
Lecture Notes:

Abnormal Psychology (PSYC 2250)

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1. Understanding Abnormality, Classification and Planning, and Assessment

By the strictest definition, "abnormal" refers to any characteristic that is substantially different than that considered "normal." However, this raises the question as to what is considered normal. In the science of psychology, "normal" is conceived as the range of variability within which most people are statistically likely to fall. In other words, a normal characteristic is defined as a characteristic that is fairly close to the average of how all people of a specific group, gender, age, etc., manifest that characteristic. For example, let us say that the "normal" or "average" adult male in the United States is 5'11" in height. Let us further assume that 85 percent of all men in the country are actually between 5'8" and 6'1" in height. Does this mean that a man slightly taller or shorter than 5'11" demonstrates an abnormal height? No. It means that what is normal is defined by the range in which most people fall. Therefore, "abnormal" for our purposes can be defined as the high and low extremes along any characteristic. Almost everyone experiences a major sadness at least once in his or her life, but only some individuals manifest a clinically significant depression. Such a depression is thus abnormal.

Abnormal psychology is the study of psychological disorders. The seemingly most advanced approach toward the study of such disorders is known as developmental psychopathology. This approach considers the biological, psychological, and sociocultural aspects of how the psychopathology (literally, the "illness of the mind") developed within the individual. Although the history of abnormal psychology has been studded by less than sensitive terms (e.g., individuals with mental retardation were referred to as imbeciles during the start of the last century), it has done much to elucidate how and why we humans encounter psychological problems. Indeed, the study of abnormal psychology continues to forge ahead as new data foster a greater understanding of the human condition.

As with any branch of study, the consideration of abnormal psychology is facilitated by the use of some system of classification. The primary source of such classification in the United States is the *Diagnostic and Statistical Manual of Mental Disorders*. This tome is written to be atheoretical; any psychological scientist or professional can use it regardless of his or her specific theoretical orientation. The *DSM*, as it is widely known, allows for the classification of many different psychological disorders based on whether an individual meets a sufficient set of symptoms (or criteria) for any given disorder. This approach to diagnosis is very powerful, but it also has its limitations. Perhaps foremost among these limitations is the political nature of the *DSM*. The *DSM* is not based strictly on scientific data, but as well upon a consensus of many working groups regarding what they deem should or should not be included in each category and disorder.

Regardless, diagnoses are made through a thorough assessment of the individual. The most comprehensive approach to assessment includes three key parts: (a) a detailed clinical interview, (b) psychological testing to include cognitive and personality testing, and (c) behavioral observations of the individual during the interview and testing. However, in reality the majority of professionals rely simply upon the clinical interview and the relevant behavioral observations. One can certainly obtain a wealth of relevant information via such a limited

approach. It does not demonstrate the same scientific validity, however, as when used in conjunction with actual psychological testing.

The accurate diagnosis of an individual's psychological disorder(s) is crucial for meaningful treatment planning. Perhaps the most difficult part of the clinical process, treatment planning is intended to yield specific goals by which the individual may be helped to heal via one or more treatment modalities. The most common modality of treatment is individual psychotherapy. However, group psychotherapy is also quite common among clinics. There is also family psychotherapy, marital/couples psychotherapy, and day treatment. Both professional and patient must be invested in the treatment process if it is to be of maximal benefit. Treatment outcome is essentially measured by determining to what extent the patient's symptoms have remitted.

2. Theoretical Perspectives

The use of one or more theoretical perspectives is necessary to more fully understand the nature of abnormal psychology. Traditionally, there have been three major schools of thought within the discipline of psychology: (a) the psychodynamic school, (b) the humanistic school, and (c) the cognitive-behavioral school. The psychodynamic school of thought was largely developed by Sigmund Freud. His theory of psychosexual development posited the notion that behavior (and therefore psychopathology) is largely determined by subconscious processes. Erik Erikson furthered these ideas in his development of a theory of psychosocial development. The power of this latter theory is that it identifies the importance of interpersonal relationships in the development of both normal and abnormal psychological development.

The humanistic school of thought was put forth by two major scholars. Carl Rogers promoted the importance of client-centered therapy. Essentially, he identified what have become widely known among the counseling professions as the basic counseling conditions: (a) empathy, (b) genuineness, and (c) unconditional positive regard. Although empirical research is still lacking in support of the nuances of this school of thought, there seems to be an overwhelming abundance of clinic anecdote supporting its use. Similarly, Abraham Maslow explored what he perceived to be the natural tendency of individuals to overcome their deficits and grow toward self-actualization. Maslow developed a hierarchy of needs to explain these processes.

The cognitive-behavioral school of thought is an integration of a broad range of purely behavioral and more cognitive approaches toward understanding human behavior. On the behavioral end, this approach is based on Ivan Pavlov's classical conditioning research, B. F. Skinner's operant conditioning research, and Albert Bandura's social conditioning research. The cognitive end of the continuum is grounded in the cognitive therapy of Aaron Beck, and in the rational-emotive therapy of Albert Ellis. Essentially, the cognitive-behavioral school of thought stipulates that abnormal behavior can be explained and treated via the use of behavioral techniques to alter cognitive and emotional patterns.

3. Mood Disorders, Anxiety Disorders, and Somatoform Disorders

By far the most common psychological disorders are the mood disorders. This category of disorders includes: (a) Major Depressive Disorder, (b) Dysthymic Disorder, (c) Bipolar Disorder I, (d) Bipolar Disorder II, and (e) Cyclothymic Disorder. The key feature of these disorders is the presence of severely depressed mood. Commonly referred to as dysphoria, such depressed mood is of the intensity that it interferes with everyday functioning. It is thought that possibly upwards of 20 percent of all individuals will experience a mood disorder at least once during their lives. Such a high prevalence of a disorder certainly pushes the bounds of what is considered "abnormal," and much thought has been devoted in the psychological community as to whether modern society fosters the development of depression.

The anxiety disorders are the second most common category of psychological disorders, and may affect upwards of 15 percent of all individuals at least once during their lifetimes. Once again we witness the oddly high prevalence of a diagnostic category. This category includes: (a) Panic Disorder, (b) Agoraphobia, (c) the Specific Phobias, (d) Social Phobia, (e) Generalized Anxiety Disorder, (f) Obsessive-Compulsive Disorder, (g) Acute Stress Disorder, and (h) Posttraumatic Stress Disorder. The universal feature of these disorders is the presence of abnormally elevated anxiety. Also known as apprehension or worry, anxiety is essentially the fear of real or imagined negative events. High anxiety can be truly debilitating to the individual with any one of these disorders.

The somatoform disorders are defined by the presence of psychological symptoms that are somaticized or converted into physical symptoms, possibly in order to obtain primary or secondary gain. Although quite rare in diagnosable forms, most individuals manifest some type of somatization during their lifetimes. For example, the development of "butterflies in the stomach" when nervous or an eye-lid twitch when upset, are everyday example of somatization. In their disordered extremes, the somatization disorders include: (a) Conversion Disorder, (b) Somatization Disorder, (c) Pain Disorder, (d) Hypochondriasis, (e) Body Dysmorphic Disorder, and (f) Undifferentiated Somatoform Disorder. When considering these disorders, it is important to remember that the pain and discomfort individuals experience are quite real, regardless of the etiology of those symptoms.

Recent studies suggest that the mood and anxiety disorders, and perhaps even the somatization disorders, may be different expressions of stress pathways in the mind-body. Specifically, research within the interdisciplinary discipline of psychoneuroimmunology is beginning to shed light upon the developmental etiology of these apparently different disorders. For example, whereas anxiety may be a chronic stress response that continues to feed itself, depression may be a chronic stress response that causes the mind-body to partially shut down. Such ideas are largely experimental at this point in time, but the research appears promising. It is ironic to note that anxiety and depression have been conceived as flip sides of the same coin for the past many decades.

4. Dissociative Disorders, and Schizophrenia and Other Psychotic Disorders

The dissociative disorders are denoted by the presence of dissociation, a disruption in the usually integrated functions of consciousness, memory, identity, or perception (per the *DSM*). They are thought to result from anxiety or conflict so severe that the integrated functions of the personality begin to uncouple. This category of disorders includes: (a) Dissociative Amnesia, (b) Dissociative Fugue, (c) Dissociative Identity Disorder, (d) and Depersonalization Disorder. These are probably some of the most poorly understood disorders listed in the *DSM*. They may occur as individual psychopathological instances, or may presage the development of a more serious psychosis.

Schizophrenia is characterized by psychosis, the presence of delusional and/or hallucinatory thought processes. Initially labeled as dementia praecox, Schizophrenia is actually a category of disorders that includes: (a) the Catatonic Type, (b) the Paranoid Type, (c) the Disorganized Type, (d) the Undifferentiated Type, and (e) the Residual Type. These five types of Schizophrenia are differentially diagnosed according to the presence of specific positive and negative symptoms. They can all be identified by considering Bleuler's "Four A's" of diagnosis: (a) association, (b) affect, (c) ambivalence, and (d) autism (not to be confused with the disorder of the same name). Contrary to popular belief, the most common symptom of Schizophrenia is not visual hallucinations. Instead, delusions and auditory hallucinations are far more common among individuals with these disorders. The other psychotic disorders include: (a) Brief Psychotic Disorder, (b) Schizophreniform Disorder, (c) Schizoaffective Disorder, (d) Delusional Disorder, and (e) Shared Psychotic Disorder. The key feature of these disorders is the presence of psychosis-like symptoms in the absence of actual psychosis. These disorders tend to be quite rare.

Unlike the majority of psychological disorders which are treated via one or more forms of psychotherapy, the primary treatment modality for the dissociative and psychotic disorders is psychoactive medication. The specific medications are known as antipsychotics or neuroleptics, and typically act by affecting the dopamine pathways in the brain. However, two hypotheses have been proposed that question that the psychosocial aspects of these otherwise seemingly biological disorders. The social causation hypothesis suggests that membership in low socioeconomic (SES) groups may increase the risk of psychosis due to the presence of pervasive environmental stressors. Conversely, the downward social drift hypothesis proposes that SES decreases once symptoms develop due to their debilitating effects. It remains unknown whether either of these hypotheses is correct. However, data do indicate that rates of psychosis within metropolitan areas are disproportionately high.

5. Sexual and Gender Identity Disorders, and Eating Disorders

The category of sexual and gender identify disorders actually includes two separate sets of psychological disorders. The sexual disorders include the paraphilias and the sexual dysfunctions. A paraphilia is defined per the *DSM* as sexual arousal that requires nonhuman objects, children or other nonconsenting persons, or suffering or humiliation of the self or partner. In other words, a paraphilia is an abnormal desire required for sexual arousal and gratification. The paraphilias include: (a) Pedophilia, (b) Exhibitionism, (c) Frotteurism, (d) Fetishism, (e) Sexual Masochism, (f) Sexual Sadism, (g) Transvestic Fetishism, and (h) Voyeurism. Most societies appear to disallow pedophilia to some extent. However, the fetishes require careful thinking about whether "abnormal" equates with "unhealthy." Perhaps the most glaring example of this question is the international pornographic industry, which is thought to be worth billions of dollars. Given the ubiquity of pornographic magazines and movies, where does "normal" arousal end and "abnormal" fetish start?

The sexual dysfunctions include: (a) Hypoactive Sexual Disorder, (b) Sexual Aversion Disorder, (c) Female Sexual Arousal Disorder, (d) Male Erectile Disorder, (e) Female Orgasmic Disorder, (f) Male Orgasmic Disorder, (g) Premature Ejaculation, and (h) the Sexual Pain Disorders (which include Dyspareunia and Vaginismus). The symptom common to these psychological disorders is sexual performance that causes distress. Such performance may be characterized by inadequate performance (as deemed by the individual) or pain during sexual intercourse. Such disorders can be quite difficult for the individual and his or her partner. Consequently, these disorders are often treated with marital/couples psychotherapy.

Gender Identity Disorder is characterized as the perception of the self as the mismatched gender. In other words, a male who literally perceives oneself as female, or a female who literally perceives oneself as male, would likely be diagnosed with this disorder. Perhaps to a greater extent than even the sexual disorders, the experience of Gender Identity Disorder can be complicated by the sociocultural implications of its symptoms. The reality is that such a disorder is often considered antithetical to many systems of religious belief. It is thus not uncommon to encounter an individual with this disorder (although the disorder itself is exceedingly rare) who lacks support from friends and family members.

The eating disorders include Anorexia Nervosa and Bulimia Nervosa, both of which are defined by maladaptive cognitive representations of one's own body with consequent interference of eating habits. Anorexia Nervosa can be diagnosed as two types, which are characterized by their labels of Restricting Type and Binging/Purging Type. Bulimia Nervosa can also be diagnosed as the Purging Type or the Nonpurging Type. Both of these disorders are far more common among females than males, and tend to be much more prevalent in industrialized countries. The reality is that psychological science is still searching for adequate answers as to why these disorders develop. Treatment in the form of psychotherapy can be successful, but the disorders are often chronic.

6. Impulse Control Disorders and Substance-related Disorders

The impulse control disorders share the key symptom of the repeated experience of an impulse, a powerfully compelling urge to act. This category of psychological disorders includes: (a) Kleptomania, (b) Pathological Gambling, (c) Pyromania, (d) Trichotillomania, and (e) Intermittent Explosive Disorder. In addition to interfering with an individual's daily functioning, these disorders tend to be quite dangerous for the individual and/or others due to their social or physical risks. Similarly, the substance-related disorders are known for their potentially pervasive, destructive impacts on those individuals experiencing the disorders and those with whom they maintain relationships. For the purposes of the present discussion, a substance is a chemical that alters behavior. The *DSM* allows for the diagnosis of Abuse or Dependence for the following categories of substances: (a) Alcohol; (b) Stimulants; (c) Amphetamines; (d) Cocaine; (e) Caffeine; (f) Cannabis; (g) Hallucinogens; (h) Heroin and Opioids; and (i) Sedatives, Hypnotics, and Anxiolytics. It sometimes surprises individuals to learn that caffeine is the most widely abused substance on the planet. It is frequently imbibed in the form of tea, coffee, soda, and other popular drinks. Indeed, per the general definition of dependence, many individuals would appear to be clinically dependent upon caffeine. Such a situation could be indicated by the need for more than a few cups/cans/bottles of caffeinated beverage per day to maintain attention and concentration.

Use of a substance is conceptualized along a spectrum of severity, from use to abuse to dependence. Abuse can be conceptualized per the *DSM* as an amount of use sufficient to impair judgment regarding obligations, hazardous behavior, illegal behavior, and/or interpersonal relationships. The concept of dependence is synonymous with addiction. This is the psychophysiological response to repeated use of an addictive substance. One can similarly become dependent or addicted to a pattern of behaviors. Hence, a number of psychologists perceive some of the impulse control disorders and the substance-related disorders to be quite directly related in terms of underlying neural mechanisms.

7. Development-related Disorders and Aging-related Disorders

Although all psychological disorders can be conceived as somehow developmental from the perspective of developmental psychopathology, a number of disorders are especially rooted in developmental problems. These development-related disorders comprise the category of disorders usually first diagnosed in infancy, childhood, or adolescence, and include eight subcategories. Mental retardation includes diagnoses based on tested intelligence: (a) Mild Mental Retardation, (b) Moderate Mental Retardation, (c) Severe Mental Retardation, and (d) Profound Mental Retardation. The pervasive developmental disorders share the key symptoms of impairment in several developmental areas or the presence of "extremely odd behavior" per the *DSM*. The pervasive developmental disorders include: (a) Autistic Disorder, (b) Rett's Disorder, (c) Childhood Disintegrative Disorder, and (d) Asperger's Disorder. The learning disorders are characterized by a deficit in academic skills that is significantly below the individual's tested intelligence. Learning disorders can be diagnosed as one of three types: (a) Mathematics Disorder, (b) Disorder of Written Expression, and (c) Reading Disorder.

The communication disorders are denoted by problems in the expression and/or comprehension of language, and include: (a) Expressive Language Disorder, (b) Mixed Receptive-Expressive Language Disorder, (c) Phonological Disorder, and (d) Stuttering. The single disorder in the category of Motor Skills Disorder is known as Developmental Coordination Disorder. This disorder is diagnosed when the individual demonstrates a marked impairment in the development of motor coordination compared with her age-related expectations. The attention-deficit and disruptive behavior disorders subcategory is comprised of those disorders characterized by poor inhibition or control of impulsive behaviors. Such impulsive behaviors are more broad than the specific impulse control disorders, and include: (a) Attention-deficit/Hyperactivity Disorder (which can be diagnosed as the Predominantly Inattentive Type, the Predominantly Hyperactive Impulsive Type, or the Combined Type), (b) Conduct Disorder, and (c) Oppositional-Defiant Disorder.

Separation Anxiety Disorder forms its own subcategory, and is identified in a child by an intense and inappropriate anxiety regarding separation from a caregiver or the home. There are also a number of additional disorders observed during infancy, childhood, or adolescence. These varied disorders include: (a) the Childhood Eating Disorders (i.e., Pica, Feeding Disorder of Infancy or Early Childhood, and Rumination Disorder), (b) the Tic Disorders (i.e., Tourette's Disorder and Coprolalia), (c) the Elimination Disorders (i.e., Enuresis and Encopresis), (d) Reactive Attachment Disorder (which can be diagnosed as the Inhibited Type or the Disinhibited Type), (e) Stereotypic Movement Disorder, and (f) Selective Mutism. As can be noted, this final collection of disorders is essentially a group of disorders lumped together that do not appear to fit neatly into any of the other categories or subcategories.

The aging-related and cognitive disorders are somewhat of a later-life analogue to the development-related disorders. Delirium is a temporary state characterized by a disturbance of consciousness and a change in cognition that develops over a short period of time. Conversely, dementia is denoted by the presence of multiple cognitive deficits, including impairment of memory. Dementia is also the result of an actual disease process in the brain. There are many types of dementia: (a) Alzheimer's Disease, (b) Substance-induced Dementia, (c) Pick's Disease,

(d) Parkinson's Disease, (e) Lewy Body Dementia, (f) the Frontotemporal Dementias, (g) Huntington's Disease, (h) Creutzfeldt-Yaakov Disease, (i) and Vascular Dementia. Diagnosis of dementia recalls the fundamental difference between the normal developmental process of senescence and the abnormal developmental process of senility. To note, Amnesic Disorder can be diagnosed in the presence of impaired memory in the absence of other cognitive impairments. This disorder can be diagnosed as one of two types, either as Amnesic Disorder Due to a General Medical Condition or as Substance-induced Persisting Amnesic Disorder.

8. Personality Disorders

The personality disorders include three major clusters of disorders, with each cluster typified by a certain quality of behavior. Cluster A is characterized by the "odd" personality disorders: (a) Paranoid Personality Disorder, (b) Schizoid Personality Disorder, and (c) Schizotypal Personality Disorder. These disorders are manifested by personality traits that appear especially eccentric or peculiar compared with more normal personality functioning. Cluster B is characterized by the "aggressive" personality disorders: (a) Antisocial Personality Disorder, (b) Borderline Personality Disorder, (c) Histrionic Personality Disorder, and (d) Narcissistic Personality Disorder. These disorders are manifested by personality traits that appear exceedingly affrontive or emotional compared with more normal personality functioning. Finally, Cluster C is characterized by the "neurotic" personality disorders: (a) Avoidant Personality Disorder, (b) Dependent Personality Disorder, and (c) Obsessive-Compulsive Personality Disorder. These disorders are manifested by personality traits that appear especially anxious or dependent compared with more normal personality functioning.

The personality disorders comprise what many researchers and clinicians of psychology consider to be the most vexing of the psychological disorders. With the exception of Mental Retardation, every other psychological disorder we have explored is considered a "clinical disorder." This term implies that the disorder is relatively limited in how broadly it affects the personality. Although clinical disorders such as Major Depressive Disorder, Generalized Anxiety Disorder, and the Schizophrenias certainly can affect all aspects of life, they are thought to be limited in the extent to which they incorporate the many facets of an individual's personality. Conversely, a "personality disorder" is thought to be written into the very fabric of one's personality.

There is another, perhaps more important, difference between the clinical disorders and the personality disorders. The clinical disorders are said to be ego-dystonic. In other words, an individual with a clinical disorder experiences the symptoms of that disorder as causing distress. The personality disorders are ego-syntonic; they do not cause the individual conscious distress because he is unaware that he is psychologically impaired. Instead, individuals with personality disorders experience distress via the disrupted relationships they have with other individuals.

9. Ethical and Legal Issues

There are many ethical issues related to work with abnormal psychology. However, perhaps the most important ethical consideration is to remember that individuals with psychological disorders are first and foremost people hurting. Individuals request treatment from professionals because they are in emotional pain and often perceive no way out of this pain. It is therefore insufficient for professionals to exercise merely their education and training in the treatment of individuals with psychological disorders. What must also be included in any professional interaction is a respect for the individuals requesting help. After all, according to the perspective of developmental psychopathology, psychological disorders arise as maladaptive attempts to cope with internal and/or environmental stressors. This may be as true of individuals with Antisocial Personality disorder who commit atrocious acts of violence as it is of individuals who become clinically depressed after the loss of a loved one. The question becomes: How will the professional balance her own biases with the necessities of treatment for the individuals under her care?