

Chapter Introduction

Break-in or Break Down?

James was busted trying to break into the Federal Bureau of Investigation (FBI). This account of the episode makes it clear he had suffered another breakdown: “James said he was overwhelmed lately with feelings of apprehension and fear that he and someone important were about to be harmed. He could not specify why he felt this way, but he was sure he had special information that the president of the United States was going to be harmed soon and that he, James, would also be harmed because he knew of the plot. These feelings eventually became so strong that James felt he had to leave his apartment and warn someone at the FBI office. James said he thought the police were going to kill him because they were agents responsible for the plot against the president.” (Kearney & Trull, 2015, p. 360).

Is James mentally ill? How is mental illness defined, categorized, and diagnosed? What causes mental illness? Let’s tackle these important questions.



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Survey Questions

60-1 Normality—What’s Normal?

Survey Question 60.1

How is abnormality defined?

The statistics are grim. The direct cost of treating people who seek help for mental illness is almost \$60 billion a year. Add the indirect costs, such as lost earnings, and the total exceeds \$315 billion a year. Hidden behind the dollar signs is the immense human cost. James’s case is but one hint of the magnitude of mental health problems. Almost 20 percent of American adults suffer from a diagnosable mental disorder in any given year (Kessler, 2010; National Institute of Mental Health, 2016a). In 2013, more than 41,000 Americans committed suicide (Centers for Disease Control, 2015h). About 90 percent of them had a diagnosable mental disorder (National Alliance on Mental Illness, 2016).

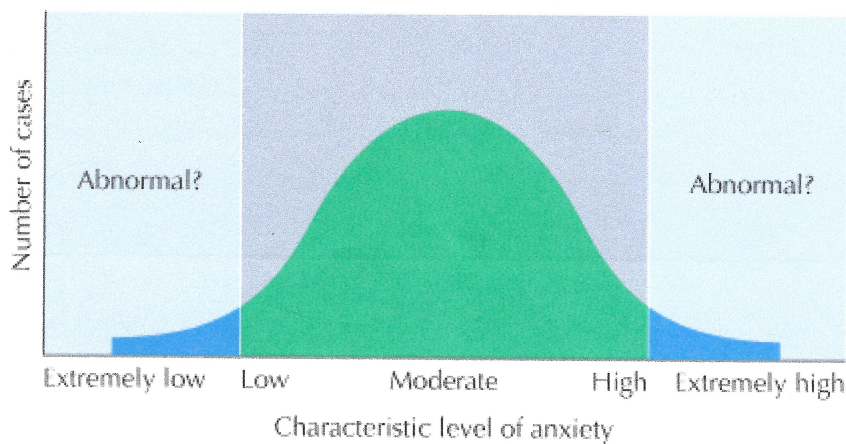
A **mental disorder** (A significant impairment in psychological functioning.) is a significant impairment in psychological functioning, such as schizophrenia or major depression. The scientific study of mental disorders is known as **psychopathology** (The scientific study of mental, emotional, and behavioral disorders; the term is also used to refer to maladaptive behavior.), although the term can also refer to mental disorders themselves and to behavior patterns that make people unhappy and impair their personal growth (Sue et al., 2017). Even though these definitions may seem obvious, to seriously classify people as mentally unhealthy raises complex and age-old issues (Luyten & Blatt, 2011). The conservative, churchgoing housewife down the street might be flagrantly psychotic and a lethal danger to her children. The reclusive eccentric who hangs out at the park could be the sanest person in town.

Let’s begin with the idea of statistical abnormality, which some psychologists use to define normality more objectively. **Statistical abnormality** (Abnormality defined on the basis of an extreme score on some dimension, such as IQ or anxiety.) refers to scoring very high or low on some dimension, such as intelligence, anxiety, or depression. Anxiety, for example, is a feature of several psychological disorders. To measure it, we could create a test to learn how many people show low, medium, or high levels of anxiety. Usually, the results of such tests will form a *normal* (bell-shaped) *curve*. (*Normal* here refers only to the *shape* of the curve.) Notice that most people score near the middle of a normal curve; very few have extremely high or low scores (**Figure 60.1**). A person who deviates from the average by being highly anxious is, by definition, statistically abnormal. So, too, is a person who never feels anxiety.

Figure 60.1

The Normal Curve and Abnormality.

The number of people displaying a personal characteristic may help define what is statistically abnormal.



But what if a statistically abnormal person is functioning well? Right. If people with statistically abnormal levels of anxiety are nevertheless functioning well in their lives, why label them mentally ill? Statistical definitions also can't tell us *where to draw the line* between normality and abnormality. For example, we could obtain the average frequency of sexual intercourse for persons of a particular age, sex, sexual orientation, and marital status. Clearly, a person who feels driven to have sex dozens of times a day has a problem. But as we move back toward the norm, we face the problem of drawing lines. How often does a normal behavior have to occur before it becomes abnormal? As you can see, statistical boundary lines tend to be somewhat arbitrary (Comer, 2013).

Performing a mildly abnormal behavior is a good way to get a sense of how social norms define "normality." Here's your assignment: do something strange in public and observe how people react. (Please don't do anything dangerous or offensive—and don't get arrested!) Try walking around campus on a sunny day carrying an open umbrella. Or stick one finger in your nose and another in your ear and walk through a shopping mall. Better yet, wear an animal mask for a day (no, not Halloween!). As we have noted, social nonconformity is just one facet of abnormal behavior. Nevertheless, actions that are regarded as "strange" within a particular culture are often the first sign to others that a person has a problem.



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Another approach is to focus on the nonconformity that may be associated with some disorders. **Social nonconformity** (Failure to conform to societal norms or the usual minimum standards for social conduct.) refers to disobeying public standards for acceptable conduct. Extreme nonconformity can lead to destructive, self-destructive, or illegal behavior. (Think, for instance, of a drug abuser or a prostitute.)

Once again, we must be careful to separate unhealthy nonconformity from creative lifestyles. Many eccentric “characters” are charming and emotionally stable. Note, too, that strictly following social norms is no guarantee of mental health. In some cases, psychopathology involves rigid conformity.

Furthermore, before we can even begin to judge a behavior as abnormal or nonconforming, we must also consider the *situational context* (social situation, behavioral setting, or general circumstances) in which it occurs. Is it abnormal to stand outside and water a lawn with a hose? It depends on whether it is raining. Is it nonconforming for a grown man to remove his pants and expose himself to another man or woman in a place of business? It depends on whether the other person is a bank clerk or a doctor.

Almost any imaginable behavior can be considered normal in some contexts. For example, in 2003, a man sawed off his own arm. Mind you, Aaron Ralston was rock climbing when he fell into a crevasse, trapping his arm between two boulders. After five days of trying to free his arm, and nearing unconsciousness, he did what he needed to do to survive (Ralston, 2004).

Social nonconformity does not automatically indicate psychopathology. For example, meet Maria Jose Cristerna, a mother of four and a former lawyer. She is the current Guinness Book of World Records record holder for the most body piercings and tattoos. Nonconformist? You bet. Mentally ill? Definitely not.



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As implied by our earlier discussion of social norms, culture is one of the most influential contexts in which any behavior is judged (Fabrega, 2004; Whitbourne & Halgin, 2013). In some cultures, it is considered normal to defecate or urinate in public or to appear naked in public. In our culture, such behaviors would be considered unusual or abnormal. In some Muslim cultures, women who remain completely housebound are considered normal, even virtuous. In some Western cultures, they might be suspected of suffering from a disorder called agoraphobia. (Agoraphobia is described in [Module 63](#).)

Thus, *cultural relativity* (the idea that judgments are made relative to the values of one's culture) can affect the definitions of psychological disorders. Still, *all* cultures classify people as abnormal if they fail to communicate with others or are consistently unpredictable in their actions. Yet another approach is to characterize psychopathology by *subjective discomfort* (private feelings of pain, unhappiness, or emotional distress).

But couldn't a person experience serious distress without psychopathology, and couldn't someone be seriously disturbed without feeling discomfort? Yes on both counts. People who

have, for example, lost a loved one or lived through a natural disaster such as a massive wildfire normally take some time to overcome their distress. Also, psychopathology doesn't always cause personal anguish. A person suffering from mania might feel elated and "on top of the world." A *lack* of discomfort may actually reveal a problem. For example, if you showed no signs of grief or distress after the violent death of a close friend, we might suspect psychopathology. In practice, though, subjective discomfort explains most instances in which people voluntarily seek professional help.

Chapter 60: Psychological Disorders: Defining Psychopathology: 60-1 Normality—What's Normal?

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Chapter 60: Psychological Disorders: Defining Psychopathology: 60-1a Mental Disorders Are Maladaptive
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60-1a Mental Disorders Are Maladaptive

*If abnormality is so hard to define, how are judgments of psychopathology made? As you can see, categorizing someone as mentally ill is far from “cut and dried.” Although the standards we have discussed thus far are *relative*, psychopathological behavior does have a core feature: It is **maladaptive** (Behavior arising from an underlying psychological or biological dysfunction that makes it difficult to adapt to the environment and meet the demands of day-to-day life.) . Rather than helping people cope successfully, maladaptive behavior arises from an underlying psychological or biological dysfunction that makes it more difficult for them to meet the demands of day-to-day life (American Psychiatric Association, 2013). Maladaptive behavior most often results in serious psychological discomfort, disability, and/or *loss of control* of thoughts, behaviors, or feelings, such as James’s overwhelming sense of impending doom.*

For example, gambling is not a problem if people bet for entertainment and can maintain self-control. However, compulsive gambling is a sign of psychopathology. Hearing uncontrollable voices is a prime example of what it means to lose control of one’s thoughts. In the most extreme cases, people become a danger to themselves or others, which is clearly maladaptive (Bennett, 2011).

In practice, deciding that a person needs help usually occurs when the person *does something* (assaults a person, hallucinates, stares into space, collects too many old pizza cartons, and so forth) that *annoys or gains the attention* of a person in a *position of power* in the person’s life (an employer, teacher, parent, spouse, or the person himself or herself). That person then does something about it. The person may voluntarily seek help, the person may be urged to see a psychologist, a police officer may be called, or a relative may start commitment proceedings.

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60-1b Abnormal Behavior and the Law

Commitment proceedings are legal proceedings that may result in the finding of [insanity \(A legal term that refers to a mental inability to manage one's affairs or to be aware of the consequences of one's actions.\)](#), which is a legal, not a psychological, term (Fuller, 2012). It refers to an inability to manage one's affairs or foresee the consequences of one's actions. People who are declared insane are not legally responsible for their actions. If necessary, they can be involuntarily committed to a mental hospital.

Legally, insanity is established by testimony from *expert witnesses* (psychologists and psychiatrists) recognized by a court of law as qualified to give opinions on a specific topic. Involuntary commitments happen most often when people are brought to emergency rooms or are arrested for committing a crime. People who are involuntarily committed are usually judged to be a danger to themselves or to others, or they are severely intellectually disabled.

What is the insanity defense? Someone accused of a crime may argue that he or she is *not guilty by reason of insanity*. In practice, this means that the accused, due to a diagnosable mental disorder, was unable to realize that what he or she did was wrong (Gowensmith, Murrie, & Boccaccini, 2013).

You may be surprised to learn that being diagnosed with a mental disorder does not automatically imply a successful insanity defense. For example, someone diagnosed with, say, an anxiety disorder who commits murder might nevertheless be well aware that murder is against the law. In fact, very few criminal trials end with this verdict (Fuller, 2012; Martin & Weiss, 2010).

What if someone suffered brain damage that caused them to engage in illegal behaviors? Good question. Someone with brain damage or an intellectual disability such as autism could plead *not guilty by reason of diminished responsibility* (Jones et al., 2013). For example, as Mr. P grew older, his interest in child pornography also grew. By the age of forty, he had begun seeking out sexual contacts with his young stepdaughter and at massage parlors. He was arrested and sent to a rehabilitation clinic, where he proceeded to seek sexual contacts with the staff and clients, despite not wanting to go to prison. All along, he maintained that he knew he was in the wrong but couldn't stop himself. A magnetic resonance imaging (MRI) scan (see [Module 8](#)) revealed a large tumor growing in a part of his brain responsible for impulse control. When it was removed, his abnormal sexual behavior disappeared as well. A few years later, he started collecting child pornography again. Another MRI confirmed that the tumor had returned (Burns & Swerdlow, 2003).

With the rise of brain-scanning technologies, cases like this have become more common (Fabian, 2011). Such cases also raise serious questions about the plea of *not guilty by reason of diminished responsibility*. Should Mr. P. be set free? Should his sentence be reduced? Is it ever appropriate to blame the person, and not his or her brain? What do you think?

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60-2 Classifying Mental Disorders—Problems by the Book

Survey Question 60.2

What are the major mental disorders?

Mental disorders are classified by using the most recent version of the *DSM*, the *Diagnostic and Statistical Manual of Mental Disorders (5th Edition)*. The *DSM-5* influences most activities in mental health settings—from diagnosis to therapy to insurance company billing (American Psychiatric Association, 2013). As even a quick scan of the *DSM-5* makes clear, a wide variety of psychological disorders are currently diagnosed and treated; hundreds of specific disorders are organized into over 20 major categories.

A partial list of major categories and specific disorders can be found in [Table 60.1](#). Many of the disorders on this list are described in the next three modules. (Others are discussed elsewhere in this book: sleep–wake disorders in [Module 24](#), problems with drug abuse and dependence in [Module 25](#), eating disorders in [Module 43](#), and sexual disorders in [Modules 46](#) and [48](#).)

Table 60.1

Major *DSM-5* Categories of Psychopathology

Problem	Primary Symptom	Typical Signs of Trouble	Examples
Neurodevelopmental Disorders	Impairment of nervous system development before adulthood	You have intellectual, communication, attentional, or motor problems that emerge early in your life.	Intellectual developmental disorder, Autism spectrum disorder, Attention deficit/hyperactivity disorder

Problem	Primary Symptom	Typical Signs of Trouble	Examples
Schizophrenia spectrum and other psychotic disorders	Loss of contact with reality	You hear or see things that others don't; your mind has been playing tricks on you.	Delusional disorder, Schizophrenia, Brief psychotic disorder
Bipolar and related disorders	Alternating mania and depression	You feel depressed, or you talk too loud and too fast and have a rush of ideas and feelings that others think are unreasonable.	Cyclothymic disorder, Bipolar I disorder, Bipolar II disorder
Depressive disorders	Depression	You feel sad and hopeless.	Persistent depressive disorder (dysthymia), Major depressive disorder, Postpartum depression, Seasonal affective disorder
Anxiety disorders	High anxiety or anxiety-related distortions of behavior	You have anxiety attacks and feel like you are going to die; or you are afraid to do things that most people can do.	Generalized anxiety disorder, Panic disorder, Agoraphobia, Specific phobia, Social phobia

Problem	Primary Symptom	Typical Signs of Trouble	Examples
Obsessive-compulsive and related disorders	Unnecessarily repetitious behavior	You spend unusual amounts of time doing things such as washing your hands or counting your heartbeats.	Obsessive compulsive disorder, Hoarding disorder
Trauma- and stressor-related disorders	Difficulty dealing with a traumatic or stressful event	You persistently re-experience a traumatic event; you have an exceptionally strong negative reaction to a traumatic event such as becoming highly anxious, depressed, or, being unable to sleep.	Adjustment disorder, Acute stress disorder, Posttraumatic stress disorder
Dissociative disorders	Amnesia, feelings of unreality, multiple identities	There are major gaps in your memory of events; you feel like you are a robot or a stranger to yourself; others tell you that you have done things that you don't remember doing.	Dissociative amnesia, Dissociative identity disorder

Problem	Primary Symptom	Typical Signs of Trouble	Examples
Somatic symptom disorders	Body complaints without an organic (physical) basis	You feel physically sick, but your doctor says nothing is wrong with you; you suffer from pain that has no physical basis; or you are preoccupied with thoughts about being sick.	Somatic symptom disorder, Factitious disorder, Conversion disorder
Feeding and eating disorders	Disturbance of food intake into the body	You eat nonfood items (pica) or have difficulty eating enough food to remain healthy.	Anorexia nervosa, Bulimia nervosa, Binge eating disorder
Elimination disorders	Disturbance of waste elimination from the body	You have trouble controlling the elimination of urine (enuresis) or feces (encopresis).	Enuresis, Encopresis
Sleep–wake disorders	Troubles falling asleep, staying asleep, or waking up.	You have difficulty getting a healthy night’s sleep; you snore, have nightmares, or fall asleep inappropriately (narcolepsy).	Insomnia disorder, Hypersomnolence disorder, Narcolepsy, Nightmare disorder

Problem	Primary Symptom	Typical Signs of Trouble	Examples
Sexual dysfunctions	Problems in sexual adjustment	You have problems with sexual desire, arousal, orgasm, or pain.	Erectile disorder, Female sexual interest/arousal disorder, Genito-pelvic pain/penetration disorder, Male hypoactive sexual desire disorder
Gender dysphoria	Disturbed gender identity	You feel that you are a man trapped in a woman's body (or the reverse).	Gender dysphoria
Disruptive, impulse control and conduct disorders	Difficulties of self-control	You are defiant and aggressive; you set fires (pyromania) or are a chronic thief (kleptomania).	Oppositional defiant disorder, Intermittent explosive disorder, Pyromania, Kleptomania,
Substance use and addictive disorders	Disturbances related to drug abuse or dependence as well as other addictive behaviors	You have been drinking too much, using illegal drugs, taking prescription drugs more often than you should, or gambling too much.	Opioid use disorder, Stimulant use disorder, Alcohol use disorder, Tobacco use disorder, Gambling disorder

Problem	Primary Symptom	Typical Signs of Trouble	Examples
Neurocognitive disorders	Impairment of nervous system development while in adulthood	Your ability to think and remember has suffered a dramatic decline in adulthood.	Delirium, Neurocognitive disorder due to Alzheimer's disease, Neurocognitive disorder due to Parkinson's disease, Neurocognitive disorder due to HIV Infection
Personality disorders	Unhealthy personality patterns	Your behavior patterns repeatedly cause problems at work, at school, and in your relationships with others.	Antisocial personality disorder, Borderline personality disorder
Paraphilic disorders	Deviant sexual behavior	You can gain sexual satisfaction only by engaging in highly atypical sexual behavior.	Pedophilic disorder, Exhibitionistic disorder, Voyeuristic disorder, Fetishistic disorder
Source: American Psychiatric Association, 2013; Sue et al., 2017.			

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60-2a Comorbidity

In addition, many disturbed people are **comorbid** (The simultaneous presence in a person of two or more mental disorders.) —that is, they suffer from more than one mental disorder at the same time. One way that comorbidity develops is when a *primary* problem causes *secondary* problems. For example, someone experiencing a prolonged and deep depression might start taking drugs (legal or otherwise) for treatment and become addicted, complicating the primary mood disorder with a secondary, substance use disorder (Fenton et al., 2012).

According to sociologist Ronald Kessler, comorbidity is quite common; more than 40 percent of all people with mental disorders are comorbid (Kessler, 2010). Not only does comorbidity increase these people's misery, it also makes it much more difficult for health care providers to diagnose and treat them.

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60-2b Mental Illness in Other Cultures

As you might well imagine, different cultures around the world have identified their own *culture-bound syndromes* you won't find in the *DSM-5* (Barlow & Durrand, 2015; López & Guarnaccia, 2000; Teo & Gaw, 2010). For example, men in some parts of Asia sometimes run *amok* after they have been insulted. After a period of brooding, they erupt into an outburst of violent, aggressive, or homicidal behavior randomly directed at people and objects. (Yes, this is the origin of the familiar expression "to run amok.") Can *amok* be understood within the framework of the *DSM-5* as a *brief psychotic disorder*?

As another example, in Japan, adolescents or young adults who refuse to leave their parents' homes for months at a time are experiencing *hikikomori*, an extreme form of social withdrawal. Is *hikikomori* a variation of the *DSM-5* disorder *agoraphobia*?

It is clear that people everywhere have a need to label and categorize troubled behavior. With some cultural sensitivity, it is often possible to understand these unusual experiences (Flaskerud, 2009; Ross, Schroeder, & Ness, 2013). By the way, culture-bound syndromes occur in all societies. For example, American psychologists Pamela Keel and Kelly Klump believe that the eating disorder *bulimia nervosa* is primarily a syndrome of Western cultures such as the United States (Keel & Klump, 2003).

Beware Medical Student's Disease

We hope that you have not already fallen prey to "medical student's disease." Medical students, it seems, have a predictable tendency to notice in themselves the symptoms of each dreaded disease they study. As a psychology student, you may notice what seem to be abnormal tendencies in your own behavior. If so, don't panic. In most instances, this shows only that pathological behavior is an *exaggeration* of normal defenses and reactions, not that your behavior is abnormal. Keep this in mind as you read on.

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60-2c The Fluidity of Psychiatric Categories

You might be surprised to learn that definitions of mental disorders change over time. For example, when the *DSM-I* was first published in 1952, *neurosis* was included. The term was dropped in later editions because it is too imprecise. Even though *neurosis* is an outdated term, you may still hear it used to loosely refer to problems involving excessive anxiety. Similarly, *homosexuality* was omitted as a disorder in 1974.

Published in 2013, the *DSM-5* reflects recent scientific advances and cultural changes (American Psychiatric Association, 2013; Birgegård, Noring, & Clinton, 2012). Regardless, the process leading up to publication of the *DSM-5* was controversial (Frances, 2012; Marecek & Gavey, 2013). Perhaps the most important, and certainly the most contentious, change has been the proliferation of disorders. The original DSM contained about 100 disorders; today, it contains over 350.

Critics charge that more and more previously “normal” people are being categorized as “mentally ill” (Frances, 2012; Lane, 2009). For example, *attention deficit hyperactivity disorder (ADHD)* was not a disorder in the original *DSM*. Since its inclusion, it has become one of the most widely diagnosed disorders among young boys, prompting critics to decry the disorder as “pathologizing boyhood” (Bruchmüller, Margraf, & Schneider, 2012).

A related concern is that psychiatric labels are getting easier and easier to apply. For example, changes to the *DSM-5* make it easier to label someone whose husband died as suffering from *major depressive disorder* rather than grief (Frances, 2012).

At the same time, some changes are more widely accepted. For example, after considerable debate, the now-outdated term *gender identity disorder* appears in the *DSM-5* as *gender dysphoria* (American Psychiatric Association, 2013; De Cuypere, Knudson, & Bockting, 2011). Opponents of the old terminology argued that many people whose physical sex does not match their gender identity are well adjusted and should not be labeled as “disordered” (Hein & Berger, 2012). The new label reflects this idea because it applies only to individuals who are deeply troubled by their gender variance.

Hopefully the updated *DSM-5* will result in better diagnosis and treatment for those of us who need help.

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60-2d The Impact of Psychiatric Labels

In case you haven't yet realized it, labeling someone mentally ill is serious business. A fascinating classic study carried out by psychologist David Rosenhan illustrates the impact of psychiatric labeling. Rosenhan and several volunteers had themselves committed to mental hospitals as "schizophrenics" (Rosenhan, 1973). After being admitted, each of these "pseudopatients" dropped all pretense of mental illness. Yet, even though they acted completely normal, none of the researchers was ever recognized by hospital *staff* as a phony patient. Real patients were not so easily fooled: It was not unusual for a patient to say to one of the researchers, "You're not crazy, you're checking up on the hospital!" or "You're a journalist."

To record his observations, Rosenhan took notes by carefully jotting things on a small piece of paper hidden in his hand. However, he soon learned that stealth was totally unnecessary. Rosenhan simply walked around with a clipboard, recording observations. No one questioned this behavior. Rosenhan's note-taking was just regarded as another symptom of his "illness." This observation clarifies why staff members failed to detect the fake patients. Because they were in a mental ward and because they had been *labeled* schizophrenic, anything the pseudopatients did was seen as a symptom of psychopathology.

To fully appreciate the implications of Rosenhan's study, imagine being falsely labeled "schizophrenic." Now imagine struggling to prove to people that you are actually normal when even denying you are "crazy" just becomes more proof of how crazy you really are. As Rosenhan's study implies, it is better to label *problems* than to label people. Think of the difference in impact between saying, "You are experiencing a serious psychological disorder" and "You're a schizophrenic." Which statement would you prefer to have said about yourself?

Social Stigma

An added problem with psychiatric labeling is that it frequently leads to prejudice and discrimination—that is, the mentally ill in our culture are often *stigmatized* (rejected and disgraced). People who have been labeled mentally ill (at any time in their lives) are less likely to be hired. They also tend to be denied housing and are more likely to be falsely accused of crimes. Sadly, the fear of stigmatization, including self-stigmatization, is one major reason many people do not seek help for their mental illness (Mojtabai et al., 2011). Thus, people who are grappling with mental illness may be harmed by social stigma as well as by their immediate psychological problems (Elkington et al., 2012).

The Oppressive Side of Psychiatric Labels

Everyone has felt or acted “crazy” during brief periods of stress or high emotion. People with psychological disorders may have problems that are more severe or long-lasting than most of us experience. Otherwise, though, they may not be that different from the rest of us. The terms used to describe mental illness are meant to aid communication about human problems. But as we have just seen, the dangers of labeling, including stigmatization, mean that if psychiatric labels are used carelessly or maliciously, they can oppress people.

Can you give an example? Sure. In the mid-1800s, slaves who tried to escape were sometimes labeled as suffering from “drapetomania,” a mental “disorder” that causes slaves to run away (Wakefield, 1992). The “cure”? Amputation of the toes. As this example suggests, psychiatric terms are easily abused. Historically, some have been applied to culturally disapproved behaviors that are not mental disorders. Another of our personal favorites is the long-outdated diagnosis of “anarchia,” a form of insanity that leads one to seek a more democratic society (Brown, 1990).

All of the following sexual behaviors were considered mental disorders not that long ago: childhood masturbation, lack of vaginal orgasm, homosexuality, and nymphomania (a woman with a healthy sexual appetite) (Wakefield, 1992). Modern critics suggest that labeling, for example, homosexuality as a deviant form of sexuality amounts to nothing more than using medical labels as a way to justify prejudice.

Even today, stereotypes of race, gender, and social class continue to affect the definitions of various disorders (Mizock & Harkins, 2011; Poland & Caplan, 2004). Gender is probably the most common source of bias in judging normality because standards tend to be based on males (Fine, 2010; Nolen-Hoeksema, 2011). According to psychologist Paula Caplan, women are penalized both for ignoring female stereotypes and for conforming to them. If a woman is independent, aggressive, and unemotional, she may be considered “overmasculinized.” Yet a woman who is vain, emotional, irrational, and dependent on others (all “feminine” traits in our culture) may be classified as having a personality disorder. Indeed, a majority of persons classified as having dependent personality disorder are women. In view of this, Caplan asks, why isn’t there a category called “delusional dominating personality disorder” for obnoxious men (Caplan, 1995)?

Because biases and prejudices can influence perceptions of disorder and normality, it is worth being extra cautious before you leap to conclusions about or label the mental health of others (American Psychiatric Association, 2013). *Animal-mask-wearing disorder?* They might be doing an assignment for their psychology class!

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Chapter 60: Psychological Disorders: Defining Psychopathology: 60-3 Diagnosing Mental Illness—Attaching a Label to the Person
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60-3 Diagnosing Mental Illness—Attaching a Label to the Person

Survey Question 60.3

How are mental disorders diagnosed?

Like physical illness, mental illness is typically diagnosed by confirming the presence and/or absence of a number of symptoms (Durand & Barlow, 2016). Consider the diagnosis of *major depressive episode*. Of course, one of the symptoms is being in a depressed (sad, empty, or hopeless) mood. But almost everybody gets a little depressed from time to time. This symptom won't qualify for this diagnosis unless the mood is unusually intense and has gone nearly all day, every day, for at least two weeks. Furthermore, there are eight additional main symptoms to consider, such as loss of interest or pleasure, difficulties with sleep, fatigue or loss of energy, and thoughts of suicide. At least five of these nine main symptoms must have occurred nearly all day, every day, for at least two weeks.

At the same time, there can't have been any *manic episodes* (or else this may be bipolar disorder) and no drug use (or this may be a *substance use disorder*). A further complicating factor is the potential presence of other symptoms not usually part of the diagnosis under consideration. Although depressed people do not typically report psychotic symptoms such as *hallucinations*, it is not unheard of and may indicate comorbidity.

In reality, diagnosing a *major depressive episode* is substantially more complicated than we have portrayed here. It takes a skilled practitioner to make accurate diagnoses. This is critical since treatments are only as good as the diagnoses they are based on (Sue et al., 2017).

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60-3a Types of Symptoms

As you begin to think about the symptoms underlying mental illness, you might find it helpful to distinguish between *positive* and *negative symptoms* (Rollins et al., 2010). *Positive symptoms*, such as delusions and hallucinations, are excesses or exaggerations compared to normal behavior. People who suffer from **delusions (Strongly held thought or belief that is at odds with reality.)** hold strong false beliefs that they insist are true, regardless of how much the facts contradict them. An example is a 34-year-old woman who was convinced that she would become “President of the United States of the World” (Mendelson & Goes, 2011).

Hallucinations (Perception with no basis in reality.) are imaginary perceptions, such as seeing, hearing, or smelling things that don’t exist in the real world. The most common hallucination is hearing voices. Sometimes these voices command patients to hurt themselves or others and, unfortunately, sometimes they obey (Barrowcliff & Haddock, 2006).

In contrast, *negative symptoms* are absences or deficiencies compared to normal behavior. Sometimes patients may be apathetic or display a lack of emotion—*flat affect*—a condition in which the face is frozen in a blank expression. Brain images from patients with “frozen faces” reveal that their brains process emotions abnormally (Lepage et al., 2011). Similarly, a reduced capacity to communicate verbally is a common symptom of some disorders such as psychosis. In fact, psychotic speech can be so garbled and chaotic that it sometimes sounds like a “word salad.”

It is one thing to identify symptoms or to diagnose a mental disorder; it is another matter entirely to understand what causes it. While much mystery still remains, in the next section we begin by describing the general factors that underlie all mental illnesses.

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Chapter 60: Psychological Disorders: Defining Psychopathology: 60-4 Causes of Mental Illness—What Went Wrong?
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60-4 Causes of Mental Illness—What Went Wrong?

Survey Question 60.4

What causes mental disorders?

Like different physical diseases, different mental illnesses undoubtedly have different underlying causes. Regardless, a small number of general factors underlie all illnesses, mental or otherwise. In the modules on health psychology we stressed the *biopsychosocial* model. As you surely recall (right?), combinations of biological, psychological, and/or social factors can underlie both poor and good health. In the same vein, biological, psychological, and/or social factors play a role in mental illness (Yim et al., 2015).

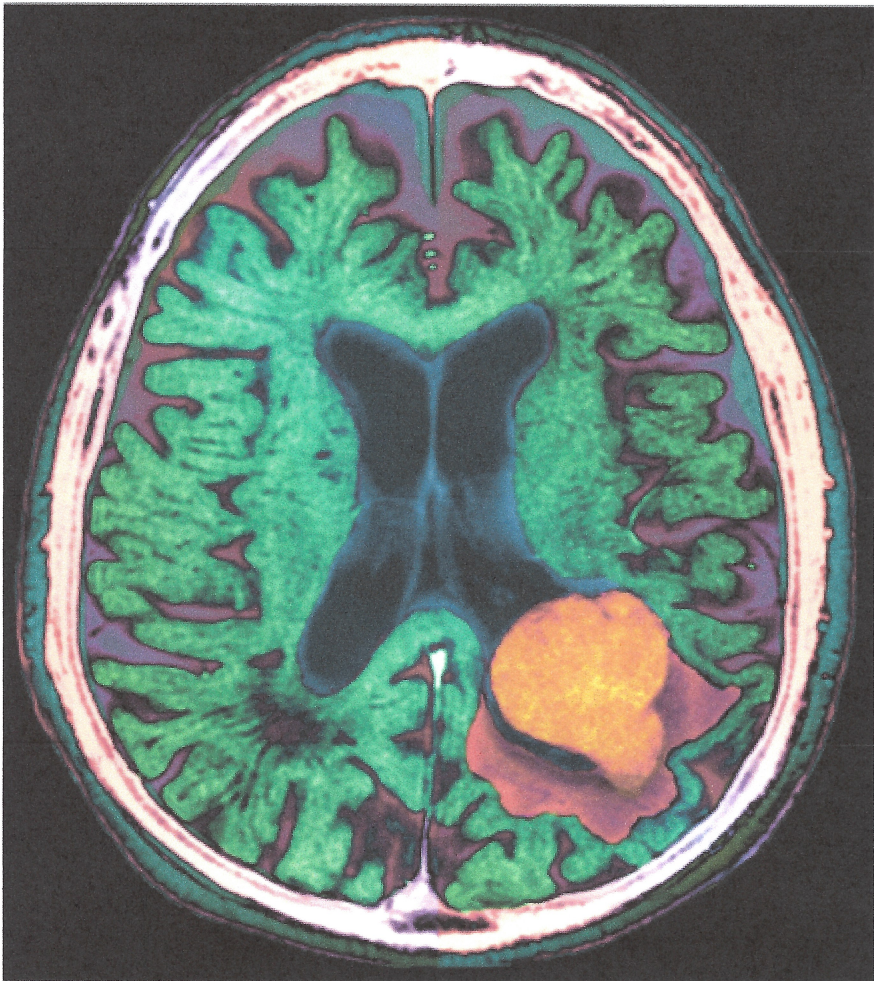
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60-4a Biological Factors

A variety of mental illnesses are directly associated with biological factors such as genetic defects, very low birth weight, chronic physical illness or disability, exposure to toxic chemicals or drugs, or head injuries. Mr. P’s abnormal sexual behaviors clearly arose due to a tumor in his brain.

This MRI scan of a human brain (viewed from the top) reveals a tumor (red spot). Mental disorders, like Mr. P’s abnormal sexual behaviors, sometimes have organic causes of this sort. However, in many instances, no organic damage can be found.



Zephyr / Science Source

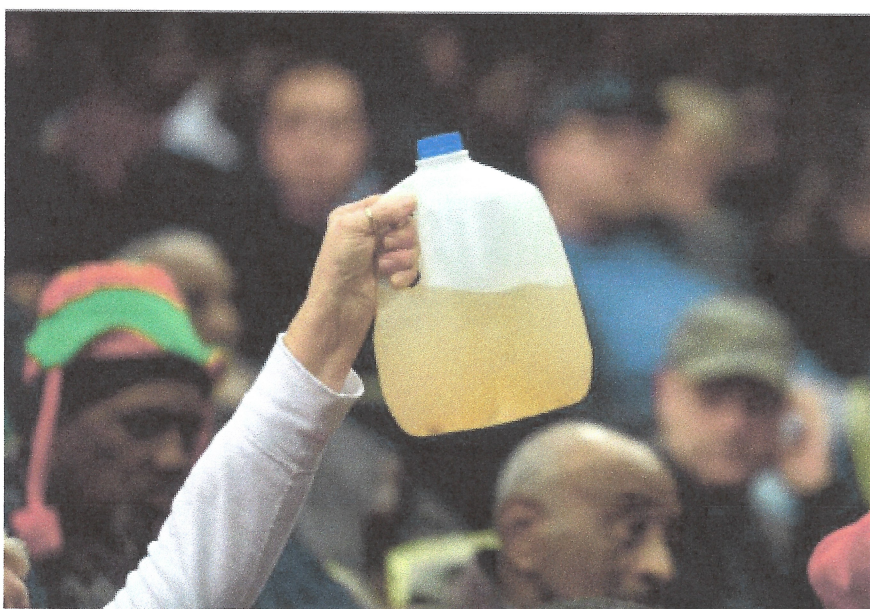
Similarly, poisoning by chemicals such as lead or mercury can damage the brain, causing intellectual disability, hallucinations, delusions, and a loss of emotional control (Kern et al., 2012). Children with high levels of lead in their blood are more likely to be arrested as adults for criminal offenses (Wright et al., 2008). That is why the current lead poisoning crisis centered in Flint, Michigan, is so frightening to parents. On a much larger scale, “poisoning”

of another type, in the form of drug abuse, also can produce deviant behavior and psychotic symptoms (American Psychiatric Association, 2013.)

In general, problems directly related to nervous system damage that arise before adulthood, such as *autism*, are termed [neurodevelopmental disorders \(Psychopathologies due to various forms of damage to the nervous system arising before adulthood.\)](#) . For example, Down syndrome, a form of intellectual disability, is caused by a genetic defect. It is also known as trisomy 21 because the defect involves an extra 21st chromosome ([Module 40](#)).

Problems not arising until adulthood, such as *Parkinson's disease*, are termed [neurocognitive disorders \(Psychopathologies due to various forms of damage to the nervous system not arising until adulthood.\)](#) . These are often serious mental impairments in old age caused by deterioration of the brain. In these disorders, we see major disturbances in memory, reasoning, judgment, impulse control, and personality (Treves & Korczyn, 2012). This combination usually leaves people confused, suspicious, apathetic, or withdrawn. Some common causes of neurocognitive disorders are circulatory problems, repeated strokes, or general shrinkage and atrophy of the brain.

The Mad Hatter, from Lewis Carroll's *Alice's Adventures in Wonderland*, was modeled after an occupational disease of the eighteenth and nineteenth centuries. In that era, hat makers were heavily exposed to mercury used in the preparation of felt. Consequently, many suffered brain damage and became psychotic, or "mad" (Kety, 1979). Such environmental exposure to toxic chemicals remains a problem to this day. Unacceptably high concentrations of lead in water supplies are currently plaguing the mostly poor families living in cities such as Flint, Michigan.



Ryan Garza/Detroit Free Press/ZUMA Press/Newscom

[Alzheimer's disease \(Age-related condition characterized by memory loss, confusion, and increasing loss of mental abilities.\)](#) (ALLS-hi-merz) is the most common neurocognitive disorder. Alzheimer's victims slowly lose the ability to work, cook, drive, read, write, or do

arithmetic. Eventually, they are mute and bedridden. Alzheimer's disease appears to be related to unusual webs and tangles in the brain that damage areas important for memory and learning (Hanyu et al., 2010; Stix, 2010). Genetic factors can increase the risk of developing this devastating disease (Treves & Korczyn, 2012).

The Genetics of Mental Illness

A variety of mental disorders from narcolepsy to schizophrenia run in families, likely indicating the involvement of an inherited genetic factor. For example, one recent study identified 128 gene variations associated with schizophrenia (Schizophrenia Working Group of the Psychiatric Genomics Consortium, 2014). While any progress in understanding schizophrenia is welcome, this still leaves researchers with more questions than answers (Sharma et al., 2016). How do particular genes, once they are identified, affect the brain? Do they modify brain structure? Do they alter neurotransmitter function? Most importantly, does any of this lead to new therapies for schizophrenia?

Our current understanding of the genetics of most mental illnesses is, like our understanding of schizophrenia, a work in progress (e.g., Halmai et al., 2013). Nevertheless, genetic analyses will undoubtedly continue to contribute to our rapidly expanding knowledge of the causes of mental illness.

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60-4b Psychosocial Factors

A variety of psychosocial factors also are associated with a variety of mental illnesses. Relevant psychological factors include stress; psychological trauma; learning disorders; and lack of knowledge, control or mastery. Contributing family factors include parents who are immature, mentally disturbed, criminal, or abusive; severe marital strife; extremely poor child discipline; and disordered family communication patterns. Relevant social conditions include poverty, stressful living conditions, homelessness, social disorganization, and overcrowding. Of these, the most important are stress and early [psychological trauma \(A psychological injury or shock, such as that caused by violence, abuse, neglect, separation, etc.\)](#) —a psychological injury or shock.

The Stress-Vulnerability Model

Most psychologists now accept that most mental illnesses are caused by a blend of environmental, psychosocial stress and inherited vulnerability (Jones & Fernyhough, 2007; Yim et al., 2015). This type of explanation is called the [stress-vulnerability model \(A model that attributes mental illness to a combination of environmental stress and inherited susceptibility.\)](#) (or the *diathesis-stress* model; see [Figure 60.2](#)).

Figure 60.2

Stress-Vulnerability Model.

Various combinations of vulnerability and stress may produce psychological problems. The top bar shows low vulnerability and low stress. The result? No problem. The same is true of the next bar down, in which low vulnerability is combined with moderate stress. Even high vulnerability (third bar) may not lead to problems if stress levels remain low. However, when high vulnerability combines with moderate or high stress (bottom two bars), the person “crosses the line” and suffers from psychopathology.