ABNORMAL PSYCHOLOGY

SPARK CHARTS

INTRODUCTION

DEFINITION

Abnormal psychology: the study of abnormal behavior, including theories and research about causes, assessment, and treatment

Psychopathology: an abnormal pattern of behavior that is unusual, distressing, dysfunctional, and that may cause the sufferer to be dangerous to self or others

A. Criteria for defining abnormal behavior include:
   1. **Personal distress:** subjective experience of suffering
   2. **Statistical rarity:** has unusual behaviors (e.g., binge eating)
   3. **Maladaptive behavior:** has impaired functioning (e.g., insomnia, poor reality testing)
   4. **Violation of social norms:** exhibits behavior that is socially undesirable
   5. **Danger to self or to others:** usually dangerous to self via poor judgment
   - No single criterion is adequate; need to consider cultural norms in defining abnormality

B. The official definition of abnormal behavior stresses:
   1. **Impairment:** difficulty in carrying out everyday functions (e.g., work, maintaining relationships) in an adaptive manner
   2. **Distress:** emotional suffering (e.g., anxiety, depression)
   3. **Significant risk of pain, death, or important loss of freedom** (e.g., self-mutiliation)

C. No sharp dividing line between normal and abnormal

MAIN THEORIES OF ABNORMAL BEHAVIOR

BIOLOGICAL THEORY

Deficits or defects in the structural or functional integrity of the nervous system lead to abnormal behavior. Types of biological abnormalities include:

A. **Defective genes:** each chromosome contains thousands of **genes** (carriers of DNA) that influence psychological and physical development. Defective genes may adversely affect development (e.g., trisomy causes Down syndrome).
   - **Behavior genetics:** the study of individual differences in behavior that are caused by differences in **genotype** (a person's genetic makeup). Typically, it takes a combination of several altered genes to cause a disorder.

B. **Structural brain abnormalities:** occurs when areas of the brain have not developed optimally or have undergone pathological changes (e.g., the **ventricles**, which are the fluid-filled portions of the cortex, often are larger in schizophrenics).

C. **Neurotransmitter imbalances:** the 100 billion neurons in the **central nervous system** (CNS) communicate by chemical messengers called **neurotransmitters**, which can become imbalanced. Biological approaches to treatment focus mainly on medications that address neurotransmitter imbalances.
   1. **Neurotransmitters** (e.g., serotonin, dopamine, norepinephrine, GABA) are released into the **synaptic cleft** (the small gap between the axon of one and the dendrites of the receiving or postsynaptic neuron). They regulate level of mood, anxiety, and cognitive functioning. Factors affecting imbalance include:
      a. Number, distribution, and functioning of receptors on the **dendrites** (the receiving branches of the neuron)
      b. **Reuptake:** the amount of neurotransmitter in the synaptic cleft, or vesicle, that is reabsorbed by the releasing neuron
      c. **Degradation:** the process by which a neurotransmitter is broken down by enzymes released by the receiving neuron

D. **Hormones:** chemicals secreted by the **endocrine glands** (e.g., pituitary). They play a role in the functioning of the nervous system and in the regulation of behavior (e.g., during adolescence, changes in the hypothalamic-pituitary-adrenal [HPA] axis are involved in the increase in cortisol, a stress-related hormone).
   - Functioning of neurotransmitters and endocrine glands is based on both biological factors and environmental stressors.

E. Methods used to assess the contribution of biological factors:
   1. **Twin studies:** concordance rates in monozygotic (100% genes in common) and dizygotic twins (50% genes in common) allow researchers to tease apart genetic causes. If the **concordance rate** (the rate at which one twin has the disorder and the other does, too) is higher in monozygotic vs. dyzgotic twins, then the argument is made for a stronger genetic component to the illness.
   2. **Studies of family history:** a researcher identifies those people with the disorder (**probands**), examines family trees, and compares that information with controls, to see what percentage of first-degree relatives also have the disorder. The problem is that one cannot tease apart genetic and environmental causes.
   3. **Adoption studies:** comparisons of rates of the disorder in the adoptive relatives vs. biological relatives of the adoptees. This helps tease apart genetic and environmental causes.

PSYCHOLOGICAL THEORIES

A. **Psychodynamic:** refers to the conflict of forces in the mind. **Sigmund Freud**, the father of **psychoanalysis**, was the founder of modern psychodynamic therapy.
   1. Key assumptions include:
      a. **Psychic determinism:** mental life is lawful (i.e., the apparently random sequences of thoughts are not really random but are guided and connected by underlying motives).
      b. **Unconscious motivation:** most of mental life, particularly wishes, operates outside of awareness
   2. The mind is organized on the basis of conflicts between:
      a. **Id:** the unconscious wishes
      b. **Ego:** coping and defense mechanisms
      c. **Superego:** the conscience
   3. **Instinctual drives:** Freud posited that **sex** (broadly defined as physical urges) and **aggression** are the two main instinctual drives
   4. **Defenses:** if a person has wishes, desires, and fantasies (based on these drives) that he/she regards as unacceptable and that arouse anxiety, he/she deals with them by means of **defense mechanisms**
      - **Defense mechanism:** any mental process or behavior can be used to ward off negative feelings (*see chart, above right*)

Defense Mechanism	Description
Repression	Keeping unacceptable wishes from consciousness
Projection	Attributing unacceptable wishes to someone else (e.g., "I don't hate you—you hate me")
Reaction formation	Transforming unacceptable wishes into their opposite (e.g., being saccharine-sweet rather than hostile)
Displacement	Redirecting a feeling from one person to another
Regression	Reverting to behavior from an earlier stage in development to avoid anxiety
Rationalization	Presenting a socially acceptable reason for behavior as a way of avoiding the real reason
Denial	Disavowing an action, thought, or feeling; refusing to admit to an aspect of reality
Intellectualization	Avoiding unpleasant feelings by adopting a highly ideational approach
Isolation of affect	Keeping ideas and their feelings they excite separate in one's mind
Sublimation	Redirecting unacceptable impulses to socially desirable behavior

   5. Symptoms arise when threatening wishes are too strong and/or defenses are too weak.
   6. Freud described **four psychosexual stages of development**: oral, anal, phallic, and genital. Excessive gratification or deprivation at a given stage can result in:
      a. **Fixation:** stagnation at that stage
      b. **Regression:** a return to aspects of a given stage at times of stress (e.g., reverting to thumb-sucking following the birth of a sibling)

B. **Behavioral:** focus on observable behavior rather than on the person's inner mental life. Abnormal behavior is based on *learning* and environmental experiences.
   1. **Classical conditioning (Pavlov):** the pairing of contiguous events makes organisms learn associations between things, creating involuntary responses to stimuli
      Elements of classical conditioning:
      a. UCS (unconditioned stimulus, food) => UCR (unconditioned response, salivation to food)
      b. UCS (food) + CS (conditioned stimulus, bell)=> UCR (salivation to food)
      c. CS (bell) => CR (conditioned response, salivation to bell)
         - **Extinction** of the conditioned response happens when, over the course of many trials, the sound of the bell is not followed by food
   2. **Operant conditioning:** the shaping of behaviors via **reinforcers** (i.e., rewards and punishments).
      a. **Positive reinforcers:** rewards that increase the probability of behavior
      b. **Negative reinforcers:** the removal of aversive stimuli that increase the probability of behavior (e.g., a social phobic feels relieved of anxiety when she avoids parties, so she continues to avoid)
      c. **Punishment:** negative consequences that decrease the probability of behavior
      d. **Thorndike's law of effect:** behaviors followed by punishment are weakened; behaviors followed by rewards are strengthened.
      e. Extinction is more difficult with a **partial**, in comparison with a **continuous**, **reinforcement** schedule.
   3. **Modeling:** learning based on observing others. Even in the absence of obvious reinforcers, we learn and behave by watching and imitating others. We are influenced by the rewards and punishments others receive for their actions.

C. **Cognitive:** one's misconceptions of the world and misinterpretations of experience lead to beliefs and thoughts that cause negative feelings and behaviors, making one more vulnerable to abnormalities
   1. Dysfunctional ideas and causal attributions are distorted, self-defeating, and irrational. These incorrect thoughts are based on faulty **schemas** (organizations of beliefs and assumptions).
   2. **Beck** and **Ellis** are major proponents of the cognitive view. Ellis focuses on common irrational beliefs that must be overcome (e.g., "Everyone must love me"). Beck emphasizes the **cognitive triad** in depressed patients (having a negative view of themselves, the world, and their future).

D. **Humanistic/existential views:** focus on man's mortality, responsibility for decision-making, and his search for meaning in life. Proponents believe that disorders arise when people feel compelled to conform to parental/societal demands instead of acting with authenticity in the pursuit of their own true values and goals. Authencity is more apt to promote **self-actualization** (the fulfillment of one's potential).

E. **Sociocultural perspectives**
   1. Focuses on the impact of social forces, family and cultural influences, and failures of society on individual mental health
   2. Failure of **support system:** family, friends, community in times of stress (e.g., poverty, gender or racial discrimination, lack of opportunity)

BIO-PSYCHO-SOCIAL INTEGRATION

Abnormality is a function of the interaction of these three sets of factors and the vulnerability they create in the individual.

THE DIATHESIS-STRESS MODEL

Individual differences in **vulnerability** (diathesis), due to biological and psychological factors, interact with **stressors** in the environment. Proponents believe that particular combinations of diathesis and stress cause abnormal behavior.

- High stress and low diathesis or low stress and high diathesis both can lead to psychological disturbance.

ABNORMAL PSYCHOLOGY

CLASSIFICATION OF MENTAL DISORDERS

CLASSIFICATION

A. DSM-IV-TR: *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed., Text Revision (DSM-IV-TR), published by the American Psychiatric Association (2000).
1. This is the current classification system of mental disorders used for insurance, research, and record-keeping. Researchers use the DSM-IV-TR to classify:
   a. **Dimensions:** quantitative (e.g., a matter of degree of the disorder)
   b. **Categories:** qualitative (e.g., presence vs. absence of a disorder)
2. Contains information on inclusion criteria, exclusion criteria, duration of disorder, and associated features
3. Includes a classification system that classifies via five axes
4. Each axis includes categories that describe **syndromes**—sets of symptoms. Each general category consists of a number of subcategories.

Axis I	All categories of **clinical syndromes** (a configuration of symptoms), except personality disorders and mental retardation
Axis II	**Personality disorders** (long-standing patterns of maladaptive behavior) and **mental retardation** (deficient cognitive functioning)
Axis III	General medical conditions
Axis IV	**Psychosocial stressors** (recent stressors, social resources, sociocultural background) and **environmental problems**
Axis V	Global level of current functioning (overall clinical rating of degree of impairment)

DIAGNOSIS

Clinical Assessment: sampling of behavior in different domains to arrive at a diagnosis, case formulation, and treatment plan.

A. Methods of assessment
1. **Interview**
   a. **Structured:** pre-set format of questions
   b. **Unstructured:** open-ended set of questions. Format depends on purpose of interviewer (i.e., research vs. treatment) and on the theoretical orientation of the interviewer.
2. **Psychological tests and questionnaires**
   a. **Performance-based measures**
      i. **Intelligence tests** (e.g., Wechsler Adult Intelligence Scale-Revised, or WAIS-R): used to derive Intelligence Quotient (IQ) based on verbal (e.g., abstract thinking, vocabulary) and nonverbal (e.g., visual-spatial ability, information processing speed) functioning. IQ of 90-110 is considered average.
      ii. **Neuropsychological tests** (e.g., Halstead-Reitan Test): used to assess cognitive/perceptual, emotional, and behavioral deficits and disturbances caused by brain dysfunctions (e.g., the Bender Visual-Motor Gestalt Test requires the reconstruction of and memory for designs, and can aid in the diagnosis of organic brain impairment).
   b. **Psychosocial/affective measures**
      i. **Projective tests** (e.g., Rorschach; Thematic Apperception Test, or TAT): tests are based on the theory that the person's interpretation of ambiguous stimuli is a good way to uncover feelings and conflicts, particularly unconscious ones.
      ii. **Self-report inventories:** structured questionnaires and rating scales
         • **BDI (Beck Depression Inventory):** 21-item questionnaire; responses indicate severity of depressive symptoms.
         • **MMPI (Minnesota Multiphasic Personality Inventory):** most popular personality inventory; tests for symptoms of personality disorders
   c. **Behavioral assessments**
      i. **Observation by others:** observations of nonverbal or verbal behaviors
      ii. **Self-observation:** patient tracks aspects of own behavior (e.g., eating, smoking), a process called **self-monitoring**
   d. **Physical assessments**
      i. **Physiological (EEG, EKG, EMG)**
         • **EEG:** electrodes on the scalp record the electrical activity of brain areas
      ii. **Neuroimaging**
         • **Structural imaging** (e.g., CT scan, MRI)
         • **Functional imaging** (e.g., fMRI, PET, SPECT): provide a picture of the structure and functioning of the brain
   e. **Multi-method assessment:** integration of several or all other types of assessments

Pros and cons of formal diagnosis using DSM-IV-R:

A. Pros:
1. Facilitates research, record-keeping, and statistical information
2. Helps one search for etiology, implications for treatment and case management decisions, and prognosis
3. Provides a common language for clinicians

B. Cons:
1. Stigmatizing
2. Categories not homogeneous
3. Condensed format leads to a loss of information

RESEARCH METHODS

A. Case study: a detailed history of an individual's life and psychological problems
B. Correlational study: examines strength of the relationship between events or characteristics
C. Epidemiological studies: study of the frequency and distribution of disorders within a population in relation to demographic factors
1. **Incidence:** number of *new* cases of a disorder that appear in a population in a specific time period.
2. **Prevalence:** number of *active* cases in a population at a specific time
   a. **Lifetime prevalence:** proportion of people in population affected at some point in their lives
   b. **Point prevalence:** number of people who have the disorder at one given point in time

D. Experiment: controlled manipulation of a variable and the observation of its effect

TYPES OF DISORDERS

ANXIETY DISORDERS

Anxiety: a state of unpleasant apprehension and tension in which a person fears some type of future negative experience

TYPES OF ANXIETY DISORDERS

A. Phobias: Characterized by disruptive and intense, irrational fears of specific objects or situations. These fears are disproportionate to the actual danger of the object or event.
1. **Specific phobias:** excessive, irrational fear caused by a particular object or event (e.g., animals, blood, injections, heights)
   a. **Agoraphobia:** fear of open, public spaces or being unable to escape a public situation if one is incapacitated, especially by a panic attack
   b. **Claustrophobia:** fear of closed spaces
   c. **Acrophobia:** fear of heights
2. **Social phobia:** constant, irrational fear of specific or general situations that involve other people; fear of social performance and being judged by others. Sufferer avoids social situations that could be embarrassing, result in a negative evaluation, or show that he/she is anxious.

B. Panic disorder: characterized by intermittent anxiety and by a sudden onslaught of symptoms called **panic attacks.** People with panic disorder can fear losing control, going crazy, or dying, and experience depersonalization and derealization. Can occur with or without agoraphobia.
1. **Panic attacks:** episodes of intense fear and four or more symptoms (e.g., heart palpitations, nausea, chest pain, dizziness, sweating, trembling, choking sensations, difficulty breathing, terror, intense apprehension). Attacks tend to be brief but are recurrent and unexpected.
2. **Depersonalization:** state of feeling estranged from one's body
3. **Derealization:** state of feeling as if the world or surroundings are not real

C. Obsessive-compulsive disorder (OCD): sufferer is compelled to repeat acts (compulsions) and/or is flooded with uncontrollable and persistent thoughts (obsessions), which cause distress and interfere with daily functioning
1. **Obsessions:** uncontrollable, intrusive, and repetitive thoughts, images, and impulses that cause anxiety
2. **Compulsions:** repetitive behavior or mental act that is performed to counteract the distress of the obsessive thoughts (e.g., hand-washing, counting)

D. Generalized anxiety disorder (GAD)
1. Sufferer experiences chronic, uncontrollable, and pervasive low-level anxiety and worry
2. Symptoms include: difficulty concentrating and sleeping, irritability, muscle tension, pounding heart, sweating, restlessness, and upset stomach

E. Post-traumatic stress disorder: intense fear in reaction to a traumatic event
1. Sufferers experience all of the following categories of symptoms:
   a. Re-experiencing the event through intrusive memories, nightmares, or flashbacks
   b. Avoidance of reminders of the event or other, unrelated people and activities
   c. Persistently increased arousal (e.g., anger, trouble sleeping, hypervigilance)

CAUSES OF ANXIETY DISORDERS

A. Biological:
1. Neurotransmitter dysregulation (e.g., deficiency of GABA in generalized anxiety disorder)
2. Increased physiological sensitivity (some people are more reactive and easily aroused)
3. Genetic factors

B. Behavioral:
1. Learned alarms (e.g., mild physical cues become linked with panic attacks)
2. Classical conditioning creates fear of non-dangerous events/objects; operant conditioning maintains avoidance of feared stimuli
3. Modeling (observational learning)

C. Cognitive:
1. Misinterpretations (e.g., overestimate probability of negative event, underestimate own ability to cope)
2. Sense of unpredictability and lack of safety/control, magical thinking (e.g., thinking that worrying or performing compulsion may superstitiously prevent feared event)

TREATMENT FOR ANXIETY DISORDERS

A. Drug therapy: benzodiazepines, beta blockers, antidepressants
B. Cognitive therapy: helps patients identify and change negative, irrational thoughts associated with their anxieties
C. Behavior therapy: focuses on extinguishing fear by exposing patient to the feared object or situation, gradually (e.g., systematic desensitization) or intensely (e.g., flooding)
• **Modeling:** therapist models behavior that the patient fears and then encourages the patient to do so
D. Psychodynamic therapy: addresses underlying, often unconscious conflicts associated with various anxieties

DISSOCIATIVE DISORDERS

Aspects of one's identity, consciousness, or memory become split off from one another. These disorders usually follow heightened stress or trauma.

TYPES

A. Dissociative identity disorder (formerly known as **multiple personality disorder**): separate personalities coexisting in the same person. A given personality may or may not be aware of the existence of **alters** (the other personalities).
- Alters have different names, different ways of speaking and relating to others, and even may have different physiological reactions (e.g., "child," "persecutor," and "helper" personalities).

B. Dissociative fugue: person loses all memory of his/her identity, moves to a new place, and assumes a new identity. Can last for days or years; usually occurs during adulthood.

C. Dissociative amnesia: loss of memory for significant personal facts, usually related to a traumatic experience
1. **Localized amnesia:** failure to recall events about the first few hours or days after a traumatic experience
2. **Selective amnesia:** failure to recall some of these events
3. **Generalized amnesia:** failure to recall anything about one's prior life

D. Depersonalization disorder: feelings of detachment, as though one is an outside observer of one's self or mental processes

MOOD DISORDERS

Mood disorders include changes in emotional state, motivation, cognition, and somatic state. About 6.6% of Americans (13–14 million) experience major depression each year. The lifetime prevalence for adults is 16.2%, with roughly a 2:1 ratio of females to males.

TYPES

A. Unipolar disorders
1. **Major depression:** women 2–3 times more likely than men to get this diagnosis
   a. **Main symptoms:** for more than two weeks, five or more symptoms (e.g., **depressed mood** [persistent periods of feeling down, sad, depressed]; crying; sleep problems; weight loss or gain; psychomotor agitation or retardation; suicidal ideation; poor concentration; **low self-esteem** and feelings of worthlessness or guilt; fatigue)
   b. **Several subtypes:** melancholic, catatonic, or psychotic features; postpartum onset; seasonal pattern (e.g., **seasonal affective disorder**, or SAD)
2. **Dysthymic disorder:** similar symptoms at a much milder level for at least two years
3. **Double depression:** major depressive episode superimposed on dysthymic disorder

B. Bipolar disorders (manic-depression): mood swings from extreme highs to extreme lows.
1. **Bipolar I (manic episode)**: elevated mood; inflated, grandiose self-image; more talkative; little sleep; flight of ideas; pressured speech; high risk-taking (e.g., foolish business ventures, excessive spending sprees, sexual promiscuity). Patient meets criteria for mania and, at some point, for major depression. Episodes of mania and depression may alternate in more or less rapid cycles or be mixed.
2. **Bipolar II (hypomanic episode)**: same but much milder; no history of a manic episode. Alternating periods of major depressive episodes and hypomanic episodes (which have similar symptoms to manic episodes, but may be shorter and are less severe and impairing).
3. **Cyclothymic disorder:** alternation of depressive symptoms (in the dysthymic range) and hypomanic episodes for at least two years.

SUICIDE

Suicide is the third leading cause of death in people 15–24, often via drug overdose. Alcoholism often is correlated to suicide as well. The elderly are more likely to commit suicide than any other age group. Up to 70% of all suicides result from a mood disorder.

A. Warning signs: social withdrawal, decline in school functioning, loss of appetite, sleep problems. More apt to occur when depression has lifted somewhat.
1. Stressful life events also contribute to serious illness. Important losses lead to sense of hopelessness and negative expectations, depression.
2. Suicide does not necessarily occur because someone is psychotic

B. Three types of suicide (Durkheim)
1. **Egoistic:** people who are alienated and are unconcerned with societal norms
2. **Anomic:** people who feel let down by society and/or have experienced major change
3. **Altruistic:** believe it will benefit society

C. Main **interventions** for those at high risk: medication, crisis intervention, hospitalization, psychotherapy

THEORIES OF MOOD DISORDERS

A. Biological theories
1. **Genetic predisposition**
   a. Stronger for bipolar disorders
   b. Genetic contribution determined by twin and adoption studies
2. **Neurotransmitter dysregulation**
   a. **Catecholamine hypothesis:** depression results from decreased levels of norepinephrine
   b. **Indoleamine hypothesis:** depression results from decreased levels of serotonin
   c. Antidepressants act to reduce the reuptake of these neurotransmitters

B. Behavioral views
1. Life stress => social withdrawal => reduction in positive reinforcements => depression
2. **Seligman's learned helplessness theory:** derived from dogs' reactions to inescapable electric shock. States that one gives up after learning that one's efforts are futile in avoiding pain and frustration.

C. Cognitive views: faulty thinking
1. **Cognitive triad (Beck):** negative view of self, others, and future
   a. **Schemas** (set of stable, organized rules and assumptions about oneself and the world) are rigid, negative, dysfunctional
   b. Schemas show indications of: overgeneralization, excessive sense of responsibility, all-or-nothing thinking.
   c. Negative automatic thoughts and cognitive distortions promote and maintain depression

D. Psychodynamic view: Freud's essay *Mourning and Melancholia*
1. Differentiates normal process of grieving from depression.
2. Both processes involve loss; key symptom in depression is self-reproach, and in depression anger is turned against the self
3. Combination of poor self-esteem, unconscious self-punishment, and sense of loss and abandonment make one vulnerable to depression

TREATMENTS FOR MOOD DISORDERS

A. Biological
1. Tricyclic antidepressants, MAO inhibitors, SSRIs
2. Electroconvulsive therapy (ECT)
3. Light therapy for SAD
4. Lithium for bipolar disorders

B. Psychological therapies
1. Behavior therapy (increase positive reinforcers)
2. Cognitive therapy (change negative thinking)

C. Psychodynamic approaches
1. Analyze sources and conflicts linked to mood disorder
2. Help clients deal with loss, role transitions, deficits in interpersonal skills

EATING DISORDERS

TYPES

A. Anorexia nervosa: 90-95% or more are females who try to starve themselves to become as thin as possible, dread weight gain, and are convinced that they are not thin enough. More common in middle- and upper-class, educated families and in athletes, dancers, and models.
1. **Diagnostic criteria:** refusal to maintain healthy body weight (at least 85% of expected weight), intense fear of weight gain, distortion of body image, amenorrhea.
2. **Two types**
   a. **Restricting:** no binge eating or purging
   b. **Binge/purge:** regular bingeing and/or purging

B. Bulimia nervosa: repeated episodes of binge eating with repeated compensatory behaviors (e.g., self-induced vomiting, use of laxatives, diuretics, enemas; fasting; excessive exercise); overfocus on body image; feelings of loss of control around food
- **Causative factors:** cultural emphasis on thinness; family dynamics (pressure for achievement, enmeshed families, deficits in sense of self, distorted body image)

TREATMENTS FOR EATING DISORDERS

A. Cognitive-behavioral therapies to correct attitudes and behaviors about eating
B. Some cases of anorexia nervosa require hospitalization and forced feeding
C. Medication: antidepressants (SSRIs)

SUBSTANCE-RELATED DISORDERS

A **psychoactive drug** is a synthetic or natural chemical that affects mental functioning (e.g., alters mood, cognitions, motivation, or states of consciousness).

TYPES

A. Substance use disorders
1. **Substance dependence:** involves three or more of the following symptoms:
   a. Physiological dependence indicated by **tolerance** (increasingly less effect from the same dose or increasing dose needed to produce the same effect) or **withdrawal** (unpleasant and possibly dangerous physical reactions that can occur when a person reduces or stops intake of a drug)
   b. Strong focus on obtaining the substance
   c. Impaired functioning due to use of the substance
   d. Inability to curtail or control use of the substance
2. **Substance abuse:** maladaptive pattern due to substance use as seen by one or more of the following:
   a. Continued use despite interpersonal difficulties, legal problems, or physically hazardous situations (e.g., drunk driving)
   b. Continued use despite interference with major responsibilities (e.g., work, school).
3. **Types of substances used:** depressants (e.g., alcohol, barbiturates), stimulants (e.g., amphetamines, cocaine), opioids (e.g., heroin), hallucinogens (e.g., LSD, PCP)
4. **Substance-induced disorders:** psychosis, sleep disorder

THEORIES

A. Biological: genetic vulnerability
B. Psychological: cognitive factors (e.g., expectation of relief from anxiety and stress)
C. Behavioral: substance use is reinforcing; stopping use leads to negative consequences (e.g., increased anxiety, withdrawal)

TREATMENTS

A. Biological: SSRIs; disulfiram (antabuse) for alcoholism
B. Cognitive-behavioral treatments: aversive classical conditioning, covert sensitization therapy, relapse prevention programs, Alcoholics Anonymous (AA)

CONTINUED ON OTHER SIDE

SLEEP DISORDERS

Dyssomnias	Symptoms
Primary insomia	Difficulty falling asleep or staying asleep
Primary hypersomnia	Excessive sleepiness
Narcolepsy	Falling asleep, often suddenly, with either **cataplexy** (episodes of bilateral loss of muscle tone) or repeated intrusions of some **REM** (rapid eye movement) sleep during the shift between sleep and wakefulness
Breathing-related sleep disorder	Breathing disturbances that disrupt sleep in the form of hypersomnia or insomnia
Circadian rhythm sleep disorder	Pattern of sleep disruption leading to hypersomnia or insomnia; due to a disturbance in circadian rhythm (e.g., due to jet lag or shift in work schedule)

Parasomnias	Symptoms
Nightmare disorder	Repeated awakenings due to nightmares
Sleep terror disorder	Repeated episodes of sudden awakening with a panicked scream, along with autonomic arousal and intense fear; not comforted by efforts of others; amnesia of the entire episode, including the dream
Sleepwalking disorder	Repeated episodes of getting out of bed during sleep and walking around with a blank stare; relatively unresponsive to others, including their attempts to awaken the sleepwalker

SEXUAL DISORDERS

Problems in desire, arousal, and/or performance that cause interpersonal problems and distress; deviant sexual activity **(paraphilias)**

TYPES

Sexual Desire Disorders	Symptoms
Hypoactive sexual desire disorder	Lack of sexual desire
Sexual aversion disorder	Marked aversion to and avoidance of sex

Sexual Arousal Disorders	Symptoms
Female sexual arousal disorder	Inability to become aroused or to maintain adequate sexual arousal
Male erectile disorder	Difficulty in attaining or sustaining erection necessary for intercourse
Orgasmic disorders	Early, delayed, or absent orgasm (e.g., **premature ejaculation**, ejaculation after minimal stimulation)
Sexual pain disorders	**Dyspareunia** (genital pain); **vaginismus** (involuntary vaginal spasm that prevents adequate intercourse)

Paraphilias	Symptoms
Exhibitionism	Genital exposure to strangers
Fetishism	Focused erotic use of inanimate objects (e.g., high heels), often to the exclusion of other sources of arousal
Frotteurism	Rubbing against a nonconsenting person for erotic stimulation
Pedophilia	Sexual contact with a prepubescent child
Sexual masochism	Sexual arousal in response to experiencing hurt, humiliation, bondage, or other suffering in a sexual encounter
Sexual sadism	Sexual arousal in response to the partner's humiliation or suffering
Transvestic fetishism	Need or desire to cross-dress in order to feel aroused
Voyeurism	Sexual arousal via looking at naked or sexually engaged, unsuspecting person
Gender identity disorder	Wishing to be the other sex in manner of dress, playmate preferences, preference for sex roles of the opposite gender; feeling trapped in the wrong body

THEORIES AND TREATMENT

Sexual disorders are caused by interaction of biological, psychological, and social factors. Treatments include medication (e.g., Viagra), sex therapy, couples and individual therapy; for gender identity disorder, counseling and possibly gender reassignment. Treatments for paraphilias include cognitive-behavioral strategies (e.g., aversion therapy) and chemical castration.

PSYCHOTIC DISORDERS

SCHIZOPHRENIA

The most severe disorder of all, schizophrenia is a complex, severely disabling disorder that takes many forms, all of which involve disturbances in reality testing.

A. History
1. **Dementia praecox:** Kraeplin believed the disorder was due to premature brain deterioration that was progressive and irreversible
2. Bleuler coined term schizophrenia ("split mind")

B. Prevalence: affects about 1% of the U.S. population in any given year; found across cultures
1. Schizophrenia typically develops in late adolescence/early adulthood (late teens, early 20s). Can develop later, especially with women. Often develops over time and has a long course or duration. Also may have an acute onset.

C. Symptoms
1. **Four domains:**
   a. **Disorganized behavior:** chaotic functioning, bizarre behavior, odd motor movements or posturing
   b. **Disturbances in thought and speech:** delusions, disorganized thinking, and/or bizarre communication characterized by nonsensical words and phrases
      • **Delusions:** false, unrealistic belief held with conviction (e.g., delusions of reference, grandeur, control)
   c. **Perceptual disturbances**
      • **Hallucinations:** projection of internal sensory experiences onto the outside world (e.g., auditory, visual)
   d. **Emotional disturbances:** very socially isolated and withdrawn, marked decreases in motivated, goal-directed behavior, disturbance in the sense of self, poor self/other differentiation; flat or inappropriate affect
2. **Two types of symptoms**
   a. **Positive symptoms** (Type I): delusions, hallucinations, speech and thought incoherence (errors of commission)
   b. **Negative symptoms** (Type II): flat affect, avolition/apathy, social withdrawal, anhedonia (errors of omission)

D. Diagnostic criteria for schizophrenia
1. Two or more of the following five symptoms must be present in a significant way for at least one month during a period of six months: delusions, hallucinations, markedly disorganized or catatonic symptoms, and negative symptoms
2. The patient must have symptoms continuously for at least six months, with at least one month of acute symptoms, as noted above
3. If the symptoms are present for at least one month but less than six months, the diagnosis of **schizophreniform disorder** (*see* Other Psychotic Disorders, *below*) is made

E. Phases of schizophrenia
1. **Prodromal phase:** early signs of deterioration, which may last for years. Typical elements of a prodromal phase are:
   a. Decreased interest in social activities
   b. Difficulty meeting requirements of daily living (e.g., lapses in work at home/school)
   c. Some strange behavior (e.g., feeling like another person is in an empty room)
2. **Acute phase:** floridly psychotic (full-blown hallucinations and/or delusions develop); very difficult to understand or communicate with the person.
3. **Residual phase:** behavior returns to prodromal level, but patient still shows difficulty meeting demands of social roles

F. Subcategories of schizophrenia
1. **Paranoid:** characterized by delusions and hallucinations, with themes of persecution and/or grandiosity; often no gross disorganization of speech and behavior; no prominent negative symptoms
2. **Disorganized** (formally called **hebephrenic**): severe disorganization of behavior and marked incoherence of thought and speech (e.g., the patient might use a **word salad** [bizarre stream of words] or **neologisms** [made-up words]); inappropriate or flat affect; odd mannerisms. One often observes poor self-care as well.
3. **Catatonic:** at least two of the following:
   a. **Stupor** (remaining motionless for long periods of time, as though comatose) or **motoric immobility** (e.g., **waxy flexibility:** patient sits in rigid, often strange posture and remains passive if the examiner alters his/her position)
   b. **Excitement:** aimless, excessive motor activity
   c. **Marked negativism**
   d. **Strange, stereotyped** movements, mannerisms, gestures
   e. **Echolalia** (automatic repetition of voices) or **echopraxia** (automatic repetition of another person's movements)
4. **Undifferentiated schizophrenia:** Does not meet criteria for any of the other three types, but does meet criteria under diagnostic criteria for schizophrenia (*see above*).

OTHER PSYCHOTIC DISORDERS

A. Schizophreniform disorder: meets criteria for schizophrenia for fewer than six months, but more than one month

B. Brief psychotic disorder: one or more of the following symptoms for at least one day but less than one month, with eventual full return to premorbid functioning: delusions, hallucinations, disorganized speech, or behavior

C. Shared psychotic disorder (*folie à deux*): two people in a close relationship who share the same delusion

D. Schizoaffective disorder: meets criteria for both schizophrenia and a mood disorder. Has delusions or hallucinations for at least two weeks in the absence of significant mood symptoms. Can be either bipolar type or depressive type.

E. Substance-induced psychotic disorder: hallucinations or delusions due to a substance

F. Delusional disorder: for at least one month, clear delusions but not bizarre (e.g., **erotomania:** delusional belief that a person of higher status is in love with one). No indication of the main schizophrenia symptoms. Behavior outside delusional beliefs is not grossly impaired.

THEORETICAL EXPLANATIONS OF SCHIZOPHRENIA

A. Biological:
1. **Genetic factors:** degree of risk correlates with degree of shared genes, but concordance rates for identical twins leave room for environmental and other factors
2. **Structural brain abnormalities** (e.g., reduction in gray matter or low metabolic rates in the prefrontal cortex and larger cerebral ventricles implies a loss of brain cells)
3. **Dopamine hypothesis:** positive symptoms of schizophrenia related to excess dopamine activity in the brain
4. **Pregnancy complications**, especially maternal influenza during gestation

B. Psychological:
1. Adverse family environment (e.g., **high "expressed emotion":** negative criticism by hostile, overinvolved family members) leads to increased stress and higher relapse rates
2. Communication deviance (e.g., **double-bind message:** inconsistent, contradictory messages, as when a parent encourages patient to be closer and then is rejecting)
3. Behavioral theories stress that schizophrenics have not learned appropriate social skills and acceptable social repsonses. Cognitive theories focus on the patient's delusional beliefs as ways of understanding their peculiar perceptions, which were biologically caused.

PSYCHOTIC DISORDERS (CONTINUED)

TREATMENT

A. Medical
1. In 1950s, major tranquilizers (called neuroleptics or anti-psychotic drugs [e.g., chlorpromazine]) discovered to control positive symptoms. These drugs block dopamine receptors in the brain. Side effects include tardive dyskinesia.
   a. **Tardive dyskinesia:** movement disorder that affects face, mouth, neck, extremities.
2. New drugs called **atypical antipsychotics** have been introduced (e.g., clozapine, which seems to help both positive and negative)

B. Psychological approaches: social skills training; family therapy; community treatment programs (e.g., halfway houses); psycho-education of the family

CHILDHOOD DISORDERS

TYPES

A. Attention-deficit hyperactivity disorder (ADHD)
1. **Symptoms:** inattention, hyperactivity, and impulsivity
2. **Biological factors:** often occurs if there are prenatal and birth complications, or immature brain development. Disorder runs in families.
3. **Psychological factors:** adverse psychological environment (e.g., disrupted families)
4. **Treatment**
   a. **Medical:** Ritalin
   b. **Behavioral:** therapy in which teachers and parents reward patient's self-control and attentiveness

B. Conduct disorder and oppositional defiant disorder
1. **Characteristics**
   a. **Conduct disorder:** person violates rights of others and societal norms for appropriate, rule-bound behavior.
   b. **Oppositional defiant disorder:** negative, irritable, uncooperative, argumentative; less severe than in conduct disorder
2. **Contributing factors:** difficult temperament, parental violence, poor parental supervision and uninvolvement, serotonin imbalances, lower physiological arousal to punishment, increased testosterone levels, genetic predisposition
3. **Treatments:** behavioral and cognitive-behavioral techniques involving both the parents and the affected child

C. Separation anxiety disorder: excessive fear and distress on separation from caregivers
1. **Causes:** parental behaviors that encourage fear; childhood traumas; **behavioral inhibition** (an innate inhibited and fearful temperament)

D. Elimination disorders: disturbances in bladder and bowel control
1. **Enuresis:** unintended urination at least twice per week for more than three months in a child over five
2. **Encopresis:** unintended defecation at least once per month for three months in a child over four

E. Motor skills disorder (developmental coordination disorder): developmental delays or difficulties, especially with motor skills

F. Communication disorders: deficits in verbal communication (e.g., stuttering)
- **Expressive language disorder:** difficulty learning or retrieving words

G. Learning disorders: performance in reading, math, or writing is below that expected for age, grade, or IQ

H. Mental retardation
1. Poor intellectual functioning: IQ below 70
   a. 50–70: mild
   b. 35–50: moderate
   c. 20–35: severe
   d. Below 20: profound
2. Maladaptation in at least two important areas of functioning (e.g., self-care, communication)
3. Biological causes
   a. Phenylketonuria (PKU), a genetically transmitted metabolic disorder
   b. Down syndrome (trisomy 21)
   c. Tay-Sachs disease
   d. Fetal alcohol syndrome
4. Treatment includes social programs (e.g., group homes) and behavioral interventions aimed at self-care and language development

I. Pervasive developmental disorders: severe impairment in several areas of functioning
1. **Autistic disorder:** severe impairment in social interaction, in communication, and in interests and activities
2. **Asperger's disorder:** impairment in social interaction (e.g., nonverbal behavior deficits, lack of peer relationships) and restricted behaviors and interests (e.g., intense preoccupation with a certain subject or object, repetitive movements)
3. **Rett's disorder:** decline of acquired developmental milestones (e.g., language or coordination skills)

J. Feeding and eating disorders of infancy or early childhood
1. **Pica:** ingestion of nonnutritive substances
2. **Rumination disorder:** rechewing and regurgitation of food instead of normal chewing and swallowing

K. Tic disorders
- **Tourette's syndrome:** frequent motor and/or vocal **tics** (rapid, stereotyped, nonrhythmic action)

DELIRIUM, DEMENTIA, AMNESTIC, AND OTHER COGNITIVE DISORDERS

TYPES

A. Delirium: disturbance in conscious experience, with attentional/perceptual and memory deficits caused by a medical or physiological condition (e.g., *due to substance intoxication or withdrawal*)

B. Dementia:
1. **Alzheimer type:** memory impairment, cognitive impairment (e.g., planning and object recognition, or *agnosia*; motor dysfunction, or *apraxia*; language disturbance, or *aphasia*) not due to other factors that can cause these deficits
2. **Vascular dementia:** progressive dementia like Alzheimer's disease, but unlike Alzheimer's, symptoms begin abruptly, often due to stroke. Cognitive dysfunction may be more localized rather than pervasive.

C. Amnestic disorders: disorders of an organic natures involving loss of memory; may be transient or chronic and caused by drug use or medication

PERSONALITY DISORDERS

Described on Axis II; chronic patterns of maladaptive, pervasive, stable, and distressing behavior and inner experience. They are clustered into three main categories.

TYPES

Cluster A: Odd/Eccentric	Symptoms
Paranoid	Suspicious, sees hidden meanings in innocent remarks, fears betrayal
Schizoid	No close friends, aloof and detached
Schizotypal	Social/interpersonal deficits with five (or more) of the following: suspicious thinking, strange beliefs, strange speech, eccentric behavior, unusual perceptions, ideas of reference, marked social anxiety

Cluster B: Dramatic/Erratic	Symptoms
Antisocial	Irresponsible, deceitful; poor regard for rights of others; lack of empathy and remorse; violates social norms; exploitative
Histrionic	Seeks center of attention, often using physical appearance; often sexually provocative/seductive; emotionally shallow; quickly assumes more intimacy than exists early in relationships; impressionistic thinking
Narcissistic	Inflated sense of self, arrogant, deficient in empathy, sees self as special, sense of entitlement
Borderline	Strong and chronic feelings of emptiness, mood instability, disturbance in identity, fears abandonment; unstable, impulsive interpersonal relationships, suicidal gestures, self-mutilation

Cluster C: Anxious/Fearful	Symptoms
Avoidant	Inhibited with others; limits social contact; fears criticism and rejection
Dependent	Wants others to make decisions; fears taking care of self; passive
Obsessive-compulsive	Rigid, preoccupied with details, perfectionistic; has difficulty delegating responsibility; hoards money, objects

IMPULSE-CONTROL DISORDERS

Impulse-Control Disorders	Symptoms
Intermittent explosive disorder	Episodes of aggressive, poorly controlled, over-reactive outbursts that lead to assaultive behavior and/or destruction of property
Kleptomania	Stealing objects not needed for personal use, preceded by a sense of rising tension and followed by a sense of relief and gratification; presumably not motivated by anger
Pyromania	Deliberate setting of fires, accompanied by a cycle of tension, fascination, gratification, and relief
Pathological gambling	Repeated, compulsive gambling of clearly maladaptive proportions
Trichotillomania	Repeated pulling out of clumps of one's hair, resulting in noticeable hair loss; preceded by rising tension and followed by gratification and relief

SOMATOFORM DISORDERS

The experience of physical symptoms for which there is no apparent physical basis

TYPES

A. Conversion disorder: symptom(s) or deficit(s) in sensory or motor function, often suggestive of a neurological condition, but without physical basis (e.g., hand paralysis)

B. Somatization disorder: history of bodily complaints with no apparent physical basis

C. Pain disorder: history of complaints about pain, not fully explained by physical cause

D. Hypochondriasis: chronic worry that one has a physical illness without physical evidence

E. Body dysmorphic disorder: excessive preoccupation with a part of one's body that one believes is defective

ADJUSTMENT DISORDERS

This overall category refers to a variety of relatively milder, but clinically significant, disturbances in mood, anxiety, and/or conduct that are reactions, within three months, to environmental stressors that do not meet criteria for an Axis I disorder.

TREATMENT

TREATMENT OF ABNORMAL BEHAVIOR

A. Drug therapy (psychopharmacology)
1. **Anxiolytics:** used primarily to reduce anxiety (e.g., benzodiazepines like Valium, Xanax, Ativan, Klonopin). Not useful for all anxiety disorders (e.g., panic disorder). Used along with SSRIs for OCD.
2. **Antidepressants:** medications to relieve symptoms of depressive disorders.
   a. **Tricylics** (TCAs such as Elavil, Tofranil, Pamelor, Anafranil): reduce the reuptake of norepinephrine and serotonin
   b. **Selective serotonin reuptake inhibitors** (SSRIs such as Prozac, Paxil, Zoloft, Luvox): reduce reabsorption of serotonin that has been released into the synapse. Can cause agitation.
   c. **Monoamine oxidase inhibitors** (MAOIs such as Nardil, Parnate): prevents the breakdown of neurotransmitters like serotonin and dopamine by inhibiting the enzyme MAO. Bad side effects if taken with cheese, red wine, and other foods.
3. **Mood stabilizers:** (e.g., Lithium, Tegretol, Depekene [valproic acid]) for bipolar disorders
4. **Antipsychotic agents** (neuroleptics such as Thorazine, Haldol, Stelazine): used to quiet positive symptoms of schizophrenia. Also used to treat acute mania. Prolonged use can cause **tardive dyskinesia** (involuntary, often tic-like, movements of limbs and face, smacking of lips, tongue protrusion) in about 20% of cases. So-called **atypical antipsychotics** include Risperadal, Zyprexa, and Clozaril. About 75% of patients relapse within a year if medication is discontinued.

B. Electroconvulsive therapy (ECT): effective for serious depression in many cases that have been refractory to medication. Brain seizure is induced via electrical current to patient's brain. Usually requires 6–12 treatments. Some studies report that 60% improve, but there is a high relapse rate.

C. Light therapy: exposure to bright light can reduce depressive symptoms in some cases of SAD

PSYCHOLOGICAL TREATMENTS

INDIVIDUAL PSYCHOTHERAPY

A. Behavior therapy
1. Application of learning principles from classical and operant conditioning
2. Main approaches:
   a. **Systematic desensitization:** helping the client practice relaxation while confronting stimuli based on a progressive hierarchy of anxiety/fear, from low to high
   b. **In vivo exposure or flooding:** presentation of the feared stimulus
   c. **Aversion therapy:** pairs the undesirable behavior with punishment
   d. **Token economy:** shapes behavior via positive reinforcements

B. Cognitive-behavioral therapy (CBT)
1. Modification of cognitions that are linked to maladaptive behavior
2. Main approaches:
   a. **Rational-emotive therapy (RET) (Ellis):** Focuses on altering irrational beliefs (e.g., one must be perfect or loved by everyone)
   b. **Cognitive therapy (Beck):** identifies the client's automatic beliefs and negative assumptions; encourages client to be objective in gathering information relevant to their maladaptive views so that disconfirmation is possible

C. Psychodynamic/interpersonal therapies
1. Aim is to promote positive personality change via insight and the healing properties of a good relationship with the therapist.
2. Main approaches:
   a. **Psychoanalysis and psychoanalytic therapy:** interpretations of the patient's **transference** (emotional reliving of past, core conflicts and relationships, via the therapist) and **resistance** (reluctance to become aware of warded-off mental contents and to institute changes based on insights). Therapeutic alliance between client and therapist is very important.
   b. **Supportive therapy:** does not explore the transference or analyze the client's defenses; instead, offers calm support, guidance, and a focus on current problems.

D. Existential-Humanistic therapy: aim is to promote client's personal growth, self-acceptance, and search for meaning
1. **Person-centered therapies:** developed by Carl Rogers, this approach aims to create conditions that enable the client to resume thwarted efforts at self-actualization. The conditions include *unconditional positive regard* by the therapist, conveyed by empathic reflection of what the client is saying and feeling.
2. **Gestalt therapy:** developed mainly by Fritz Perls, this approach focuses on gaining conscious access to blocked emotions and bodily sensations; uses the *empty chair technique*, in which the client addresses someone with whom he or she has a conflicted relationship.
3. **Existential therapy:** focuses on issues of alienation, personal responsibility, meaning of life, authenticity, mortality

E. Eclectic/integrative therapies: various attempts to borrow techniques from several of the major approaches to best meet the therapeutic needs of a given client

F. Brief psychotherapies: a variety of time-limited approaches that try to condense the work of therapy into a much shorter period of time

G. Crisis intervention: deals with immediate problem (e.g., telephone hotline for rape victims, suicidal individuals, runaways).

GROUP PSYCHOTHERAPIES

A. Family therapy: treats the family as the unit, based on the idea that the identified client often expresses the fact that there are significant psychological problems in the patterns of family interaction
1. **Structural family therapy (Minuchin):** assumes that changes in the patterns of interactions (e.g., rigidity, overprotectiveness, enmeshment, faulty communication) will facilitate less pathological functioning for each family member

B. Couples therapy: variety of approaches, but common goals are improving communication, identifying unproductive power struggles and incompatibilities, increasing each partner's awareness of and respect for the other partner's issues and vulnerabilities. Homework assignments, contracts, and videotaped playback of the session are some of the techniques used.

MILIEU THERAPY AND OTHER COMMUNITY INTERVENTIONS

Focus is on the social context of psychopathology

A. Creation of **therapeutic communities** for schizophrenic patients; residential psychiatric hospitals for those with severe emotional or substance abuse problems; halfway houses; day treatment centers

B. Primary and secondary prevention programs: aim at prevention or early detection of potential mental illness
1. **Primary prevention:** programmatic efforts in the general population to forestall behaviors that have a high psychiatric risk (e.g., educational programs to prevent teenage pregnancy)
2. **Secondary prevention:** identification of high risk populations followed by interventions (e.g., having college students serve as buddies or mentors to children at risk, such as those from abusive family environments)

RESEARCH IN PSYCHOTHERAPY

A. Most studies that combine data from individual research projects (meta-analyses) find that therapy works but that no one approach is consistently superior.

B. Efficacy vs. effectiveness: key unresolved issue in psychotherapy research
1. **Efficacy studies** show that certain treatments can provide a benefit. Studies used include the following:
   a. Randomized clinical trials (RCTs)
   b. Patients who do not have comorbid conditions
   c. Patients treated for a specified time period
   d. Patients randomly assigned to different treatments conducted according to a manual to which the therapists adhere
2. **Effectiveness** refers to whether results from the efficacy studies can be generalized to the real world of clinical practice

PSYCHOPATHOLOGY AND SOCIETY

A. Legal issues
1. **Competence to stand trial:** can the person participate in his own defense?
2. **Insanity defense:** was the person so mentally incapacitated at the time he/she committed the crime that he/she is not responsible for the act?

B. Mental hospital commitment
1. **Involuntary commitment:** criteria for being placed in a mental hospital include:
   a. Imminent danger to self or to others
   b. Diagnosable mental disorder
   c. Profound disability
   - Approximately 25% of inpatients are hospitalized involuntarily.
2. Short-term commitments do not require a court order, but longer ones do. Patients have a right to be treated as well as a right to refuse treatment.

C. Clinicians
1. Clinicians are required to protect patient confidentiality except:
   a. When involuntary commitment is necessary
   b. To take steps to protect a client and others from physical harm
   c. To report suspected cases of child abuse or elder abuse

GLOSSARY

Abnormal psychology: the study of the development of abnormal behavior

Acute: relatively sudden or of short duration

Anhedonia: the condition of not being able to feel pleasure

Chronic: of long duration

Comorbidity: meeting the diagnostic criteria for more than one disorder

Diagnosis: the decision that an individual's particular symptoms, problems, or issues can be labeled as a specific disorder

Diathesis: an individual's propensity or vulnerability toward having a particular abnormality or disease

Etiology: the causes of a disorder

Prevalence: at a given time, the percentage of people in a population who have a particular disorder or disease

Proband (also known as the index case): the individual who has the genetic trait or diagnosis that a researcher or psychiatrist wants to investigate

Prognosis: an estimation of how a disorder or disease will develop and what its outcome will be

Psychopathology: behavioral, emotional, or thought patterns that are deemed deviant or atypical because they cause personal distress, are statistically rare, cause impaired functioning, and are a violation of social norms

Syndrome: a set of symptoms that occur together