

# Abnormal Behavior

## 13.1 Defining Psychological Disorders

This chapter describes how psychological disorders are defined and diagnosed and presents explanations of their possible causes.

Because it is often difficult to distinguish normal from abnormal behavior, there have been several approaches for defining **abnormal behavior**. None of the definitions presented, however, is broad enough to cover all instances of abnormal or psychological disorders.

### **Deviation from Average (Statistical Approach)**

A statistical definition. Behaviors that are infrequent or rare are considered abnormal. The problem is that not all rare behaviors (e.g., genius) are abnormal.

### **Deviation from Ideal (Valuative Approach)**

Considers standard behavior or what most people do. Abnormal behavior occurs when behavior deviates from the norm or what most people do. Problems with this definition are that norms change over time and people don't always agree on what ideal behavior is.

### **Subjective Discomfort (Personal Approach)**

Behavior is abnormal if it produces distress or anxiety in an individual. A

problem with this definition is that people may be feeling no distress but may be engaging in bizarre behaviors.

#### **Inability to Function (Practical Approach)**

Inability to function effectively and adapt to the demands of society are considered symptoms of abnormal behavior according to this definition. This definition does not consider personal choice.

**Insanity** is a legal term and indicates that a person cannot be held responsible for his or her actions because of mental illness.

### **13.2 Models of Psychopathology**

Psychologists use different models to understand and explain psychological disorders. A **model** is a representation that helps to organize knowledge.

#### **Medical Model (Biological Model)**

Assumes the underlying cause or **etiology** of a mental disorder has a biological basis. Views psychopathology as similar to physical illness. Medication and medical therapies are often used as treatments.

#### **Learning Model**

Abnormal behaviors are learned the same way as normal behaviors—through conditioning, reinforcements, imitation, etc. Abnormal behaviors are not considered symptoms of some underlying disease—the behaviors themselves are the problem. Treatments consist of retraining and conditioning.

#### **Psychoanalytic Model (Psychodynamic Model)**

Abnormal behaviors represent unconscious motives and conflicts. Psychoanalysis is used as treatment.

Humanistic-Existential Model  
*فلسفة الوجودية*

(Phenomenological Model)  
*النموذج الفينومولوجي*

Cognitive Model  
*النموذج المعرفي*

Abnormal behaviors occur as a result of failure to fulfill one's self-potential. Emphasizes the effects of a faulty self-image. Client-centered and Gestalt therapies are used to increase self-acceptance.

*ألمة سوء*  
Faulty or negative thinking can cause depression or anxiety. Focus of treatment is on changing faulty, irrational, or negative thinking.

### 13.3 Diagnosing and Classifying Psychological Disorders */aɪθ/*

A number of schemes have been developed for classifying and diagnosing psychological disorders. No scheme is perfect, however, and all have been criticized.

One standard system that is used by most professionals is the **Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)**, which is published by the American Psychiatric Association. DSM-IV describes more than 300 specific mental disorders. A historical overview of the DSM.

**DSM**

Published in 1952 according to a format that had been used by the army during World War II.

**DSM-II**

In 1968 the DSM was revised to conform with different classifications used by the World Health Organization.

**DSM-III**

A 1977 revision that described mental disorders in greater detail.

**DSM-III-R**

A 1987 revision of the third edition which clarified and updated DSM-III.

**DSM-IV**

Published in 1994, this is the latest edition.

**DSM-IV-TR**

Released in 2000, this text revision saw most of its changes in Associated Features and Disorders; Specific Culture, Age, and Gender Features; Prevalence; Course; and the Familial Pattern sections.

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DSM-IV evaluates each individual according to five dimensions or axes and is therefore considered a multi<sup>10</sup>axial system of classification.

- Axis I** Describes any mental disorder or clinical syndrome that might be present.
- Axis II** Describes any personality disorder that might be present.
- Axis III** Describes any physical or medical <sup>disease</sup> disorders that might be present.
- Axis IV** Rates severity of psychosocial stressors in the individual's life during the past year.
- Axis V** Assesses level of adaptive functioning currently and during the past year.

The major categories of mental disorders described in DSM-IV are described in the remaining sections of this chapter.

### 13.4 Anxiety Disorders

*Description.* Intense feelings of apprehension and anxiety that impede daily functioning. Approximately 8 – 15% of adults in this country are affected by anxiety disorders.

*Types.* Different types of anxiety disorders include:

**Generalized anxiety Disorders** Characterized by continuous, long-lasting uneasiness and tension. Person usually cannot identify a specific cause.

**Panic Disorders** Recurrent attacks of overwhelming anxiety that include heart palpitations, shortness of breath, sweating, faintness, and great fear. Often referred to as **panic attacks**.

**Phobic Disorders** Intense, irrational fears of specific objects or situations. Common phobias include fears of snakes, insects, spiders, and mice/

rats. **Agoraphobia** is the fear of being in public places (or away from home) and is often associated with panic disorders.

### **Obsessive-Compulsive Disorders**

**Obsessions** are persistent, unwanted thoughts that are unreasonable (e.g., worry over germs). **Compulsions** are repetitive behaviors performed according to certain rules or rituals (e.g., repetitive counting or checking).

*Causes.* No one theory or model adequately explains all cases of anxiety disorders. **Genetic factors** play a role; if one identical twin has a panic disorder, for example, there is a 30% chance that the other twin will have it also. **Chemical deficiencies** in the brain (low levels of certain **neurotransmitters**) and an overreaction to **lactic acid** may produce some kinds of anxiety disorder, especially **obsessive-compulsive disorder**. Anxiety can also be a **learned response** to stress. They can also be inappropriate and inaccurate **cognitions** about one's world.

## **13.5 Somatoform Disorders**

*Description.* Patterns of behavior characterized by complaints of physical symptoms in the absence of any real physical illness. About 1 person in 300 has a somatoform disorder, and they are slightly more common in women than in men.

*Types.* Hypochondriasis and conversion disorder are the two main types of somatoform disorders.

### **Hypochondriasis**

Involves a constant fear of illness, and normal aches and pains are misinterpreted as signs of disease.

### **Conversion Disorder**

An appearance of a physical disturbance or illness that is caused by psychological reasons. Usually has a rapid onset. Numbness or paralysis, such as **glove anesthesia**, for example.

*Cause.* Conversion disorders seem to occur when an individual is under some kind of stress. The physical condition allows the person to escape or reduce the source of this stress.

### 13.6 Mood Disorders

*Description.* Mood disorders involve moods or emotions that are extreme and unwarranted. These disturbances in emotional feelings are strong enough to intrude on everyday living.

*Types.* The most serious types of mood disorders are major depression and bipolar disorders.

#### Major Depression

Characterized by frequent episodes of intense hopelessness, lowered self-esteem, problems concentrating and making decisions, changes in eating and sleeping patterns, fatigue, reduced sex drive, and thoughts of death. Occurs twice as frequently among females as males. Can occur at any time during the life cycle; an estimated 5–8% of all Americans will suffer from major depression at least once in their lifetime. Approximately one-half of people who attempt suicide are depressed.

#### Dysthymic Disorder

More common and less severe than major depression. Similar symptoms as major depression, but they are less intense and last for a longer period (at least two years).

#### Seasonal Affective Disorder (SAD)

Depressive symptoms occur during the winter months when the periods of daylight are shorter. Usually crave extra sleep and eat more carbohydrates.

#### Bipolar I Disorder

Characterized by two emotional extremes—depression and mania. **Mania** is

an elated, very active emotional state. Manic episodes alternate every few days, weeks, or years with periods of deep depression. Sometimes mood swings and behavior are severe enough to be classified as psychosis.

### **Bipolar II Disorder**

Also characterized by extreme mood swings. Episodes include depression and at least one episode of **hypomania** (mania that is not severe enough to interfere with everyday life).

### **Cyclothymia**

A slightly more common pattern of less extreme mood swings than bipolar disorder.

*Causes.* Both psychological and biological theories have been proposed to explain the cause of mood disorders. There is evidence that both are correct.

Traditional **psychodynamic theory** states, for example, that depression is more frequent in people with strong dependency needs and represents anger or aggression turned inward at oneself.

Other theorists have related mood disorders to cognitive or learning factors. For instance, **Martin Seligman** suggested that depression results from **learned helplessness** or a state where people feel a lack of control over their lives and believe that they cannot cope and escape from stress so they give up trying and become depressed. **Aaron Beck** proposed that faulty thinking or cognitions cause depression because depressed people typically see themselves as losers, blaming themselves when anything goes wrong. **Learning theorists** propose that depression is learned through reinforcement or imitation of depressive behaviors.

Biological factors also appear to play a role in mood disorders. For instance, there is evidence that depression can be caused by a **chemical imbalance** in the brain because the **norepinephrine** and **serotonin** systems are malfunctioning. The cyclical nature of many mood disorders suggests that abnormalities in **biological rhythms** may also play a role. **Genetics** may also play a role. This appears

especially true for bipolar disorder. For example, if one member of an identical-twin pair develops bipolar disorder, 72% of the other members usually develop the disorder. Children with depressed parents are also more likely to develop depression.

### 13.7 Dissociative Disorders

*Description.* Characterized by a loss of contact with portions of consciousness or memory, resulting in disruptions in one's sense of self. They appear to be an attempt to overcome anxiety and stress by dissociating oneself from the core of one's personality and result in a loss of memory, identity, or consciousness.

*Types.* The major dissociative disorders are:

**Psychogenic Amnesia** Either partial or total memory loss that can last from a few hours to many years. Usually remembers nonthreatening aspects of life. There appears to be no physical cause but often results from stress. (That is, one "doesn't remember" stressful aspects of one's life.)

**Psychogenic Fugue** People suddenly leave or "flee" their present life and establish a new, different existence and identity in a new location. Their former life is blocked from memory. Often they return from their fugue state to their former life just as suddenly as they left.

**Multiple Personality Disorder** One person develops two or more distinct personalities.

*Cause.* Dissociative disorders allow people to escape from an anxiety producing situation. The person either produces a new personality to deal with the stress, or the situation that caused the stress is forgotten or left behind. For instance, researchers have found that about 94% of people with multiple personalities were abused as children. Not all abused children, however, exhibit multiple personalities.



## 13.8 Personality Disorders

*Description.* Personality disorders are patterns of traits that are long-standing, maladaptive, and inflexible and keep a person from functioning properly in society. Behavior often disrupts social relationships. Personality disorders are coded on **Axis II** of the **DSM-IV** system for diagnosing mental disorders (see section 5.3 above).

*Types.* Representative types of personality disorders are described below.

- Antisocial** Displays no regard for moral or ethical rules and continuously violates the rights of others. Is manipulative, impulsive, and lacks feelings for others. Also appears to lack a conscience or guilt.
- Narcissistic** An exaggerated sense of self and self-importance; preoccupied with fantasies of success. Lacks empathy. Often expects special treatment.
- Paranoid** Continual unjustified suspicion and mistrust of people. Often appears cold and unemotional. Easily offended.
- Histrionic** Overreacts and overdramatic in response to minor situations. Often seen as vain, shallow, dependent, or manipulative.
- Avoidant** Tends to be a "loner," or social snob. Oversensitive to rejection or possible humiliation. Has low self-esteem.
- Schizotypal** Not disturbed enough to be diagnosed as schizophrenic. Strangeness in thinking, speech, and behavior.

*Causes.* Suggested causes for personality disorders range from problems in family relationships to a biological inability to experience emotions. A growing body of evidence indicates that biological problems may be the cause of many personality disorders.

### 13.9 Schizophrenic Disorders

*Description.* **Schizophrenia** is a serious **psychotic disorder** (i.e., one is out-of-touch with reality). Schizophrenia is **NOT** the same as multiple personality disorder described previously with the dissociative disorders. Schizophrenia includes **disorders of thought**. Schizophrenics display problems in both how they think and what they think.

Schizophrenic thinking is often **incoherent**. For instance, they sometimes use **neologisms** or words that only have meaning to the person speaking them (e.g., the word “glump”). **Loose associations**, where thought appears logically unconnected, is another characteristic that is sometimes seen. **Word salad** describes a jumble of words that are spoken that do not make sense.

The **content** of a schizophrenic’s thinking is also disturbed. Various kinds of delusions are common. **Delusions** are false beliefs that are maintained even though they are clearly out of touch with reality. Common delusions are beliefs that they are being controlled by someone else, that someone is out to get them, that they are a famous person from history (e.g., the President of the United States), and that their thoughts are being broadcast so that others are able to know what they are thinking.

A person with schizophrenia may also experience **hallucinations** or the experience of perceiving things that do not actually exist. The most common hallucination is hearing voices that do not exist.

Schizophrenics also tend to display **flat** (absent) or **inappropriate affect**. Even dramatic events tend to produce little or no emotional reaction from a schizophrenic. The emotional responses they do display often are bizarre and unexpected.

A person with schizophrenia usually has little interest in others and appears **socially withdrawn**.

**Abnormal motor behavior** may also occur, such as unusual pacing back and forth, rocking constantly, or being immobilized for long periods of time.

Schizophrenia usually involves a noticeable **deterioration in functioning**. That is, the person used to function adaptively (and did

not display symptoms of schizophrenia) but now the quality of work, social relations, and personal care have deteriorated. Their previous level of functioning has broken down.

*Types.* Five major subtypes of schizophrenia are described in DSM-IV.

### **Disorganized**

Severe deterioration of adaptive behavior. Speech incoherent. Strange facial grimaces common. Inappropriate silliness, babbling, giggling, and obscene behavior may be displayed. Includes 5% of schizophrenics.

### **Catatonic**

Characterized by disordered movement. Alternates between extreme withdrawal where the body is kept very still and extreme excitement where movement is rapid and speech incoherent. **Waxy flexibility** describes the odd posturing. Makes up about 8% of all cases.

### **Paranoid**

Delusions of persecution or grandeur. Judgment is impaired and unpredictable. Often includes anxiety, anger, jealousy, or argumentativeness. Hallucinations are common. Tends to appear later in life than the other types. Onset is often sudden. Less impaired. Makes up about 40% of all schizophrenics.

### **Undifferentiated**

No one subtype dominates. About 40% of all schizophrenics receive this diagnosis.

### **Residual**

Has had a prior episode of schizophrenia but currently is not displaying major symptoms. Subtle indications of schizophrenia may be observed, however.

*Causes.* Genetic, biological, psychological, and environmental factors have been used to explain the origin of schizophrenia. No one theory, however, can adequately account for all forms of schizophrenia.

Twin studies have suggested a **hereditary or genetic** component to schizophrenia. When one identical twin is identified as schizophrenic, the other twin has a 42 – 48% chance of also developing schizophrenia. Children of schizophrenics who are adopted by nonschizophrenics also have a higher incidence of schizophrenia than control populations. Schizophrenia, therefore, does run in families.

Most people with schizophrenic relatives, however, do not develop schizophrenia. This has led researchers to conclude that what might be inherited is a **predisposition or genetic vulnerability** for schizophrenia. What is needed for schizophrenia to develop is this genetic predisposition plus environmental stress. This is often referred to as the **predisposition or vulnerability model** and the **diathesis-stress model**.

**Neurochemical factors** are also related to schizophrenia. Schizophrenia appears to be accompanied by changes in the activity of one or more **neurotransmitters** in the brain. The **dopamine hypothesis** suggests that schizophrenia occurs when there is excess activity in those areas of the brain using dopamine to transmit nerve impulses. Excessive dopamine appears related to delusions.

Some researchers have suggested that **structural abnormalities in the brain** are linked to schizophrenia. Studies have suggested that schizophrenic individuals have difficulty focusing their attention and display bizarre behaviors because of brain abnormalities. Such structural abnormalities might include shrinking or deterioration of cells in the cerebral cortex that cause enlargements of the brain's fluid-filled ventricles, reduced blood flow in parts of the brain, and abnormalities in **brain lateralization** or in the ways the hemispheres of the brain communicate with each other.

**Psychoanalytic theorists** propose that schizophrenia represents a regression to earlier stages in life when the id was the most dominant aspect of personality.

Other theorists assert that schizophrenia is a learned behavior and consists of a set of inappropriate responses to social stimuli. This is sometimes referred to as the **learned-inattention theory**. Defecative or faulty communication patterns within the family may also be learned and therefore result in schizophrenia. Such faulty communication might include unintelligible speech, stories with no ending,

extensive contradictions, and poor attention to child's attempts at communicating.

The **two-strike theory** suggests a prenatal link to schizophrenia. According to this theory, the **first strike** is an inherited susceptibility of the fetal brain to be disrupted by exposure to the flu virus during the second trimester of pregnancy. The **second strike** occurs when exposure to the flu virus actually occurs during the second trimester of pregnancy. Microscopic examination of the brains of schizophrenics does indicate that whatever is going wrong in their brains probably occurred during the second trimester of pregnancy.

It appears, therefore, that schizophrenia is associated with several possible causes. Schizophrenia is probably not caused by a single factor but by a combination of interrelated variables.