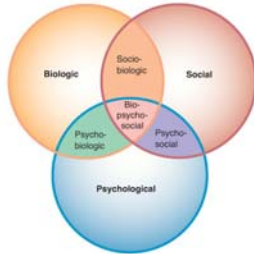


Models of Disorders



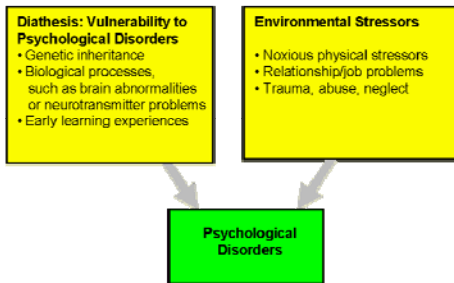
- Biopsychosocial model (George Engel, 1977)
 - Taught in nearly all clinical psychology doctoral programs and medical schools.
 - Bio – Underlying biological causes of disorders (e.g., neurons are firing when they're not supposed to be).
 - Psycho – Underlying psychological causes of disorders (e.g., a tendency to catastrophize problems).
 - Social – Underlying social causes of disorders (e.g., how family dynamics, culture, etc. influence how we think/feel).
- "We are just as interested in what's going on at the family level as we are in what's going on at the cellular level, and we see all these things as interrelated."
- To truly understand and treat disease, one must understand the complex role of biology, psychology, and sociology.
- Rejects the notion that all psychological disorders are the result of underlying medical condition (old "medical model").
 - Indeed, some medical conditions may be the result of psychological factors.



Biopsychosocial Nature of APD



Diathesis-Stress Model



Test of Diathesis-Stress

- Schiffman et al. (2004)
 - Videotaped 265 Danish children (11-13 years old) having lunch in 1972.
 - In 1991, 242 of them given psychiatric evaluation.
 - 16 developed schizophrenia
- Researchers coded videotapes for different behaviors.
 - People who developed schizophrenia later in life were:
 - Less sociable (e.g., less likely to smile, laugh)
 - More likely to produce involuntary hand movements
 - More likely to raise eyebrows, rapidly shift eyes, and produce facial ticks
- Important – these children did **not** have schizophrenia at the time the videotape was made, but you can see differences even before the disease manifested itself.
 - They possessed traits (possibly from birth) associated with schizophrenia, but not the full-blown disorder.
- Most schizophrenics do not show active symptoms (e.g., hallucinations) until later in life, and often after some stressor occurs.

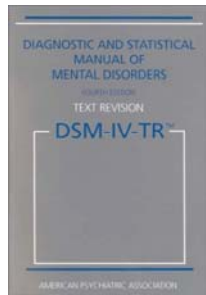
1. Face above hair
2. Hair on nose from above
3. Head (symmetrical) visible at normal angle
4. Eyebrows (like held at inner corner of eye)
5. Hyperextended (back on ears)
6. Excess ear distance
7. Inter-ear distance
8. Inter-ear distance
9. Inter-ear distance
10. Soft and pliable nose
11. High-arched palate
12. Exaggerated tongue
13. Tongue with insufficient space
14. Curved 4th finger
15. Single transverse groove on 4th finger
16. Hand not longer than second toe
17. Flared (spread) webbing of two middle toes
18. Gap between first and second toes



| Point list of Minor Physical Anomalies in Child's face | Schizophrenia | | Other | | No Mental Illness | |
|--|---------------|------|-------|------|-------------------|------|
| | N | % | N | % | N | % |
| Low IQ (2) | 6 | 23.1 | 30 | 42.9 | 76 | 51.2 |
| High IQ (2) | 20 | 76.9 | 40 | 57.1 | 71 | 48.6 |

Diagnosing Disorders

- DSM (Diagnostic & Statistical Manual of Mental Disorders)
 - DSM-I first published in 1952
 - DSM-IV current edition (1994); DSM-V scheduled for 2011
 - DSM-IV-PC – designed for physicians; contains psychological disorders most likely to be seen by primary care physicians
- Contains diagnostic criteria of all known psychological disorders
 - Similar to ICD-10 (International Classification of Diseases) published by World Health Organization
 - Translated into 22 languages



Cautionary Statement

- "...The DSM provides diagnostic categories and criteria for their diagnoses. **The proper use of these requires clinical training, knowledge and skills to apply them.** Their use by people without this background is likely to lead to an inappropriate application of diagnoses... The content of the DSM does not reflect all opinions on the subject of psychopathology... [Additionally], **what is and what is not considered a mental disorder changes over time.** For example, several decades ago homosexuality was commonly considered a mental disorder, and it was listed in the DSM as such. Today, homosexuality is seen by most psychologists and psychiatrists as a normal sexual orientation... **The categories do not represent a complete list of all psychiatric disorders or research topics.** For instance, the DSM does not categorize mental disorders that are specific to other (i.e. non-American) cultures, such as koro, susto, or taijin kyofusho."

Drapetomania



- Samuel Cartwright (1851)
 - “If the white man attempts to oppose the Deity’s will, by trying to make the negro anything else than “the submissive knee-bender” (which the Almighty declared he should be)...the negro will run away; but if he keeps him in the position that we learn from the Scriptures he was intended to occupy...the negro is spell-bound, and cannot run away.”
 - Cartwright’s “cure”: “...whipping the devil out of them.”
- Obviously, “disorders” change with the culture.

Criteria for Any Disorder

- 3 “Ds” of Psychological Disorders
 - Deviant – abnormal in some way
 - Dysfunctional – causes problems
 - Distress – causes pain to the individual

Two Primary Types of Disorders

- Axis-I
 - Major clinical disorders
 - Psychotic disorders
 - Mood disorders
 - Anxiety disorders
 - Dissociative disorders
 - Etc...
- Axis-II
 - Personality disorders and mental retardation
 - Narcissism
 - Borderline
 - Hysterical
 - Antisocial
 - Etc...
- Axis-III
 - Medical disorders
- Axis-IV
 - Social or environmental problems (e.g., breakup of relationship)
- Axis-V
 - Overall level of functioning (between 0-100)

Axis-I (schizophrenia)

- Most common type of psychotic disorder (1% population)
 - Means “split-mind”, but not multiple-personality-disorder (MPD)!!!
 - MPD is really called dissociative-identity-disorder (DID)
- Diagnostic criteria:
 - 2 or more of the following, present for significant portion of 1 month period
 - delusions
 - hallucinations (RARE!)
 - disorganized speech (e.g., frequent derailment or incoherence)
 - grossly disorganized or catatonic behavior
 - negative symptoms (e.g., affective flattening) **MOST FREQUENT!**
 - Only 1 symptom required if it is particularly bizarre.
 - 1 or more areas of functioning (e.g., work) are markedly below normal
 - Continuous signs of disturbance for at least 6 months (including 1 month of active symptoms)
 - *Not* the result of drug use or medical condition
 - *Not* the result of environmental influences (e.g., surviving disaster)

Axis-I (schizophrenia)

- Paranoid
 - Preoccupation with one or more delusions or frequent auditory hallucinations.
 - None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.
- Catatonic
 - motonic immobility (including waxy flexibility)
 - excessive motor activity (that is apparently purposeless and not influenced by external stimuli)
 - extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved)
 - peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures)
 - stereotyped movements, prominent mannerisms, or prominent grimacing
- Disorganized (All of the following are prominent):
 - disorganized speech (“word salad”)
 - disorganized behavior
 - flat or inappropriate affect
 - The criteria are not met for Catatonic Type.

Axis-I (schizophrenia)

- Onset:
 - Males: late teens to early 20’s
 - Female: late teens to late 20’s
 - Often occurs after some sort of disturbance (diathesis-stress)
 - The later the onset the better as far as the severity of the disorder. Surprisingly, positive symptomatology is correlated with better outcomes.
- Treatment:
 - No known cause or cure (almost certainly of biological origin)
 - Antipsychotics (haldo) can control positive symptoms (hallucinations). Newer meds can control negative symptoms.
 - Meds have gotten a lot better over the years. Tardive dyskinesia not as much of an issue any longer.
 - Psychotherapy can help patient cope with symptoms and function better
 - Depending on the severity of the disorder, the natural coping abilities of the patient, and the response to medications and psychotherapy, some schizophrenics can lead relatively normal lives (some can even win the Nobel Prize)

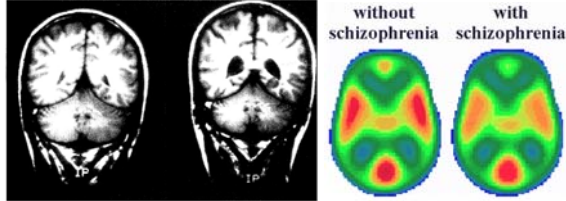


John Nash
Nobel Prize
winner (1994)



Axis-I (schizophrenia)

SCHIZOPHRENIA IN IDENTICAL TWINS



MRI scans of 28-year-old male identical twins showing the enlarged brain ventricles in the twin with schizophrenia (right) compared to his well brother (left).

Axis-I (schizophrenia)

A 20th-century artist, Louis Wain, who was fascinated by cats, painted these pictures over a period of time in which he developed schizophrenia. The pictures mark progressive stages in the illness and exemplify what it does to the victim's perception.



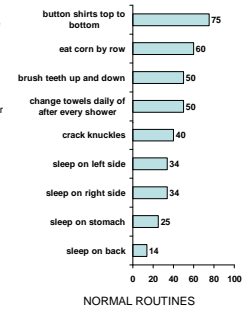
Axis-I (Obsessive-compulsive disorder)

- Obsessions
 - Recurring, persisting thoughts, impulses or images inappropriately intrude into awareness and cause marked distress or anxiety.
 - These ideas are not just excessive worries about ordinary problems.
 - The person tries to ignore or suppress these ideas or to neutralize them by thoughts or behavior.
 - There is insight that these ideas are a product of the patient's own mind.
- Compulsions
 - The person feels the need to repeat physical behaviors (checking the stove to be sure it is off, hand washing) or mental behaviors (counting things, silently repeating words).
 - These behaviors occur as a response to an obsession or in accordance with strictly applied rules.
 - The aim of these behaviors is to reduce or eliminate distress or to prevent something that is dreaded.
 - These behaviors are either not realistically related to the events they are supposed to counteract or they are clearly excessive for that purpose.



Axis-I (Obsessive-compulsive disorder)

- During some part of the illness the patient recognizes that the obsessions or compulsions are unreasonable or excessive.
- The obsessions and/or compulsions are associated with at least 1 of:
 - Cause severe distress.
 - Take up time (more than an hour per day).
 - Interfere with the patient's usual routine or social, work or personal functioning.
- The symptoms are not directly caused by a general medical condition or by substance use, including medications and drugs of abuse.



Axis-I (Obsessive-compulsive disorder)

- Onset:
 - First onset often occurs by age 15
 - Second peak of disorder generally occurs during 20's
 - Likely to persist throughout life in varying degrees of severity
- Treatment:
 - May be related to lack of serotonin, which can be alleviated with SSRIs, like Prozac
 - Exposure and prevention therapy very useful and effective
 - Expose someone to something that elicits compulsions, then prevent patient from acting upon compulsions.
 - Condition them to understand that not acting upon their compulsions will not cause any sort of real harm.



Axis-II (Narcissistic Personality Disorder)

- A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
 - Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
 - Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
 - Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
 - Requires excessive admiration.
 - Has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations.
 - Is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends.
 - Lacks empathy; is unwilling to recognize or identify with the feelings and needs of others.
 - Is often envious of others or believes that others are envious of him or her.
 - Shows arrogant, haughty behaviors or attitudes.



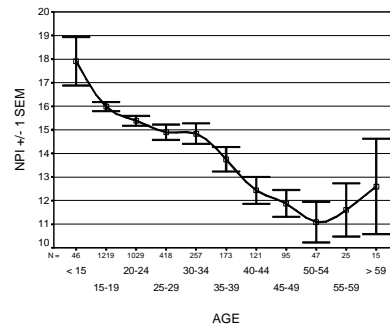
Echo: "Let us join one another."

Narcissus: "Hands off! I would rather die than you should have me!"

Axis-II (Narcissistic Personality Disorder)

- Prevalence:
 - Less than 1% of general population (but is this accurate?)
- Onset:
 - Personality disorders, as a rule, cannot be diagnosed prior to adulthood.
 - Many if not most children are pretty damned narcissistic!
- Causes:
 - Unknown – may have biological or genetic influences
 - Society may play a role.
 - When children are given "unconditional praise" this may lead to a sense of entitlement and narcissism.
 - "everyone's a winner!"
 - California Self-Esteem Task Force (ugh...)

Does narcissism fall with age?



Are people getting more narcissistic?

