a result, they may begin to avoid places where attacks have occurred in the past, such as driving, using an elevator, or being in public places. In Canada, 12-month and lifetime prevalence rates for panic attacks are 1.6% and 3.7%, respectively (Health Canada, 2006).

Phobias

A **phobia** (from the Greek word *phobos*, which means fear) is *a specific fear of a certain object, situation, or activity*. The fear experience can range from a sense of unease to a full-blown panic attack. Most people learn to live with their phobias, but for others the fear can be so debilitating that they go to extremes to avoid the fearful situation. A sufferer of arachnophobia (fear of spiders), for example, may refuse to enter a room until it has been checked thoroughly for spiders, or may refuse to vacation in the countryside because spiders may be there. Phobias are characterized by their specificity and their irrationality. A person with acrophobia (a fear of height) could fearlessly sail around the world on a sailboat with no concerns yet refuse to go out onto the balcony on the fifth floor of a building.

A common phobia is **social phobia**, *extreme shyness around people or discomfort in social situations*. Social phobia may be specific to a certain event, such as speaking in public or using a public restroom, or it can be a more generalized anxiety toward almost all people outside of close family and friends. People with social phobia will often experience physical symptoms in public, such as sweating profusely, blushing, stuttering, nausea, and dizziness. They are convinced that everybody around them notices these symptoms as they are occurring. Women are somewhat more likely than men to suffer from social phobia.

The most incapacitating phobia is **agoraphobia**, defined as *anxiety about being in places or situations from which escape might be difficult or embarrassing, or in which help may not be available* (American Psychiatric Association, 2000). Typical places that provoke the panic attacks are parking lots; crowded streets or shops; and bridges, tunnels, or expressways. People (mostly women) who suffer from agoraphobia may have great difficulty leaving their homes and interacting with other people.

Phobias are one of the most common anxiety disorders, are among the most common psychiatric illnesses, and are about twice as prevalent in women as in men (Fredrikson, Annas, Fischer, & Wik, 1996; Kessler, Meron-Ruscio, Shear, & Wittchen, 2009). In most cases phobias first appear in childhood and adolescence, and usually persist into adulthood. Table 13.3, “The Most Common Phobias,” presents a list of the common phobias that are diagnosed by psychologists.

Table 13.3 The Most Common Phobias.

Name	Description
Acrophobia	Fear of heights
Agoraphobia	Fear of situations in which escape is difficult
Arachnophobia	Fear of spiders
Astraphobia	Fear of thunder and lightning
Claustrophobia	Fear of closed-in spaces
Cynophobia	Fear of dogs
Mysophobia	Fear of germs or dirt
Ophidiophobia	Fear of snakes
Pteromerhanophobia	Fear of flying
Social phobia	Fear of social situations
Trypanophobia	Fear of injections
Zoophobia	Fear of small animals

Obsessive-Compulsive Disorders

Although he is best known his perfect shots on the field, the British soccer star David Beckham (Figure 13.6, “David Beckham”) also suffers from obsessive-compulsive disorder (OCD). As he describes it, “I have got this obsessive-compulsive disorder where I have to have everything in a straight line or everything has to be in pairs. I’ll put my Pepsi cans in the fridge and if there’s one too many then I’ll put it in another cupboard somewhere. I’ve got that problem. I’ll go into a hotel room. Before I can relax, I have to move all the leaflets and all the books and put them in a drawer. Everything has to be perfect” (Dolan, 2006).

David Beckham’s experience with obsessive behaviour is not unusual. We all get a little obsessive at times. We may continuously replay a favorite song in our heads, worry about getting the right outfit for an upcoming party, or find ourselves analyzing a series of numbers that seem to have a certain pattern. And our everyday compulsions can be useful. Going back inside the house once more to be sure that we really did turn off the sink faucet or checking the mirror a couple of times to be sure that our hair is combed are not necessarily bad ideas.

Obsessive-compulsive disorder (OCD) is a psychological disorder that is diagnosed when an individual continuously experiences distressing or frightening thoughts, and engages in **obsessions** (repetitive thoughts) or **compulsions** (repetitive behaviours) in an attempt to calm these thoughts. OCD is diagnosed when the obsessive thoughts are so disturbing and the compulsive behaviours are so time consuming that they cause distress and significant dysfunction in a person’s everyday life. Washing your hands once or even twice to make sure that they are clean is normal; washing them 20 times is not. Keeping your fridge neat is a good idea; spending hours a day on



Figure 13.6 David Beckham. Source:

it is not. The sufferers know that these rituals are senseless, but they cannot bring themselves to stop them, in part because the relief that they feel after they perform them acts as a reinforcer, making the behaviour more likely to occur again.

Sufferers of OCD may avoid certain places that trigger the obsessive thoughts, or use alcohol or drugs to try to calm themselves down. OCD has a low prevalence rate (about 1% of the population in a given year) in relation to other anxiety disorders, and usually develops in adolescence or early adulthood (Horwath & Weissman, 2000; Samuels & Nestadt, 1997). The course of OCD varies from person to person. Symptoms can come and go, decrease, or worsen over time.

Post-traumatic Stress Disorder (PTSD)

People who have survived a terrible ordeal, such as combat, torture, sexual assault, imprisonment, abuse, natural disasters, or the death of someone close to them may develop *post-traumatic stress disorder (PTSD)*. The anxiety may begin months or even years after the event. People with **PTSD** experience *high levels of anxiety* along with *reexperiencing* the trauma (flashbacks), and a strong desire to *avoid any reminders of the event*. They may lose interest in things they used to enjoy; startle easily; have difficulty feeling affection; and may experience terror, rage, depression, or insomnia. The symptoms may be felt especially when approaching the area where the event took place or when the anniversary of that event is near.

PTSD has affected approximately 8% of the population (Kessler, Berglund, Jin, Demler, & Walters, 2005). PTSD is

a frequent outcome of childhood or adult *sexual abuse*, a disorder that has its own *Diagnostic and Statistical Manual of Mental Disorders DSM* diagnosis. Women are more likely to develop PTSD than men (Davidson, 2000).

Romeo Dallaire, seen in Figure 13.7 “Roméo Dallaire,” who served as Canadian Lieutenant General and Force Commander of UNAMIR, the ill-fated United Nations peacekeeping force for Rwanda in 1993 and 1994, attempted to stop the genocide that was being waged by Hutu extremists against Tutsis and Hutu moderates. Dallaire has worked to bring understanding of post-traumatic stress disorder to the general public. He was a visiting lecturer at several Canadian and American universities and a Fellow of the Carr Center for Human Rights Policy, Kennedy School of Government at Harvard University. He has also pursued research on conflict resolution and the use of child soldiers and written several articles and chapters in publications on conflict resolution, humanitarian assistance, and human rights. Recently he wrote a book about the use of child soldiers, *They Fight Like Soldiers, They Die Like Children*.



Figure 13.7 Roméo Dallaire.

Risk factors for PTSD include the degree of the trauma’s severity, the lack of family and community support, and additional life stressors (Brewin, Andrews, & Valentine, 2000). Many people with PTSD also suffer from another

mental disorder, particularly depression, other anxiety disorders, and substance abuse (Brady, Back, & Coffey, 2004).

Dissociative Disorders: Losing the Self to Avoid Anxiety

In 1985, Michelle Philpots of England suffered a head injury in a motorcycle accident. Five years later, she reinjured her head in a serious car accident. These injuries did enough cumulative damage to Philpots's brain that she eventually started having seizures and was diagnosed with epilepsy. By 1994, she was suffering from anterograde amnesia and had completely lost the ability to create new memories, as all of her memories are wiped clean after she goes to sleep. Upon waking, she believes that it is still 1994. Even though Philpots was in a relationship with her husband long before she suffered amnesia, they did not actually get married until 1997. As a result, Philpots's husband has to show her their wedding pictures every morning in order to remind her that they're married. A popular movie, *50 First Dates*, is loosely based on Philpots's story.

People who experience anxiety are haunted by their memories and experiences, and although they desperately wish to get past them, they normally cannot. In some cases, however, such as with Michelle Philpots, people who become overwhelmed by stress experience an altered state of consciousness in which they become detached from the reality of what is happening to them. A **dissociative disorder** is *a condition that involves disruptions or breakdowns of memory, awareness, and identity*. The dissociation is used as a defence against the trauma.

Dissociative Amnesia and Fugue

Dissociative amnesia is *a psychological disorder that involves extensive, but selective, memory loss, but in which there is no physiological explanation for the forgetting* (van der Hart & Nijenhuis, 2009). The amnesia is normally brought on by a trauma — a situation that causes such painful anxiety that the individual “forgets” in order to escape. These kinds of trauma include disasters, accidents, physical abuse, rape, and other forms of severe stress (Cloninger & Dokucu, 2008). Although the personality of people who experience dissociative amnesia remains fundamentally unchanged — and they recall how to carry out daily tasks such as reading, writing, and problem solving — they tend to forget things about their personal lives — for instance, their name, age, and occupation — and may fail to recognize family and friends (van der Hart & Nijenhuis, 2009).

A related disorder, **dissociative fugue**, is *a psychological disorder in which an individual loses complete memory of his or her identity and may even assume a new one, often far from home*. The individual with dissociative fugue experiences all the symptoms of dissociative amnesia but also leaves the situation entirely. The fugue state may last for just a matter of hours or may continue for months. Recovery from the fugue state tends to be rapid, but when people recover they commonly have no memory of the stressful event that triggered the fugue or of events that occurred during their fugue state (Cardeña & Gleaves, 2007).

Dissociative Identity Disorder

You may remember the story of Sybil (a pseudonym for Shirley Ardell Mason, who was born in 1923), a person who, over a period of 40 years, claimed to possess 16 distinct personalities (Figure 13.8, “Sybil”). Mason was in therapy for many years trying to integrate these personalities into one complete self. A TV movie about Mason's life, starring Sally Field as Sybil, appeared in 1976.

Sybil suffered from the most severe of the dissociative disorders, *dissociative identity disorder*. **Dissociative identity disorder** is *a psychological disorder in which two or more distinct and individual personalities exist in the same person, and there is an extreme memory disruption regarding personal information about the other*



Figure 13.8 Sybil. Shirley Ardell Mason.

personalities (van der Hart & Nijenhuis, 2009). Dissociative identity disorder was once known as *multiple personality disorder*, and this label is still sometimes used. This disorder is sometimes mistakenly referred to as schizophrenia.

In some cases of dissociative identity disorder, there can be more than 10 different personalities in one individual. Switches from one personality to another tend to occur suddenly, often triggered by a stressful situation (Gillig, 2009). The **host personality** is the *personality in control of the body most of the time*, and the *alter personalities* tend to differ from each other in terms of age, race, gender, language, manners, and even sexual orientation (Kluft, 1996). A shy, introverted individual may develop a boisterous, extroverted alter personality. Each personality has unique memories and social relationships (Dawson, 1990). Women are more frequently diagnosed with dissociative identity disorder than are men, and when they are diagnosed also tend to have more “personalities” (American Psychiatric Association, 2000).

The dissociative disorders are relatively rare conditions and are most frequently observed in adolescents and young adults. In part because they are so unusual and difficult to diagnose, clinicians and researchers disagree about the legitimacy of the disorders, and particularly about dissociative identity disorder. Some clinicians argue that the descriptions in the *DSM* accurately reflect the symptoms of these patients, whereas others believe that patients are faking, role-playing, or using the disorder as a way to justify behaviour (Barry-Walsh, 2005; Kihlstrom, 2004; Lilienfeld & Lynn, 2003; Lipsanen et al., 2004). Even the diagnosis of Shirley Ardell Mason (Sybil) is disputed. Some experts claim that Mason was highly hypnotizable and that her therapist unintentionally suggested the existence of her multiple personalities (Miller & Kantrowitz, 1999).

Explaining Anxiety and Dissociation Disorders

Both nature and nurture contribute to the development of anxiety disorders. In terms of our evolutionary experiences, humans have evolved to fear dangerous situations. Those of us who had a healthy fear of the dark, of storms, of high places, of closed spaces, and of spiders and snakes were more likely to survive and have descendants. Our evolutionary experience can account for some modern fears as well. A fear of elevators may be a modern version of our fear of closed spaces, while a fear of flying may be related to a fear of heights.

Also supporting the role of biology, anxiety disorders, including PTSD, are heritable (Hettema, Neale, & Kendler, 2001), and molecular genetics studies have found a variety of genes that are important in the expression of such disorders (Smoller et al., 2008; Thoeringer et al., 2009). Neuroimaging studies have found that anxiety disorders are linked to areas of the brain that are associated with emotion, blood pressure and heart rate, decision making, and action monitoring (Brown & McNiff, 2009; Damsa, Kosel, & Moussally, 2009). People who experience PTSD also have a somewhat smaller hippocampus in comparison with those who do not, and this difference leads them to have a very strong sensitivity to traumatic events (Gilbertson et al., 2002).

Whether the genetic predisposition to anxiety becomes expressed as a disorder depends on environmental factors. People who were abused in childhood are more likely to be anxious than those who had normal childhoods, even with the same genetic disposition to anxiety sensitivity (Stein, Schork, & Gelernter, 2008). And the most severe anxiety and dissociative disorders, such as PTSD, are usually triggered by the experience of a major stressful event. One problem is that modern life creates a lot of anxiety. Although our life expectancy and quality of life have improved over the past 50 years, the same period has also created a sharp increase in anxiety levels (Twenge, 2006). These changes suggest that most anxiety disorders stem from perceived, rather than actual, threats to our well-being.

Anxieties are also learned through classical and operant conditioning. Just as rats that are shocked in their cages develop a chronic anxiety toward their laboratory environment (which has become a conditioned stimulus for fear), rape victims may feel anxiety when passing by the scene of the crime, and victims of PTSD may react to memories or reminders of the stressful event. Classical conditioning may also be accompanied by *stimulus generalization*. A single dog bite can lead to generalized fear of all dogs; a panic attack that follows an embarrassing moment in one place may be generalized to a fear of all public places. People's responses to their anxieties are often reinforced. Behaviours become compulsive because they provide relief from the torment of anxious thoughts. Similarly, leaving or avoiding fear-inducing stimuli leads to feelings of calmness or relief, which reinforces phobic behaviour.

In contrast to the anxiety disorders, the causes of the dissociative orders are less clear, which is part of the reason that there is disagreement about their existence. Unlike most psychological orders, there is little evidence of a genetic predisposition; they seem to be almost entirely environmentally determined. Severe emotional trauma during childhood, such as physical or sexual abuse, coupled with a strong stressor, is typically cited as the underlying cause (Alpher, 1992; Cardeña & Gleaves, 2007). Kihlstrom, Glisky, and Angiulo (1994) suggest that people with personalities that lead them to fantasize and become intensely absorbed in their own personal experiences are more susceptible to developing dissociative disorders under stress. Dissociative disorders can in many cases be successfully treated, usually by psychotherapy (Lilienfeld & Lynn, 2003).

Key Takeaways

- Anxiety is a natural part of life, but too much anxiety can be debilitating. Every year millions of people suffer from anxiety disorders.
- People who suffer from generalized anxiety disorder experience anxiety, as well as a variety of physical symptoms.
- Panic disorder involves the experience of panic attacks, including shortness of breath, heart palpitations, trembling, and dizziness.
- Phobias are specific fears of a certain object, situation, or activity. Phobias are characterized by their specificity and their irrationality.

- A common phobia is social phobia — extreme shyness around people or discomfort in social situations.
- Obsessive-compulsive disorder is diagnosed when a person’s repetitive thoughts are so disturbing and his or her compulsive behaviours so time consuming that they cause distress and significant disruption in a person’s everyday life.
- People who have survived a terrible ordeal, such as combat, torture, rape, imprisonment, abuse, natural disasters, or the death of someone close to them, may develop PTSD.
- Dissociative disorders, including dissociative amnesia and dissociative fugue, are conditions that involve disruptions or breakdowns of memory, awareness, and identity. The dissociation is used as a defence against the trauma.
- Dissociative identity disorder, in which two or more distinct and individual personalities exist in the same person, is relatively rare and difficult to diagnose.
- Both nature and nurture contribute to the development of anxiety disorders.

Exercises and Critical Thinking

1. Under what situations do you experience anxiety? Are these experiences rational or irrational? Does the anxiety keep you from doing some things that you would like to be able to do?
2. Do you or people you know suffer from phobias? If so, what are the phobias and how do you think the phobias began? Do they seem more genetic or more environmental in origin?

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Image Attributions

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13.3 Mood Disorders: Emotions as Illness

Learning Objectives

1. Summarize and differentiate the various forms of mood disorders, in particular dysthymia, major depressive disorder, and bipolar disorder.
2. Explain the genetic and environmental factors that increase the likelihood that a person will develop a mood disorder.

The everyday variations in our feelings of happiness and sadness reflect our **mood**, which can be defined as *the positive or negative feelings that are in the background of our everyday experiences*. In most cases we are in a relatively good mood, and this positive mood has some positive consequences — it encourages us to do what needs to be done and to make the most of the situations we are in (Isen, 2003). When we are in a good mood our thought processes open up, and we are more likely to approach others. We are more friendly and helpful to others when we are in a good mood than we are when we are in a bad mood, and we may think more creatively (De Dreu, Baas, & Nijstad, 2008). On the other hand, when we are in a bad mood we are more likely to prefer to be alone rather than interact with others, we focus on the negative things around us, and our creativity suffers.

It is not unusual to feel down or low at times, particularly after a painful event such as the death of someone close to us, a disappointment at work, or an argument with a partner. We often get depressed when we are tired, and many people report being particularly sad during the winter when the days are shorter. **Mood (or affective) disorders** are *psychological disorders in which the person's mood negatively influences his or her physical, perceptual, social, and cognitive processes*. People who suffer from mood disorders tend to experience more intense — and particularly more intense negative — moods. About 5% of the Canadian population suffers from a mood disorder in a given year (Health Canada, 2002).

The most common symptom of mood disorders is negative mood, also known as sadness or *depression* (Figure 13.9, “Depression”). Consider the feelings of this person, who was struggling with depression and was diagnosed with *major depressive disorder*:

“

I didn't want to face anyone; I didn't want to talk to anyone. I didn't really want to do anything for myself...I couldn't sit down for a minute really to do anything that took deep concentration...It was like I had big huge weights on my legs and I was trying to swim and just kept sinking. And I'd get a little bit of air, just enough to survive and then I'd go back down again. It was just constantly, constantly just fighting, fighting, fighting, fighting, fighting. (National Institute of Mental Health, 2010)



Figure 13.9 Depression.

Mood disorders can occur at any age, and the median age of onset is 32 years (Kessler, Berglund, Demler, Jin, & Walters, 2005). Recurrence of depressive episodes is fairly common and is greatest for those who first experience depression before the age of 15 years. About twice as many women as men suffer from depression (Culbertson, 1997). This gender difference is consistent across many countries and cannot be explained entirely by the fact that women are more likely to seek treatment for their depression. Rates of depression have been increasing, although the reasons for this increase are not known (Kessler et al., 2003).

As you can see in the list below, the experience of depression has a variety of negative effects on our behaviours. In addition to the loss of interest, productivity, and social contact that accompanies depression, the person's sense of hopelessness and sadness may become so severe that he or she considers or even succeeds in committing suicide. In 2009 there were 3,890 suicides in Canada, a rate of 11.5 per 100,000 (Navaneelan, 2012). Almost all the people who commit suicide have a diagnosable psychiatric disorder at the time of their death (Statistics Canada, 2012; Sudak, 2005).

Behaviours Associated with Depression

- Changes in appetite; weight loss or gain
- Difficulty concentrating, remembering details, and making decisions
- Fatigue and decreased energy
- Feelings of hopelessness, helplessness, and pessimism
- Increased use of alcohol or drugs
- Irritability, restlessness
- Loss of interest in activities or hobbies once pleasurable, including sex
- Loss of interest in personal appearance
- Persistent aches or pains, headaches, cramps, or digestive problems that do not improve with treatment
- Sleep disorders, either trouble sleeping or excessive sleeping
- Thoughts of suicide or attempts at suicide

Dysthymia and Major Depressive Disorder

The level of depression observed in people with mood disorders varies widely. People who experience depression for many years, to the point that it becomes to seem normal and part of their everyday life, and who feel that they are rarely or never happy, will likely be diagnosed with a mood disorder. If the depression is mild but long-lasting, they will be diagnosed with **dysthymia**, *a condition characterized by mild, but chronic, depressive symptoms that last for at least two years.*

If the depression continues and becomes even more severe, the diagnosis may become that of *major depressive disorder*. **Major depressive disorder (clinical depression)** is *a mental disorder characterized by an all-encompassing low mood accompanied by low self-esteem and loss of interest or pleasure in normally enjoyable activities.* Those who suffer from major depressive disorder feel an intense sadness, despair, and loss of interest in pursuits that once gave them pleasure. These negative feelings profoundly limit the individual's day-to-day functioning and ability to maintain and develop interests in life (Fairchild & Scogin, 2008).

About 4.8% of Canadian adults suffer from a major depressive disorder in any given year. Major depressive disorder occurs about twice as often in women as it does in men (Kessler, Chiu, Demler, & Walters, 2005; Kessler et al., 2003). In some cases clinically depressed people lose contact with reality and may receive a diagnosis of *major depressive episode with psychotic features*. In these cases the depression includes delusions and hallucinations.

Bipolar Disorder

Juliana is a 21-year-old single woman. Over the past several years she had been treated by a psychologist for depression, but for the past few months she had been feeling a lot better. Juliana had landed a good job in a law office and found a steady boyfriend. She told her friends and parents that she had been feeling particularly good — her energy level was high and she was confident in herself and her life.

One day Juliana was feeling so good that she impulsively quit her new job and left town with her boyfriend on a road trip. But the trip didn't turn out well because Juliana became impulsive, impatient, and easily angered. Her euphoria continued, and in one of the towns that they visited she left her boyfriend and went to a party with some strangers that she had met. She danced into the early morning and ended up having sex with several of the men.

Eventually Juliana returned home to ask for money, but when her parents found out about her recent behaviour and confronted her, she acted aggressively and abusively to them, so they referred her to a social worker. Juliana was hospitalized, where she was diagnosed with bipolar disorder.

While dysthymia and major depressive disorder are characterized by overwhelming negative moods, **bipolar disorder** is *a psychological disorder characterized by swings in mood from overly "high" to sad and hopeless, and back again, with periods of near-normal mood in between.* Bipolar disorder is diagnosed in cases such as Juliana's, where experiences with depression are followed by a more normal period and then a period of mania or euphoria in which the person feels particularly awake, alive, excited, and involved in everyday activities but is also impulsive, agitated, and distracted. Without treatment, it is likely that Juliana would cycle back into depression and then eventually into mania again, with the likelihood that she would harm herself or others in the process.

Based on his intense bursts of artistic productivity (in one two-month period in 1889 he produced 60 paintings), personal writings, and behaviour (including cutting off his own ear), it is commonly thought that Vincent van Gogh suffered from bipolar disorder. He committed suicide at age 37 (Thomas & Bracken, 2001). His painting, *Starry Night*, is shown in Figure 13.10.



Figure 13.10 Starry Night by Vincent van Gogh.

Bipolar disorder is an often chronic and lifelong condition that may begin in childhood. Although the normal pattern involves swings from high to low, in some cases the person may experience both highs and lows at the same time. Determining whether a person has bipolar disorder is difficult due to the frequent presence of comorbidity with both depression and anxiety disorders. Bipolar disorder is more likely to be diagnosed when it is initially observed at an early age, when the frequency of depressive episodes is high, and when there is a sudden onset of the symptoms (Bowden, 2001).

Explaining Mood Disorders

Mood disorders are known to be at least in part genetic, because they are heritable (Berrettini, 2006; Merikangas et al., 2002). Neurotransmitters also play an important role in mood disorders. Serotonin, dopamine, and norepinephrine are all known to influence mood (Sher & Mann, 2003), and drugs that influence the actions of these chemicals are often used to treat mood disorders.

The brains of those with mood disorders may in some cases show structural differences from those without them. Videbech and Ravnkilde (2004) found that the hippocampus was smaller in depressed subjects than in normal subjects, and this may be the result of reduced *neurogenesis* (the process of generating new neurons) in depressed people (Warner-Schmidt & Duman, 2006). Antidepressant drugs may alleviate depression in part by increasing neurogenesis (Duman & Monteggia, 2006).

Research Focus: Using Molecular Genetics to Unravel the Causes of Depression

Avshalom Caspi and his colleagues (Caspi et al., 2003) used a longitudinal study to test whether genetic predispositions might lead some people, but not others, to suffer from depression as a result of environmental stress. Their research focused on a particular gene, the 5-HTT gene, which is known to be important in the production and use of the neurotransmitter *serotonin*. The researchers focused on this gene because serotonin is known to be important in depression, and because selective serotonin reuptake inhibitors (SSRIs) have been shown to be effective in treating depression.

People who experience stressful life events, for instance involving threat, loss, humiliation, or defeat, are likely to experience depression. But biological-situational models suggest that a person's sensitivity to stressful events depends on his or her genetic makeup. The researchers therefore expected that people with one type of genetic pattern would show depression following stress to a greater extent than people with a different type of genetic pattern.

The research included a sample of 1,037 adults from Dunedin, New Zealand. Genetic analysis on the basis of DNA samples allowed the researchers to divide the sample into two groups on the basis of the characteristics of their 5-HTT gene. One group had a short version (or *allele*) of the gene, whereas the other group did not have the short allele of the gene.

The participants also completed a measure where they indicated the number and severity of stressful life events that they had experienced over the past five years. The events included employment, financial, housing, health, and relationship stressors. The dependent measure in the study was the level of depression reported by the participant, as assessed using a structured interview test (Robins, Cottler, Bucholtz, & Compton, 1995).

As you can see in Figure 13.11 as the number of stressful experiences the participants reported increased from 0 to 4, depression also significantly increased for the participants with the short version of the gene (top panel). But for the participants who did not have a short allele, increasing stress did not increase depression (bottom panel). Furthermore, for the participants who experienced four stressors over the past five years, 33% of the participants who carried the short version of the gene became depressed, whereas only 17% of participants who did not have the short version did.

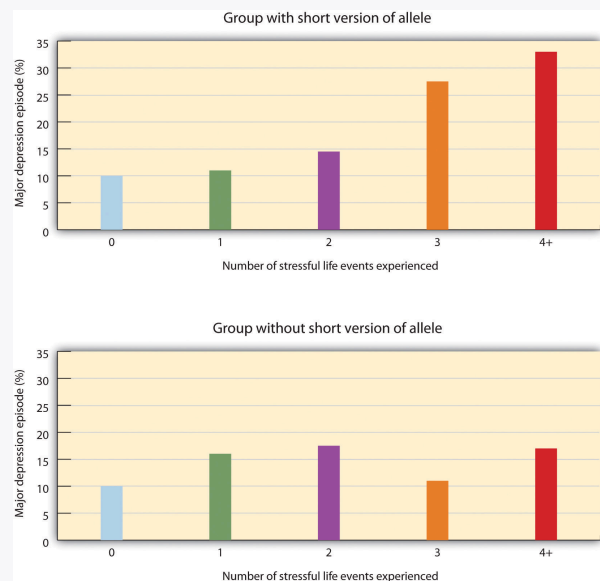


Figure 13.11 Research. [\[Long Description\]](#)

This important study provides an excellent example of how genes and environment work together: an individual's response to environmental stress was influenced by his or her genetic makeup.

But psychological and social determinants are also important in creating mood disorders and depression. In terms

of psychological characteristics, mood states are influenced in large part by our cognitions. Negative thoughts about ourselves and our relationships to others create negative moods, and a goal of cognitive therapy for mood disorders is to attempt to change people’s cognitions to be more positive. Negative moods also create negative behaviours toward others, such as acting sad, slouching, and avoiding others, which may lead those others to respond negatively to the person, for instance by isolating that person, which then creates even more depression (Figure 13.12, “Cycle of Depression”). You can see how it might become difficult for people to break out of this “cycle of depression.”



Figure 13.12 Cycle of Depression. Negative thoughts cause negative emotions which may cause negative behaviours which may lead to negative responses from others which may cause more negative thoughts.

Weissman et al. (1996) found that rates of depression varied greatly among countries, with the highest rates in European and North American countries and the lowest rates in Asian countries. These differences seem to be due to discrepancies between individual feelings and cultural expectations about what one should feel. People from European and North American cultures report that it is important to experience emotions such as happiness and excitement, whereas the Chinese report that it is more important to be stable and calm. Because North Americans may feel that they are not happy or excited but that they are supposed to be, this may increase their depression (Tsai, Knutson, & Fung, 2006).

Key Takeaways

- Mood is the positive or negative feelings that are in the background of our everyday experiences.
- We all may get depressed in our daily lives, but people who suffer from mood disorders tend to experience more intense — and particularly more intense negative — moods.
- The most common symptom of mood disorders is negative mood.
- If a person experiences mild but long-lasting depression, he or she will be diagnosed with dysthymia. If the depression continues and becomes even more severe, the diagnosis may become that of major depressive disorder.

- Bipolar disorder is characterized by swings in mood from overly “high” to sad and hopeless, and back again, with periods of near-normal mood in between.
- Mood disorders are caused by the interplay among biological, psychological, and social variables.

Exercises and Critical Thinking

1. Give a specific example of the negative cognitions, behaviours, and responses of others that might contribute to a cycle of depression like that shown in Figure 13.12, “Cycle of Depression.”
2. Given the discussion about the causes of negative moods and depression, what might people do to try to feel better on days that they are experiencing negative moods?

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Image Attributions

Figure 13.9: “sad looking woman” by [Bradley Gordon](#) is licensed under [CC BY 2.0](#) license (http://creativecommons.org/licenses/by/2.0/deed.en_CA)

Figure 13.11: Adapted from Caspi, A., et al., 2003.

Long Description

Figure 13.11 long description: Genetics and Causes of Depression

Number of stressful life events experienced	Major Depression Episode (%)	
	Group with short version of allele	Group without short version of allele
0	10%	10%
1	11%	16%
2	14%	18%
3	28%	11%
4 or more	33%	18%

[\[Return to Figure 13.11\]](#)

13.4 Schizophrenia: The Edge of Reality and Consciousness

Learning Objectives

1. Categorize and describe the three major symptoms of schizophrenia.
2. Differentiate the five types of schizophrenia and their characteristics.
3. Identify the biological and social factors that increase the likelihood that a person will develop schizophrenia.

The term *schizophrenia*, which in Greek means split mind, was first used to describe a psychological disorder by Eugen Bleuler (1857-1939), a Swiss psychiatrist who was studying patients who had very severe thought disorders. **Schizophrenia** is a serious psychological disorder marked by delusions, hallucinations, loss of contact with reality, inappropriate affect, disorganized speech, social withdrawal, and deterioration of adaptive behaviour (Figure 13.13, “Schizophrenia”).



Figure 13.13 Schizophrenia. People with schizophrenia may exhibit disorganized behaviour, as this person does.

Schizophrenia is the most chronic and debilitating of all psychological disorders. It affects men and women equally, occurs in similar rates across ethnicities and across cultures, and affects at any one time approximately 350,000 people in Canada (Public Health Agency of Canada, 2012). Onset of schizophrenia is usually between the ages of 16 and 30 and rarely after the age of 45 or in children (Mueser & McGurk, 2004; Nicolson, Lenane, Hamburger, Fernandez, Bedwell, & Rapoport, 2000).

Symptoms of Schizophrenia

Schizophrenia is accompanied by a variety of symptoms, but not all patients have all of them (Lindenmayer & Khan, 2006). As you can see in Table 13.4, “Positive, Negative, and Cognitive Symptoms of Schizophrenia,” the symptoms are divided into *positive symptoms*, *negative symptoms*, and *cognitive symptoms* (American Psychiatric Association, 2008; National Institute of Mental Health, 2010). Positive symptoms refer to the presence of abnormal behaviours or experiences (such as hallucinations) that are not observed in normal people, whereas negative symptoms (such as lack of affect and an inability to socialize with others) refer to the loss or deterioration of thoughts and behaviours that are typical of normal functioning. Finally, cognitive symptoms are the changes in cognitive processes that accompany schizophrenia (Skrabalo, 2000). Because the patient has lost contact with reality, we say that he or she is experiencing **psychosis**, which is *a psychological condition characterized by a loss of contact with reality*.

Table 13.4 Positive, Negative, and Cognitive Symptoms of Schizophrenia.

[Skip Table]		
Positive symptoms	Negative symptoms	Cognitive symptoms
Hallucinations	Social withdrawal	Poor executive control
Delusions (of grandeur or persecution)	Flat affect and lack of pleasure in everyday life	Trouble focusing
Derailment	Apathy and loss of motivation	Working memory problems
Grossly disorganized behaviour	Distorted sense of time	Poor problem-solving abilities
Inappropriate affect	Lack of goal-oriented activity	
Movement disorders	Limited speech	
	Poor hygiene and grooming	

People with schizophrenia almost always suffer from **hallucinations** — *imaginary sensations that occur in the absence of a real stimulus or which are gross distortions of a real stimulus*. Auditory hallucinations are the most common and are reported by approximately three-quarters of patients (Nicolson, Mayberg, Pennell, & Nemeroff, 2006). Schizophrenic patients frequently report hearing imaginary voices that curse them, comment on their behaviour, order them to do things, or warn them of danger (National Institute of Mental Health, 2009). Visual hallucinations are less common and frequently involve seeing God or the devil (De Sousa, 2007).

Schizophrenic people also commonly experience **delusions**, which are *false beliefs not commonly shared by others within one’s culture, and maintained even though they are obviously out of touch with reality*. People with *delusions of grandeur* believe that they are important, famous, or powerful. They often become convinced that they are someone else, such as the president or God, or that they have some special talent or ability. Some claim to have been assigned to a special covert mission (Buchanan & Carpenter, 2005). People with *delusions of persecution* believe that a person or group seeks to harm them. They may think that people are able to read their minds and control their thoughts (Maher, 2001). If a person suffers from delusions of persecution, there is a good chance that he or she will become violent, and this violence is typically directed at family members (Buchanan & Carpenter, 2005).

People suffering from schizophrenia also often suffer from the positive symptom of **derailment** — *the shifting from one subject to another, without following any one line of thought to conclusion* — and may exhibit *grossly disorganized behaviour* including inappropriate sexual behaviour, peculiar appearance and dress, unusual agitation (e.g., shouting and swearing), strange body movements, and awkward facial expressions. It is also common for

schizophrenia sufferers to experience *inappropriate affect*. For example, a patient may laugh uncontrollably when hearing sad news. Movement disorders typically appear as agitated movements, such as repeating a certain motion again and again, but can in some cases include *catatonia*, a state in which a person does not move and is unresponsive to others (Janno, Holi, Tuisku, & Wahlbeck, 2004; Rosebush & Mazurek, 2010).

Negative symptoms of schizophrenia include social withdrawal, poor hygiene and grooming, poor problem-solving abilities, and a distorted sense of time (Skrabalo, 2000). Patients often suffer from flat affect, which means that they express almost no emotional response (e.g., they speak in a monotone and have a blank facial expression) even though they may report feeling emotions (Kring, 1999). Another negative symptom is the tendency toward incoherent language, such as repeating the speech of others (“echo speech”). Some schizophrenics experience motor disturbances, ranging from complete catatonia and apparent obliviousness to their environment to random and frenzied motor activity during which they become hyperactive and incoherent (Kirkpatrick & Tek, 2005).

Not all schizophrenic patients exhibit negative symptoms, but those who do also tend to have the poorest outcomes (Fenton & McGlashan, 1994). Negative symptoms are predictors of deteriorated functioning in everyday life and often make it impossible for sufferers to work or to care for themselves.

Cognitive symptoms of schizophrenia are typically difficult for outsiders to recognize but make it extremely difficult for the sufferer to lead a normal life. These symptoms include *difficulty comprehending information and using it to make decisions* (the **lack of executive control**), difficulty maintaining focus and attention, and problems with working memory (the ability to use information immediately after it is learned).

Explaining Schizophrenia

There is no single cause of schizophrenia. Rather, a variety of biological and environmental risk factors interact in a complex way to increase the likelihood that someone might develop schizophrenia (Walker, Kestler, Bollini, & Hochman, 2004).

Studies in molecular genetics have not yet identified the particular genes responsible for schizophrenia, but it is evident from research using family, twin, and adoption studies that genetics are important (Walker & Tessner, 2008). As you can see in Figure 13.14, “Genetic Disposition to Develop Schizophrenia,” the likelihood of developing schizophrenia increases dramatically if a close relative also has the disease.

Neuroimaging studies have found some differences in brain structure between schizophrenic and normal patients. In some people with schizophrenia, the cerebral ventricles (fluid-filled spaces in the brain) are enlarged (Suddath, Christison, Torrey, Casanova, & Weinberger, 1990). People with schizophrenia also frequently show an overall loss of neurons in the cerebral cortex, and some show less activity in the frontal and temporal lobes, which are the areas of the brain involved in language, attention, and memory. This would explain the deterioration of functioning in language and thought processing that is commonly experienced by schizophrenic patients (Galderisi et al., 2008).

Many researchers believe that schizophrenia is caused in part by excess dopamine, and this theory is supported by the fact that most of the drugs useful in treating schizophrenia inhibit dopamine activity in the brain (Javitt & Laruelle, 2006). Levels of serotonin may also play a part (Inayama et al., 1996). But recent evidence suggests that the role of neurotransmitters in schizophrenia is more complicated than was once believed. It also remains unclear whether observed differences in the neurotransmitter systems of people with schizophrenia cause the disease, or if they are the result of the disease itself or its treatment (Csernansky & Grace, 1998).

A genetic predisposition to developing schizophrenia does not always develop into the actual disorder. Even if a person has an identical twin with schizophrenia, that person still has less than a 50% chance of developing it, and

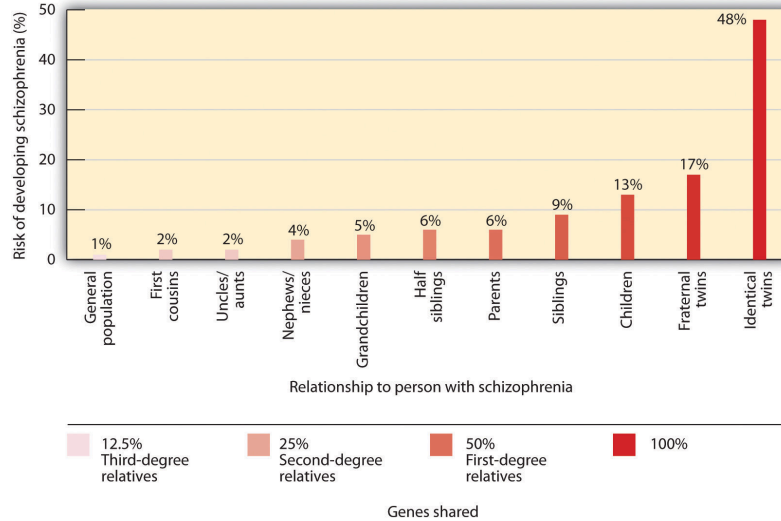


Figure 13.14 Genetic Disposition to Develop Schizophrenia. The risk of developing schizophrenia increases substantially if a person has a relative with the disease. [\[Long Description\]](#)

over 60% of all schizophrenic people have no first- or second-degree relatives with schizophrenia (Gottesman & Erlenmeyer-Kimling, 2001; Riley & Kendler, 2005). This suggests that there are important environmental causes as well.

One hypothesis is that schizophrenia is caused in part by disruptions to normal brain development in infancy that may be caused by poverty, malnutrition, and disease (Brown et al., 2004; Murray & Bramon, 2005; Susser et al., 1996; Waddington, Lane, Larkin, & O’Callaghan, 1999). Stress also increases the likelihood that a person will develop schizophrenic symptoms; onset and relapse of schizophrenia typically occur during periods of increased stress (Walker, Mittal, & Tessner, 2008). However, it may be that people who develop schizophrenia are more vulnerable to stress than others and not necessarily that they experience more stress than others (Walker, Mittal, & Tessner, 2008). Many homeless people are likely to be suffering from undiagnosed schizophrenia.

Another social factor that has been found to be important in schizophrenia is the degree to which one or more of the patient’s relatives is highly critical or highly emotional in their attitude toward the patient. Hooley and Hiller (1998) found that schizophrenic patients who ended a stay in a hospital and returned to a family with high expressed emotion were three times more likely to relapse than patients who returned to a family with low expressed emotion. It may be that the families with high expressed emotion are a source of stress to the patient.

Key Takeaways

- Schizophrenia is a serious psychological disorder marked by delusions, hallucinations, and loss of contact with reality.
- Schizophrenia is accompanied by a variety of symptoms, but not all patients have all of them.
- Because the schizophrenic patient has lost contact with reality, we say that he or she is experiencing psychosis.

- Positive symptoms of schizophrenia include hallucinations, delusions, derailment, disorganized behaviour, inappropriate affect, and catatonia.
- Negative symptoms of schizophrenia include social withdrawal, poor hygiene and grooming, poor problem-solving abilities, and a distorted sense of time.
- Cognitive symptoms of schizophrenia include difficulty comprehending and using information and problems maintaining focus.
- There is no single cause of schizophrenia. Rather, there are a variety of biological and environmental risk factors that interact in a complex way to increase the likelihood that someone might develop schizophrenia.

Exercise and Critical Thinking

1. How should society deal with people with schizophrenia? Is it better to keep patients in psychiatric facilities against their will, but where they can be observed and supported, or to allow them to live in the community, where they may commit violent crimes against themselves or others? What factors influence your opinion?

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Image Attributions

Figure 13.13: by Max Avdeev, <http://www.flickr.com/photos/avdeev/4203380988>

Figure 13.14: Adapted from Gottesman, 1991.

Long Descriptions

Figure 13.14 long description: Genetic disposition to develop schizophrenia

Genes shared	Relationship to person with schizophrenia	Risk of developing schizophrenia (%)
Third-degree relatives (12.5%)	First cousins	2%
	Uncles and aunts	2%
Second-degree relatives (25%)	Nephews and nieces	4%
	Grandchildren	5%
First-degree relatives (50%)	Half-siblings	6%
	Parents	6%
100%	Siblings	9%
	Children	13%
	Fraternal twins	17%
	Identical twins	48%

[\[Return to Figure 13.14\]](#)

13.5 Personality Disorders

Learning Objectives

1. Categorize the different types of personality disorders and differentiate antisocial personality disorder from borderline personality disorder.
2. Outline the biological and environmental factors that may contribute to a person developing a personality disorder.

To this point in the chapter we have considered the psychological disorders of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* categorization system. A **personality disorder** is a disorder characterized by inflexible patterns of thinking, feeling, or relating to others that cause problems in personal, social, and work situations. Personality disorders tend to emerge during late childhood or adolescence and usually continue throughout adulthood (Widiger, 2006). The disorders can be problematic for the people who have them, but they are less likely to bring people to a therapist for treatment.

The personality disorders are summarized in Table 13.5, “Descriptions of the Personality Disorders.” They are categorized into three types: those characterized by *odd or eccentric behaviour*, those characterized by *dramatic or erratic behaviour*, and those characterized by *anxious or inhibited behaviour*. As you consider the personality types described in Table 13.5, I’m sure you’ll think of people that you know who have each of these traits, at least to some degree. Probably you know someone who seems a bit suspicious and paranoid, who feels that other people are always “ganging up on him,” and who really do not trust other people very much. Perhaps you know someone who fits the bill of being overly dramatic — the “drama queen” who is always raising a stir and whose emotions seem to turn everything into a big deal. Or you might have a friend who is overly dependent on others and can’t seem to get a life of her own.

The personality traits that make up the personality disorders are common — we see them in the people with whom we interact every day — yet they may become problematic when they are rigid, overused, or interfere with everyday behaviour (Lynam & Widiger, 2001). What is perhaps common to all the disorders is the person’s inability to accurately understand and be sensitive to the motives and needs of the people around them.

Table 13.5 Descriptions of the Personality Disorders.¹

[Skip Table]

Cluster	Personality disorder	Characteristics
A. Odd/ eccentric	Schizotypal	Peculiar or eccentric manners of speaking or dressing. Strange beliefs. “Magical thinking” such as belief in ESP or telepathy. Difficulty forming relationships. May react oddly in conversation, not respond, or talk to self. Speech elaborate or difficult to follow. (Possibly a mild form of schizophrenia.)
	Paranoid	Distrust in others, suspicion that people have sinister motives. Apt to challenge the loyalties of friends and read hostile intentions into others’ actions. Prone to anger and aggressive outbursts but otherwise emotionally cold. Often jealous, guarded, secretive, overly serious.
	Schizoid	Extreme introversion and withdrawal from relationships. Prefers to be alone, little interest in others. Humourless, distant, often absorbed with own thoughts and feelings, a daydreamer. Fearful of closeness, with poor social skills, often seen as a “loner.”
B. Dramatic/ erratic	Antisocial	Impoverished moral sense or “conscience.” History of deception, crime, legal problems, impulsive and aggressive or violent behaviour. Little emotional empathy or remorse for hurting others. Manipulative, careless, callous. At high risk for substance abuse and alcoholism.
	Borderline	Unstable moods and intense, stormy personal relationships. Frequent mood changes and anger, unpredictable impulses. Self-mutilation or suicidal threats or gestures to get attention or manipulate others. Self-image fluctuation and a tendency to see others as “all good” or “all bad.”
	Histrionic	Constant attention seeking. Grandiose language, provocative dress, exaggerated illnesses, all to gain attention. Believes that everyone loves him. Emotional, lively, overly dramatic, enthusiastic, and excessively flirtatious.
	Narcissistic	Inflated sense of self-importance, absorbed by fantasies of self and success. Exaggerates own achievement, assumes others will recognize they are superior. Good first impressions but poor longer-term relationships. Exploitative of others.
C. Anxious/ inhibited	Avoidant	Socially anxious and uncomfortable unless he or she is confident of being liked. In contrast with schizoid person, yearns for social contact. Fears criticism and worries about being embarrassed in front of others. Avoids social situations due to fear of rejection.
	Dependent	Submissive, dependent, requiring excessive approval, reassurance, and advice. Clings to people and fears losing them. Lacking self-confidence. Uncomfortable when alone. May be devastated by end of close relationship or suicidal if breakup is threatened.
	Obsessive-compulsive	Conscientious, orderly, perfectionist. Excessive need to do everything “right.” Inflexibly high standards and caution can interfere with his or her productivity. Fear of errors can make this person strict and controlling. Poor expression of emotions. (Not the same as obsessive-compulsive disorder.)

The personality disorders create a bit of a problem for diagnosis. For one, it is frequently difficult for the clinician to accurately diagnose which of the many personality disorders a person has, although the friends and colleagues of the person can generally do a good job of it (Oltmanns & Turkheimer, 2006). And the personality disorders are highly comorbid; if a person has one, it’s likely that he or she has others as well. Also, the number of people with personality disorders is estimated to be as high as 15% of the population (Grant et al., 2004), which might make us wonder if these are really disorders in any real sense of the word.

Although they are considered as separate disorders, the personality disorders are essentially milder versions of more severe disorders (Huang et al., 2009). For example, *obsessive-compulsive personality disorder* is a milder version of **obsessive-compulsive disorder (OCD)**, and *schizoid and schizotypal personality disorders* are characterized

by symptoms similar to those of schizophrenia. This overlap in classification causes some confusion, and some theorists have argued that the personality disorders should be eliminated from the *DSM*. But clinicians normally differentiate Axis I and Axis II disorders, and thus the distinction is useful for them (Krueger, 2005; Phillips, Yen, & Gunderson, 2003; Verheul, 2005).

Although it is not possible to consider the characteristics of each of the personality disorders in this book, let's focus on two that have important implications for behaviour. The first, *borderline personality disorder (BPD)*, is important because it is so often associated with suicide, and the second, *antisocial personality disorder (APD)*, because it is the foundation of criminal behaviour. Borderline and antisocial personality disorders are also good examples to consider because they are so clearly differentiated in terms of their focus. BPD (more frequently found in women than men) is known as an *internalizing disorder* because the behaviours that it entails (e.g., suicide and self-mutilation) are mostly directed toward the self. APD (mostly found in men), on the other hand, is a type of *externalizing disorder* in which the problem behaviours (e.g., lying, fighting, vandalism, and other criminal activity) focus primarily on harm to others.

Borderline Personality Disorder

Borderline personality disorder (BPD) is a psychological disorder characterized by a prolonged disturbance of personality accompanied by mood swings, unstable personal relationships, identity problems, threats of self-destructive behaviour, fears of abandonment, and impulsivity. BPD is widely diagnosed — up to 20% of psychiatric patients are given the diagnosis, and it may occur in up to 2% of the general population (Hyman, 2002). About three-quarters of diagnosed cases of BPD are women.

People with BPD fear being abandoned by others. They often show a clinging dependency on the other person and engage in manipulation to try to maintain the relationship. They become angry if the other person limits the relationship, but also deny that they care about the person. As a defence against fear of abandonment, borderline people are compulsively social. But their behaviours, including their intense anger, demands, and suspiciousness, repel people.

People with BPD often deal with stress by engaging in self-destructive behaviours, for instance by being sexually promiscuous, getting into fights, binge eating and purging, engaging in self-mutilation or drug abuse, and threatening suicide. These behaviours are designed to call forth a “saving” response from the other person. People with BPD are a continuing burden for police, hospitals, and therapists. Borderline individuals also show disturbance in their concepts of identity: they are uncertain about self-image, gender identity, values, loyalties, and goals. They may have chronic feelings of emptiness or boredom and be unable to tolerate being alone.

BPD has both genetic and environmental roots. In terms of genetics, research has found that those with BPD frequently have neurotransmitter imbalances (Zweig-Frank et al., 2006), and the disorder is heritable (Minzenberg, Poole, & Vinogradov, 2008). In terms of environment, many theories about the causes of BPD focus on a disturbed early relationship between the child and his or her parents. Some theories focus on the development of attachment in early childhood, while others point to parents who fail to provide adequate attention to the child's feelings. Others focus on parental abuse (both sexual and physical) in adolescence, as well as on divorce, alcoholism, and other stressors (Lobbestael & Arntz, 2009). The dangers of BPD are greater when they are associated with childhood sexual abuse, early age of onset, substance abuse, and aggressive behaviours. The problems are amplified when the diagnosis is comorbid (as it often is) with other disorders, such as substance abuse disorder, major depressive disorder, and post-traumatic stress disorder (PTSD) (Skodol et al., 2002).

Research Focus: Affective and Cognitive Deficits in BPD

Posner et al. (2003) hypothesized that the difficulty that individuals with BPD have in regulating their lives (e.g., in developing meaningful relationships with other people) may be due to imbalances in the fast and slow emotional pathways in the brain. Specifically, they hypothesized that the fast emotional pathway through the amygdala is too active, and the slow cognitive-emotional pathway through the prefrontal cortex is not active enough in those with BPD.

The participants in their research were 16 patients with BPD and 14 healthy comparison participants. All participants were tested in a functional magnetic resonance imaging (fMRI) machine while they performed a task that required them to read emotional and nonemotional words, and then press a button as quickly as possible whenever a word appeared in a normal font and not press the button whenever the word appeared in an italicized font.

The researchers found that while all participants performed the task well, the patients with BPD had more errors than the controls (both in terms of pressing the button when they should not have and not pressing it when they should have). These errors primarily occurred on the negative emotional words.

Figure 13.15 shows the comparison of the level of brain activity in the emotional centres in the amygdala (left panel) and the prefrontal cortex (right panel). In comparison to the controls, the BPD patients showed relatively larger affective responses when they were attempting to quickly respond to the negative emotions, and showed less cognitive activity in the prefrontal cortex in the same conditions. This research suggests that excessive affective reactions and lessened cognitive reactions to emotional stimuli may contribute to the emotional and behavioural volatility of borderline patients.

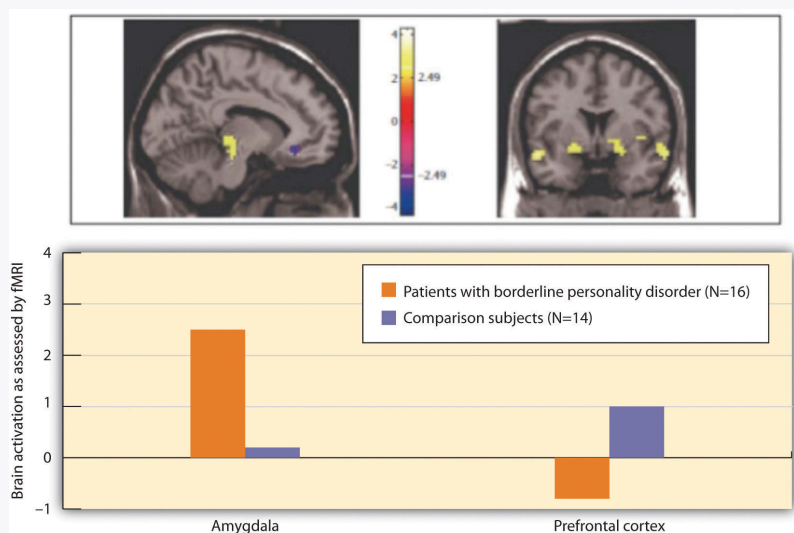


Figure 13.15 BPD Research. Individuals with BPD showed less cognitive and greater emotional brain activity in response to negative emotional words.

Antisocial Personality Disorder (APD)

In contrast to borderline personality disorder, which involves primarily feelings of inadequacy and a fear of abandonment, antisocial personality disorder (APD) is characterized by a disregard of the rights of others, and a tendency to violate those rights without being concerned about doing so. **APD** is a *pervasive pattern of violation of the rights of others that begins in childhood or early adolescence and continues into adulthood*. APD is about three times more likely to be diagnosed in men than in women. To be diagnosed with APD the person must be 18 years of age or older and have a documented history of conduct disorder before the age of 15. People having antisocial personality disorder are sometimes referred to as “sociopaths” or “psychopaths.”

People with APD feel little distress for the pain they cause others. They lie, engage in violence against animals and people, and frequently have drug and alcohol abuse problems. They are egocentric and frequently impulsive, for instance suddenly changing jobs or relationships. People with APD soon end up with a criminal record and often spend time incarcerated. The intensity of antisocial symptoms tends to peak during the 20s and then may decrease over time.

Biological and environmental factors are both implicated in the development of antisocial personality disorder (Rhee & Waldman, 2002). Twin and adoption studies suggest a genetic predisposition (Rhee & Waldman, 2002), and biological abnormalities include low autonomic activity during stress, biochemical imbalances, right hemisphere abnormalities, and reduced gray matter in the frontal lobes (Lyons-Ruth et al., 2007; Raine, Lencz, Bihrlé, LaCasse, & Colletti, 2000). Environmental factors include neglectful and abusive parenting styles, such as the use of harsh and inconsistent discipline and inappropriate modelling (Huesmann & Kirwil, 2007).

Key Takeaways

- A personality disorder is a disorder characterized by inflexible patterns of thinking, feeling, or relating to others that causes problems in personal, social, and work situations.
- Personality disorders are categorized into three clusters, characterized by odd or eccentric behaviour, dramatic or erratic behaviour, and anxious or inhibited behaviour.
- Although they are considered as separate disorders, the personality disorders are essentially milder versions of more severe Axis I disorders.
- *Borderline personality disorder* is a prolonged disturbance of personality accompanied by mood swings, unstable personal relationships, and identity problems, and it is often associated with suicide.
- *Antisocial personality disorder* is characterized by a disregard of others' rights and a tendency to violate those rights without being concerned about doing so.

Exercises and Critical Thinking

1. What characteristics of men and women do you think make them more likely to have APD and BDP, respectively? Do these differences seem to you to be more genetic or more environmental?
2. Do you know people who suffer from antisocial personality disorder? What behaviours do they engage in, and why are these behaviours so harmful to them and others?

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Image Attributions

Figure 13.15: Adapted from Posner et al., 2003.

Notes

1. Adapted from American Psychiatric Association, 2013

13.6 Somatoform, Factitious, and Sexual Disorders

Learning Objectives

1. Differentiate the symptoms of somatoform and factitious disorders.
2. Summarize the sexual disorders and paraphilias.

Although mood, anxiety, and personality disorders represent the most prevalent psychological disorders, there are a variety of other disorders that affect people. This complexity of symptoms and classifications helps make it clear how difficult it is to accurately and consistently diagnose and treat psychological disorders. In this section we will review three other disorders that are of interest to psychologists and that affect millions of people: *somatoform disorder*, *factitious disorder*, and *sexual disorder*.

Somatoform and Factitious Disorders

Somatoform and factitious disorders both occur in cases where psychological disorders are related to the experience or expression of physical symptoms. The important difference between them is that in somatoform disorders the physical symptoms are real, whereas in factitious disorders they are not.

One case in which psychological problems create real physical impairments is in the somatoform disorder known as somatization disorder (also called Briquet's syndrome or Brissaud-Marie syndrome). **Somatization disorder** is a psychological disorder in which a person experiences numerous long-lasting but seemingly unrelated physical ailments that have no identifiable physical cause. A person with somatization disorder might complain of joint aches, vomiting, nausea, muscle weakness, and sexual dysfunction. The symptoms that result from a somatoform disorder are real and cause distress to the individual, but they are due entirely to psychological factors. The somatoform disorder is more likely to occur when the person is under stress, and it may disappear naturally over time. Somatoform disorder is more common in women than in men, and usually first appears in adolescents or those in their early 20s.

Another type of somatoform disorder is **conversion disorder**, a psychological disorder in which patients experience specific neurological symptoms such as numbness, blindness, or paralysis, but where no neurological explanation is observed or possible (Agaki & House, 2001). The difference between conversion and somatoform disorders is in terms of the location of the physical complaint. In somatoform disorder the malaise is general, whereas in conversion disorder there are one or several specific neurological symptoms.

Conversion disorder gets its name from the idea that the existing psychological disorder is "converted" into the physical symptoms. It was the observation of conversion disorder (then known as *hysteria*) that first led Sigmund Freud to become interested in the psychological aspects of illness in his work with Jean-Martin Charcot. Conversion disorder is not common (a prevalence of less than 1%), but it may in many cases be undiagnosed. Conversion disorder occurs twice or more frequently in women than in men.

There are two somatoform disorders that involve preoccupations. We have seen an example of one of them, *body dysmorphic disorder*, in the Chapter 13, “Defining Psychological Disorders,” opener. Body dysmorphic disorder (BDD) is a psychological disorder accompanied by an imagined or exaggerated defect in body parts or body odour. There are no sex differences in prevalence, but men are most often obsessed with their body build, their genitals, and hair loss, whereas women are more often obsessed with their breasts and body shape. BDD usually begins in adolescence.

Hypochondriasis (hypochondria) is another *psychological disorder that is focused on preoccupation, accompanied by excessive worry about having a serious illness*. The patient often misinterprets normal body symptoms such as coughing, perspiring, headaches, or a rapid heartbeat as signs of serious illness, and the patient’s concerns remain even after he or she has been medically evaluated and assured that the health concerns are unfounded. Many people with hypochondriasis focus on a particular symptom such as stomach problems or heart palpitations.

Two other psychological disorders relate to the experience of physical problems that are not real. Patients with factitious disorder fake physical symptoms in large part because they enjoy the attention and treatment that they receive in the hospital. They may lie about symptoms, alter diagnostic tests such as urine samples to mimic disease, or even injure themselves to bring on more symptoms. In the more severe form of factitious disorder known as **Münchhausen syndrome**, *the patient has a lifelong pattern of a series of successive hospitalizations for faked symptoms*.

Factitious disorder is distinguished from another related disorder known as **malinger**, which also *involves fabricating the symptoms of mental or physical disorders, but where the motivation for doing so is to gain financial reward; to avoid school, work, or military service; to obtain drugs; or to avoid prosecution*.

The somatoform disorders are almost always comorbid with other psychological disorders, including anxiety and depression and dissociative states (Smith et al., 2005). People with BDD, for instance, are often unable to leave their house, are severely depressed or anxious, and may also suffer from other personality disorders.

Somatoform and factitious disorders are problematic not only for the patient; they also have societal costs. People with these disorders frequently follow through with potentially dangerous medical tests and are at risk for drug addiction from the drugs they are given and for injury from the complications of the operations they submit to (Bass, Peveler, & House, 2001; Looper & Kirmayer, 2002). In addition, people with these disorders may take up hospital space that is needed for people who are really ill. To help combat these costs, emergency room and hospital workers use a variety of tests for detecting these disorders.

Sexual Disorders

Sexual disorders refer to a variety of problems revolving around performing or enjoying sex. These include disorders related to *sexual function, gender identity, and sexual preference*.

Disorders of Sexual Function

Sexual dysfunction is a *psychological disorder that occurs when the physical sexual response cycle is inadequate for reproduction or for sexual enjoyment*. There are a variety of potential problems (Table 13.6, “Sexual Dysfunctions as Described in the *DSM*”), and their nature varies for men and women (Figure 13.16, “Prevalence of Sexual Dysfunction in Men and Women”). Sexual disorders affect up to 43% of women and 31% of men (Laumann, Paik, & Rosen, 1999). Sexual disorders are often difficult to diagnose because in many cases the dysfunction occurs

at the partner level (one or both of the partners are disappointed with the sexual experience) rather than at the individual level.

Table 13.6 Sexual Dysfunctions as Described in the *DSM*.¹

[Skip Table]	
Disorder	Description
Hypoactive sexual desire disorder	Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity
Sexual aversion disorder	Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner
Female sexual arousal disorder	Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement
Male erectile disorder	Persistent or recurrent inability to attain or maintain an adequate erection until completion of the sexual activity
Female orgasmic disorder	Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase
Male orgasmic disorder	Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity
Premature ejaculation	Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it
Dyspareunia	Recurrent or persistent genital pain associated with sexual intercourse in either a male or a female
Vaginismus	Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse

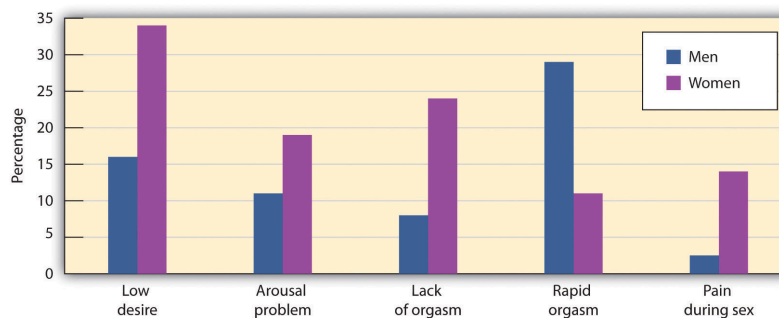


Figure 13.16 Prevalence of Sexual Dysfunction in Men and Women. This chart shows the percentage of respondents who reported each type of sexual difficulty over the previous 12 months. [\[Long Description\]](#)

Hypoactive sexual desire disorder, one of the most common sexual dysfunctions, refers to a *persistently low or nonexistent sexual desire*. How low sexual desire is defined, however, is problematic because it depends on the person's sex and age, on cultural norms, as well as on the relative desires of the individual and the partner. Again, the importance of dysfunction and distress is critical. If neither partner is much interested in sex, for instance, the lack of interest may not cause a problem. Hypoactive sexual desire disorder is often comorbid with other psychological disorders, including mood disorders and problems with sexual arousal or sexual pain (Donahay & Carroll, 1993).

Sexual aversion disorder refers to an *avoidance of sexual behaviour caused by disgust or aversion to genital contact*. The aversion may be a phobic reaction to an early sexual experience or sexual abuse, a misattribution of negative emotions to sex that are actually caused by something else, or a reaction to a sexual problem such as erectile dysfunction (Kingsberg & Janata, 2003).

Female sexual arousal disorder refers to *persistent difficulties becoming sexually aroused or sufficiently lubricated in response to sexual stimulation in women*. The disorder may be comorbid with hypoactive sexual desire or orgasmic disorder, or mood or anxiety disorders.

Male erectile disorder (sometimes referred to as impotence) refers to *persistent and dysfunctional difficulty in achieving or maintaining an erection sufficient to complete sexual activity*. Prevalence rates vary by age, from about 6% of university-aged males to 35% of men in their 70s. About half the men aged 40 to 70 report having problems getting or maintaining an erection “now and then.”

Most erectile dysfunction occurs as a result of physiological factors, including illness, and the use of medications, alcohol, or other recreational drugs. Erectile dysfunction is also related to anxiety, low self-esteem, and general problems in the particular relationship. Assessment for physiological causes of erectile dysfunction is made using a test in which a device is attached to the man’s penis before he goes to sleep. During the night the man may have an erection, and if he does the device records its occurrence. If the man has erections while sleeping, this provides assurance that the problem is not physiological.

One of the most common sexual dysfunctions in men is *premature ejaculation*. It is not possible to exactly specify what defines premature, but if the man ejaculates before or immediately upon insertion of the penis into the vagina, most clinicians will identify the response as premature. Most men diagnosed with **premature ejaculation** *ejaculate within one minute after insertion* (Waldinger, 2003). Premature ejaculation is one of the most prevalent sexual disorders and causes much anxiety in many men.

Female orgasmic disorder refers to *the inability to obtain orgasm in women*. The woman enjoys sex and foreplay and shows normal signs of sexual arousal but cannot reach the peak experience of orgasm. *Male orgasmic disorder* includes a delayed or retarded ejaculation (very rare) or (more commonly) premature ejaculation.

Finally, **dyspareunia** and **vaginismus** refer to *sexual pain disorders that create pain and involuntary spasms, respectively, in women, and thus make it painful to have sex*. In most cases these problems are biological and can be treated with hormones, creams, or surgery.

Sexual dysfunctions have a variety of causes. In some cases the primary problem is biological, and the disorder may be treated with medication. Other causes include a repressive upbringing in which the parents have taught the person that sex is dirty or sinful, or the experience of sexual abuse (Beitchman, Zucker, Hood, & DaCosta, 1992). In some cases the sex problem may be due to the fact that the person has a different sexual orientation than he or she is engaging in. Other problems include poor communication between the partners, a lack of sexual skills, and (particularly for men) performance anxiety.

It is important to remember that most sexual disorders are temporary — they are experienced for a period of time, in certain situations or with certain partners, and then (without, or if necessary with, the help of therapy) go away. It is also important to remember that there are a wide variety of sex acts that are enjoyable. Couples with happy sex lives work together to find ways that work best for their own styles. Sexual problems often develop when the partners do not communicate well with each other, and are reduced when they do.

Gender Identity Disorder

Gender identity refers to the *identification with a sex*. Most children develop an appropriate attachment to their own sex. In some cases, however, children or adolescents — sometimes even those as young as three or four years old — believe that they have been trapped in a body of the wrong sex. **Gender identity disorder** (GID, or transsexualism) is diagnosed *when the individual displays a repeated and strong desire to be the other sex, a persistent discomfort with one's sex, and a belief that one was born the wrong sex, accompanied by significant dysfunction and distress*. GID usually appears in adolescence or adulthood and may intensify over time (Bower, 2001). Since many cultures strongly disapprove of cross-gender behaviour, it often results in significant problems for affected persons and those in close relationships with them.

Gender identity disorder is rare, occurring only in about one in every 12,000 males and one in every 30,000 females (Olsson & Möller, 2003). The causes of GID are as of yet unknown, although they seem to be related in part to the amount of testosterone and other hormones in the uterus (Kraemer, Noll, Delsignore, Milos, Schnyder, & Hepp, 2009).



Figure 13.17 Transsexuality.

The classification of GID as a mental disorder has been challenged because people who suffer from GID do not regard their own cross-gender feelings and behaviours as a disorder and do not feel that they are distressed or dysfunctional (Figure 13.17, “Transsexuality”). People suffering from GID often argue that a “normal” gender identity may not necessarily involve an identification with one’s own biological sex. GID represents another example, then, of how culture defines disorder; the 2013 *DSM* has changed the categorizations used in this domain.

Paraphilias

A third class of sexual disorders relates to sexual practices and interest. In some cases sexual interest is so unusual that it is known as a **paraphilia** — *a sexual deviation where sexual arousal is obtained from a consistent pattern of inappropriate responses to objects or people, and in which the behaviours associated with the feelings are distressing and dysfunctional*. Paraphilias may sometimes be only fantasies, and in other cases may result in actual sexual behaviour (Table 13.7, “Some Paraphilias”).

Table 13.7 Some Paraphilias.

Paraphilia	Behaviour or fantasy that creates arousal
Bestiality	Sex with animals
Exhibitionism	Exposing genitals to an unsuspecting person
Fetishism	Nonliving or unusual objects or clothing of the opposite sex
Frotteurism	Rubbing up against unsuspecting persons
Masochism	Being beaten, humiliated, bound, or otherwise made to suffer
Pedophilia	Sexual activity with a prepubescent child
Sadism	Witnessing suffering of another person
Voyeurism	Observing an unsuspecting person who is naked, disrobing, or engaged in intimate behaviour

People with paraphilias are usually rejected by society but for two different reasons. In some cases, such as *voyeurism* and *pedophilia*, the behaviour is unacceptable (and illegal) because it involves a lack of consent on the part of the recipient of the sexual advance. But other paraphilias are rejected simply because they are unusual, even though they are consensual and do not cause distress or dysfunction to the partners. *Sexual sadism* and *sexual masochism*, for instance, are usually practiced consensually, and thus may not be harmful to the partners or to society. A recent survey found that individuals who engage in sadism and masochism are as psychologically healthy as those who do not (Connolly, 2006). Again, as cultural norms about the appropriateness of behaviours change, the new revision of the *DSM* (2013), changed its classification system of these behaviours.

Key Takeaways

- Somatoform disorders, including body dysmorphic disorder and hypochondriasis, occur when people become excessively and inaccurately preoccupied with the potential that they have an illness or stigma.
- Patients with factitious disorder fake physical symptoms in large part because they enjoy the attention and treatment that they receive in the hospital. In the more severe form of factitious disorder known as Münchhausen syndrome, the patient has a lifelong pattern with a series of successive hospitalizations for faked symptoms.
- Sexual dysfunction is a psychological disorder that occurs when the physical sexual response cycle is inadequate for reproduction or for sexual enjoyment. The types of problems experienced

are different for men and women. Many sexual dysfunctions are only temporary or can be treated with therapy or medication.

- Gender identity disorder (GID, also called transsexualism) is a rare disorder that is diagnosed when the individual displays a repeated and strong desire to be the other sex, a persistent discomfort with one's sex, and a belief that one was born the wrong sex, accompanied by significant dysfunction and distress.
- The classification of GID as a mental disorder has been challenged because people who suffer from it do not regard their own cross-gender feelings and behaviours as a disorder and do not feel that they are distressed or dysfunctional.
- A paraphilia is a sexual deviation where sexual arousal is obtained from a consistent pattern of inappropriate responses to objects or people, and in which the behaviours associated with the feelings are distressing and dysfunctional. Some paraphilias are illegal because they involve a lack of consent on the part of the recipient of the sexual advance, but other paraphilias are simply unusual, even though they may not cause distress or dysfunction.

Exercises and Critical Thinking

1. Consider the biological, personal, and social-cultural aspects of gender identity disorder. Do you think that this disorder is really a “disorder,” or is it simply defined by social-cultural norms and beliefs?
2. Consider the paraphilias in Table 13.7, “Some Paraphilias.” Do they seem like disorders to you, and how would one determine if they were or were not?
3. View one of the following films and consider the diagnosis that might be given to the characters in it: *Antwone Fisher*, *Ordinary People*, *Girl Interrupted*, *Grosse Pointe Blank*, *A Beautiful Mind*, *What About Bob?*, *Sybil*, *One Flew Over the Cuckoo's Nest*.

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Image Attributions

Figure 13.16: Adapted from Laumann, Paik, & Rosen, 1999.

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Long Descriptions

Figure 13.16 long description: Prevalence of sexual dysfunction in men and women.

Type of Sexual Dysfunction	Percentage of men	Percentage of women
Low desire	16%	34%
Arousal problem	11%	19%
Lack of orgasm	8%	24%
Rapid orgasm	29%	11%
Pain during sex	3%	14%

[\[Return to Figure 13.16\]](#)

Notes

1. Adapted from American Psychiatric Association, 2000.

13.7 Chapter Summary

More psychologists are involved in the diagnosis and treatment of psychological disorder than in any other aspect of psychology.

About 10% to 15% of Canadians are estimated to be affected by a psychological disorder during any one year. The impact of mental illness is particularly strong on people who are poorer, of lower socioeconomic class, and from disadvantaged ethnic groups.

A psychological disorder is an unusual, distressing, and dysfunctional pattern of thought, emotion, or behaviour. Psychological disorders are often comorbid, meaning that a given person suffers from more than one disorder.

The stigma of mental disorder affects people while they are ill, while they are healing, and even after they have healed. But mental illness is not a fault, and it is important to work to help overcome the stigma associated with disorder.

All psychological disorders are determined by multiple biological, psychological, and social factors.

Psychologists diagnose disorder using the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The *DSM* organizes the diagnosis of disorder according to five dimensions (or axes) relating to different aspects of disorder or disability. The *DSM* uses categories, and patients with close approximations to the prototype are said to have that disorder.

One critique of the *DSM* is that many disorders — for instance, attention-deficit/hyperactivity disorder (ADHD), autistic disorder, and Asperger's disorder — are being diagnosed significantly more frequently than they were in the past.

Anxiety disorders are psychological disturbances marked by irrational fears, often of everyday objects and situations. They include generalized anxiety disorder (GAD), panic disorder, phobia, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD). Anxiety disorders affect about 350,000 Canadians every year.

Dissociative disorders are conditions that involve disruptions or breakdowns of memory, awareness, and identity. They include dissociative amnesia, dissociative fugue, and dissociative identity disorder.

Mood disorders are psychological disorders in which the person's mood negatively influences his or her physical, perceptual, social, and cognitive processes. They include dysthymia, major depressive disorder, and bipolar disorder. Mood disorders affect about 5% of Canadians every year.

Schizophrenia is a serious psychological disorder marked by delusions, hallucinations, loss of contact with reality, inappropriate affect, disorganized speech, social withdrawal, and deterioration of adaptive behaviour. About 350,000 Canadians have schizophrenia.

A personality disorder is a long-lasting but frequently less severe disorder characterized by inflexible patterns of thinking, feeling, or relating to others that causes problems in personal, social, and work situations. They are characterized by odd or eccentric behaviour, by dramatic or erratic behaviour, or by anxious or inhibited behaviour.

Two of the most important personality disorders are borderline personality disorder (BPD) and antisocial personality disorder (APD).

Somatization disorder is a psychological disorder in which a person experiences numerous long-lasting but seemingly unrelated physical ailments that have no identifiable physical cause. Somatization disorders include conversion disorder, body dysmorphic disorder (BDD), and hypochondriasis.

Patients with factitious disorder fake physical symptoms in large part because they enjoy the attention and treatment that they receive in the hospital.

Sexual disorders refer to a variety of problems revolving around performing or enjoying sex. Sexual dysfunctions include problems relating to loss of sexual desire, sexual response or orgasm, and pain during sex.

Gender identity disorder (GID, also called transsexualism) is diagnosed when the individual displays a repeated and strong desire to be the other sex, a persistent discomfort with one's sex, and a belief that one was born the wrong sex, accompanied by significant dysfunction and distress. The classification of GID as a mental disorder has been challenged because people who suffer from GID do not regard their own cross-gender feelings and behaviours as a disorder and do not feel that they are distressed or dysfunctional.

A paraphilia is a sexual deviation where sexual arousal is obtained from a consistent pattern of inappropriate responses to objects or people, and in which the behaviours associated with the feelings are distressing and dysfunctional.