

CHAPTER 12
Psychological Disorders
CHAPTER OUTLINE

Psychopathology involves patterns of thought, emotion, and behavior that are maladaptive, disruptive, or uncomfortable, either for the person affected or others. In the United States, about half of adults have a psychological disorder at some point in their lives.

I. DEFINING PSYCHOLOGICAL DISORDERS

How do psychologists define abnormal behavior

A. What Is Abnormal?

1. One approach is to define abnormal behavior as **statistically infrequent**, deviating from what most people do or from what the average person does.
2. By a **norm violation** criterion, abnormal behavior is that which breaks current social rules or cultural norms—sociocultural standards of how we should or should not behave.
3. Another approach is to use **personal suffering** as a criterion for abnormality. By this view, behaviors that bring distress are abnormal.

B. Behavior in Context: A Practical Approach

The *practical approach* includes aspects of all these criteria. It defines abnormal behavior based on its *content*, *context*, and subjective *consequences*. Special attention is given to **impaired functioning**, difficulty in fulfilling one's expected roles in life. In short, abnormality is seen as those patterns of thought, behavior, and emotional reaction that impair functioning, cause discomfort, and/or disrupt the lives of others.

1. The *content* of behavior—what a person does—is likely to be called abnormal by society if it is maladaptive, irrational, and unpredictable.
2. The *context* of behavior refers to where and when a behavior occurs. Behavior is more likely to be called abnormal when it is inappropriate for the context.
3. The *consequences* of behavior describe how much distress or suffering the behavior causes.
4. Norms based on age, gender, culture, and the particular situation and historical period are also considered.

II. EXPLAINING PSYCHOLOGICAL DISORDERS

What causes abnormality?

The *supernatural model* attributes deviant behavior to supernatural powers (demons and gods). This model was the main approach centuries ago, through the late Middle Ages; however, it is still in use today in many cultures around the world.

A. The Biopsychosocial Model

Today, most researchers follow the **biopsychosocial model**, which attributes psychological disorders to the combination and interaction of biological factors, psychological processes, and sociocultural contexts.

1. *Biological Factors*

- a) The *medical model* explains behavior disorders as physical diseases or imbalances of bodily processes. This model gave rise to the concept of abnormality as *mental illness* to be treated by medical doctors.
- b) The medical model today is called the **neurobiological model** as it focuses on biological disturbances, especially in the brain.

2. Psychological Processes

Psychological models see mental disorders as due to psychological processes such as wants, needs, emotions, learning experiences, and outlook on the world that are disrupted

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by problems people experience as they try to resolve inner conflicts or to overcome the effects of stressful events.

- a) Sigmund Freud's *psychodynamic approach* viewed abnormal behavior as due to unresolved, mostly unconscious, clashes between instinctual desires and the demands of environment and society. Such conflicts were presumed to have begun in childhood. The modern psychodynamic model focuses more on early interpersonal relationships.
 - b) *Social-cognitive* theorists see disorders as learned behaviors, thoughts, and expectations.
 - c) The *humanistic approach* views abnormal behaviors as blocks in one's growth toward self-actualization, usually by a failure to be aware of and to express true feelings.
3. Sociocultural Context
- The **sociocultural model** suggests that social and cultural factors also influence people's behavior and mental processes. Gender, age, marital status; physical, social, and economic situations; and the cultural values, traditions, and expectations of people all can influence the labeling and experience of disorders.
- a) For example, women in many cultures are freer to express emotional distress, which may contribute to the higher rates of depression seen in women. Whereas the acceptance of excessive alcohol use for men but not for women may explain the higher rates of alcohol abuse in men.
 - b) Some psychological disorders are *culture-general*—found in most cultures—and some are *culture-specific*—seen in only certain cultures.
- B. Diathesis-Stress as an Integrative Explanation
- The **diathesis-stress model** integrates physical, environmental, and psychological factors to describe abnormality. According to this model, inherited biological characteristics and early experiences can create a predisposition, or *diathesis*, for developing a disorder, but it takes a certain amount of stress to actually trigger it.

III. CLASSIFYING PSYCHOLOGICAL DISORDERS

How many psychological disorders have been identified?

- A. A Classification System: DSM-IV-TR
1. The most commonly used classification system for psychological disorders is the fourth edition of the ***Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)***, the “official” diagnostic classification system of the American Psychiatric Association.
 - a) DSM-IV only describes abnormal behavior patterns; it does not state causes.
 - b) There are five dimensions, or *axes*, for DSM-IV evaluation.
 - (1) **Axis I** records major mental disorders.
 - (2) **Axis II** notes personality disorders and mental retardation
 - (3) **Axis III** reflects any relevant physical conditions.
 - (4) **Axis IV** records any psychosocial or environmental problems.
 - (5) **Axis V** is a rating of one's current level of psychological, social, and occupational functioning on a scale of 100 to 1.
 - c) DSM formally eliminated vague terms like *neurosis* (used to describe anxiety-oriented problems) and *psychosis* (used to describe more extreme problems in which people were “out of touch with reality”).
 - d) Revisions of the DSM that are under way may include a *dimensional approach* in which each symptom displayed would be recognized and described whether or not it is normally part of a particular diagnosis.

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- B. Evaluating the Diagnostic System
1. A major concern of diagnosing disorders is *interrater reliability*: the degree to which different diagnosticians give the same label to the same person. DSM has improved interrater reliability, more so for Axis I than for Axis II diagnoses.
 2. Another important question about psychodiagnosis is *validity*: Do labels give accurate information? Evidence supports the validity of some DSM-IV criteria, but suggests low validity for other categories.
 3. The current diagnostic system has been criticized on several grounds.
 - a) A person's problem may not fit neatly into one of the available, predesignated categories.
 - b) The same symptoms may appear as part of more than one disorder.
 - c) Diagnostic judgments are, ultimately, subjective, and therefore may sometimes be wrong or affected by personal bias.
 - d) Thomas Szasz (pronounced "zaws") argues that DSM-IV and the medical model are dehumanizing, labeling people instead of describing them. He argues that rather than receiving the stigma of a categorical label, a patient's behaviors should be recognized as unique ways of living that the clinician needs to understand, not "treat."
- C. *Thinking Critically: Is Psychological Diagnosis Biased?*
1. *What am I being asked to believe or accept?*
Clinicians base diagnoses partly on the ethnic group of the client.
 2. *Is there evidence available to support the claim?*
African-Americans are diagnosed with schizophrenia more frequently than European-Americans; they are overrepresented in public mental health hospitals and underrepresented in private hospitals and outpatient clinics.
 3. *Can that evidence be interpreted another way?*
There may be real differences in psychological functioning associated with ethnic group. For example, if African-Americans are exposed to more stressors (e.g., violence, poverty), they could be more vulnerable to serious mental disorders.
 4. *What evidence would help to evaluate the alternatives?*
Experiments could have diagnosticians label clients based on case histories, test scores, and so on. Unknown to diagnosticians, cases could be selected in pairs of clients with about the same objective amount of disorder, with one pair member identified as European American and the other as African-American. Or the same case materials labeled as either African-American or European American could be presented to different diagnosticians. If African-American labeled cases were seen as more seriously disordered than others, bias would be suggested. Studies could be done to identify factors influencing diagnostic judgments following extensive interview with patients.
 5. *What conclusions are most reasonable?*
Evidence suggests there is bias based on ethnicity for at least some diagnoses, although this may be unintentional. DSM-IV is imperfect, as are its users. Reducing bias may require more than detecting and eliminating deliberate discrimination. It may also involve research into clinicians' limited information-processing capacities.

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IV. ANXIETY DISORDERS

What is a phobia?

Anxiety involves increased heart rate, rapid breathing, sweating, a dry mouth, and a sense of dread. When it becomes intense, lasting, or disruptive of daily life, it is called an **anxiety disorder**.

A. Types of Anxiety Disorders

Posttraumatic stress disorder is described in the chapter on health, stress, and coping.

1. **Phobia** is a strong, irrational fear of an object or situation that is not likely to be dangerous. The phobic usually realizes that the fear goes beyond what makes sense.
 - a) **Specific phobias** involve fear of specific situations or things.
 - b) **Social phobias** involve chronic anxiety over others' negative evaluations or acting in a way that is embarrassing or humiliating.
 - c) **Agoraphobia** is a strong fear of being separated from a safe place (e.g., home) or person (e.g., spouse) or of being in situations (such as crowds) that are difficult to leave or where help may be unavailable.
2. **Generalized anxiety disorder** is characterized by excessive and long-lasting anxiety that is not focused on any particular object or situation.
3. **Panic disorder** consists of recurrent *panic attacks*: unpredictable attacks of heart palpitations, dizziness, chest pain, sweating, faintness, and a feeling of impending death. People worry constantly about having a panic attack and may limit their activities. This sometimes leads to agoraphobia.
4. **Obsessive-compulsive disorder (OCD)** consists of persistent, often upsetting thoughts (*obsessions*) that may produce strong urges to perform repetitive, ritualistic behaviors (*compulsions*). The obsessions and compulsions are constant intrusions and may severely impair daily activities.

B. Causes of Anxiety Disorders

1. *Biological Factors*
 - a) Some people appear to have inherited predispositions to develop anxiety disorders.
 - b) Abnormalities in the brain's neurotransmitter systems underlie some anxiety disorders.
2. *Psychological Factors*

Environmental stressors and psychological factors are also involved in most anxiety disorders.

 - a) Anxiety disorder sufferers may exaggerate dangers of certain stimuli and underestimate their own ability to deal with threatening events.

C. Linkages: Anxiety Disorders and Learning

1. Learning principles may explain some anxiety disorders. In OCD, compulsive behavior relieves anxiety, so it is strengthened by negative reinforcement. But such actions do not relieve the obsessive thoughts, which later cause anxiety to return, thus continuing the vicious cycle.
2. Phobias may result when a once neutral stimulus becomes an aversive conditioned stimulus after being associated with a traumatic event (unconditioned stimulus). Once a fear is learned, one may avoid the feared object, preventing discovery that there is no need to be afraid. People may be *biologically prepared* to learn certain fears, perhaps explaining why phobias are common for some objects (e.g., snakes, spiders), but rare for others (e.g., books, chalk).

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V. SOMATOFORM DISORDERS

Can mental disorder cause blindness?

Somatoform disorders involve symptoms of a *somatic*, or physical, disorder without a physical cause. These appear to be psychological disorders that simply take physical form.

- A. In **conversion disorder** (once called *hysteria*), one appears to be, but is not, blind, deaf, paralyzed, or insensitive to pain in parts of the body.
- B. In **hypochondriasis** one has a strong, unjustified fear of coming down with a specific illness, such as cancer, heart disease, or AIDS.
- C. In **somatization disorder**, people make dramatic and vague reports of a multitude of physical problems rather than any specific illness.
- D. **Pain disorder** consists of complaints of severe, often constant pain with no physical cause.
- E. Somatoform disorders may be learned ways of gaining attention and can produce benefits by relieving sufferers of unpleasant responsibilities. Some may be triggered by severe stressors. Others may be a result of attentional focus on threat-confirming information and oversensitivity to physical sensations. Some cultures may encourage channeling psychological conflicts into physical symptoms.

VI. DISSOCIATIVE DISORDERS

What disorders create sudden memory loss?

Dissociative disorders are marked by intense disruptions in memory, identity, or consciousness.

- A. In **dissociative fugue**, one suddenly loses all autobiographical memory, assuming a new identity in a new locale.
- B. **Dissociative amnesia** involves a sudden memory loss, but one does not leave home or create a new identity.
- C. In **dissociative identity disorder (DID)**, a person displays more than one identity, each of which may speak, act, and write differently. Each personality has its own memories, wishes, impulses, and even distinctive biological features. This condition used to be known as multiple personality disorder (MPD).
- D. Psychodynamic theorists see dissociative disorders as massive repression of unwanted impulses or memories, resulting in a “new person” to act out these impulses.
- E. Social-cognitive theorists argue that one behaves differently depending on the situation. In a dissociative disorder, this variation is so extreme that one feels and is regarded by others as a “different person.” Memory loss may be an escape from unpleasant situations.
- F. Research suggests most DID sufferers have endured events that they need to forget, such as childhood abuse; are skilled users of self-hypnosis to induce a trance-like state; and have found they could escape trauma and stress by creating new personalities. Some skeptics suggest that DID may just be a socially approved method of expressing distress.

VII. MOOD DISORDERS

How common is depression?

Mood disorders, also called *affective disorders* (*affect* refers to emotion), involve extremes of mood, especially if these extremes are inconsistent with the events around a person.

- A. Depressive Disorders
 - 1. **Major depressive disorder** involves feeling sad or hopeless for long time periods; one often loses interest in all activities. Symptoms include feelings of guilt, inadequacy, and

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worthlessness; changes in eating habits and body weight; sleep problems; and poor concentration or decision making.

- a) In severe cases people may express strange, false beliefs called **delusions**.
 - b) Major depression may consist of a single episode, but more commonly episodes are recurrent.
2. **Dysthymic disorder** is a less severe pattern of depression. One has sad mood, lack of interest, and loss of pleasure but in a milder form and spread out for at least two years. A dysthymic person can still function reasonably well.
 3. *Suicide and Depressions*
Suicide is closely tied to depression.
 - a) Suicide rates differ depending on age, gender, and ethnicity.
 - b) Predicting suicide is difficult since suicidal thoughts are much more common than suicide attempts.
 - (1) In general, the risk of suicide is greater in people who have made a specific plan, have given away their belongings, and are impulsive.
 - (2) Although about 10% of unsuccessful suicide attempters try again and succeed, most who commit suicide had made no prior attempts.
 - (3) People who talk about suicide are at *greater* risk to try it. It is a dangerous myth that a person is “safe” as long as he or she keeps talking about suicide.
- B. Bipolar Disorder
1. **Bipolar disorder**, sometimes called *manic depression*, is the alternating appearance of two emotional extremes, or poles. One extreme resembles major depression. The other is **mania**, a very agitated emotional state consisting of total optimism, boundless energy, a belief of having extraordinary powers, and a bevy of wild, impulsive ideas.
 2. **Cyclothymic disorder** is a pattern of less extreme mood swings.
- C. Causes of Mood Disorders
1. *Biological Factors*
 - a) Twin and family studies suggest that mood disorders, especially bipolar disorder, have a heritable component.
 - b) Possible causes of mood disorders may be problems in the prefrontal cortex, the hippocampus, the amygdala and other brain regions involved in mood.
 - c) Imbalances of several neurotransmitter systems, especially norepinephrine, serotonin, and dopamine, may be important.
 - d) Hormonal systems that respond to stressors appear to be overly responsive in depressed people. This may explain the observed link between depression and stressful events.
 - e) Disruption of biological rhythms may also play a role in some cases. *Seasonal affective disorder (SAD)* appears to be caused by disruptions in circadian rhythms during shorter-daylight months. Exposure to a few hours of light a day alleviates many of the symptoms.
 2. *Psychological and Social Factors*
 - a) *Biopsychosocial* explanations emphasize the impact of anxiety, negative thinking, and other psychological and emotional responses caused by trauma, losses, and other stressful events.
 - b) *Social-cognitive* theories suggest that the way people think about their stressors can increase or decrease the likelihood of mood disorders.
 - (1) Depression may be due to *learned helplessness*, a learned feeling of a lack of control over one’s life, especially stressors.

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- (2) Aaron Beck's cognitive theory says that depression develops from poor mental habits: People blame themselves when things go wrong, focus on and exaggerate negative aspects of events, and jump to overly generalized, pessimistic conclusions.
- (3) *Attributional style* may be important. Long-lasting depression is more likely among those who attribute problems to a permanent, generalized lack of competence, rather than to temporary or external causes. A negative attributional style is a risk factor for depression— not just a result of it.
- (4) Depression may be more likely in those who use a *ruminative style*, which involves a tendency to dwell on negative events, about why they occur, and about feeling depressed. Depression may be less likely in those who use a *distracting style*, which involves pursuing activities that help counteract a negative mood.

VIII. SCHIZOPHRENIA

Is Schizophrenia the same as "split personality"?

Schizophrenia causes severely disturbed thought, emotion, perception, and behavior. It is a serious disorder that can dramatically impair one's ability to communicate with others or engage in daily functioning. Schizophrenia occurs in 1 to 2 percent of the population—equally among men and women—and tends to strike in adolescence or early adulthood. The better a person's *premorbid adjustment*, the level of functioning before symptoms begin, the better the ultimate prognosis for his or her disease outcome.

A. Symptoms of Schizophrenia

Schizophrenia does *not* mean "split personality." Rather, a "split" occurs between mental faculties, so that one's emotions may be at odds with one's thoughts or perceptions. One's mind is split from reality.

1. Schizophrenic thought and language are often disorganized
 - a) *Neologisms* are "new words," meaningful only to the speaker.
 - b) *Loose associations* involve the tendency to move from one thought to another unconnected, or only superficially connected, thought. A *word salad* is verbal expression of a jumble of unconnected thoughts.
2. The content of schizophrenic thinking is often disturbed.
 - a) Delusions (false beliefs) of persecution are common (e.g., "The CIA is tapping my phone").
 - b) *Ideas of reference* are delusions that everything is somehow related to oneself. (e.g. "Radio static is sending messages to me.")
 - c) Delusions of grandeur may be present (e.g., "I am God's personal messenger").
 - d) In *thought broadcasting*, one thinks that one's thoughts are heard by others.
 - e) In *thought blocking* or *withdrawal*, one thinks that others prevent or steal one's thoughts.
 - f) *Thought insertion* is the belief that others' thoughts appear in one's mind.
3. Problems with attention and perceptual disorders may appear. Many schizophrenics experience **hallucinations**, false perceptions in the absence of sensations. Hallucinations are usually auditory, in the form of voices.
4. Schizophrenics may have *flat affect*, showing little or no emotion. Those who do display emotion may do so inappropriately.
5. Some schizophrenics appear agitated, waving their limbs, grimacing, or pacing. Others move little, holding a single posture for hours.

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6. Low motivation, poor social skills, poor personal hygiene, and an inability to function day to day commonly occur.
- B. Categorizing Schizophrenia
1. Schizophrenic symptoms are sometimes divided into *positive symptoms*, additions of abnormality, like hallucinations and delusions, and *negative symptoms*, subtractions of normality, like flat affect and lack of pleasure and emotion.
 2. Some divide symptoms into whether they are *psychotic* (hallucinations, delusions), *disorganized* (incoherent speech, chaotic behavior), or *negative* (lack of speech or motivation).
 3. The DSM-IV lists five major subtypes of depression.
 - a) In *paranoid schizophrenia*, delusions of persecution or grandeur are accompanied by anxiety, anger, superiority, argumentativeness, or jealousy. Onset is often sudden, later in life, and signs of impairment may be subtle.
 - b) People with *disorganized schizophrenia* have jumbled and unrelated delusions and hallucinations, incoherent speech, inappropriate affect, and neglected personal hygiene.
 - c) *Catatonic schizophrenia* involves disorder of movement. The person alternates between total immobility or stupor and wild excitement. “Waxy flexibility” occurs when people assume virtually any posture physically imposed on them, but they will not initiate movement on their own.
 - d) *Undifferentiated schizophrenics* show abnormal behavior, thought, and emotion not easily placed in any other subtype.
 - e) *Residual schizophrenics* have a prior schizophrenic episode, but are not currently displaying symptoms.
- C. Causes of Schizophrenia
1. *Biological Factors*
 - a) Schizophrenia tends to run in families. Children of schizophrenics are about ten times more likely to develop schizophrenia themselves. Identical twins, who share identical genes, are much more likely to both share schizophrenia than are nonidentical twins, who are no more genetically similar than any brother or sister.
 - b) Dysregulation of the neurotransmitter dopamine is strongly implicated in schizophrenia.
 - c) *Neurodevelopmental* abnormalities such as prenatal trauma may play a role.
 2. *Psychological and Sociocultural Factors*

Psychological factors and sociocultural influences are not considered primary causes of schizophrenia, but they may contribute to the appearance of schizophrenia and influence its course.
 3. *Vulnerability Theory*

The diathesis-stress model forms the basis for the vulnerability theory, which suggests that vulnerability to schizophrenia is mainly biological, that people have differing degrees of vulnerability, that vulnerability is influenced partly by genetics and partly by the environment, and that psychological components may help determine whether the disease occurs and its course if it does occur.

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IX. PERSONALITY DISORDERS

Which personality disorder often leads to crime?

A. **Personality disorders** are long-standing, inflexible ways of behaving that are not disorders as much as dysfunctional styles of living. They can create problems for those who display them and for others. They are described on Axis II of DSM-IV

1. Personality disorders are grouped into three clusters
 - a) The *odd-centric* cluster includes paranoid, schizoid, and schizotypal personality disorders.
 - b) The *anxious-fearful* cluster includes dependent, obsessive-compulsive, and avoidant personality disorders.
 - c) The *dramatic-erratic* cluster includes histrionic, narcissistic, borderline, and antisocial personality disorders.
2. In **antisocial personality disorder** (formerly moral insanity, psychopathy, or sociopathy), one shows a long-term pattern of irresponsible, impulsive, unscrupulous behavior beginning early in life. Antisocial personality disorder is the most serious personality disorder from the view of public safety.
 - a) A hallmark of those displaying antisocial personality is a lack of anxiety, remorse, or guilt.
 - b) Some research suggests that antisocial personality disorder may result from a genetic predisposition. Psychological and sociocultural factors that may contribute include various features of impoverished home environments.

B. Focus on Research: Exploring Links Between Child Abuse and Antisocial Personality Disorder

People with antisocial personality disorder do often claim to have been abused as children. However, retrospective reports of possible causes for an outcome are often biased since the outcome is already known. Moreover, people with antisocial personality disorder are, by definition, more likely to lie. Furthermore, such claims have no control group—how often are non-antisocial people abused as children?

1. *What was the researchers' question?*
Can childhood abuse cause antisocial personality disorder? Cathy Widom (1989) decided to perform a *prospective* quasi-experimental design by first finding cases of childhood abuse, then looking for the effects of that abuse on adult behavior.
2. *How did the researchers answer the question?*
Wisdom identified 416 adults whose backgrounds included official records of childhood physical or sexual abuse before age eleven. Next, she selected a control group of 283 people who matched the abused group in age, gender, ethnicity, hospital of birth, schools attended, and area of residence. All study participants were interviewed and their school and police records were examined.
3. *What did the researchers find?*
Results found that compared to members of the control group, people in the abused group were more likely to have committed juvenile crimes, to have been arrested as adults, and to have committed violent crimes. The abused group showed a significantly higher rate of antisocial personality disorder than the control group. Failure to graduate from high school was also associated with antisocial personality.
4. *What do the results mean?*

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These data imply that childhood abuse can be associated with adult antisocial personality disorder, strongly suggesting (but not proving) that abuse can be one of the causes for the disorder.

5. *What do we still need to know?*
More research is needed to discover whether antisocial personality disorder stems from abuse itself, from one of the factors accompanying it, or from some specific combination of known and still unknown risk factors.

X. A SAMPLING OF OTHER PSYCHOLOGICAL DISORDERS

How do children's disorders differ from adults' disorders?

A. Psychological Disorders of Childhood

1. The *externalizing*, or *undercontrolled*, category of disorders includes behaviors that disturb people in the child's environment.
 - a) *Conduct disorders* involve aggression, disobedience, destructiveness, and other obnoxious behavior.
 - b) In *attention-deficit hyperactivity disorder (ADHD)*, children are impulsive, hyperactive and/or inattentive. They cannot concentrate on an activity or control themselves as well as other similar aged children from their culture.
2. The *internalizing*, or *overcontrol*, category of disorders includes children suffering internal distress, especially depression, anxiety, and social withdrawal.
 - a) In *separation anxiety disorder*, a child constantly worries about being lost, kidnapped, or injured, or that a parent will be harmed.
 - b) Children with *pervasive developmental disorders*, also known as *autistic spectrum disorders*, show severe deficits in communication, impaired social relationships, and unusual behavior patterns.
 - (1) *Autistic disorder* is a very severe condition, usually evident within thirty months after birth. Autistic babies show no sign of attachment to anyone and they often show serious language development problems.
 - (2) *Asperger's disorder* is a less severe autistic spectrum disorder.

B. Substance-Related Disorders

1. DSM-IV defines **substance-related disorder** as use of a psychoactive drug (e.g., alcohol, cocaine, heroin) for months or years, in ways that harm the user or others. **Addiction** is a physical need for a substance. DSM-IV calls this *physiological dependence*. *Substance abuse* is a pattern of use that causes serious social, legal, or interpersonal problems. This is psychological dependence.
2. *Alcohol Use Disorders*
Alcohol dependence or alcohol abuse, commonly called **alcoholism**, is a pattern of frequent alcohol use that may lead to addiction and almost always causes severe social, physical, and other problems.
 - a) Alcoholism is implicated in half of all traffic fatalities, homicides, and suicides annually; it also figures prominently in rape, child abuse, overall hospitalization, and work absenteeism.
 - b) The biopsychosocial model sees alcoholism as due to a combination of genetic characteristics and what has been learned in social and cultural environments.
3. *Heroin and Cocaine Dependence*
Dependence causes serious health problems due to the drug itself and the poor eating and health habits it engenders. Death also occurs from overdose, contaminated drugs, acquired immune deficiency syndrome (AIDS), or suicide. Both nature and nurture probably play a role in continued drug use.

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XI. MENTAL ILLNESS AND THE LAW

Can insanity protect criminals from punishment?

Insanity is a legal term, not a psychiatric diagnosis. It provides two types of protection:

- A. If at the time of trial, a court believes that a person cannot understand charges against him or her or assist in his or her own defense, the person is declared *mentally incompetent* to stand trial.
- B. Severe mental illness can sometimes legally shield one from punishment for a crime even if brought to trial. People can be found not *guilty by reason of insanity* if, at the time of the crime, mental illness prevented them from understanding what they were doing, knowing the act was wrong, and resisting the impulse to do wrong (except in federal cases). Insanity pleas are rare (1 in 200 cases) and are even less often successful (2 of every 1000 attempts).
 - 1. If found “guilty but mentally ill” a person is supposed to receive treatment for his or her disorder while in prison.