Lecture Notes:

- Some mental health resources available to you as a U of T student:
    1. Health & Wellness Center. This is your first stop for any health related needs you have. This includes physical health and psychological health. These resources are offered to all UTSC students.
    2. SCSU benefit plan. You must purchase this to get its benefits. The SCSU benefits plan, if you are a member, also provides some resources for mental health care.
- **Mental Disorder:** Persistent disturbance or dysfunction in behaviour, thoughts, or emotions that causes significant distress or impairment.
- **Medical Model:** Abnormal, distressing psychological experiences are classified as illnesses that have biological causes.
- **Biopsychosocial Model:** Abnormal, distressing psychological experiences are classified as illnesses that have biological, psychological, and social causes.
- **PSYCHOPATHOLOGY:** The scientific study of mental disorders.
- **OVERPATHOLOGIZING:** Attributing diverse or atypical behaviours or thoughts to psychological illness, particularly when diagnostic criteria are not met.
- **DIAGNOSTIC CRITERIA:** A set of symptoms, behaviours, or characteristics that must be present in order to diagnose an individual with a disorder.
- **ONSET:** The chronological age or situational period when the symptoms of a disorder first appear in an individual.
- **PROGNOSIS:** The likely course (trajectory, development) of a disorder.
- **RISK FACTORS:** A set of biological, psychological, and social characteristics that increase the likelihood of having the disorder.
- **ETIOLOGY:** The biological, psychological, and/or social causes of a disorder.
- **COMORBIDITIES:** Other psychological or physical disorders that frequently co-occur with the disorder in question.
- Diagnostic criteria for physiological disorders can sometimes be quite simple. But, for most mental disorders, there is not a black-and-white diagnostic test. Instead, clinicians rely on a set of criteria that are evaluated with a number of different instruments:
    - Questionnaires
    - Interviews
    - Patient history
- The **Diagnostic and Statistical Manual of Mental Disorders (DSM)** is in its fifth edition. The DSM-5 was published in 2013 and was published by the American Psychiatric Association. It is used predominantly in North America, while the ICD-10 (International Classification of Diseases) is used elsewhere. It uses a biopsychosocial model. Lastly, it is only to be used by clinicians for diagnosis.
- The DSM-5 divides mental disorders into 22 categories, including:
    - Anxiety disorders
    - Depressive disorders
    - Bipolar (and related) disorders
    - Personality disorders
    - Obsessive-compulsive disorders
- The DSM-5 includes information about each disorder that it classifies:
    - Diagnostic criteria
    - Onset
    - Prognosis

    - Risk factors/etiology
    - Comorbidities
- Most DSM disorders have three diagnostic criteria in common:
    1. Causes significant distress/affects functioning.
    2. Cannot be attributed to substance use or other medical condition.
    3. Cannot be better described by another DSM diagnosis.
- The Diagnostic and Statistical Manual is not the only way to think about psychological disorders and it has faced many criticisms. Some criticisms are that it is:
    - Overpathologizing
    - Binary (black and white) system
- To illustrate the DSM components, we'll start by talking about one common type of mental illness, anxiety disorders. There are 2 types of anxiety disorders: Fear and anxiety.
- Fear and anxiety are adaptive reactions to threats. However, anxiety that interferes with normal functioning is **maladaptive**. It decreases our fitness for survival. This pathological anxiety can be classified as one of many anxiety disorders.
- The DSM-5 recognizes 12 types of anxiety disorder. We will examine:
    - Generalized anxiety disorder (GAD)
    - Phobic disorders
    - Panic disorder
- **Generalized anxiety disorder (GAD):**
- **Generalized anxiety disorder** is an anxiety disorder in which worries are not focused on any specific threat. We can use GAD as a case study for examining the different parts of the DSM.
- Diagnostic criteria for GAD:
    1. Excessive anxiety and worry, occurring more days than not for at least 6 months, about more than one event/stressor.
    2. The individual finds it difficult to control the worry.
    3. Three or more of these symptoms:
        a. Restlessness
        b. Fatigue
        c. Concentration deficiency
        d. Irritability
        e. Muscle tension
        f. Sleep disturbance
    4. Causes significant distress/affects functioning.
    5. Cannot be attributed to substance use or other medical condition.
    6. Cannot be better described by another DSM diagnosis.

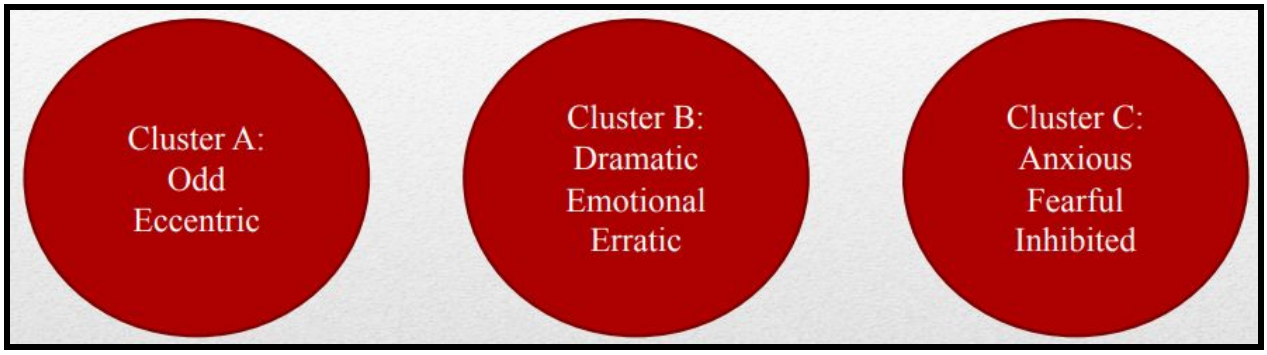
    Note: 4, 5, 6 are common across many disorders.
- The onset of GAD rarely occurs prior to adolescence. The median age for diagnosis is age 30, but many patients report having anxiety symptoms for a long time before reporting them. In the population, the level of anxiety is constant throughout the lifespan, but the content of worries changes.
- For individuals, severity of symptoms waxes and wanes across the lifespan. Furthemore, full remission is rare.

- **Phobic Disorder:**
- A more specific type of anxiety disorder is a **phobic disorder**, a disorder characterized by marked, persistent, excessive fear of specific objects, activities, or situations. Usually the person recognizes the irrationality of their fear but cannot control it.
- **Specific phobia** (12% prevalence):
    - Animals (e.g., dogs, cats, spiders, snakes)
    - Natural environments (e.g. earthquakes, darkness)
    - Ituations (e.g. elevators, enclosed spaces)
    - Medical events (e.g. blood, injections, injury)
    - Other (e.g., loud noises, costumed characters, choking)
- **Social phobia**, a maladaptive fear of being publicly humiliated or embarrassed, has 13% prevalence.
- One theory of why phobic disorders are so common is the **preparedness theory**. It states that we may be evolutionarily adapted to fear certain types of stimulus. Evidence for this hypothesis comes from conditioning. However, these fears may be overdeveloped in some individuals.
- A final type of anxiety disorder is **panic disorder**. Feelings of panic are normal when faced with immediate, life-threatening danger, but many individuals experience panic even when not in danger.
- A **panic disorder** is a sudden occurrence of multiple psychological and physical symptoms typically associated with terror. These symptoms include:
    - Shortness of breath
    - Heart palpitations
    - Sweating
    - Dizziness
    - Derealisation (feeling that the world is unreal)
    - Fear of death/“losing one’s mind”
- Panic episodes are relatively common. About 1/3 of Canadians experience a panic attack once or more per year and typically during extreme stress. However, these occasional panic episodes are not sufficient for a diagnosis . To be diagnosed, an individual must experience: recurrent, unexpected attacks and significant fear of another attack.
- **Mood Disorders:**
- **Mood disorders** are some of the most well-known psychopathological disorders. They are mental disorders that have mood disturbance as their prominent feature.
- Examples of mood disorders are:
    - Depressive disorders:
        - Major depressive disorder (unipolar depression)
        - Dysthymia
        - Double depression
    - Bipolar disorders
- Depressive disorders are present in 22% of the female Canadian population and 14% of the male Canadian population. About 1 in 12 Canadians will experience major depression in their lives.
- The most well-known depressive disorder is major **depressive disorder**, also known as **unipolar depression**. It is a severely depressed mood and/or inability to experience pleasure that lasts two or more weeks and is accompanied by feelings of worthlessness, lethargy, sleep disturbance, and/or appetite disturbance.

- Diagnostic criteria of depressive disorder:
    1. Five or more of the following symptoms present during the same 2-week period:
        a. Depressed mood
        b. Diminished interest
        c. Significant weight loss/gain
        d. Insomnia or hypersomnia
        e. Psychomotor agitation or retardation
        f. Fatigue
        g. Feelings of worthlessness/guilt
        h. Diminished concentration/decisiveness
        i. Recurrent thoughts of death/suicidal ideation
    2. No evidence of a manic episode (abnormal, persistent high mood).
    3. Symptoms cause clinically significant distress/impairment.
    4. Not better described by another DSM disorder.
    5. Not attributable to another medical condition or physiological effects of substance use.
- Onset: May appear at any age, but is most likely to appear in the 20s.
- Prognosis:
    - 2/5 of individuals recover within 3 months.
    - 4/5 of individuals recover within 1 year.
    - 1/5 of individuals do not experience remission.
- Risk factors for MDD:
    - Temperamental (particularly neuroticism, or negative affect).
    - Environmental (childhood experiences, stressful life events).
    - Biological (neurotransmitter imbalance).
    - Genetic (family members of individuals with MDD are 2-4 times more likely to be diagnosed with MDD; ~40% heritability)
- Comorbidity: Substance-related disorders, panic disorders, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa
- Psychological factors can affect an individual's susceptibility to depression. Many theorists argue that it is the way we think about things that cause depression, rather than the things themselves.
- The **helplessness theory** argues that the way a person thinks about failure makes her more or less likely to be depressed:
    - Attribute failures to internal characteristics.
    - Believe that failures are permanent (stable).
    - Believe that failures are global (apply to many areas of life).
- Sometimes depression lasts for a long time.
- Moderate depressive symptoms that last for more than two years are referred to as dysthymia or dysthymic disorder.
- When dysthymia is punctuated by episodes of major depression, it is called double depression.
- Mood disorders are not always unipolar. **Bipolar disorders** are characterized by cycles of abnormal, persistent high mood (mania) and low mood (depression).
  Bipolar I disorder: At least one manic episode, possibly with hypomanic and depressive episodes as well.
  Bipolar II disorder: Presence of both hypomanic and depressive episodes; no manic episodes.

- Diagnostic criteria for Bipolar I disorder:
    1. Distinct period of abnormal, persistently elevated mood; increased activity or energy; lasting at least 1 week (manic episode).
    2. Three or more of the following:
        a. Inflated self-esteem
        b. Decreased need for sleep
        c. Talkative
        d. Racing thoughts
        e. Distractibility
        f. Increase in goal-directed activity or psychomotor agitation
        g. Excessive involvement in activities with a high potential for painful consequences
    3. Symptoms cause clinically significant distress/impairment.
    4. Not better described by another DSM disorder.
    5. Not attributable to another medical condition or physiological effects of substance use.
- Prevalence:
    - 1 in 40 individuals
    - Not different between women and men (1.1 : 1)
- Onset:
    - Mean age of first episode = 18 years
    - Onset can occur for the first time in the 60s and 70s
- Prognosis:
    - 90% of individuals who experience a manic episode will experience more of them throughout life
    - Full remission is very rare
- Risk factors:
    - Genetic (among the most heritable disorders; coincidence among identical twins = 40-70%)
    - Environmental (high stress, highly emotionally expressive family members; separation/divorce)
    - Psychological (high neuroticism, high conscientiousness)
- Comorbidity:
    - Anxiety disorders
    - Substance use disorders
    - Attention deficit hyperactivity disorder (ADHD)
    - Behavioural disorders
- **Personality disorders** are particularly unusual patterns of behaviour (relative to one's cultural context) that are maladaptive, distressing to oneself or others, and resistant to change.

- The DSM classifies 10 different personality disorders and divides them into 3 clusters.



- One of the most complex and interesting personality disorders is **antisocial personality disorder**, which is a pervasive pattern of disregard for and violation of the rights of others, beginning in childhood and lasting through adulthood.
- **Note:** Antisocial personality disorder is not psychopathy.
- Diagnostic criteria:
    1. Three or more of the following:
        a. Failure to conform to social norms with respect to lawful behaviour.
        b. Deceitfulness.
        c. Impulsivity/failure to plan ahead.
        d. Irritability/aggressiveness.
        e. Reckless disregard for own or others' safety.
        f. Irresponsibility.
        g. Lack of remorse.
    2. The individual is at least 18 years of age.
    3. There is evidence of **conduct disorder** in childhood. This conduct disorder is a persistent pattern of behaviour involving aggression to people or animals, destruction of property, deceitfulness, theft, etc.
       Note: There are many children with conduct disorder but do not get antisocial personality disorder. However, all adults with antisocial personality disorder have had conduct disorder in their childhood.
    4. The behaviours cannot only be occurring during the course of schizophrenia or bipolar disorder.
    5. Symptoms cause clinically significant distress/impairment.
    6. Not better described by another DSM disorder.
    7. Not attributable to another medical condition or physiological effects of substance use.

  However, there's a caveat. Many people with antisocial personality disorder are not distressed by their symptoms.
- **Obsessive-Compulsive Disorder (OCD):**
- **Obsession:** A pattern of unwanted, inappropriate, and persistent thoughts.
- **Compulsion:** Repetitive, ritualistic behaviours.
- Some common obsessions include contamination, doubting, arranging in a specific pattern, and aggressive thoughts.
- Some common compulsions include: checking, cleaning, and repeating actions.

Textbook Notes:

- **Module 15.1 Defining and Classifying Psychological Disorders:**
- **Defining Abnormal Behaviour:**
- As the ascension of scientific thought began to displace the religious domination of the Middle Ages, explanations for mental illness shifted from demon possession to physical illnesses. **Asylums**, residential facilities for the mentally ill, were set up across Europe, with the general goal of curing the patients' bodily afflictions that gave rise to their symptoms. However, their treatments would certainly not meet modern standards of medical care and were generally ineffective.
- Philippe Pinel's , a physician in France, and Dorothea Dix's, a schoolteacher in the United States advocacy for the mentally ill led to widespread reforms that ushered in a new approach, called moral treatment, which led to patients being treated with kindness and decency, able to roam the hospital halls and get outside for fresh air. However, there were still virtually no effective treatments, and many people afflicted with mental illness were permanently incarcerated.
- By the 1950s, approximately 66 000 people were in psychiatric hospitals in Canada. Things began to change in 1955 when the drug chlorpromazine (also known as Thorazine) was introduced. Suddenly, people with schizophrenia and other disorders involving being "out of touch" with reality were able to function independently, even holding down jobs and living at home with their families. The success of chlorpromazine and other medications led to widespread **deinstitutionalization**, the movement of large numbers of psychiatric in-patients from their care facilities back into regular society, which led to a drop in the number of psychiatric inpatients by over 80% over the next three decades.
- The **medical model** sees psychological conditions through the same lens as Western medicine tends to see physical conditions, as sets of symptoms, causes, and outcomes, with treatments aimed at changing physiological processes in order to alleviate symptoms.
- In recent decades, the medical model has begun to give way to the biopsychosocial model, which includes physiological processes within a holistic view of the person as a set of multiple interacting systems.
- Example of the biopsychosocial model:

	Diabetes	**Major Depression**
Biological	Genetic influences on pancreatic function; excessive refined sugars	Genetic influences on neurotransmitter production and function; sleep disruption; lack of positive emotional arousal
Psychological	Poor food choices; sedentary lifestyle; alcohol abuse	Negative self-concept; pessimism; negative life experiences

Sociocultural	Familial and cultural foods and traditions; limited budget for groceries; lack of physical and nutritional education in schools; lack of role models	Lack of social support; social withdrawal; lack of psychological services; stigma regarding psychological treatments

- **What is "Normal" Behaviour?:**
- The key criterion used by psychologists in deciding whether a person has a disorder is whether the person's thoughts, feelings, or behaviours are **maladaptive**, meaning that they causes distress to oneself or others, impairs day-to-day functioning, or increases the risk of injury or harm to oneself or others.
- However, there are many exceptions to this guideline. Some behaviours fulfill these criteria but do not necessarily indicate mental illness. Consider the following:
    - Heavy drug users and people with psychopathic tendencies may not think they have a problem.
    - Family members may be concerned about a person's involvement in a new relationship, or may disapprove of body modifications such as tattoos or piercings.
    - Mourning the loss of a loved one or having a religious conversion may interfere with one's day-to-day activities.
    - Activists may get arrested for protesting government actions and extreme sports enthusiasts may risk death or injury out of passion for their sport.
- **Psychology's Puzzle: How to Diagnose Psychological Disorders:**
- Building on the military's diagnostic system, as well as the sixth edition of the World Health Organization's International Statistical Classification of Disease, the American Psychiatric Association created the **Diagnostic and Statistical Manual of Mental Disorders (DSM)**, a standardized manual to aid in the diagnosis of disorders; this edition described the symptoms of 106 different mental disorders. The purpose for developing the DSM was to provide mental health workers with a reliable method for diagnosing mental illness and to ensure consistency across different institutions and hospitals.
- Originally, the DSM was rooted in a psychobiological view, which argued that mental disorders represented an individual's specific reactions to psychological, social, and biological processes. However, other emphases changed over the years, from an initial focus on psychodynamic views to a later focus on cognitive and biological perspectives. By the mid-1990s, the DSM had gone through several revisions and was expanded to include over 350 different disorders.
- The DSM remains the standard reference manual in the mental health field, particularly in North America. The latest edition, the DSM-5, was published in May 2013. In order to aid in the process of diagnosis, the DSM-5 describes three important pieces of information for each disorder: a set of symptoms and the number of symptoms that must be met in order to have the disorder; the **etiology** (origins or causes) of symptoms; and a prognosis or prediction of how these symptoms will persist or change over time.
- **Critiquing the DSM:**
- The central issue is that there are no perfect ways of measuring psychological disorders as the diagnostic process is highly subjective.
- In order to try to help clinicians cut through some of this confusion, the DSM offers lists of specific symptoms that are indicative of specific disorders. This is an attempt to make

the diagnostic process more objective, which should decrease the likelihood that diagnoses are based on individual clinicians' biases. Unfortunately, this doesn't entirely solve the problem for many reasons. For one, a clinician still has to subjectively decide whether a client displays each symptom and whether it is severe enough to be considered a symptom or just normal experience. Another problem is that different disorders often share many common symptoms; as a result, different mental health professionals might make different diagnoses. The DSM was created, in large part, to help make the process of diagnosing a disorder more objective and reliable, but the very nature of human experience is often subjective, vague, and unreliable. An additional weakness of the DSM is that there is a fine, and essentially arbitrary, line between whether a person is considered to have a disorder or not.

- The DSM also implies that disorders can be objectively defined. This way of thinking has contributed to the stigmatization of mental illness, and has added to the discomfort and resistance people feel towards the mental health field. It has also led to serious problems when the biases and norms operating in a particular time and place get expressed as scientific fact.
- Critics also express concern that giving mental health workers more labels with which to diagnose clients is not necessarily a good thing and may lead to over-diagnosis.
- Critics charge that the handy availability of the ADHD diagnosis makes it too easy to label children as having a "condition" and then medicate them. Studies have shown that between 20% to 70% of children diagnosed with ADHD no longer met the criteria once they reached adulthood this raises the possibility that many children are being medicated for what is, essentially, normal development.
- Perhaps one solution for improving the diagnostic accuracy of the DSM is to develop more objective, biological indicators such as genetic markers, indicators of neurotransmitter dysfunction, or brain abnormalities, that are involved in the symptoms and functional deficits experienced by the individual.
- **The Power of a Diagnosis:**
- The long-term effects of receiving a specific diagnosis can be substantial.
- Small differences in initial diagnosis can lead to big differences in long-term treatment and outcomes.
- An additional concern is that once a person has been labelled as having a disorder, the label itself may change how that person is viewed by others, and how subsequent behaviours are interpreted.
- Psychological disorders may not present the same across different cultures, and a lack of appreciation for these cultural differences can potentially lead to misdiagnosis. For example, **post-traumatic stress disorder (PTSD)** is a common psychological illness involving recurring thoughts, images, and nightmares associated with a traumatic event; it induces symptoms of tension and anxiety and can seriously interfere with many aspects of a person's life. Despite the seemingly universal physiological symptoms of PTSD, researchers have found differences in the cognitive and emotional symptoms between different groups.
- **Working the Scientific Literacy Model Labelling and Mental Disorders:**
- It is the case that being labelled with a mental illness can potentially damage a person's material, social, and psychological well-being in a variety of ways.
- For example, seeing oneself as mentally ill can be associated with low self-esteem or feelings of helplessness. In some cases, a diagnosis may lead a person to indulge in even more extreme or destructive behaviour patterns. Because of stigma and negative

attitudes towards the mentally ill, people may expect that other people will reject and devalue them. This may lead them to withdraw from social contact and fail to seek the support that could help them. People may also become demoralized about their capabilities and themselves in general, which then interferes with their motivations and goal-related striving.

- **Applications of Psychological Diagnoses:**
- One of the most important things to appreciate about psychological disorders is that there is no perfect test for identifying them.
- The fact that our measurements of psychological disorders are not nearly as accurate as we would like makes these issues even more difficult to deal with. In many cases, we cannot even say with confidence whether someone is mentally ill and what psychological illness or disorder they have.
- **The Mental Disorder Defence (AKA the Insanity Defence):**
- In Canada, the insanity defence is now referred to as the **mental disorder defence**. This defence does not deny that the person committed the offence, but claims that the defendant was in such an extreme, abnormal state of mind when committing the crime that he or she could not discern that the actions were legally or morally wrong.
- **<u>Module 15.2 Personality and Dissociative Disorders:</u>**
- **Defining and Classifying Personality Disorders:**
- Mental health professionals identify **personality disorders** as particularly unusual patterns of behaviour (relative to one's cultural context) that are maladaptive, distressing to oneself or others, and resistant to change.
- Obviously, many people experience these basic patterns of behaviour to varying degrees. It is important to remember that personality disorders represent extreme cases. Importantly, personality disorders often persist throughout a person's life.
- The DSM-5 identifies 10 distinct personality disorders, which are categorized into three different clusters based on shared features.
    - Cluster A disorders are characterized by odd or eccentric behaviour.
    - Cluster B disorders are indicated by dramatic, emotional, and erratic behaviour.
    - Cluster C disorders are characterized by anxious, fearful, and inhibited behaviour.
- In addition to these 10 disorders, the DSM-5 also identifies Personality Disorder Not Otherwise Specified, which is a diagnosis given to individuals who exhibit patterns of behaviour consistent with that of a personality disorder, but which does not fit into any of the personality disorder categories described above.
- **Borderline Personality:**
- One of the clearest examples of the emotional dysfunction that lies at the core of personality disorders is found in **borderline personality disorder (BPD)** which is characterized by intense extremes between positive and negative emotions, an unstable sense of self, impulsivity, and difficult social relationships.
- People with BPD experience a wide range of emotions including extremely positive states such as joy, excitement, and love, but also very powerful destructive emotions such as anger, despair, and shame.
- It is believed that borderline personality disorder arises out of the person's attempts to deal with deeply rooted insecurity and severe emotional disturbances that are ultimately rooted in emotionally difficult experiences.
- **Narcissistic personality disorder (NPD)** is characterized by an inflated sense of self-importance and an excessive need for attention and admiration, as well as intense

self-doubt and fear of abandonment. The central focus on the narcissistic person's own feelings and self-importance leaves little room for empathy for others. Instead, they tend to be manipulative and put themselves first, ensuring their own needs are met in their relationships regardless of the toll it takes on others.

- **Histrionic Personality:**
- Emotional dysfunction can also be seen in **histrionic personality disorder (HPD)**, which is characterized by excessive attention seeking and dramatic behaviour.
- **Working the Scientific Literacy Model Antisocial Personality Disorder:**
- In contrast to histrionic personality disorder, which is associated with dramatic behaviour, the diagnosis of **antisocial personality disorder (APD)** is given to individuals who have a profound lack of empathy or emotional connection with others, a disregard for others' rights or preferences, and a tendency toward imposing their own desires, often violently, onto others regardless of the consequences for other people or, often when younger, other animals.
- APD (often referred to as psychopathy) tends to be highly resistant to treatment, in part because individuals with APD are not alarmed or distressed by their actions.
- People with APD tend to be physically and verbally abusive, and destructive, and frequently find themselves in trouble with the law.
- Symptoms of the disorder typically appear during childhood and adolescence, including harming or torturing people or animals, destroying property, stealing, and being deceitful.
- People with APD show very weak startle responses when exposed to unpleasant stimuli.
- **Psychological Factors:**
- People with narcissistic (NPD) or histrionic (HPD) personality disorder also tend to have deeply rooted negative beliefs about the self, how they are regarded, and whether they are loved by others. Much of their dysfunctional behaviour patterns stem from attempts to compensate for these negative self-beliefs.
- Adults with APD and children with conduct disorders (often a precursor to APD) have difficulty learning tasks that require decision making and following complex rules.
- **Sociocultural Factors:**
- Children begin to develop social skills and emotional attachments at home and in their local neighbourhood and community. Not surprisingly, then, troubled homes and communities can contribute to the development of antisocial personality disorder. People with APD have often themselves experienced trauma or abuse.
- In general, personality disorders often involve extensive emotional damage from childhood experiences, ranging from physical violence and sexual abuse to the profound invalidation and insecurity of being repeatedly abandoned or neglected as a child.
- **Types of Dissociative Disorders:**
- In a few cases, some people have such extreme dissociative experiences that they may be diagnosed with a **dissociative disorder**, a category of mental disorders characterized by a split between a person's conscious awareness and their feelings, cognitions, memory, and identity.
- Dissociative disorders include the following conditions:
    - Dissociative fugue: A period of profound autobiographical memory loss. People in fugue states may go so far as to develop a new identity in a new location with no recollection of their past.
    - Depersonalization disorder: A strong sense of the surreal, the feeling that one is not connected to one's body, the feeling of disconnection from one's regular identity and awareness.

    - Dissociative amnesia: A severe loss of memory, usually for a specific stressful event, when no biological cause for amnesia is present.
- Probably the most familiar member of this category is **dissociative identity disorder (DID)**, in which a person experiences a split in identity such that they feel different aspects of themselves as though they were separated from each other. This can be severe enough that the person constructs entirely separate personalities, only one of which will generally be in control at a time. This is also sometimes referred to as **multiple personality disorder**.
- These distinct personalities, or alters, may be so different from one another as to have different genders, sexual orientations, memories, personalities, and autobiographical senses of self and who they are.
- In most cases, dissociative disorders such as DID are thought to be brought on by extreme stress.
- DID is a very rare condition, affecting only about 1% of psychiatric patients, and therefore only a very small fraction of 1% of the general population.
- One approach to testing for DID is to check for memory dissociations between alter identities.
- Another approach to examining DID is to record patterns of brain activity.
- **Module 15.3 Anxiety, Obsessive–Compulsive, and Depressive Disorders:**
- **Anxiety Disorders:**
- **Anxiety disorders** are a category of disorders involving fear or nervousness that is excessive, irrational, and maladaptive. They also are among the most frequently diagnosed disorders, affecting approximately one in every eight Canadians.
- People often attempt to cope with anxiety by limiting themselves to environments, activities, and people that make them feel safe and secure, and by developing rigid habits and ways of doing things that keep life predictable and under control. These patterns evolve in order to help the anxious person manage his or her fear, but they also can limit people's freedom to live their lives as they would like.
- In most people's experience, anxiety occurs as a natural part of the fight-or-flight response. We experience this response as a racing, pounding heartbeat with increased respiration, as our autonomic systems prepare our bodies for quick action.
- **Varieties of Anxiety Disorders:**
- What separates anxiety disorders from normal experiences of anxiety is the intensity and long duration of the response. Anxiety disorders are also distinct in that the response may not be directly connected to one's current circumstances; instead, the anxiety can be free-floating. Either way, anxiety disorders cause a great deal of emotional distress and interfere with people's daily lives.
- **Generalized anxiety disorder (GAD)** involves frequently elevated levels of anxiety, generally from the normal challenges and stresses of everyday life.
- A person with GAD fears disaster lurking around every corner, and may experience symptoms ranging from difficulty sleeping or breathing to difficulty concentrating because of intrusive thoughts. However, because the anxiety arises out of the ongoing situations and circumstances of life, people often have difficulty understanding their experience and cannot identify specific reasons for which they are anxious.
- People with GAD often have unstable, irritable moods, experience difficulty concentrating, and have sleep problems.
- **Panic disorder** is an anxiety disorder marked by occasional episodes of sudden, very intense fear. This condition is distinct from GAD because the anxiety occurs in short

segments, but can be much more severe. The key feature of this disorder is **panic attacks**—brief moments of extreme anxiety that include a rush of physical activity paired with frightening thoughts. A panic attack escalates when the fear causes increased physical arousal, and the increased physical symptoms feed the frightening thoughts. The escalation rarely goes on for more than ten minutes, after which the individual will eventually return to a more relaxed state.

- A substantial subset of people with panic disorder develop a recurring fear that the panic will strike again, particularly in an environment in which they would be exposed and unable to escape from people, such as a shopping mall or other public space. This fear can result in **agoraphobia** (which is often associated with panic disorder), an intense fear of having a panic attack in public; as a result of this fear, the individual may begin to avoid public settings and increasingly isolate him- or herself. In its most extreme forms, agoraphobia leads an individual to stay inside his home almost all the time.
- Thus far, our discussion of phobias has focused on fearful responses to specific stimuli such as snakes. **Social anxiety disorder** is a very strong fear of being judged by others or being embarrassed or humiliated in public.
- People who experience social anxiety deal with going out in public by developing familiar routines and retaining control over their ability to exit circumstances if their anxiety becomes too strong. Social anxiety generally leads people to limit their social activities in favour of not exposing themselves to anxiety, thus making it difficult to succeed and live a normal life in many different ways.
- **Working the Scientific Literacy Model Specific Phobias:**
- In contrast to GAD, where an individual's anxiety can be applied to just about any situation, a **phobia** is a severe, irrational fear of a very specific object or situation.
- A **specific phobia** involves an intense fear of a specific object, activity, or organism.
- A table of phobias:

	Currently Experiencing the Phobia	**Have Experienced the Phobia at One Time**
Animals (snakes, birds, or other animals)	4.7%	50.3%
Natural environment (e.g., heights, storms, water)	5.9%	62.7%
Blood or bodily injury (including injections)	4.0%	42.5%
Situations (e.g., dentists, hospitals, crowded places)	5.2%	55.6%

Other specific objects	1.0%	10.6%

- While phobias often develop as a result of unpleasant or frightening experiences; there's nothing like getting bitten by a dog to make a person afraid of dogs, the overwhelming majority of the triggers for phobias are objects or situations that we may need to fear, or at least be cautious about.
- Phobias can also develop without direct, personal experience.
- **The Vicious Cycle of Anxiety Disorders:**
- The most important part of psychological therapy for anxiety disorders is **exposure**, in which the person is repeatedly and in stages exposed to the object of her fear so that she can work past her emotional reactions.
- For exposure to be most effective, it should be coupled with helping the person to calm themselves down and to learn to tolerate the aversive feelings they are experiencing.
- **Obsessive–Compulsive Disorder (OCD):**
- Until 2013, **obsessive–compulsive disorder (OCD)** was categorized as an anxiety disorder. In the DSM-5, OCD was placed into its own category. Individuals with OCD tend to be plagued by unwanted, inappropriate, and persistent thoughts (obsessions), and to engage in repetitive, often quite ritualistic behaviours (compulsions).
- **Mood Disorders:**
- Mood disorders are very common, affecting almost 10% of adults in Canada and the U.S.
- Due to a combination of biological, cognitive, and sociocultural differences, rates of depression are twice as high among women as among men, and three times as high among people living in poverty.
- **Major depression** is a disorder marked by prolonged periods of sadness, feelings of worthlessness and hopelessness, social withdrawal, and cognitive and physical sluggishness.
- Depression can lead to problems piling up at work and at home, relationships being strained or crumbling, and financial problems starting to interfere with daily life. People deep in depression may find it almost impossible to take care of more than the barest necessities of their lives; their social lives suffer as they stop returning phone calls or emails. Other people may notice and get annoyed or have hurt feelings, which leads the depressed person to feel even worse about himself.
- **Bipolar disorder** (formerly referred to as manic depression) is characterized by extreme highs and lows in mood, motivation, and energy.
- It shares many symptoms with major depression—some distinguish the two by referring to major depression as unipolar depression—but it occurs only about a third as often.
- Bipolar disorder involves depression at one end and mania—an extremely energized, positive mood—at the other end. Mania may take several forms: talking excessively fast, racing thoughts, impulsive and spontaneous decisions, or high-risk behaviours. The experience of a manic episode can be exhilarating and parts of it can be highly enjoyable, but the costs of such excessive, indiscriminate, risky behaviour can be very high. Unfortunately, during a manic state, individuals feel little concern about the potential consequences of their actions. Later, as they come into a more normal frame of mind, they may feel a great deal of remorse and embarrassment for their actions, which contributes to their counter-swing into depression.

- Bipolar disorder encompasses both ends of an emotional continuum, and individuals with bipolar disorder can move from one end to the other at different rates.
- **Cognitive Aspects of Depression:**
- Depression affects cognition as well as emotion. People with depression can become confused and can have difficulty concentrating and making decisions, all of which contribute to growing feelings of helplessness and feeling incapable of doing anything right.
- As a depressed person begins to emphasize negative, self-defeating, and self-critical thoughts, they develop a characteristic depressive or pessimistic explanatory style.
- **Biological Aspects of Depression:**
- Brain-imaging research has identified two primary regions of interest related to depression:
    1. The limbic system, which is active in emotional responses and processing.
    2. The dorsal (back) of the frontal cortex, which generally plays a role in controlling thoughts and concentrating.
- As is the case with panic disorder, a vicious cycle appears to occur with depression. The overactive limbic system responds strongly to emotions and sends signals that lead to a decrease in frontal lobe activity, and this decrease in frontal lobe functioning reduces the ability to concentrate and control what one thinks about.
- Various neurotransmitters, especially serotonin, dopamine, and norepinephrine, are involved in depression. Serotonin appears to be particularly important. People with depression typically have lower serotonin levels than non-depressed individuals. Many anti-depressant medications block the reuptake of serotonin, which leaves more serotonin in the synapse, available to stimulate the postsynaptic neurons.
- The negative emotions of depression are also linked with stress reactions throughout the body.
- Research at the genetic level is also uncovering factors that contribute to the likelihood of being diagnosed with depression. Twin studies suggest an underlying genetic risk for developing major depression. Additionally, behavioural genetics researchers have found that people who inherit two copies of the short version of the 5-HTT gene are at greater risk for developing depression, whereas those who inherit two long copies are at a far lower risk. The gene–environment interaction becomes apparent after an accumulation of events. This interaction between a genetic predisposition for a disorder and life stress is known as the **diathesis–stress model** of psychological disorders.
- **Suicide:**
- Suicide is four times more likely among males than among females.
- Furthermore, the highest suicide rates are actually observed among the elderly population.
- Here are some warning signs that someone may commit suicide:
    - Talks about committing suicide
    - Has trouble eating or sleeping
    - Exhibits drastic changes in behaviour
    - Withdraws from friends or social activities
    - Loses interest in school, work, or hobbies
    - Prepares for death by writing a will and making final arrangements
    - Gives away prized possessions
    - Has attempted suicide before
    - Takes unnecessary risks

    - Has recently experienced serious losses
    - Seems preoccupied with death and dying
    - Loses interest in his or her personal appearance
    - Increases alcohol or drug use

- **Module 15.4 Schizophrenia:**
- **Symptoms and Types of Schizophrenia:**
- **Schizophrenia** refers to what many psychologists and psychiatrists believe is a brain disease that causes the person to experience significant breaks from reality, a lack of integration of thoughts and emotions, and problems with attention and memory.
- **Stages of Schizophrenia:**
- In most cases of schizophrenia, there are three distinct phases: prodromal, active, and residual. These tend to occur in sequence, although individuals may cycle through all three many times.
- In the **prodromal phase**, people may become easily confused and have difficulty organizing their thoughts, they may lose interest and begin to withdraw from friends and family, and they may lose their normal motivations, withdraw from life, and spend increasing amounts of time alone, often deeply engrossed in their own thoughts. It is not uncommon for other people to get upset as a result of these behaviours, assuming the person is lazy or otherwise being irresponsible.
- In the **active phase**, people typically experience delusional thoughts, hallucinations, or disorganized patterns of thoughts, emotions, and behaviour.
- This phase usually transitions into the **residual phase**, in which people's predominant symptoms have disappeared or lessened considerably, and they may simply be withdrawn, have trouble concentrating, and generally lack motivation.
- The symptoms of schizophrenia are most pronounced in the active phase of the disease.
- **Symptoms of Schizophrenia:**
- Schizophrenia is associated with a number of different symptoms. A key distinction is made between positive and negative symptoms.
- **Positive symptoms** refer to the presence of maladaptive behaviours, such as confused and paranoid thinking, and inappropriate emotional reactions.
- In contrast, **negative symptoms** involve the absence of adaptive behaviour, such as absent or flat emotional reactions, lack of interacting with others in a social setting, and lack of motivation.
- One common positive symptom is the presence of **hallucinations**, alterations in perception, such that a person hears, sees, smells, feels, or tastes something that does not actually exist, except in that person's own mind. These experiences are often accompanied by **delusions**, beliefs that are not based on or well integrated with reality.
- In addition to hallucinations and delusions, individuals with schizophrenia often have **disorganized behaviour**. This term describes the considerable difficulty people with schizophrenia may have completing the tasks of everyday life—cooking, taking care of one's hygiene, socializing.
- Individuals with schizophrenia experience several additional problems with cognitive functioning. These range from basic, low-level physiological responses, such as excessive eye blinking in response to stimulation, to more complex cognitive skills, such as those required for standardized achievement tests—test scores tend to drop during adolescence as the disorder begins and progresses.

- Social interaction is often very difficult for people with schizophrenia. These individuals typically have difficulty reasoning about social situations and show relatively poor social adjustment.
- **Common Sub-Types of Schizophrenia:**
- These subtypes were dropped from official practice in 2013, as they are artificial categorizations of complex behaviour patterns, and are often not reliably measurable; but, they are still commonly used and are therefore worth being aware of:
    - **Paranoid schizophrenia**: Symptoms include delusional beliefs that one is being followed, watched, or persecuted, and may also include delusions of grandeur or the belief that one has some secret, insight, power, or some other characteristic that makes one particularly special.
    - **Disorganized schizophrenia**: Symptoms include thoughts, speech, behaviours, and emotions that are poorly integrated and incoherent. People with disorganized schizophrenia may also show inappropriate, unpredictable mannerisms.
    - **Catatonic schizophrenia**: Symptoms include episodes in which a person remains mute and immobile—sometimes in bizarre positions—for extended periods. Individuals may also exhibit repetitive, purposeless movements.
    - **Undifferentiated schizophrenia**: This category includes individuals who show a combination of symptoms from more than one type of schizophrenia.
    - **schizophrenia**: This category reflects individuals who show some symptoms of schizophrenia but are either in transition to a full-blown episode or in remission.
- **Genetics:**
- Studies using twin, adoption, and family history methods have shown that as genetic relatedness increases, the chance that a relative of a person with schizophrenia will also develop the disorder increases.
- **Schizophrenia and the Nervous System:**
- One important neurological characteristic of people with schizophrenia is the size of the brain's ventricles (the fluid-filled spaces in the core of the brain). People with schizophrenia have ventricles that are 20% to 30% larger than people without schizophrenia. The reason for these larger ventricles is a loss of brain matter, which amounts to a reduction of total brain volume by approximately 2% in those individuals with schizophrenia. In particular, the reduced volume can be found in structures such as the amygdala and hippocampus.
- The brains of people with schizophrenia are not just different in size; they also function differently. People with schizophrenia show lower levels of activity in their frontal lobes, both in resting states and when engaged in cognitive tasks, suggesting that these brain regions are not functioning at an optimal level.
- People with schizophrenia have an increased rate of firing in dopamine-releasing cells. Some of this over-activity is in a part of the brain known as the basal ganglia, which is involved in a number of functions including reward responses. As a result of this firing, stimuli that should be meaningless are interpreted as being quite noteworthy.
- Glutamate, another neurotransmitter, appears to be underactive in certain brain regions, including the hippocampus and the frontal cortex. Glutamate is the brain's primary excitatory neurotransmitter, so a reduction of glutamate in those areas would correspond to a reduction of their functioning.
- **Working the Scientific Literacy Model The Neurodevelopmental Hypothesis:**
- People who develop schizophrenia often exhibit identifiably abnormal patterns of behaviour early on. Indeed, the **neurodevelopmental hypothesis** suggests that the

adult manifestation of what we call “schizophrenia” is the outgrowth of disrupted neurological development early in the person’s life.

- **Environmental and Social Influences on Schizophrenia:**
- Some research suggests that a very small proportion of people who use marijuana develop psychotic symptoms, possibly because the drug interacts with the genes involved in schizophrenia.
- Head injuries occurring prior to age 10 also put people who are genetically vulnerable to schizophrenia at greater risk for developing the disorder.

Definitions:

- **Active phase:** Phase of schizophrenia during which people typically experience delusional thoughts, hallucinations, or disorganized patterns of thoughts, emotions, and behaviour.
- **Agoraphobia:** Often associated with panic disorder, agoraphobia results from an intense fear of having a panic attack in public; as a result of this fear, the individual may begin to avoid public settings and increasingly isolate him- or herself.
- **Antisocial personality disorder (APD):** A profound lack of empathy or emotional connection with others, a disregard for others’ rights or preferences, and a tendency toward imposing one’s own desires, often violently, onto others regardless of the consequences for other people or, often when younger, other animals.
- **Anxiety disorders:** A category of disorders involving fear or nervousness that is excessive, irrational, and maladaptive.
- **Asylums:** Residential facilities for the mentally ill.
- **Bipolar disorder:** Characterized by extreme highs and lows in mood, motivation, and energy.
- **Borderline personality disorder (BPD):** A disorder characterized by intense extremes between positive and negative emotions, an unstable sense of self, impulsivity, and difficult social relationships.
- **Catatonic schizophrenia:** Symptoms include episodes in which a person remains mute and immobile—sometimes in bizarre positions—for extended periods. Individuals may also exhibit repetitive, purposeless movements.
- **Deinstitutionalization:** The movement of large numbers of psychiatric in-patients from their care facilities back into regular society.
- **Delusions:** Beliefs that are not based on reality (at least from the perspective of the person’s general culture).
- **Diagnostic and Statistical Manual of Mental Disorders (DSM):** A standardized manual to aid in the diagnosis of disorders.
- **Diathesis–stress model:** The interaction between a genetic predisposition for a disorder and life stress.
- **Disorganized behaviour:** The considerable difficulty people with schizophrenia may have completing the tasks of everyday life.
- **Disorganized schizophrenia:** Symptoms include thoughts, speech, behaviour, and emotions that are poorly integrated and incoherent; people with disorganized schizophrenia may also show inappropriate, unpredictable mannerisms.
- **Dissociative disorder:** A category of mental disorders characterized by a split between conscious awareness from feeling, cognition, memory, and identity.
- **Dissociative identity disorder (DID):** A person experiences a split in identity such that they feel different aspects of themselves as though they were separated from each

other; this can be severe enough that the person constructs entirely separate personalities, only one of which will generally be in control at a time.

- **Etiology:** Origins or causes.
- **Exposure:** Repeatedly and in stages exposing an individual to the object of his fear so that he can work past his emotional reactions.
- **Generalized anxiety disorder (GAD):** Involves frequently elevated levels of anxiety, generally from the normal challenges and stresses of everyday life.
- **Hallucinations:** Alterations in perception, such that a person hears, sees, smells, feels, or tastes something that does not actually exist, except in that person's own mind.
- **Histrionic personality disorder (HPD):** Characterized by excessive attention seeking and dramatic behaviour.
- **Major depression:** A disorder marked by prolonged periods of sadness, feelings of worthlessness and hopelessness, social withdrawal, and cognitive and physical sluggishness.
- **Maladaptive behaviour:** Behaviour that hinders a person's ability to function in work, school, relationships, or society.
- **Medical model:** Sees psychological conditions through the same lens as Western medicine tends to see physical conditions—as sets of symptoms, causes, and outcomes, with treatments aimed at changing physiological processes in order to alleviate symptoms.
- **Mental disorder defence:** Claims that the defendant was in such an extreme, abnormal state of mind when committing the crime that he or she could not discern that the actions were legally or morally wrong.
- **Multiple personality disorder:** A person experiences a split in identity such that they feel different aspects of themselves as though they were separated from each other; this can be severe enough that the person constructs entirely separate personalities, only one of which will generally be in control at a time.
- **Narcissistic personality disorder (NPD):** Characterized by an inflated sense of self-importance and an excessive need for attention and admiration, as well as intense self-doubt and fear of abandonment.
- **Negative symptoms:** The absence of adaptive behaviour, such as absent or flat emotional reactions, lack of interacting with others in a social setting, and lack of motivation.
- **Neurodevelopmental hypothesis:** The adult manifestation of what we call "schizophrenia" is the outgrowth of disrupted neurological development early in the person's life.
- **Obsessive-compulsive disorder (OCD):** Plagued by unwanted, inappropriate, and persistent thoughts (obsessions), and tending to engage in repetitive, almost ritualistic, behaviours (compulsions).
- **Panic attacks:** Brief moments of extreme anxiety that include a rush of physical activity paired with frightening thoughts.
- **Panic disorder:** An anxiety disorder marked by occasional episodes of sudden, very intense fear.
- **Paranoid schizophrenia:** Symptoms include delusional beliefs that one is being followed, watched, or persecuted, and may also include delusions of grandeur or the belief that one has some secret, insight, power, or some other characteristic that makes one particularly special.

- **Parasitic processing:** Mutually reinforcing feedback loops linking different cognitive and neural processes together.
- **Personality disorders:** Particularly unusual patterns of behaviour (relative to one's cultural context), that are maladaptive, distressing to oneself or others, and resistant to change.
- **Phobia:** A severe, irrational fear of a very specific object or situation.
- **Post-traumatic stress disorder (PTSD):** Is a common psychological illness involving recurring thoughts, images, and nightmares associated with a traumatic event; it induces symptoms of tension and anxiety and can seriously interfere with many aspects of a person's life.
- **Positive symptoms:** The presence of maladaptive behaviours, such as confused and paranoid thinking, and inappropriate emotional reactions.
- **Prodromal phase:** Phase of schizophrenia during which people may become easily confused and have difficulty organizing their thoughts, they may lose interest and begin to withdraw from friends and family, and they may lose their normal motivations, withdraw from life, and spend increasing amounts of time alone, often deeply engrossed in their own thoughts.
- **Residual phase:** Phase of schizophrenia during which people's predominant symptoms have disappeared or lessened considerably, and they may simply be withdrawn, have trouble concentrating, and generally lack motivation.
- **Residual schizophrenia:** This category reflects individuals who show some symptoms of schizophrenia but are either in transition to a full-blown episode or in remission.
- **Schizophrenia:** A brain disease that causes the person to experience significant breaks from reality, a lack of integration of thoughts and emotions, and problems with attention and memory.
- **Social anxiety disorder:** A very strong fear of being judged by others or being embarrassed or humiliated in public.
- **Specific phobia:** An intense fear of a specific object, activity, or organism.
- **Undifferentiated schizophrenia:** This category includes individuals who show a combination of symptoms from more than one type of schizophrenia.