**Psychological Disorder: What Makes a Behaviour Abnormal?**

The focus of this chapter and the next is, to many people, the heart of psychology. This emphasis on **abnormal psychology** — *the application of psychological science to understanding and treating mental disorders* — is appropriate, as more psychologists are involved in the diagnosis and treatment of psychological disorder than in any other endeavour, and these are probably the most important tasks psychologists face. In 2012, approximately 2.8 million people, or 10.1% of Canadians aged 15 and older, reported symptoms consistent with at least one of six mental or substance use disorders in the past 12 months (Pearson, Janz, & Ali, 2013). At least a half billion people are affected worldwide. The six disorders measured by the Canadian Mental Health Survey were major depressive episode, bipolar disorder, generalized anxiety disorder, and abuse of or dependence on alcohol, cannabis, or other drugs. The impact of mental illness is particularly strong on people who are poorer, of lower socioeconomic class, and from disadvantaged ethnic groups.

People with psychological disorders are also stigmatized by the people around them, resulting in shame and embarrassment, as well as prejudice and discrimination against them. Thus the understanding and treatment of psychological disorder has broad implications for the everyday life of many people. Table 13.1, "Prevalence Rates for Psychological Disorders in Canada, 2012," shows the **prevalence**, *the frequency of occurrence of a given condition in a population at a given time,* of some of the major psychological disorders in Canada.

| | Lifetime | 12-month |
|---|---|---|
| | percent | |
| Mental or substance disorders | 33.1 | 10.1 |
| Substance use disorder | 21.6 | 4.4 |
| Alcohol abuse or dependence | 18.1 | 3.2 |
| Cannabis abuse or dependence | 6.8 | 1.3 |
| Other drug abuse or dependence (excluding Cannabis) | 4 | 0.7 |
| Mood disorder | 12.6 | 5.4 |
| Major Depressive Episode | 11.3 | 4.7 |
| Bipolar Disorder | 2.6 | 1.5 |
| Generalized Anxiety Disorder | 8.7 | 2.6 |

Table 13.1. Prevalence Rates for Psychological Disorders in Canada, 2012, adapted by J. Walinga from Statistics Canada 2013. [Long Description]

In this chapter our focus is on the disorders themselves. We will review the major psychological disorders and consider their causes and their impact on the people who suffer from them. Then in Chapter 14, "Treating Psychological Disorders," we will turn to consider the treatment of these disorders through psychotherapy and drug therapy.

# Defining Disorder

**A psychological disorder** is *an ongoing dysfunctional pattern of thought, emotion, and behaviour that causes significant distress, and that is considered deviant in that person's culture or society* (Butcher, Mineka, & Hooley, 2007). Psychological disorders have much in common with other medical disorders. They are out of the patient's control, they may in some cases be treated by drugs, and their treatment is often covered by medical insurance. Like medical

problems, psychological disorders have both biological (nature) as well as environmental (nurture) influences. These causal influences are reflected in the bio-psycho-social model of illness (Engel, 1977).

The **bio-psycho-social model of illness** is *a way of understanding disorder that assumes that disorder is caused by biological, psychological, and social factors* (Figure 13.1, "The Bio-Psycho-Social Model"). The *biological component* of the bio-psycho-social model refers to the influences on disorder that come from the functioning of the individual's body. Particularly important are genetic characteristics that make some people more vulnerable to a disorder than others and the influence of neurotransmitters. The *psychological component* of the bio-psycho-social model refers to the influences that come from the individual, such as patterns of negative thinking and stress responses. The **social component** of the bio-psycho-social model refers to *the influences on disorder due to social and cultural factors such as socioeconomic status, homelessness, abuse, and discrimination*.

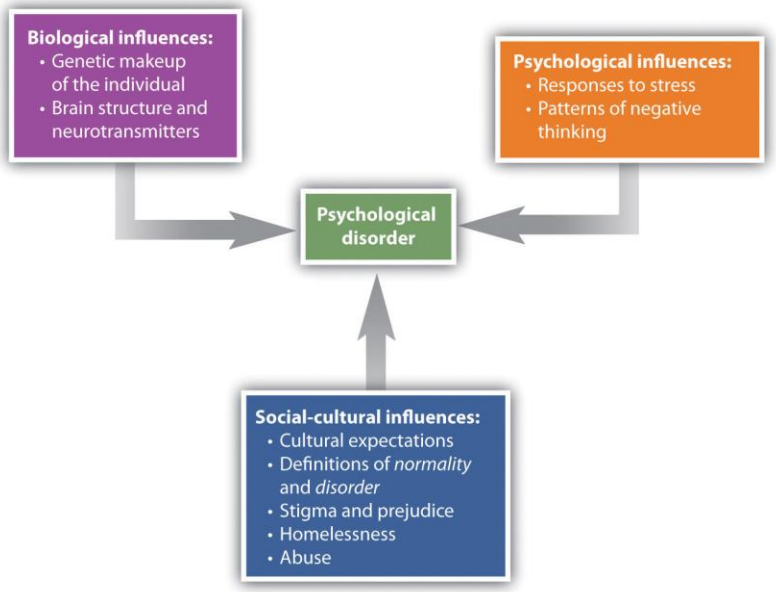



Figure 13.1 The Bio-Psycho-Social Model. The bio-psycho-social model of disorder proposes that disorders are caused by biological, psychological, and social-cultural factors.

To consider one example, the psychological disorder of schizophrenia has a biological cause because it is known that there are patterns of genes that make a person vulnerable to the disorder (Gejman, Sanders, & Duan, 2010). But whether or not the person with a biological vulnerability experiences the disorder depends in large part on psychological factors such as how the individual responds to the stress he or she experiences, as well as social factors such as whether or not the person is exposed to stressful environments in adolescence and whether or not the person has support from people who care about him or her (Sawa & Snyder, 2002; Walker, Kestler, Bollini, & Hochman, 2004). Similarly, mood and anxiety disorders are caused in part by genetic factors such as hormones and neurotransmitters, in part by the individual's particular thought patterns, and in part by the ways that other people in the social environment treat the person with the disorder. We will use the bio-psycho-social model as a framework for considering the causes and treatments of disorder.

Although they share many characteristics with them, psychological disorders are nevertheless different from medical conditions in important ways. For one, diagnosis of psychological disorders can be more difficult. Although a medical doctor can see cancer in the lungs using an MRI scan or see blocked arteries in the heart using cardiac catheterization, there is no corresponding test for psychological disorder. Current research is beginning to provide more evidence about the role of brain structures in psychological disorder, but for now the brains of people with severe mental disturbances often look identical to those of people without such disturbances.

Because there are no clear biological diagnoses, psychological disorders are instead diagnosed on the basis of clinical observations of the behaviours that the individual engages in. These observations find that emotional states and behaviours operate on a continuum, ranging from more normal and accepted to more deviant, abnormal, and unaccepted. The behaviours that are associated with disorder are in many cases the same behaviours that we engage in during our normal everyday life. Washing one's hands is a normal healthy activity, but it can be overdone by those with an *obsessive-compulsive disorder (OCD)*. It is not unusual to worry about and try to improve one's body image. The dancer in Figure 13.2, "How Thin Is Too Thin?" needs to be thin for her career, but when does her dieting turn into a psychological disorder? Psychologists believe this happens when the behaviour becomes distressing and dysfunctional to the person. Robert's struggle with his personal appearance, as discussed at the beginning of this chapter, was clearly unusual, unhealthy, and distressing to him.

Figure 13.2 How Thin Is Too Thin?

Whether a given behaviour is considered a psychological disorder is determined not only by whether a behaviour is unusual (e.g., whether it is mild anxiety versus extreme anxiety) but also by whether a behaviour is **maladaptive** — *that is, the extent to which it causes distress (e.g., pain and suffering) and dysfunction (impairment in one or more important areas of functioning) to the individual* (American Psychiatric Association, 2013). An intense fear of spiders, for example, would not be considered a psychological disorder unless it has a significant negative impact on the sufferer's life, for instance by causing him or her to be unable to step outside the house. The focus on distress and dysfunction means that behaviours that are simply unusual (such as some political, religious, or sexual practices) are not classified as disorders.

Put your psychology hat on for a moment and consider the behaviours of the people listed in Table 13.2, "Diagnosing Disorder." For each, indicate whether you think the behaviour is or is not a psychological disorder. If you're not sure, what other information would you need to know to be more certain of your diagnosis?

**Table 13.2 Diagnosing Disorder.**

[Skip Table]

| Yes | No | Need more information | Description |
|---|---|---|---|
| | | | Jackie frequently talks to herself while she is working out her math homework. Her roommate sometimes hears her and wonders if she is okay. |
| | | | Charlie believes that the noises made by cars and planes going by outside his house have secret meanings. He is convinced that he was involved in the start of a nuclear war and that the only way for him to survive is to find the answer to a difficult riddle. |
| | | | Harriet gets very depressed during the winter months when the light is low. She sometimes stays in her pajamas for the whole weekend, eating chocolate and watching TV. |

**Table 13.2 Diagnosing Disorder.**

[Skip Table]

| Yes | No | Need more information | Description |
|---|---|---|---|
| | | | Frank seems to be afraid of a lot of things. He worries about driving on the highway and about severe weather that may come through his neighbourhood. But mostly he fears mice, checking under his bed frequently to see if any are present. |
| | | | A worshiper speaking in “tongues” at an Evangelical church views himself as “filled” with the Holy Spirit and is considered blessed with the gift to speak the “language of angels.” |

A trained clinical psychologist would have checked off “need more information” for each of the examples in Table 13.2, “Diagnosing Disorder,” because although the behaviours may seem unusual, there is no clear evidence that they are distressing or dysfunctional for the person. Talking to ourselves out loud is unusual and can be a symptom of schizophrenia, but just because we do it once in a while does not mean that there is anything wrong with us. It is natural to be depressed, particularly in the long winter nights, but how severe should this depression be, and how long should it last? If the negative feelings last for an extended time and begin to lead the person to miss work or classes, then they may become symptoms of a mood disorder. It is normal to worry about things, but when does worry turn into a debilitating anxiety disorder? And what about thoughts that seem to be irrational, such as being able to speak the language of angels? Are they indicators of a severe psychological disorder, or part of a normal religious experience? Again, the answer lies in the extent to which they are (or are not) interfering with the individual’s functioning in society.

Another difficulty in diagnosing psychological disorders is that they frequently occur together. For instance, people diagnosed with anxiety disorders also often have mood disorders (Hunt, Slade, & Andrews, 2004), and people diagnosed with one personality disorder frequently suffer from other personality disorders as well. **Comorbidity** *occurs when people who suffer from one disorder also suffer at the same time from other disorders*. Because many psychological disorders are comorbid, most severe mental disorders are concentrated in a small group of people (about 6% of the population) who have more than three of them (Kessler, Chiu, Demler, & Walters, 2005).

## Psychology in Everyday Life: Combating the Stigma of Abnormal Behaviour

Every culture and society has its own views on what constitutes abnormal behaviour and what causes it (Brothwell, 1981). The Old Testament Book of Samuel tells us that as a consequence of his sins, God sent King Saul an evil spirit to torment him (1 Samuel 16:14). Ancient Hindu tradition attributed psychological disorder to sorcery and witchcraft. During the Middle Ages it was believed that mental illness occurred when the body was infected by evil spirits, particularly the devil. Remedies included whipping, bloodletting, purges, and trepanation (cutting a hole in the skull, Figure 13.3) to release the demons.

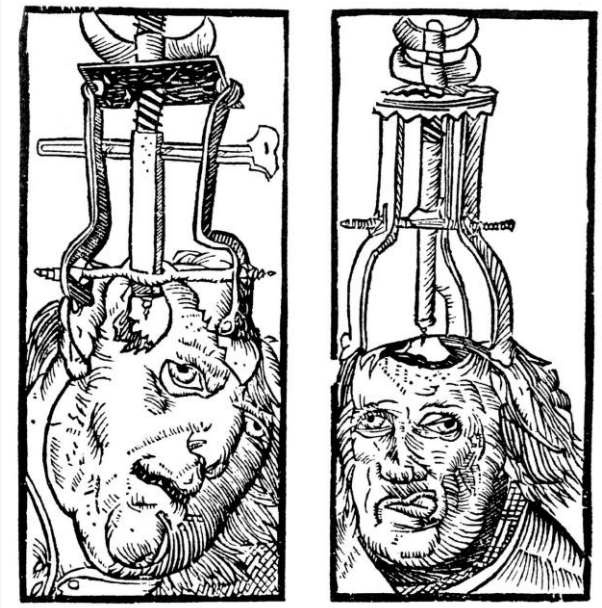


Figure 13.3 Trepanation. Trepanation (drilling holes in the skull) has been used since prehistoric times in attempts to cure epilepsy, schizophrenia, and other psychological disorders.

Until the 18th century, the most common treatment for the mentally ill was to incarcerate them in asylums or "madhouses." During the 18th century, however, some reformers began to oppose this brutal treatment of the mentally ill, arguing that mental illness was a medical problem that had nothing to do with evil spirits or demons. In France, one of the key reformers was Philippe Pinel (1745-1826), who believed that mental illness was caused by a combination of physical and psychological stressors, exacerbated by inhumane conditions. Pinel advocated the introduction of exercise, fresh air, and daylight for the inmates, as well as treating them gently and talking with them.

Reformers such as Phillipe Pinel (1745-1826), Dorothea Dix (1802-1887), Richard M. Bucke (1837-1902), Charles K. Clarke (1857-1924), Clifford W. Beers (1876-1943), and Clarence M. Hincks (1885-1964) were instrumental in creating mental hospitals that treated patients humanely and attempted to cure them if possible (Figure 13.5). These reformers saw mental illness as an underlying psychological disorder, which was diagnosed according to its symptoms and which could be cured through treatment.

Dr Richard Bucke was appointed superintendent of the Asylum for the Insane in Hamilton in 1876 and a year later of the asylum in London, Ontario. He believed mental illness was a failure of the human biological adaptive process. In his attempts to reform the crude treatment of mentally ill patients he abandoned the practice of pacifying the inmates with alcohol or restraining them,  and inaugurated regular cultural and sports events for patients.

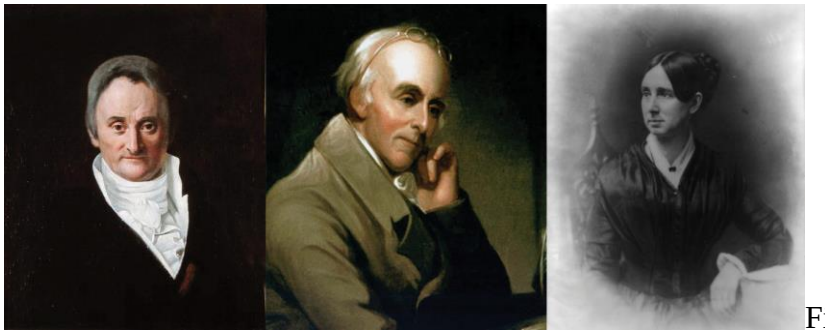
Dr Charles Clarke was an assistant superintendent at the Hamilton asylum in the early 1880s, and later superintendent of the asylum at Kingston, Ontario. By 1887 he had changed the asylum from a jail to a hospital and was instructing nurses and attendants in the care of the mentally ill. By 1893 he was advocating that the term "asylum" be dropped and that special hospitals be constructed for the mentally ill.

Dr Clarence Hincks, born in St Mary's, Ontario, was interested in mental health  partly due to his own experiences with severe depression. In 1918, with Beers's help, he organized the Canadian National Committee for Mental Hygiene, which later became the Canadian Mental Health Association.

Dix was a Massachusetts schoolteacher who wrote, lectured, and informed the public and legislators about the deplorable conditions in mental institutions like those shown in Figure 13.4. She was successful in influencing a number of state legislatures either to establish or improve their mental institutions, and because of her efforts a mental hospital was built in St. John's, Newfoundland, in 1885. She also lobbied the Nova Scotia legislature and oversaw the building of a hospital for mental patients in that province.

Phillipe Pinel was a French physician who became intensely interested in mental health in the 1770s. He took a psychological approach as opposed to the prominent biological approach that was the custom and introduced new forms of treatments that involved close contact with and careful observation of patients. Pinel visited each patient up to several times a day, engaging them in lengthy conversations, and took careful notes in an effort to assemble a detailed case history and a natural history of the patient's illness. At the time, his therapy was quite contrary to the usual practices of bleeding, purging, or blistering.


Figure 13.4 Asylums for People with Mental Disorders. Until the early 1900s people with mental disorders were often imprisoned

in asylums such as these.  Figure 13.5 Portraits of Philippe Pine, Benjamin Rush, and Dorothea Dix. Reformers such as Philippe Pinel, Benjamin Rush, and Dorothea Dix fought the often brutal treatment of the mentally ill and were instrumental in changing perceptions and treatment of them.

Despite the progress made since the 1800s in public attitudes about those who suffer from psychological disorders, people, including police, coworkers, and even friends and family members, still stigmatize people with psychological disorders. A **stigma** refers to *a disgrace or defect that indicates that person belongs to a culturally devalued social group*. In some cases the stigma of mental illness is accompanied by the use of disrespectful and dehumanizing labels, including names such as crazy, nuts, mental, schizo, and retard.

The stigma of mental disorder affects people while they are ill, while they are healing, and even after they have healed (Schefer, 2003). On a community level, stigma can affect the kinds of services social service agencies give to people with mental illness, and the treatment provided to them and their families by schools, workplaces, places of worship, and health-care providers. Stigma about mental illness also leads to employment discrimination, despite the fact that with appropriate support, even people with severe psychological disorders are able to hold a job (Boardman, Grove, Perkins, & Shepherd, 2003; Leff & Warner, 2006; Ozawa & Yaeda, 2007; Pulido, Diaz, & Ramirez, 2004).

The mass media has a significant influence on society's attitude toward mental illness (Francis, Pirkis, Dunt, & Blood, 2001). While media portrayal of mental illness is often sympathetic, negative stereotypes still remain in newspapers, magazines, film, and television. (See the following video for an  example.)

*Television advertisements may perpetuate negative stereotypes about the mentally ill. For example, in 2010 Burger King ran an ad called "The King's Gone Crazy," in which the company's mascot runs around an office complex carrying out acts of violence and wreaking havoc.*

**Watch: "Burger King: The King's Gone Crazy" [YouTube]**:
http://www.youtube.com/watch?v=xYA7AnVwejo

The most significant problem of the stigmatization of those with psychological disorder is that it slows their recovery. People with mental problems internalize societal attitudes about mental illness, often becoming so embarrassed or ashamed that they conceal their difficulties and fail to seek treatment. Stigma leads to lowered self-esteem, increased isolation, and hopelessness, and it may negatively influence the individual's family and professional life (Hayward & Bright, 1997).

Despite all of these challenges, however, many people overcome psychological disorders and go on to lead productive lives. It is up to all of us who are informed about the causes of psychological disorder and the impact of these conditions on people to understand, first, that mental illness is not a "fault" any more than is cancer. People do not choose to have a mental illness. Second, we must all work to help overcome the stigma associated with disorder. Organizations such as the Canadian Mental Health Association (CMHA) help by working to reduce the negative impact of stigma through education, community action, and individual support.