

Another reason for our curiosity is that so many of us have felt, either personally or through friends or family, the bewilderment and pain of a psychological disorder that may bring unexplained physical symptoms, irrational fears, or a feeling that life is not worth living. Indeed, as members of the human family, most of us will at some point encounter a person with a psychological disorder.

The World Health Organization (WHO, 2010) reports that, worldwide, some 450 million people suffer from mental or behavioral disorders. These disorders account for 15.4 percent of the years of life lost due to death or disability—scoring slightly below cardiovascular conditions and slightly above cancer (Murray & Lopez, 1996). Rates and symptoms of psychological disorders vary by culture, but two terrible maladies appear more consistently worldwide: depression and schizophrenia.

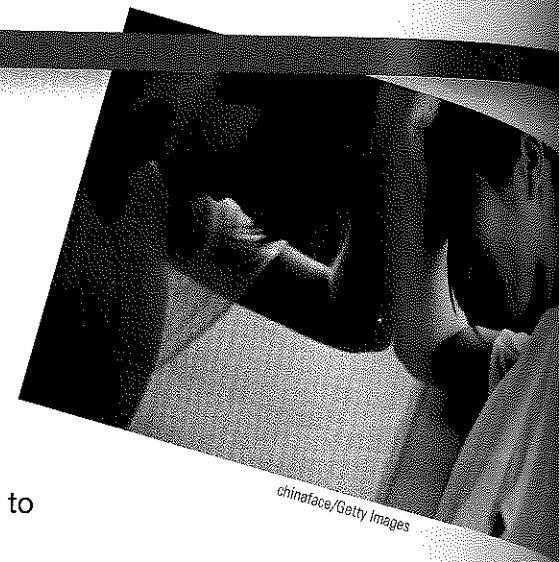
# Module 65

## Introduction to Psychological Disorders

### Module Learning Objectives

- 65-1 Discuss how we draw the line between normality and disorder.
- 65-2 Discuss the controversy over the diagnosis of attention-deficit/hyperactivity disorder.
- 65-3 Contrast the medical model with the biopsychosocial approach to psychological disorders.
- 65-4 Describe how and why clinicians classify psychological disorders.
- 65-5 Explain why some psychologists criticize the use of diagnostic labels.
- 65-6 Discuss the prevalence of psychological disorders, and summarize the findings on the link between poverty and serious psychological disorders.

Most people would agree that someone who is too depressed to get out of bed for weeks at a time has a psychological disorder. But what about those who, having experienced a loss, are unable to resume their usual social activities? Where should we draw the line between sadness and depression? Between zany creativity and bizarre irrationality? Between normality and abnormality? Let's start with these questions:



- How should we *define* psychological disorders?
- How should we *understand* disorders? How do underlying biological factors contribute to disorder? How do troubling environments influence our well-being? And how do these effects of nature and nurture interact?
- How should we *classify* psychological disorders? And can we do so in a way that allows us to help people without stigmatizing them with *labels*?

## Defining Psychological Disorders

### 65-1 How should we draw the line between normality and disorder?

A **psychological disorder** is a syndrome marked by a “clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior” (American Psychiatric Association, 2013). Disturbed, or *dysfunctional*, behaviors are *maladaptive*—they interfere with normal day-to-day life. An intense fear of spiders may be abnormal, but if it doesn’t interfere with your life, it is not a disorder. Marc’s cleaning rituals (from this unit’s opening) did interfere with his work and leisure. If occasional sad moods persist and become disabling, they may signal a psychological disorder. Distress often accompanies dysfunctional behaviors. Marc, Greta, and Stuart were all distressed by their behaviors or emotions.

Over time, definitions of what makes for a “significant disturbance” have varied. From 1952 through December 9, 1973, homosexuality was classified as a mental illness. By day’s end on December 10, it was not. The American Psychiatric Association had dropped homosexuality as a disorder because more and more of its members no longer viewed it as a psychological problem. (Later research revealed that the stigma and stresses that often accompany homosexuality, however, increase the risk of mental health problems [Hatzenbuehler et al., 2009; Meyer, 2003].) In this new century, controversy swirls over the frequent diagnosing of children with *attention-deficit/hyperactivity disorder* (see Thinking Critically About: ADHD—Normal High Energy or Disordered Behavior? on the next page).

“Who in the rainbow can draw the line where the violet tint ends and the orange tint begins? Distinctly we see the difference of the colors, but where exactly does the one first blendingly enter into the other? So with sanity and insanity.” —HERMAN MELVILLE, *BILLY BUDD, SAILOR*, 1924

**psychological disorder**  
a syndrome marked by a clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior. (Adapted from American Psychiatric Association, 2013.)

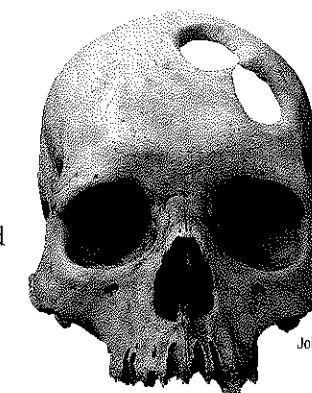


**Culture and normality**  
Young men of the West African Wodaabe tribe put on elaborate makeup and costumes to attract women. Young American men may buy flashy cars with loud stereos to do the same. Each culture may view the other’s behavior as abnormal.

## Understanding Psychological Disorders

### 65-3 How do the medical model and the biopsychosocial approach understand psychological disorders?

To explain puzzling behavior, people in earlier times often presumed the work of strange forces—the movements of the stars, godlike powers, or evil spirits. Had you lived during the Middle Ages, you might have said, “The devil made him do it,” and you might have



**Yesterday’s “therapy”** In other times and places, psychologically disordered people sometimes received brutal treatments, including the trepanation evident in this Stone Age skull. Drilling skull holes like these may have been an attempt to release evil spirits and cure those with mental disorders. Did this patient survive the “cure”?

John W. Verano

approved of a cure to rid the evil force by exorcising the demon. Until the last two centuries, “mad” people were sometimes caged in zoo-like conditions or given “therapies” appropriate to a demon: beatings, burning, or castration. In other times, therapy included pulling teeth, removing lengths of intestines, cauterizing the clitoris, or giving transfusions of animal blood (Farina, 1982).

## Thinking Critically About

### ADHD—Normal High Energy or Disordered Behavior?

#### 65-2 Why is there controversy over attention-deficit/hyperactivity disorder?

Eight-year-old Todd has always been energetic. At home, he chatters away and darts from one activity to the next, rarely settling down to read a book or focus on a game. At play, he is reckless and overreacts when playmates bump into him or take one of his toys. At school, his exasperated teacher complains that fidgety Todd doesn’t listen, follow instructions, or stay in his seat and do his lessons. As he matures to adulthood, Todd’s hyperactivity likely will subside, but his inattentiveness may persist (Kessler et al., 2010).

If taken for a psychological evaluation, Todd may be diagnosed with **attention-deficit/hyperactivity disorder (ADHD)**, as are some 11 percent of American 4- to 17-year-olds who display its key symptoms (extreme inattention, hyperactivity, and impulsivity) (Schwarz & Cohen, 2013). Studies also find 2.5 percent of adults—though a diminishing number with age—exhibiting ADHD symptoms (Simon et al., 2009). Psychiatry’s new diagnostic manual loosens the criteria for adult ADHD, leading critics to fear increased diagnosis and overuse of prescription drugs (Frances, 2012).

To skeptics, being distractible, fidgety, and impulsive sounds like a “disorder” caused by a single genetic variation: a Y chromosome. And sure enough, ADHD is diagnosed three times more often in boys than in girls. Does energetic child + boring school = ADHD overdiagnosis? Is the label being applied to healthy schoolchildren who, in more natural outdoor environments, would seem perfectly normal?

Skeptics think so. In the decade after 1987, they note, the proportion of American children being treated for ADHD nearly quadrupled (Olson et al., 2003). How commonplace the diagnosis is depends in part on teacher referrals. Some teachers refer lots of kids for ADHD assessment, others none. ADHD rates have varied by a factor of 10 in different counties of New York State (Carlson, 2000). Although African-American youth display more ADHD symptoms than do Caucasian youth, they less often receive an ADHD diagnosis (Miller et al., 2009). Depending on where they live, children who are “a persistent pain in the neck in school” are often diagnosed with ADHD and given powerful prescription drugs, notes Peter Gray (2010). But the problem resides less in the child, he argues, than in today’s abnormal environment

that forces children to do what evolution has not prepared them to do—to sit for long hours in chairs.

On the other side of the debate are those who argue that the more frequent diagnoses of ADHD today reflect increased awareness of the disorder, especially in those areas where rates are highest. They acknowledge that diagnoses can be subjective and sometimes inconsistent—ADHD is not as objectively defined as is a broken arm. Nevertheless, declared the World Federation for Mental Health (2005), “there is strong agreement among the international scientific community that ADHD is a real neurobiological disorder whose existence should no longer be debated.” A consensus statement by 75 researchers noted that in neuroimaging studies, ADHD has associations with abnormal brain activity patterns (Barkley et al., 2002).

What, then, is known about ADHD’s causes? It is not caused by too much sugar or poor schools. There is mixed evidence suggesting that extensive TV watching and video gaming are associated with reduced cognitive self-regulation and ADHD (Bailey et al., 2011; Courage & Setliff, 2010; Ferguson, 2011). ADHD often coexists with a learning disorder or with defiant and temper-prone behavior. ADHD is *heritable*, and research teams are sleuthing the culprit genes and abnormal neural pathways (Nikolas & Burt, 2010; Poelmans et al., 2011; Volkow et al., 2009; Williams et al., 2010). It is treatable with medications such as Ritalin and Adderall, which are considered stimulants but help calm hyperactivity and increase the ability to sit and focus on a task—and to progress normally in school (Barbarelli et al., 2007). Psychological therapies, such as those focused on shaping behaviors in the classroom and at home, have also helped address the distress of ADHD (Fabiano et al., 2008).

The bottom line: Extreme inattention, hyperactivity, and impulsivity can derail social, academic, and vocational achievements, and these symptoms can be treated with medication and other therapies. But the debate continues over whether normal rambunctiousness is too often diagnosed as a psychiatric disorder, and whether there is a cost to the long-term use of stimulant drugs in treating ADHD.

#### attention-deficit/hyperactivity disorder (ADHD)

a psychological disorder marked by the appearance by age 7 of one or more of three key symptoms: extreme inattention, hyperactivity, and impulsivity.

## The Medical Model

In opposition to brutal treatments, reformers, including Philippe Pinel (1745–1826) in France, insisted that madness is not demon possession but a sickness of the mind caused by severe stresses and inhumane conditions. For Pinel and others, “moral treatment” included boosting patients’ morale by unchaining them and talking with them, and by replacing brutality with gentleness, isolation with activity, and filth with clean air and sunshine. While such measures did not often cure patients, they were certainly more humane.

By the 1800s, the discovery that syphilis infects the brain and distorts the mind drove further gradual reform. Hospitals replaced asylums, and the medical world began searching for physical causes and treatments of mental disorders. Today, this **medical model** is recognizable in the terminology of the mental *health* movement: A mental *illness* (also called a *psychopathology*) needs to be *diagnosed* on the basis of its *symptoms* and *treated* through *therapy*, which may include time in a psychiatric *hospital*.

The medical perspective has gained credibility from recent discoveries that genetically influenced abnormalities in brain structure and biochemistry contribute to many disorders. But as we will see, psychological factors, such as chronic or traumatic stress, also play an important role.

**medical model** the concept that diseases, in this case psychological disorders, have physical causes that can be *diagnosed*, *treated*, and, in most cases, *cured*, often through treatment in a *hospital*.



“Moral treatment” Under Philippe Pinel’s influence, hospitals sometimes sponsored patient dances, often called “lunatic balls,” depicted in this painting by George Bellows (*Dance in a Madhouse*).

## The Biopsychosocial Approach

Today’s psychologists contend that all behavior, whether called normal or disordered, arises from the interaction of nature (genetic and physiological factors) and nurture (past and present experiences). To presume that a person is “mentally ill,” they say, attributes the condition to a “sickness” that must be identified and cured. But difficulty in the person’s environment, the person’s current interpretations of events, or the person’s bad habits and poor social skills may also be factors.

Evidence of such effects comes from links between specific disorders and cultures (Beardsley, 1994; Castillo, 1997). Cultures differ in their sources of stress, and they produce different ways of coping. The eating disorders anorexia nervosa and bulimia nervosa, for example, have occurred mostly in Western cultures. In Malaysia, *amok* describes a sudden outburst of violent behavior (thus the phrase “run amok”). Latin America lays claim to *susto*, a condition marked by severe anxiety, restlessness, and a fear of black magic. *Taijin-kyofusho*, social anxiety about one’s appearance combined with a readiness to blush and a fear of eye contact, appears in Japan, as does the extreme withdrawal of *hikikomori*. Such disorders may share an underlying dynamic (such as anxiety) while differing in the symptoms (an eating problem or a type of fear) manifested in a particular culture.

But not all disorders are culture-bound. Depression and schizophrenia occur worldwide. From Asia to Africa and across the Americas, schizophrenia’s symptoms often include irrationality and incoherent speech.

#### FYI

Increasingly, North American disorders, such as eating disorders, are, along with McDonald’s and MTV, spreading across the globe (Watters, 2010).



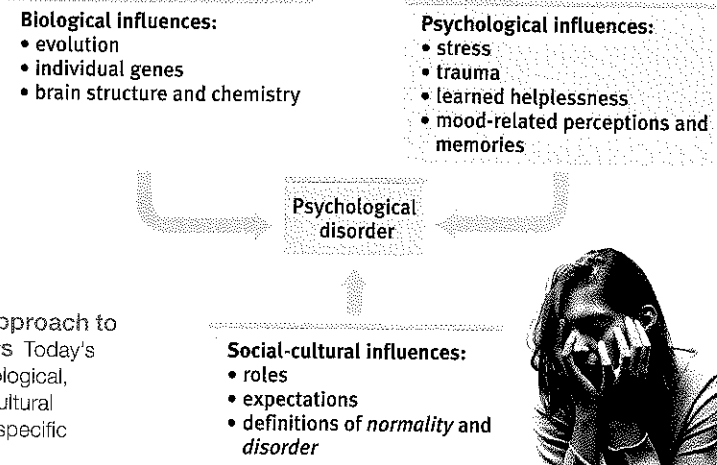


Figure 65.1

The biopsychosocial approach to psychological disorders Today's psychology studies how biological, psychological, and social-cultural factors interact to produce specific psychological disorders.

## Classifying Psychological Disorders

### 65-4 How and why do clinicians classify psychological disorders?

In biology and the other sciences, classification creates order. To classify an animal as a “mammal” says a great deal—that it is warm-blooded, has hair or fur, and nourishes its young with milk. In psychiatry and psychology, too, classification orders and describes symptoms. To classify a person's disorder as “schizophrenia” suggests that the person talks incoherently; hallucinates or has delusions (bizarre beliefs); shows either little emotion or inappropriate emotion; or is socially withdrawn. “Schizophrenia” provides a handy shorthand for describing a complex disorder.

In psychiatry and psychology, diagnostic classification aims not only to describe a disorder but also to predict its future course, imply appropriate treatment, and stimulate research into its causes. Indeed, to study a disorder we must first name and describe it. The most common system for describing disorders and estimating how often they occur is the American Psychiatric Association's 2013 *Diagnostic and Statistical Manual of Mental Disorders*, now in its fifth edition (**DSM-5**). Physicians and mental health workers use the detailed “diagnostic criteria and codes” in the DSM-5 to guide medical diagnoses and define who is eligible for treatments, including medication. For example, a person may be diagnosed with and treated for “insomnia disorder” if he or she meets *all* of the following criteria:

- Is dissatisfied with sleep quantity or quality (difficulty initiating, maintaining, or returning to sleep).
- Sleep disturbance causes distress or impairment in everyday functioning.
- Occurs at least three nights per week.
- Present for at least three months.
- Occurs despite adequate opportunity for sleep.
- Is not explained by another sleep disorder (such as narcolepsy).
- Is not caused by substance use or abuse.
- Is not caused by other mental disorders or medical conditions.

In this new DSM edition, some diagnostic labels have changed. For example, “autism” and “Asperger's syndrome” are no longer included; they have been combined into “autism spectrum disorder.” “Mental retardation” has become “intellectual disability.” New categories include “hoarding disorder” and “binge-eating disorder.”

To assess the whole set of influences—genetic predispositions and physiological states, inner psychological dynamics, and social and cultural circumstances—the biopsychosocial model helps (FIGURE 65.1). This approach recognizes that mind and body are inseparable. Negative emotions contribute to physical illness, and physical abnormalities contribute to negative emotions. We are mind embodied and socially embedded.

Some new or altered diagnoses are controversial. “Disruptive mood dysregulation disorder” is a new DSM-5 diagnosis for children “who exhibit persistent irritability and frequent episodes of behavior outbursts three or more times a week for more than a year.” Will this diagnosis assist parents who struggle with unstable children, or will it “turn tantrums into a mental disorder” and lead to overmedication, as the chair of the previous DSM edition has warned (Frances, 2012)?

Critics have long faulted the DSM for casting too wide a net and bringing “almost any kind of behavior within the compass of psychiatry” (Eysenck et al., 1983). They worry that the DSM-5 will extend the pathologizing of everyday life—for example, by turning bereavement grief into depression and boyish rambunctiousness into ADHD (Frances, 2013). Others respond that depression and hyperactivity, though needing careful definition, are genuine disorders even, for example, those triggered by a major life stress such as a death when the grief does not go away (Kendler, 2011; Kupfer, 2012).

## Labeling Psychological Disorders

### 65-5 Why do some psychologists criticize the use of diagnostic labels?

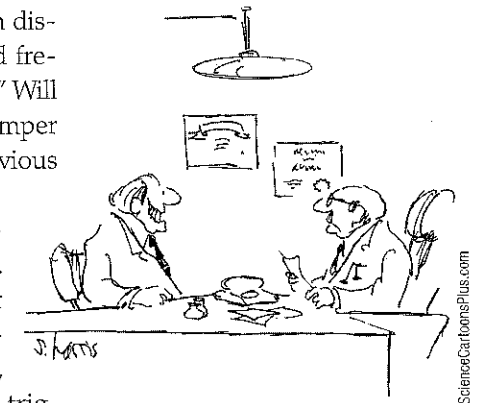
The DSM has other critics who register a more fundamental complaint—that these labels are at best arbitrary and at worst value judgments masquerading as science. Once we label a person, we view that person differently (Farina, 1982). Labels create preconceptions that guide our perceptions and our interpretations.

In a now-classic study of the biasing power of labels, David Rosenhan (1973) and seven others went to hospital admissions offices, complaining of “hearing voices” saying *empty*, *hollow*, and *thud*. Apart from this complaint and giving false names and occupations, they answered questions truthfully. All eight normal people were misdiagnosed with disorders.

Should we be surprised? As one psychiatrist noted, if someone swallows blood, goes to an emergency room, and spits it up, should we fault the doctor for diagnosing a bleeding ulcer? Surely not. But what followed the diagnosis in the Rosenhan study was startling. Until being released an average of 19 days later, the “patients” exhibited no further symptoms such as hearing voices. Yet after analyzing their (quite normal) life histories, clinicians were able to “discover” the causes of their disorders, such as reacting with mixed emotions about a parent. Even the routine behavior of taking notes was misinterpreted as a symptom.

Labels matter. When people in another experiment watched videotaped interviews, those told the interviewees were job applicants perceived them as normal (Langer et al., 1974, 1980). Those who thought they were watching psychiatric or cancer patients perceived them as “different from most people.” Therapists who thought an interviewee was a psychiatric patient perceived him as “frightened of his own aggressive impulses,” a “passive, dependent type,” and so forth. A label can, as Rosenhan discovered, have “a life and an influence of its own.”

Surveys in Europe and North America have demonstrated the stigmatizing power of labels (Page, 1977). Getting a job or finding a place to rent can be a challenge for those known to be just released from prison—or a mental hospital. But as we are coming to understand that many psychological disorders are diseases of the brain, not failures of character, the stigma seems to be lifting (Solomon, 1996). Public figures are feeling freer to “come out” and speak with candor about their struggles with disorders such as depression. And the more contact people have with individuals with disorders, the more accepting their attitudes are (Kolodziej & Johnson, 1996). People express greatest sympathy for people whose disorders are gender atypical—for men suffering depression (which is more common among women), or for women plagued by alcohol use disorder (Wirth & Bodenhausen, 2009).



“I'm always like this, and my family was wondering if you could prescribe a mild depressant.”

### FYI

A book of case illustrations accompanying the previous DSM edition provides several examples for this unit.

**DSM-5** the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition; a widely used system for classifying psychological disorders.

“One of the unpardonable sins, in the eyes of most people, is for a man to go about unlabeled. The world regards such a person as the police do an unmuzzled dog, not under proper control.” -T. H. HUXLEY, *EVOLUTION AND ETHICS*, 1893

“My sister suffers from a bipolar disorder and my nephew from schizoaffective disorder. There has, in fact, been a lot of depression and alcoholism in my family and, traditionally, no one ever spoke about it. It just wasn't done. The stigma is toxic.” -ACTRESS GLENN CLOSE, “MENTAL ILLNESS: THE STIGMA OF SILENCE,” 2009

**Accurate portrayal**  
Recent films have offered some realistic depictions of psychological disorders. *Black Swan* (2010), shown here, portrayed a main character suffering a delusional disorder. *Temple Grandin* (2010) dramatized a lead character who successfully copes with autism spectrum disorder. *A Single Man* (2009) depicted depression.



Photograph: Phoenix Pictures/The Kobal Collection

**AP® Exam Tip**

Notice that the term *insanity* comes out of the legal system. It is not a psychological or medical diagnosis and does not appear in the DSM-5.

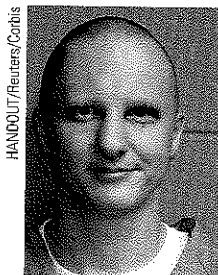
violence than the perpetrators (Marley & Bulia, 2001). Indeed, reported the U.S. Surgeon General's Office (1999, p. 7), "There is very little risk of violence or harm to a stranger from casual contact with an individual who has a mental disorder." (Although most people with psychological disorders are not violent, those who are create a moral dilemma for society. For more on this topic, see Thinking Critically About: Insanity and Responsibility.)

**Thinking Critically About**

**Insanity and Responsibility**

"My brain . . . my genes . . . my bad upbringing made me do it." Such defenses were anticipated by Shakespeare's Hamlet. If I wrong someone when not myself, he explained, "then Hamlet does it not, Hamlet denies it. Who does it then? His madness." Such is the essence of a legal insanity defense. "Insanity" is a legal rather than a psychological concept, and was created in 1843 after a deluded Scotsman tried to shoot the prime minister (who he thought was persecuting him) but killed an assistant by mistake. Like U.S. President Ronald Reagan's near-assassin, John Hinckley, Scotsman Daniel M'Naghten was sent to a mental hospital rather than to prison.

In both cases, the public was outraged. "Hinckley Insane, Public Mad," declared one headline. They were mad again when a deranged Jeffrey Dahmer in 1991 admitted murdering 15 young men and eating parts of their bodies. They were mad in 1998 when 15-year-old Kip Kinkel, driven by "those voices in my head," killed his parents and two fellow Springfield, Oregon, students and wounded 25 others. They were mad in 2002 when Andrea Yates, after being taken off her antipsychotic medication, was tried in Texas for drowning her five children. And they were mad in 2011, when an irrational Jared Loughner gunned down a crowd of people, including survivor Congresswoman Gabrielle Giffords, in an Arizona supermarket parking lot. Following their arrest, most of these people were sent to jails, not hospitals. (Hinckley was sent to a psychiatric hospital and later, after another trial, Yates was instead hospitalized.) As Yates' fate illustrates, 99 percent of those whose insanity defense is accepted are nonetheless institutionalized, often for as long as those convicted of crimes (Lilienfeld & Arkowitz, 2011).



HANDOUT/Reuters/Corbis

**Jail or hospital?** Jared Lee Loughner was charged with the 2011 Tucson, Arizona, shooting that killed six people and left over a dozen others injured, including U.S. Representative Gabrielle Giffords. Loughner had a history of mental health issues, including paranoid beliefs, and was diagnosed with schizophrenia. Usually, however, schizophrenia is only associated with violence when accompanied by substance abuse (Fazel et al., 2009).

Most people with psychological disorders are not violent. But what should society do with those who are? What do we do with disturbed individuals who mow down innocents at movie theaters and schools? Sometimes there is nothing to be done, as in the case of the 2012 Sandy Hook Elementary School tragedy in Connecticut, where the shooter's final fatal shot was self-inflicted. Many people who have been executed or are now on death row have been limited by intellectual disability or motivated by delusional voices. The State of Arkansas forced one murderer with schizophrenia, Charles Singleton, to take two anti-psychotic drugs—in order to make him mentally competent, so that he could then be put to death.

Which of Yates' two juries made the right decision? The first, which decided that people who commit such rare but terrible crimes should be held responsible? Or the second, which decided to blame the "madness" that clouds their vision? As we come to better understand the biological and environmental basis for all human behavior, from generosity to vandalism, when should we—and should we not—hold people accountable for their actions?

Nevertheless, stereotypes linger in media portrayals of psychological disorders. Some are reasonably accurate and sympathetic. But too often people with disorders are portrayed as objects of humor or ridicule (*As Good as It Gets*), as homicidal maniacs (Hannibal Lecter in *Silence of the Lambs*), or as freaks (Nairn, 2007). Apart from the few who experience threatening delusions and hallucinated voices that command a violent act, and from those whose dysfunctionality includes substance abuse, mental disorders seldom lead to violence (Douglas et al., 2009; Elbogen & Johnson, 2009; Fazel et al., 2009, 2010). In real life, people with disorders are more likely to be the victims of

Not only can labels bias perceptions, they can also change reality. When teachers are told certain students are "gifted," when students expect someone to be "hostile," or when interviewers check to see whether someone is "extraverted," they may act in ways that elicit the very behavior expected (Snyder, 1984). Someone who was led to think you are nasty may treat you coldly, leading you to respond as a mean-spirited person would. Labels can serve as self-fulfilling prophecies.

But let us remember the *benefits* of diagnostic labels. Mental health professionals use labels to communicate about their cases, to comprehend the underlying causes, and to discern effective treatment programs. Diagnostic definitions also inform patient self-understandings. And they are useful in research that explores the causes and treatments of disordered behavior.

**Rates of Psychological Disorders**

**65-6** How many people suffer, or have suffered, from a psychological disorder? Is poverty a risk factor?

Who is most vulnerable to psychological disorders? At what times of life? To answer such questions, various countries have conducted lengthy, structured interviews with representative samples of thousands of their citizens. After asking hundreds of questions that probed for symptoms—"Has there ever been a period of two weeks or more when you felt like you wanted to die?"—the researchers have estimated the current, prior-year, and lifetime prevalence of various disorders.

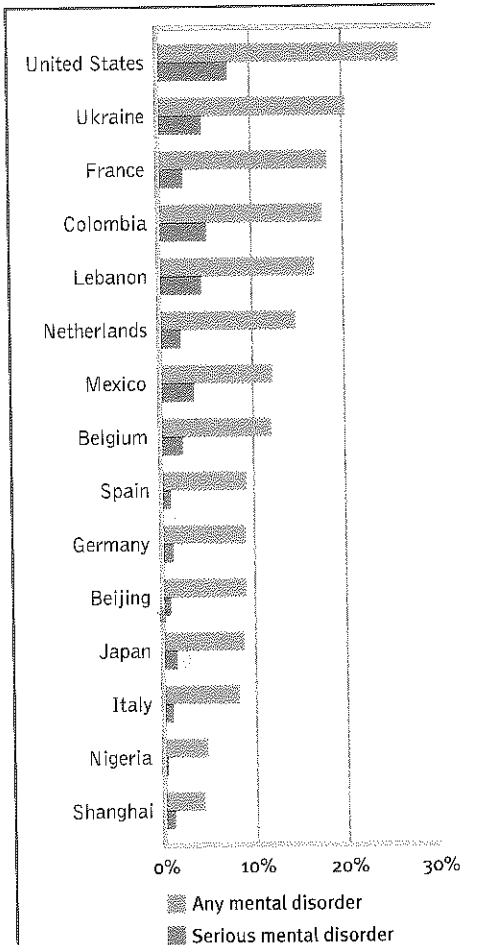
How many people have, or have had, a psychological disorder? More than most of us suppose:

- The U.S. National Institute of Mental Health (2008, based on Kessler et al., 2005) estimates that 26 percent of adult Americans "suffer from a diagnosable mental disorder in a given year" (**TABLE 65.1**).
- A large-scale World Health Organization (2004a) study—based on 90-minute interviews of 60,463 people—estimated the number of prior-year mental disorders in 20 countries. As **FIGURE 65.2** displays, the lowest rate of reported mental disorders was in Shanghai, the highest rate in the United States. Moreover, immigrants to the United States from Mexico, Africa, and Asia average better mental health than their native U.S. counterparts (Breslau et al., 2007; Maldonado-Molina et al., 2011). For example, compared with people who have recently immigrated from Mexico, Mexican-Americans born in the United States are at greater risk of mental disorder—a phenomenon known as the *immigrant paradox* (Schwartz et al., 2010).

**Table 65.1** Percentage of Americans Reporting Selected Psychological Disorders in the Past Year

Psychological Disorder	Percentage
Generalized anxiety	3.1
Social anxiety disorder	6.8
Phobia of specific object or situation	8.7
Mood disorder	9.5
Obsessive-compulsive disorder (OCD)	1.0
Schizophrenia	1.1
Posttraumatic stress disorder (PTSD)	3.5
Attention-deficit/hyperactivity disorder (ADHD)	4.1
Any mental disorder	26.2

Source: National Institute of Mental Health, 2008.



**Figure 65.2** Prior-year prevalence of disorders in selected areas From World Health Organization (WHO, 2004a) interviews in 20 countries.



Who is most vulnerable to mental disorders? As we have seen, the answer varies with the disorder. One predictor of mental disorder, poverty, crosses ethnic and gender lines. The incidence of serious psychological disorders has been doubly high among those below the poverty line (CDC, 1992). Like so many other correlations, the poverty-disorder association raises a chicken-and-egg question: Does poverty cause disorders? Or do disorders cause poverty? It is both, though the answer varies with the disorder. Schizophrenia understandably leads to poverty. Yet the stresses and demoralization of poverty can also precipitate disorders, especially depression in women and substance use disorder in men (Dohrenwend et al., 1992). In one natural experiment on the poverty-pathology link, researchers tracked rates of behavior problems in North Carolina Native American children as economic development enabled a dramatic reduction in their community's poverty rate. As the study began, children of poverty exhibited more deviant and aggressive behaviors. After four years, children whose families had moved above the poverty line exhibited a 40 percent decrease in the behavior problems, while those who continued in their previous positions below or above the poverty line exhibited no change (Costello et al., 2003).

As **TABLE 65.2** indicates, there is a wide range of risk and protective factors for mental disorders. At what times of life do disorders strike? Usually by early adulthood. "Over 75 percent of our sample with any disorder had experienced its first symptoms by age 24," reported Lee Robins and Darrel Regier (1991, p. 331). The symptoms of antisocial personality disorder and of phobias are among the earliest to appear, at a median age of 8 and 10, respectively. Symptoms of alcohol use disorder, obsessive-compulsive disorder, bipolar disorder, and schizophrenia appear at a median age near 20. Major depression often hits somewhat later, at a median age of 25. Such findings make clear the need for research and treatment to help the growing number of people, especially teenagers and young adults, who suffer the bewilderment and pain of a psychological disorder.

**Table 65.2 Risk and Protective Factors for Mental Disorders**

Risk Factors	Protective Factors
Academic failure	Aerobic exercise
Birth complications	Community offering empowerment, opportunity, and security
Caring for chronically ill or patients with neurocognitive disorder	Economic independence
Child abuse and neglect	Effective parenting
Chronic insomnia	Feelings of mastery and control
Chronic pain	Feelings of security
Family disorganization or conflict	Literacy
Low birth weight	Positive attachment and early bonding
Low socioeconomic status	Positive parent-child relationships
Medical illness	Problem-solving skills
Neurochemical imbalance	Resilient coping with stress and adversity
Parental mental illness	Self-esteem
Parental substance abuse	Social and work skills
Personal loss and bereavement	Social support from family and friends
Poor work skills and habits	
Reading disabilities	
Sensory disabilities	
Social incompetence	
Stressful life events	
Substance abuse	
Trauma experiences	

Source: World Health Organization (WHO, 2004b,c).

Although mindful of the pain, we can also be encouraged by the many successful people—including Leonardo da Vinci, Isaac Newton, and Leo Tolstoy—who pursued brilliant careers while enduring psychological difficulties. So have 18 U.S. presidents, including the periodically depressed Abraham Lincoln, according to one psychiatric analysis of their biographies (Davidson et al., 2006). The bewilderment, fear, and sorrow caused by psychological disorders are real. But, as Unit XIII shows, hope, too, is real.

### Before You Move On

▶ **ASK YOURSELF**

How would you draw the line between sending disturbed criminals to prisons or to mental hospitals? Would the person's history (for example, having suffered child abuse) influence your decisions?

▶ **TEST YOURSELF**

What is the biopsychosocial approach, and why is it important in our understanding of psychological disorders?

Answers to the Test Yourself questions can be found in Appendix E at the end of the book.

## Module 65 Review

**65-1** How should we draw the line between normality and disorder?

- According to psychologists and psychiatrists, a *psychological disorder* is a syndrome marked by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior.

**65-2** Why is there some controversy over attention-deficit/hyperactivity disorder?

- A child who by age 7 displays extreme inattention, hyperactivity, and impulsivity may be diagnosed with *attention-deficit/hyperactivity disorder (ADHD)* and treated with medication and other therapy.
- The controversy centers on whether the growing number of ADHD cases reflects overdiagnosis or increased awareness of the disorder. Long-term effects of stimulant-drug treatment for ADHD are not yet known.

**65-3** How do the medical model and the biopsychosocial approach understand psychological disorders?

- The *medical model* assumes that psychological disorders are mental illnesses with physical causes that can be diagnosed, treated, and, in most cases, cured through therapy, sometimes in a hospital.

- The biopsychosocial approach assumes that three sets of influences—biological (evolution, genetics, brain structure and chemistry), psychological (stress, trauma, learned helplessness, mood-related perceptions and memories), and social-cultural (roles, expectations, definitions of "normality" and "disorder")—interact to produce specific psychological disorders.

**65-4** How and why do clinicians classify psychological disorders?

- The American Psychiatric Association's *DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition)* contains diagnostic labels and descriptions that provide a common language and shared concepts for communication and research.
- Some critics believe the DSM editions have become too detailed and extensive.