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# WHAT ARE PSYCHOLOGICAL DISORDERS?

A psychological disorder is a mental health problem marked by aberrant thoughts, feelings, and actions. Psychopathology is the study of psychiatric illnesses, their symptoms, etiology (i.e., the causes of the diseases), and therapy. Psychopathology is also a term that refers to the outward expression of a psychiatric disease. While reaching consensus might be challenging, it is critical for mental health practitioners to agree on which thoughts, feelings, and actions are actually aberrant in the sense that they suggest the existence of psychopathology. Certain patterns of behavior and inner experience are simply classified as abnormal and plainly indicate the presence of a psychiatric disorder. The individual who washes his hands 40 times a day and the individual who claims to hear demon voices display behaviors and inner experiences that most would consider abnormal: beliefs and actions that reflect the presence of a psychiatric condition. However, take the fear a young man feels while speaking with beautiful women or the loneliness and desire for home that a freshman feels during her first semester of college—these emotions may not be present on a consistent basis, but they fall within the typical range. Therefore, what thoughts, feelings, and behaviors constitute a real psychiatric disorder? Psychologists strive to separate psychological diseases from purely situational, peculiar, or unusual interior feelings and actions.

## Definition of Psychological Disorder

Perhaps the easiest way to conceptualize psychological illnesses is to designate unusual actions, thoughts, and interior sensations as indications of a condition. For instance, if you ask a classmate out and get rejected, you are likely to feel devastated. Such emotions would be natural. If you were excessively depressed—to the point that you lost interest in things, had trouble eating or sleeping, felt completely useless, and considered suicide—your sentiments would be abnormal, out of the ordinary, and might indicate the presence of a psychiatric disease. However, just because something is uncommon does not always imply that it is disordered.

Is it fair to view conduct or interior experiences that differ from generally recognized cultural standards or expectations as disordered if we can agree that simply being atypical is an inadequate requirement for having a psychiatric disorder? Using this criterion, a lady walking around a subway station in July wearing a bulky winter coat and yelling obscenities at passersby may be regarded to be displaying indications of a psychiatric condition. Her activities and clothing are contrary to socially accepted guidelines guiding suitable attire and behavior; these features are unusual.

## Harmful Dysfunction

How can a condition be conceived if none of the criteria stated thus far are sufficient to define the presence of a psychological disorder? Many efforts have been made to define the precise aspects of psychiatric illnesses, but none have been completely successful. There is no general definition of psychological condition that can be applied to all instances in which a problem is suspected to exist (Zachar & Kendler, 2007). However, Wakefield (1992) developed one of the most influential conceptualizations, defining psychological disease as a detrimental malfunction. Wakefield maintained that natural internal mechanisms—that is, evolutionary-honed psychological processes like cognition, perception, and learning—serve crucial tasks like allowing us to see the world as others do and engage in rational reasoning, problem solving, and communication. Learning, for example, enables us to identify a dread with a possible risk in such a manner that the intensity of anxiety is roughly proportional to the degree of real danger. Dysfunction happens when an internal mechanism fails and is unable to execute its regular function. However, the presence of a malfunction does not determine the presence of a condition. The dysfunction must be detrimental in the sense that it has a negative impact on the individual or on others, as determined by the individual's culture's standards. Significant internal suffering (e.g., high levels of worry or depression) or issues in daily functioning (e.g., in one's social or professional life) may result from the injury.

# DIAGNOSING AND CLASSIFYING PSYCHOLOGICAL DISORDERS

The identification of key indications and symptoms is a first step in the research of psychiatric diseases. How can mental health practitioners determine if a person's inner feelings and behaviors are actually indicative of a psychological disorder? It is critical to arrive at an accurate diagnosis—that is, to correctly recognize and name a group of specific symptoms. This procedure allows specialists to communicate about the disease with patients, colleagues, and the general public by allowing them to utilize a common language with others in the field. A correct diagnosis is required to guide proper and successful therapy. For these reasons, categorization systems that systematically categorize psychiatric diseases are required.

## The diagnostic and statistical manual of mental disorders

Although other categorization systems have been produced over time, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association is the one that is utilized by the majority of mental health practitioners in the United States (2013). (It should be noted that the American Psychiatric Association is not the same as the American Psychological Association; both are abbreviated APA.)

The DSM's first edition, released in 1952, categorized psychiatric illnesses using a system created by the United States Army during World War II (Clegg, 2012).

The DSM has undergone multiple changes and editions since then. The DSM-5, published in 2013, is the most recent edition (APA, 2013). The DSM-5 covers several disorder categories (for example, anxiety disorders, depressive disorders, and dissociative disorders). Each disorder is thoroughly described, including an overview of the disorder (diagnostic features), specific symptoms required for diagnosis (diagnostic criteria), prevalence information (what percentage of the population is thought to be affected by the disorder), and risk factors associated with the disorder.

The DSM-5 additionally discusses comorbidity, or the co-occurrence of two disorders. According to the DSM-5, 41% of patients with obsessive-compulsive disorder (OCD) also match the diagnostic criteria for major depressive disorder. Drug use is often comorbid with various mental diseases; six out of ten persons with a drug use problem also have another type of mental illness (National Institute on Drug Abuse [NIDA], 2007).

The DSM has evolved significantly in the half-century since it was first published. For example, homosexuality was classified as a condition in the first two editions of the DSM; but, in 1973, the APA agreed to remove it from the handbook (Silverstein, 2009). Furthermore, beginning with the DSM-III in 1980, mental diseases were detailed in considerably greater depth, and the number of diagnosable problems, as well as the size of the manual itself, grew significantly. DSM-I had 106 diagnoses and was 130 pages long, but DSM-III had more than twice as many diagnoses (265) and was almost seven times as long (886 pages) (Mayes & Horowitz, 2005). Although DSM-5 is lengthier than DSM-IV, the book only covers 237 disorders, a drop from the 297 listed in DSM-IV. The most recent edition, DSM-5, incorporates updates to the arrangement and nomenclature of categories, as well as the diagnostic criteria for specific illnesses (Regier, Kuhl, & Kupfer, 2012), while highlighting the role of gender and cultural variance in the manifestation of certain symptoms (Fisher, 2010).

Some fear that developing new diagnoses may overpathologize the human situation by transforming basic human concerns into mental diseases (The Associated Press, 2013). Indeed, the discovery that approximately half of all Americans will fit the criteria for a DSM condition at some time in their lives (Kessler et al., 2005) undoubtedly contributes to much of this skepticism. The DSM-5 is also attacked for loosening diagnostic criteria, threatening to "transform our current diagnostic inflation into diagnostic hyperinflation" (Frances, 2012, para. 22). DSM-IV, for example, said that symptoms of major depressive disorder could not be attributed to natural grief (loss of a loved one). The DSM-5, on the other hand, has abolished this bereavement exception, implying that grief and sadness following the death of a loved one might constitute major depressive disorder.

## The Internal Classification of Diseases

The International Categorization of Diseases (ICD) is a second generally accepted classification system. The World Health Organization (WHO) published the International Classification of Diseases (ICD), which was created in Europe shortly after World War II and, like the DSM, has been updated multiple times. The DSM and ICD classifications of psychiatric illnesses are comparable, as are the criteria for individual disorders;

nonetheless, there are minor discrepancies. Although the ICD is used for clinical purposes, it is also used to study population health and to track the prevalence of illnesses and other health concerns across the world (WHO, 2013). The ICD is now in its tenth version (ICD-10), but efforts are underway to create a new edition (ICD-11) that, in conjunction with the revisions in DSM-5, will assist to integrate the two categorization systems as much as feasible (APA, 2013).

According to a study that contrasted the usage of the two categorization systems, the ICD is more commonly utilized for clinical diagnosis across the world, whilst the DSM is more valued for research (Mezzich, 2002). The DSM criteria serve as the foundation for the majority of research results addressing the origin and treatment of psychiatric illnesses (Oltmanns & Castonguay, 2013). The DSM also offers more detailed diagnostic criteria, as well as a lengthy and informative explanation section (Regier et al., 2012). The DSM is the preferred categorization system among mental health specialists in the United States, and this chapter is based on the DSM paradigm.

# PERSPECTIVES ON PSYCHOLOGICAL DISORDERS

Scientists and mental health practitioners may approach understanding or explaining the underlying mechanisms that lead to the development of a psychological problem from different angles. The viewpoint used to describe a psychiatric condition is critical because it contains explicit assumptions about how to best investigate the disorder, its origin, and what kind of therapies or treatments are most useful. Different points of view give different ways of thinking about the nature of psychopathology.

## Biological Perspectives of Psychological Disorders

The biological approach considers psychological problems to be connected to biological phenomena such as hereditary factors, chemical imbalances, and brain abnormalities; it has received a lot of attention and recognition in recent decades (Wyatt & Midkiff, 2006). Many forms of evidence show that most psychiatric problems have a hereditary component; in fact, there is little disagreement that some disorders are predominantly caused by genetic factors.

## The Diathesis-Stress Model of Psychological Disorders

Despite improvements in understanding the molecular underpinnings of psychological diseases, the psychosocial approach remains critical. This viewpoint highlights the significance of learning, stress, flawed and self-defeating thought habits, and environmental influences. So, maybe the best approach to think about psychological illnesses is to consider them to be the result of a mix of biological and psychological processes. Many are the result of a complex blending of biological and sociocultural elements, rather than a single cause.

To forecast the risk of a condition, the diathesis-stress model (Zuckerman, 1999) incorporates biological and psychological components. According to the diathesis-stress model, people who have an underlying proclivity for a disorder (i.e., a diathesis) are more likely than others to develop a disorder when exposed to adverse environmental or psychological events (i.e., stress), such as childhood maltreatment, negative life events, trauma, and so on. A diathesis is not always a biological sensitivity to sickness; some diatheses are psychological in nature (e.g., a tendency to think about life events in a pessimistic, selfdefeating way).

The diathesis-stress model's central premise is that both elements, diathesis and stress, are required for the development of a condition. Various models investigate the link between the two variables: the degree of stress required to cause the condition is inversely related to the level of diathesis.

# ANXIETY DISORDERS

Anxiety is something that everyone encounters from time to time. Although anxiety and dread are closely connected, there are significant variations between the two emotions. Anxiety is characterized by worry, avoidance, and caution in the face of a prospective threat, danger, or other unpleasant occurrence, whereas fear is characterized by an immediate reaction to an imminent threat (Craske, 1999). While most people dislike anxiety, it is necessary for our health, safety, and well-being. Anxiety pushes us to take measures that help us avoid potential future issues, such as studying for examinations, keeping a healthy weight, and being on time at work. Anxiety also encourages us to avoid doing things that might lead to difficulties in the future, such as accruing debts and indulging in criminal activities. Most people's intensity and duration of anxiety are proportional to the size of the possible threat they confront. Assume a single lady in her late 30s wants to marry but is anxious about having to settle for a partner who is less gorgeous and educated than wanted. This lady would most certainly suffer more intense and prolonged worry than a 21-year-old college junior who is having problems finding a date for the yearly gathering. Some people, on the other hand, feel worry that is excessive, persistent, and out of proportion to the real threat; if one's fear has a disruptive effect on one's life, this is a strong sign that the individual is suffering from an anxiety disorder.

Anxiety disorders are characterized by excessive and persistent dread and anxiety, as well as accompanying behavioral problems (APA, 2013). Although anxiety is widespread, anxiety disorders cause significant discomfort. Anxiety disorders are frequent as a group: around 25%–30% of the U.S. population fits the criteria for at least one anxiety disorder over their lifetime (Kessler et al., 2005). Furthermore, these illnesses tend to be far more frequent in women than in males; throughout a 12-month period, around 23% of women and 14% of men will have at least one anxiety disorder (National Comorbidity Survey, 2007). Anxiety disorders are the most common type of mental disorder, and they are commonly comorbid with one another and with other mental disorders (Kessler, Ruscio, Shear, & Wittchen, 2009).

## Specific Phobia

Phobia is a Greek word for fear. A particular phobia (previously known as simple phobia) is characterized by excessive, unpleasant, and persistent dread or anxiety about a single item or scenario (such as animals, enclosed spaces, elevators, or flying) (APA, 2013). Even though people recognize that their degree of dread and anxiety in regard to the phobic stimuli is illogical, some persons with a specific phobia may go to tremendous efforts to avoid the phobic stimulus (the item or scenario that causes the fear and anxiety). Typically, the dread and anxiety elicited by a phobic stimuli are detrimental to the person's life. For example, a guy who is afraid of flying may refuse to accept a position that needs regular air travel, so jeopardizing his career. Specific phobias are prevalent; around 12.5 percent of the population in the United States will fit the criteria for a specific phobia at some point in their lives (Kessler et al., 2005). One kind of fear, agoraphobia, is classified as a distinct anxiety disorder in the DSM-5. Agoraphobia, which literally means "fear of the marketplace," is characterized by severe dread, anxiety, and avoidance of circumstances in which it may be difficult to escape or find help if one suffers panic attack symptoms (a condition of acute anxiety that we shall address momentarily). These settings include taking public transit, being in open places (parking lots), being in enclosed locations (stores), being in crowds, or being outside alone (APA, 2013). Agonaphobia affects around 1.4 percent of all Americans at some point in their lives (Kessler et al., 2005).

## Acquisition of Phobias through Learning

Many hypotheses contend that phobias emerge as a result of learning. According to Rachman (1977), phobias may be developed through three primary learning processes. The first route is classical conditioning. Classical conditioning, as you may know, is a type of learning in which an initially neutral stimulus is manipulated. Psychological Disorders 559 coupled with an unconditioned stimulus (UCS) that instinctively triggers an unconditioned response (UCR), triggering the same reaction because to its connection with the unconditioned stimulus The reaction is known as a conditioned response (CR).

For example, a youngster who has been bitten by a dog may develop a phobia of dogs as a result of her previous association with pain. The dog bite is the UCS in this situation, and the terror it causes is the UCR.

Because a dog was connected with the bite, any dog may become a conditioned stimulus, prompting dread; the child's fear of dogs therefore becomes a CR. The second method of acquiring phobias is through vicarious learning, such as modeling. For example, a youngster who witnesses his cousin reacting terribly to spiders may later display similar worries, despite the fact that spiders have never posed any risk to him. This phenomena has been seen in humans as well as nonhuman animals (Olsson & Phelps, 2007). A study of laboratory-reared monkeys found that after seeing wild-reared monkeys respond nervously to snakes, they quickly developed a phobia of snakes (Mineka & Cook, 1993).

The third route is through vocal communication or information transmission. A youngster may develop a phobia of snakes if her parents, siblings, friends, and classmates continuously teach her how filthy and poisonous snakes are.

People are more prone to acquire phobias of things that provide little actual threat to them, such as animals and heights, and less likely to develop phobias of items that pose legitimate danger in modern society, such as motorbikes and firearms (hman & Mineka, 2001). Why would this be the case? According to one idea, the human brain is evolutionarily inclined to link specific items or circumstances with dread (Seligman, 1971). According to this idea, our ancestors connected particular stimuli (such as snakes, spiders, heights, and thunder) with possible danger throughout our evolutionary history. The mind has evolved over time to be more prone to developing phobias of certain things than of others. Experimental evidence consistently shows that conditioned phobias develop more rapidly in response to fear-relevant stimuli (pictures of snakes and spiders) than in response to fear-irrelevant stimuli (images of flowers and fruit) (hman & Mineka, 2001). Such prepared learning has also been shown in monkeys. Monkeys in one research (Cook & Mineka, 1989) saw videotapes of model monkeys reacting fearfully to either fear-relevant stimuli (toy snakes or a toy crocodile) or fear-irrelevant stimuli (toy crocodile) (flowers or a toy rabbit). Fears evolved in the observer monkeys in response to fear-relevant stimuli but not in response to fear-irrelevant stimuli.

## Social Anxiety Disorder

Social anxiety disorder (formerly known as social phobia) is characterized by excessive and persistent dread or worry, as well as avoidance of social settings in which the person may be judged poorly by others (APA, 2013). Social anxiety disorder, like particular phobias, is widespread in the United States; a little more than 12% of all Americans experience it at some point in their lives (Kessler et al., 2005).

The worry and anxiety in social anxiety disorder stem from the individual's concern that he would act in a humiliating or embarrassing manner, such as seeming silly, displaying anxiety symptoms (blushing), or doing or saying something that will result in rejection (such as offending others). Individuals with social anxiety disorder typically struggle with

social circumstances such as public speaking, talking, meeting strangers, dining in restaurants, and, in certain cases, using public facilities. Although many individuals experience anxiety in social circumstances such as public speaking, the dread, worry, and avoidance associated with social anxiety disorder are extremely stressful and can lead to major life impairments.

Adults with this disease have poorer educational attainment and wages (Katzelnick et al., 2001), perform worse at work and are more likely to be jobless (Moitra, Beard, Weisberg, & Keller, 2011), and are more dissatisfied with their family lives, friends, leisure activities, and money (Stein & Kean, 2000). When persons with social anxiety disorder are unable to avoid circumstances that cause worry, they generally engage in safety behaviors, which are mental or behavioral activities that alleviate anxiety in social contexts by lowering the likelihood of bad social outcomes. Avoiding eye contact, practicing sentences before speaking, speaking short, and not talking about oneself are all examples of safety practices (Alden & Bieling, 1998).

Other instances of safe conduct are as follows (Marker, 2013):

* taking on duties in social events that reduce engagement with others (e.g., snapping photographs, setting up equipment, or assisting with meal preparation)
* taking on duties in social events that reduce engagement with others (e.g., snapping photographs, setting up equipment, or assisting with meal preparation)
* sitting at the rear of the room to minimize inspection or interaction with others;
* wearing bland, neutral clothing to avoid drawing attention to oneself; and • avoiding drugs or activities that may induce anxiety symptoms (such as caffeine, warm clothing, and physical exertion).

Although these behaviors are intended to keep the person with social anxiety disorder from doing something awkward that might draw criticism, they usually aggravate the problem because they do not allow the individual to disprove his negative beliefs, frequently eliciting rejection and other negative reactions from others (Alden & Bieling, 1998). Self-medication, such as consuming alcohol, may be used by people with social anxiety disorder to alleviate the anxious symptoms they feel in social situations (Battista & Kocovski, 2010). When confronted with such scenarios, the use of alcohol may become negatively reinforcing, encouraging persons with social anxiety disorder to turn to the drink anytime they encounter anxious symptoms. However, using alcohol as a coping technique for social anxiety can come at a high cost: a number of large-scale studies have found a significant proportion of comorbidity between social anxiety disorder and alcohol use disorder (Morris, Stewart, & Ham, 2005).

As with particular phobias, it is quite likely that the concerns associated with social anxiety disorder might arise as a result of training events. For example, a kid who is exposed to adverse social experiences at a young age (e.g., bullying at school) may build unfavorable social pictures of herself that are subsequently triggered in anxiety-provoking circumstances (Hackmann, Clark, & McManus, 2000).

Behavioral inhibition is one of the most well-established risk factors for developing social anxiety disorder (Clauss & Blackford, 2012). Behavioral inhibition is considered to be an inherent feature that is defined by a continuous dread and constraint when confronted with new persons or situations (Kagan, Reznick, & Snidman, 1988). Behavioral inhibition appears extremely early in life; behaviorally inhibited toddlers and preschoolers react with considerable care and constraint in novel settings, and they are frequently timid, afraid, and shy around strange individuals (Fox, Henderson, Marshall, Nichols, & Ghera, 2005). A recent statistical assessment of research found that behavioral inhibition is related with a sevenfold increase in the likelihood of developing social anxiety disorder, indicating that it is a substantial risk factor for the illness (Clauss & Blackford, 2012).

## Panic Disorder

Imagine you're at the mall with your buddies one day when you start sweating and shaking, your heart starts beating, you have difficulties breathing, and you feel dizzy and sick. This episode lasts 10 minutes and is terrible because you begin to believe that you will die. When you go to your doctor the next morning and relate what occurred, she informs you that you had a panic attack. If you have another one of these episodes two weeks later and fear for a month or longer that it may happen again, you have likely acquired panic disorder.

People with panic disorder have recurrent (more than one) and unexpected panic attacks, as well as at least one month of persistent worry about more panic attacks, worry about the consequences of the attacks, or self-defeating changes in behavior related to the attacks (e.g., avoidance of exercise or unfamiliar situations) (APA, 2013). Panic attacks, like other anxiety disorders, cannot be caused by the physiological effects of medications and other substances, a physical condition, or another mental problem. A panic attack is described as a time of intense dread or discomfort that begins suddenly and peaks within 10 minutes. Its symptoms include racing heart, sweating, trembling, choking feelings, hot flashes or chills, dizziness or lightheadedness, thoughts of losing control or going insane, and dread of death (APA, 2013). Sometimes panic attacks are predicted, happening as a result of certain environmental stimuli (such as being in a tunnel); other times, these episodes are unexpected and occur at random (such as when relaxing). To be diagnosed with panic disorder, a person must have unexpected panic episodes, according to the DSM-5.

A panic episode is frequently scary. Individuals with panic disorder sometimes misunderstand the symptoms of a panic attack as an indication that something is seriously wrong within (believing, for example, that the beating heart signifies an impending heart attack) rather than recognizing them as signs of great worry. Because numerous symptoms of panic attacks are similar to those associated with cardiac issues (e.g., palpitations, racing pulse, and a pounding sensation in the chest), panic attacks can occasionally result in visits to the emergency department (Root, 2000). Unsurprisingly, persons suffering from panic disorder are concerned about future attacks and may become fixated with changing their behavior in order to avoid future panic attacks.

As a result, panic disorder is frequently described as fear of terror (Goldstein & Chambless, 1978). Panic episodes are not mental diseases in and of themselves. Indeed, around 23% of Americans have isolated panic episodes without matching the criteria for panic disorder (Kessler et al., 2006), demonstrating that panic attacks are very prevalent. Panic disorder, on the other hand, is significantly less frequent, hitting 4.7 percent of Americans at some point in their lives (Kessler et al., 2005). Many persons with panic disorder develop agoraphobia, which is characterized by dread and avoidance of circumstances in which escape may be difficult or aid may be unavailable if signs of a panic attack emerge. Comorbid disorders, such as other anxiety disorders or major depressive illness, are common in people with panic disorder (APA, 2013).

The exact etiology of panic disorder is unknown to researchers. Children are more likely to acquire panic disorder if one or both parents have the disease (Biederman et al., 2001), and family and twin studies show that the heritability of panic disorder is about 43%. (Hettema, Neale, & Kendler, 2001). However, the precise genes and gene activities implicated in this illness remain unknown (APA, 2013).

According to neurobiological ideas, the locus coeruleus, a part of the brain, may have a role in panic disorder. The locus coeruleus, located in the brainstem, is the brain's primary source of norepinephrine, a neurotransmitter that initiates the body's fight-or-flight response. The activation of the locus coeruleus is connected with anxiety and terror, and studies with nonhuman primates has demonstrated that electrical or chemical stimulation of the locus coeruleus induces panic-like symptoms (Charney et al., 1990). These observations have given rise to the hypothesis that panic disorder is caused by aberrant norepinephrine activity in the locus coeruleus (Bremner, Krystal, Southwick, & Charney, 1996).

According to conditioning theories of panic disorder, panic attacks are classical conditioning reactions to subtle body sensations similar to those that occur when one is worried or afraid (Bouton, Mineka, & Barlow, 2001). Consider a youngster who suffers from asthma. Acute asthma attacks include symptoms such as shortness of breath, coughing, and chest tightness, which can cause panic and worry.

Later, when the child encounters minor signs that match the terrifying symptoms of previous asthma attacks (for example, shortness of breath after ascending stairs), he may get apprehensive, afraid, and ultimately have a panic attack. In this case, the modest symptoms are a conditioned stimulus, and the panic episode is a conditioned reaction. The discovery that panic disorder is roughly three times more common in persons with asthma than in those without asthma (Weiser, 2007) lends credence to the idea that panic disorder might develop through classical conditioning.

Cognitive variables may be important in panic disorder. In general, cognitive theories (Clark, 1996) contend that people with panic disorder are more likely to interpret typical body sensations tragically, which sets the setting for panic episodes. For example, a person may notice body changes that are consistently caused by seemingly harmless

occurrences like as rising from a seated posture (dizziness), exercising (increased heart rate, shortness of breath), or consuming a big cup of coffee (increased heart rate, trembling). These modest physical changes are interpreted tragically by the person ("Perhaps I'm having a heart attack!"). Such interpretations cause dread and worry, which in turn cause further physical symptoms; as a result, the individual has a panic attack. Findings show that those who have more severe catastrophic ideas about their feelings have more frequent and severe panic attacks, and that lowering catastrophic thoughts about their sensations is as beneficial as medicine in reducing panic episodes in people who have panic disorder (Good & Hinton, 2009).

# OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

Obsessive-compulsive disorder and associated disorders are a range of overlapping disorders characterized by intrusive, unpleasant thoughts and repetitive activities. Many of us have unpleasant ideas from time to time (for example, desiring double cheeseburgers while dieting), and many of us participate in repeated actions from time to time (e.g., pacing when nervous). However, obsessive-compulsive and associated disorders intensify unwanted thoughts and repetitive actions to the point that they interfere with daily living. Obsessive-compulsive disorder (OCD), body dysmorphic disorder, and hoarding disorder are all included in this group.

Obsessive-compulsive disorder (OCD) is characterized by intrusive and unwanted thoughts and urges (obsessions), as well as the need to engage in repetitive behavioral or mental activities (compulsions). For example, a person with this disease may spend hours each day washing his hands or continually checking and rechecking to ensure that a stove, faucet, or light has been switched off.

Obsessions are more than just undesirable ideas that appear to pop into our heads from time to time, such as recalling an insensitive remark made lately by a coworker, and they are more substantial than day-to-day anxieties we may have, such as legitimate fears of getting laid off from a job. Obsessions, on the other hand, are defined as frequent, unplanned, and unwanted thoughts and desires that are extremely invasive, unpleasant, and stressful (APA, 2013). Concerns about germs and contamination are common obsessions, as are doubts ("Did I turn off the water?"), order and symmetry ("I need all the spoons on the tray to be set a specific manner"), and violent or lusty drives. Typically, the individual is aware that such ideas and desires are unreasonable and attempts to suppress or dismiss them, but finds it incredibly difficult to do so. These obsessive symptoms can occasionally overlap, thus a person may experience contamination as well as violent obsessions (Abramowitz & Siqueland, 2013).

Compulsions are repetitive and ritualistic behaviors that are often performed largely to alleviate the anguish caused by obsessions or to diminish the possibility of a dreaded occurrence (APA, 2013). Compulsions frequently include repetitive and thorough hand washing, cleaning, verifying (e.g., that a door is locked), and arranging (e.g., lining up all the pencils in a certain sequence), as well as mental tasks such as counting, praying, or reciting something to oneself. Compulsions associated with OCD are not practiced for pleasure, nor are they realistically linked to the source of the pain or dreaded event. OCD affects approximately 2.3 percent of the U.S. population (Ruscio, Stein, Chiu, & Kessler, 2010), and if untreated, it is a chronic disorder that causes lifelong interpersonal and psychological issues (Norberg, Calamari, Cohen, & Riemann, 2008).

## Causes of OCD

The findings of family and twin research imply that OCD has a moderate hereditary component. The disorder is five times more common in first-degree relatives of persons with OCD than in people without the disease (Nestadt et al., 2000). Furthermore, the concordance rate of OCD among identical twins is roughly 57 percent; whereas, the concordance rate for fraternal twins is 22 percent (Bolton, Rijsdijk, O'Connor, Perrin, & Eley, 2007). Several studies have identified over two dozen possible genes that may be linked with OCD; these genes influence the action of three neurotransmitters: serotonin, dopamine, and glutamate (Pauls, 2010). Many of these studies have tiny sample sizes and have yet to be reproduced. As a result, greater study in this area is required.

The orbitofrontal cortex (Kopell & Greenberg, 2008), a frontal lobe region implicated in learning and decision-making (Rushworth, Noonan, Boorman, Walton, & Behrens, 2011), is thought to play a significant role in OCD. When persons with OCD are presented with activities such as looking at a photo of a toilet or images hanging crookedly on a wall, the orbitofrontal cortex becomes highly hyperactive (Simon, Kaufmann, Müsch, Kischkel, & Kathmann, 2010). The orbitofrontal cortex is one of numerous linked brain areas that regulate the perceived emotional worth of inputs as well as the selection of both behavioral and cognitive responses (Graybiel & Rauch, 2000). Other parts of the OCD circuit, such the orbitofrontal cortex, exhibit increased activity during symptom provocation (Rotge et al., 2008), indicating that anomalies in these regions may cause OCD symptoms (Saxena, Bota, & Brody, 2001). People with OCD have much greater levels of connection in the orbitofrontal cortex and other parts of the OCD circuit than those without OCD, which is consistent with this interpretation (Beucke et al., 2013).

The findings stated above were based on imaging investigations, and they emphasize the possible role of brain dysfunction in OCD. However, one significant shortcoming of these findings is the inability to explain variations in obsessions and compulsions. Another problem is that the correlational association between neurological abnormalities and OCD symptoms does not suggest causality (Abramowitz & Siqueland, 2013).

# POSTTRAUMATIC STRESS DISORDER

Extremely stressful or traumatic experiences, such as battle, natural disasters, and terrorist acts, increase the chance of acquiring psychiatric problems such as posttraumatic stress disorder in those who see them (PTSD). Because its symptoms were identified in troops who had engaged in military action, this disease was known as shell shock and battle neurosis for most of the twentieth century. By the late 1970s, it was obvious that women who had endured sexual traumas (such as rape, domestic abuse, and incest) frequently exhibited the same set of symptoms as soldiers (Herman, 1997).

Because these symptoms may occur in anybody who had undergone psychological trauma, the name posttraumatic stress disorder was coined.

PTSD was formerly classified as an anxiety disorder in prior DSM versions. It is currently classified as a Trauma-and-Stressor-Related Disorder in the DSM-5. To be diagnosed with PTSD, a person must have been exposed to, witnessed, or experienced the specifics of a traumatic encounter (e.g., as a first responder), one that involves "actual or threatened death, significant injury, or sexual violence" (APA, 2013, p. 271). Combat, threatened or real physical attack, sexual assault, natural catastrophes, terrorist attacks, and vehicle accidents are examples of such situations. Because of this requirement, PTSD is the only condition included in the DSM that has a specific etiology (severe trauma).

PTSD symptoms include intrusive and distressing memories of the event, flashbacks (states that can last from a few seconds to several days in which the individual relives the event and behaves as if it were happening right now [APA, 2013]), avoidance of stimuli associated with the event, persistently negative emotional states (e.g., fear, anger, guilt, and shame), feelings of detachment from others, irritability, proneness to outbursts, and an (jumpiness). These symptoms must be present for at least one month in order for PTSD to be diagnosed.

PTSD affects approximately 7% of adults in the United States, including 9.7% of women and 3.6 percent of men (National Comorbidity Survey, 2007), with higher rates among people exposed to mass trauma and people whose jobs involve duty-related trauma exposure (e.g., police officers, firefighters, and emergency medical personnel) (APA, 2013). One year after Hurricane Katrina, over 21% of inhabitants in impacted regions suffered from PTSD (Kessler et al., 2008), while 12.6 percent of Manhattan residents were found to have PTSD 2–3 years later (Kessler et al., 2008). (DiGrande et al., 2008)

# MOOD DISORDERS

Mood disorders are characterized by significant mood and emotion disturbances—most commonly sadness, but occasionally mania and exhilaration (Rothschild, 1999). Our emotions and emotional states fluctuate in all of us, and these changes are frequently driven by events in our lives. If our favorite team wins the World Series, we are overjoyed; nevertheless, if a love relationship ends or we lose our job, we are depressed. We might feel wonderful or unhappy for no apparent reason at times. People suffering with mood disorders experience mood changes as well, but their variations are intense, distort their view on life, and damage their ability to operate. The DSM-5 divides mood disorders into two broad groups. Depressive disorders are a set of conditions characterized by depression as the primary component. Depression is a broad phrase that refers to a state of severe and persistent sadness. Depression is a complex mental condition characterized by a wide variety of symptoms of varying intensity. People who are depressed are gloomy, disheartened, and despairing. These people lose interest in previously loved activities, typically suffer a decline in urges such as hunger and sex, and frequently doubt their own value. The severity of depressive illnesses varies, but this chapter focuses on the most well-known: major depressive disorder (sometimes called unipolar depression).

The term "bipolar and associated disorders" refers to a category of conditions in which mania is the distinguishing trait. Mania is characterized by intense excitement and agitation. Mania causes people to become overly chatty, act recklessly, or attempt to perform many things at the same time. Bipolar disorder is the most well-known of these illnesses.

## Major Depressive Disorder

The DSM-5 defines severe depressive disorder as having a "depressed mood most of the day, nearly every day" (feeling sad, empty, hopeless, or seeming emotional to others), as well as a loss of interest and pleasure in regular activities (APA, 2013). In addition to feeling unbearably miserable for the most of the day, persons suffering from depression will lose interest or enjoyment in formerly pleasurable activities such as hobbies, sports, sex, social events, time spent with family, and so on. Friends and family members may note that the individual has abandoned formerly cherished interests; for example, an ardent tennis player who gets severe depressive illness may stop playing tennis (Rothschild, 1999). To be diagnosed with major depressive disorder, you must have at least five symptoms for at least two weeks; these symptoms must cause severe distress or limit normal functioning, and they cannot be caused by substances or a medical condition.

At least one of the two symptoms listed above, as well as any combination of the following symptoms, must be present (APA, 2013):

* significant weight loss (when not dieting) or weight gain, as well as a significant decrease or increase in appetite;
* difficulty falling asleep or sleeping excessively;
* psychomotor agitation (the person is noticeably fidgety and jittery, as evidenced by behaviors such as inability to sit, pacing, hand-wringing, pulling or rubbing of the skin, clothing, or other objects) or psychomotor retardation (the person talks and moves slowly, for example, talking softly,

Major depressive illness is classified as episodic, which means that its symptoms normally peak for a short period of time and then gradually fade. Approximately 50–60% of persons who have had an episode of major depressive disorder will have a second episode; those who have had two episodes have a 70% risk of having a third episode, and those who have had three episodes have a 90% chance of having a fourth episode (Rothschild, 1999). Despite the fact that the episodes might linger for months, the vast majority of persons diagnosed with this disorder (about 70%) recover within a year.

However, a significant percentage do not recover; after 5 years, around 12% show considerable indicators of impairment associated with major depressive illness (Boland & Keller, 2009). In the long run, many people who fully recover will continue experience mild symptoms that vary in intensity (Judd, 2012).

# BIPOLAR DISORDER

A person suffering from bipolar illness (also known as manic depression) frequently has mood states that vary between depression and mania; that is, the individual's mood is said to alternate from one emotional extreme to the other (in contrast to unipolar, which indicates a persistently sad mood). A person must have had a manic episode at least once in his life to be diagnosed with bipolar disorder; although significant depression episodes are prevalent in bipolar disorder, they are not essential for a diagnosis (APA, 2013). A manic episode is defined by the DSM-5 as a "distinct period of abnormally and persistently high, expansive, or irritable mood and abnormally and consistently enhanced activity or energy lasting at least one week" that lasts the majority of the day (APA, 2013, p. 124). During a manic episode, some people feel nearly euphoric and become too chatty, sometimes beginning discussions with strangers; others get very angry and complain or make unpleasant comments. The individual may speak loudly and quickly, displaying a flight of ideas and abruptly jumping from one issue to another. These people are quickly sidetracked, making it difficult to have a discussion. They may display grandiosity, which is characterized by excessive yet unwarranted self-esteem and self-confidence.

For example, individuals may quit their work in order to "hit it rich" in the stock market, although lacking the necessary expertise, experience, and cash. They may take on many things at once (for example, multiple time-consuming projects at work) and exhibit little, if any, need for sleep; others may go for days without sleeping. Patients may also participate in risky pleasure activities, such as shopping sprees, reckless driving, making unwise investments, excessive gambling, or engaging in sexual encounters with strangers (APA, 2013). During a manic episode, people frequently believe they are not unwell and do not require therapy. However, the irresponsible actions that frequently follow these episodes—behaviors that might be antisocial, unlawful, or physically dangerous to others—may need involuntary hospitalization (APA, 2013). Any people with bipolar illness will have a rapid-cycling subtype, which is defined by at least four manic episodes (or some combination of at least four manic and severe depressive episodes) within a year.

# SUICIDE

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## Risk Factors for Suicide

Suicidal ideation is more prevalent among those who use drugs or alcohol. Individuals who abuse alcohol are ten times more likely to commit suicide than the overall population (Wilcox, Conner, & Caine, 2004). Those who have already attempted suicide are at a higher risk of suicidal conduct. Among those who attempt suicide, 16% attempt again within a year, and over 21% attempt again within four years (Owens, Horrocks, & House, 2002). Suicidal people are more likely to end their lives if they have access to a fatal means of action, such as a weapon in their house (Brent & Bridge, 2003). Withdrawal from social interactions, a sense of being a burden to others, and participating in reckless and risk-taking activity may all be antecedents to suicide behavior (Berman, 2009). Suicidal conduct is predicted by a sense of entrapment or feeling unable to escape one's unhappy feelings or external circumstances (e.g., an abusive relationship with no apparent way out) (O'Connor, Smyth, Ferguson, Ryan, & Williams, 2013). In recent years, there have been stories of juvenile suicides as a result of cyberbullying. A few years ago, Phoebe Prince, a 15-year-old Massachusetts high school girl, committed herself after receiving constant abuse and bullying from her classmates via texting and Facebook (McCabe, 2010).

Suicides have the potential to spread to others. For example, the suicide of another person, particularly a family member, increases one's own risk of suicide (Agerbo, Nordentoft, & Mortensen, 2002). Furthermore, extensively publicized suicides tend to inspire others to commit suicide. According to one research that looked at suicide data in the United States from 1947 to 1967, rates of suicide soared for the first month after a suicide story appeared on the front page of the New York Times (Phillips, 1974). Austrian researchers discovered a considerable rise in the incidence of suicides by firearm in the three weeks after widespread coverage of a celebrity suicide by gun in Austria's leading daily (Etzersdorfer, Voracek, & Sonneck, 2004). According to a study of 42 research, media coverage of celebrity deaths is more than 14 times more likely to spark copycat suicides than coverage of non-celebrity suicides (Stack, 2000). This study also found that the medium of coverage matters: television stories are far less likely to cause an increase in suicides than print ones. According to research, a trend is growing in which people utilize online social media to leave suicide notes, while it is unclear to what degree suicide notes on such medium may incite copycat suicides (Ruder, Hatch, Ampanozi, Thali, & Fischer, 2011). Nonetheless, it is legitimate to speculate that suicide notes placed on social media by individuals may affect the actions of other susceptible people who come across them (Luxton, June, & Fairall, 2012).

Brain chemistry is one component that may have a role in suicide. Recent neurological research indicates that serotonin dysfunction is associated with suicidal conduct (Pompili et al., 2010). Low serotonin levels indicate future suicide attempts and completions, and low levels have been found post-mortem in suicide victims (Mann, 2003). As previously stated, serotonin dysfunction is recognized to play a key part in depression; low levels of serotonin have also been related to aggressiveness and impulsivity (Stanley et al., 2000). The combination of these three features is a probable recipe for suicide, particularly violent suicide. Those with severe depressive illness who had very low levels of serotonin attempted suicide more frequently and violently than patients with larger levels, according to a famous research done in the 1970s (Asberg, Thorén, Träskman, Bertilsson, & Ringberger, 1976; Mann, 2003).

# SCHIZOPHRENIA

Schizophrenia is a debilitating psychiatric condition marked by significant disruptions in cognition, perception, emotion, and behavior. Schizophrenia affects about 1% of the population at some point in their lives, and the illness is often diagnosed in early adulthood (early to mid-20s). The majority of persons with schizophrenia have substantial difficulty with many daily tasks, such as working, paying bills, caring for oneself (grooming and cleanliness), and establishing connections with others. With schizophrenia, frequent hospitalizations are more typically the norm than the exception. Even if they get the greatest therapies available, many people with schizophrenia will have substantial social and vocational impairment for the rest of their lives.

What exactly is schizophrenia? To begin, schizophrenia is not an illness characterized by a split personality; that is, schizophrenia is not synonymous with dissociative identity disorder (also known as multiple personality disorder). Because the term schizophrenia, created by Swiss psychiatrist Eugen Bleuler in 1911, originates from Greek roots that relate to a "splitting" (schizo) of mental processes (phrene), these conditions are frequently misconstrued (Green, 2001). Schizophrenia is classified as a psychotic condition, which means that the person's ideas, perceptions, and actions are damaged to the degree that she cannot function properly in daily life. In layman's words, someone who suffers from a psychotic condition (that is, has a psychosis) is cut off from the reality in which the majority of us live.

## Symptoms of Schizophrenia

Hallucinations, delusions, disordered thinking, disorganized or aberrant motor action, and negative symptoms are the most common signs of schizophrenia (APA, 2013). A hallucination is a perceptual experience that happens when no external stimuli are present. Auditory hallucinations (hearing voices) affect around two-thirds of schizophrenia patients and are by far the most prevalent type of hallucination (Andreasen, 1987). The voices may be known or strange, they could converse or quarrel, or they could offer a running commentary on the person's conduct (Tsuang, Farone, & Green, 1999).

Visual hallucinations (seeing things that aren't there) and olfactory hallucinations are less prevalent (smelling odors that are not actually present). Delusions are beliefs that are diametrically opposed to reality and are steadfastly held even in the face of opposing facts. Many of us possess ideas that others find strange, yet a delusion is easily identifiable since it is blatantly nonsensical. A person suffering from schizophrenia may believe that his mother is scheming with the FBI to poison his coffee, or that his next-door neighbor is an enemy spy out to murder him. These are known as paranoid delusions, and they entail the (false) conviction that other individuals or agencies are conspiring to harm the person. People suffering from schizophrenia may also have grandiose delusions, which are ideas that one possesses exceptional power, unique knowledge, or is immensely significant. For example, someone who claims to be Jesus Christ, or to have knowledge dating back 5,000 years, or to be a brilliant philosopher is suffering from grandiose delusions. Other delusions include the notion that one's thoughts are being taken from one's brain (thought withdrawal) or that thoughts have been implanted within one's mind (thought insertion).

Somatic delusion is another sort of delusion, which is the conviction that something extremely aberrant is occurring to one's body (for example, that one's kidneys are being devoured by cockroaches). Disorganized thinking is characterized by disconnected and disorganized cognitive processes, which are mainly recognized by what a person says. The speaker may ramble, make loose linkages (jump from topic to issue), or speak in such a chaotic and incoherent manner that it appears as if the person is arbitrarily blending words. Disorganized thinking is frequently characterized by plainly nonsensical utterances (e.g., "Fenway Park is located in Boston. Boston is where I call home. As a result, I live at Fenway Park." Tangentiality is defined as replying to others' words or queries with replies that are either barely linked or unrelated to what was said or requested. For example, if a person with schizophrenia is asked if she would want to receive specific work training, she may respond that she once travelled on a train somewhere. To a person suffering from schizophrenia, the tangential (somewhat connected) relationship between job training and riding a train is sufficient to elicit such a reaction.

Disorganized or aberrant motor behavior refers to unexpected actions and movements, such as being abnormally active, participating in funny child-like activities (giggling and self-absorbed smiles), engaging in repetitive and purposeless motions, or displaying bizarre facial expressions and gestures. In other situations, the individual will display catatonic behaviors, such as posturing, in which the person maintains a stiff and odd position for lengthy periods of time, or catatonic stupor, a complete absence of movement and vocal conduct. Negative symptoms are those that manifest as obvious declines or absences in certain behaviors, feelings, or desires (Green, 2001). A person with decreased emotional expression expresses no emotion through his facial expressions, voice, or gestures, even when such emotions are usual or anticipated.

Asociality, or social retreat and a lack of interest in social relationships with others, is another unfavorable characteristic. Anhedonia is a last negative symptom that refers to an inability to enjoy pleasure. An individual suffering from anhedonia has little interest in what most others regard to be joyful activities, such as hobbies, recreation, or sexual activity.

# PERSONALITY DISORDERS

Personality refers to a person's steady, consistent, and distinct manner of thinking about, feeling about, acting on, and responding to the environment. People with personality disorders have a personality type that departs significantly from cultural standards, is widespread and rigid, originates in youth or early adulthood, and produces discomfort or impairment (APA, 2013). Individuals with these illnesses, in general, have persistent personality types that are exceedingly problematic and frequently cause issues for them and those with whom they come into touch. Their maladaptive personality characteristics typically cause individuals to disagree with others, interfere with their capacity to form and sustain social connections, and hinder them from achieving realistic life objectives.

The DSM-5 defines ten personality disorders, which are arranged into three distinct groups. Paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder are all Cluster A diseases. People with these diseases have an unusual or quirky demeanor. Antisocial personality disorder, histrionic personality disorder, narcissistic personality disorder, and borderline personality disorder are all Cluster B disorders. People with these diseases are frequently impulsive, theatrical, highly emotional, and unpredictable. Avoidant personality disorder, dependent personality disorder, and obsessive-compulsive personality disorder (which is not the same as obsessive-compulsive disorder) are all Cluster C disorders. People with these diseases may look apprehensive and scared.

## Borderline Personality Disorder

The term "borderline personality disorder" was coined in the late 1930s to characterize patients who seemed anxious yet were prone to short psychotic episodes—people who were considered to be literally on the borderline between anxiety and psychosis (Freeman, Stone, Martin, & Reinecke, 2005). Today, the term "borderline personality disorder" has an entirely different connotation. Borderline personality disorder is distinguished by instability in interpersonal interactions, self-image, and mood, as well as a high level of impulsivity (APA, 2013). People suffering with borderline personality disorder cannot bear the notion of being alone and will go to great lengths (including suicide gestures and self-mutilation) to prevent abandonment or separation (whether real or imagined). subsequently condemned at the least evidence that she looks to be losing interest.

Because these people have a shaky sense of self, they may suddenly change their personal opinions, hobbies, job aspirations, and social circle. For example, after having spent tens of thousands of dollars on obtaining a law degree and having performed well in the program, a law student may contemplate dropping out and pursuing a job in another sector. Borderline personality disorder patients may be very impulsive and engage in dangerous and self-destructive activities such as excessive gambling, irresponsible spending of money, substance misuse, unsafe sex, and reckless driving. They can be grumpy, caustic, bitter, and verbally abusive at times, displaying intense and inappropriate anger that they struggle to manage.

## Antisocial Personality Disorder

Most people spend their lives with a moral compass, a feeling of right and wrong. Most people learn at an early age that there are some things they should not do. We are taught not to lie or cheat. We are taught that taking things that do not belong to us is bad, as does exploiting others for selfish benefit. We also learn the value of upholding our end of the bargain, of doing what we say we will do. People with antisocial personality disorder, on the other hand, appear to lack a moral compass. These people act as though they have no concept of right and wrong and are unconcerned about it. Not surprise, these individuals pose a severe challenge for others and society as a whole.

According to the DSM-5, an individual with antisocial personality disorder (also known as psychopathy) has no respect for the rights or feelings of others. This lack of concern manifests itself in a variety of ways, including repeating unlawful crimes, lying to or deceiving others, impulsivity and recklessness, irritation and aggression toward others, and failing to behave responsibly (e.g., leaving bills unpaid) (APA, 2013). The worst thing of antisocial personality disorder is that persons with it have no regret for their actions; these people will injure, manipulate, exploit, and abuse others without feeling any shame. Antisocial personality disorder symptoms can appear early in life; nevertheless, a person must be at least 18 years old to be diagnosed.

People suffering with antisocial personality disorder appear to regard the world as self-serving and cruel. They appear to believe that they should utilize all methods required to get by in life. They tend to see people as pawns to be exploited or abused for a certain purpose, rather as living, thinking, feeling beings. They frequently have an exaggerated sense of self-esteem and can look excessively haughty. They usually exhibit superficial charm; for example, they may say exactly what they believe another person wants to hear without truly meaning it. They lack empathy: they are unable to grasp the emotional perspectives of others. People with this disorder may engage in illegal activities, be cruel to others, quit their jobs with no plans to return, have multiple sexual partners, get into fights with others on a regular basis, and show reckless disregard for themselves and others (e.g., repeated arrests for driving while intoxicated) (APA, 2013).

A effective method to think about antisocial personality disorder is to break it down into three basic concepts: disinhibition, boldness, and meanness (Patrick, Fowles, & Krueger, 2009). Disinhibition is characterized by a proclivity for impulse control issues, a lack of planning and thoughtfulness, a demand on rapid pleasure, and an inability to restrict conduct. Boldness is defined as the ability to remain cool in threatening situations, great self-assurance, a sense of power, and a desire for thrills. Meanness is described as "aggressive resource seeking without concern for others," and it is characterized by a lack of empathy, contempt for and lack of intimate connections with others, and a proclivity to achieve goals through cruelty (Patrick et al., 2009, p. 913).

# DISORDERS IN CHILDHOOD

The majority of the illnesses we've addressed thus far are normally diagnosed in adults, while they can and do occur in infancy. However, there are a few illnesses that, when present, are detected early in infancy, frequently before a kid starts school. These diseases are classified as neurodevelopmental disorders in the DSM-5, and they entail developmental issues in personal, social, academic, and intellectual functioning (APA, 2013). In this part, we'll look at two of them: attention deficit hyperactivity disorder and autism.

## Attention Deficit/Hyperactivity Disorder (ADHD)

A child with ADHD has a consistent pattern of inattention, hyperactivity, and impulsive conduct that disrupts normal functioning (APA, 2013). Some symptoms of inattention include difficulty with and avoidance of tasks requiring sustained attention (such as conversations or reading), failure to follow instructions (often resulting in failure to complete schoolwork and other duties), disorganization (difficulty keeping things in order, poor time management, sloppy and messy work), lack of attention to detail, becoming easily distracted, and forgetfulness. Fidgeting or squirming, leaving one's seat in situations where remaining seated is expected, having difficulty sitting still (e.g., in a restaurant), running around and climbing on things, blurting out responses before another person's question or statement has been completed, difficulty waiting one's turn for something, and interrupting and intruding on others are all symptoms of hyperactivity. The hyperactive youngster frequently comes across as loud and rowdy. The child's conduct is rash, impulsive, and appears to occur without much deliberation; these qualities may explain why teenagers and young adults diagnosed with ADHD obtain more traffic fines and are involved in more car accidents than others (Thompson, Molina, Pelham, & Gnagy, 2007).

ADHD affects around 5% of children (APA, 2013). Guys are three times more likely than females to have ADHD; however, such findings may reflect boys' greater proclivity to engage in violent and antisocial conduct, and therefore a larger risk of being sent to psychological clinics (Barkley, 2006). Children with ADHD had poorer grades and standardized test scores than their non-ADHD peers, as well as greater rates of expulsion, grade retention, and dropping out (Loe & Feldman, 2007). They are also less loved and more frequently rejected by their peers (Hoza et al., 2005).

ADHD was once assumed to disappear by adolescence. Longitudinal studies, on the other hand, have revealed that ADHD is a persistent condition that can last throughout adolescence and adulthood (Barkley, Fischer, Smallish, & Fletcher, 2002). According to a recent research, 29.3 percent of persons who were diagnosed with ADHD decades ago still experienced symptoms (Barbaresi et al., 2013). This study also found that approximately 81 percent of individuals whose ADHD lasted into adulthood had at least one additional comorbid condition, compared to 47 percent of those whose ADHD did not.

## Causes of ADHD

According to family and twin studies, genetics have a crucial impact in the development of ADHD. In a review of 26 research, Burt (2009) found that the median rate of concordance for identical twins was.66 (one study claimed a rate of.90), while the median rate of concordance for fraternal twins was.20. This study also discovered that the median concordance rate for unrelated (adoptive) siblings was.09; while this figure is modest, it is more than zero, suggesting that the environment may have some impact. Another study found that inattention and hyperactivity were inherited at 71% and 73% of the time, respectively (Nikolas & Burt, 2010).

At least two of the genes linked with ADHD are considered to be involved in the regulation of the neurotransmitter dopamine (Gizer, Ficks, & Waldman, 2009), implying that dopamine may play a role in ADHD. Indeed, stimulant drugs used to treat ADHD, such as methylphenidate (Ritalin) and amphetamine plus dextroamphetamine (Adderall), increase dopamine activity. People with ADHD had lower dopamine activity in important brain areas, particularly those related with motivation and reward (Volkow et al., 2009), lending credence to the notion that dopamine impairments may play a role in the development of this condition (Swanson et al., 2007).

Brain imaging studies have revealed that children with ADHD had anomalies in their frontal lobes, a region rich in dopamine. When compared to children who do not have ADHD, individuals with ADHD appear to have reduced frontal brain volume and less frontal lobe activity when doing mental activities. Remember that one of the frontal lobes' duties is to inhibit our conduct. Thus, anomalies in this area may help to explain the hyperactive, uncontrollable behavior associated with ADHD.

Many people were aware of the link between dietary issues and childhood behavior by the 1970s. At the time, many people felt that sugar and food additives, such as artificial coloring and flavoring, were to blame for hyperactivity. Part of the attractiveness of this concept was undoubtedly that it gave a straightforward explanation for (and therapy for) behavioral issues in youngsters. A statistical evaluation of 16 research, on the other hand, revealed that sugar consumption has no influence on children's behavioral and cognitive performance (Wolraich, Wilson, & White, 1995). Furthermore, while dietary additives have been proven to promote hyperactivity in non-ADHD children, the effect is minor (McCann et al., 2007). Numerous studies, however, have found a link between prenatal nicotine exposure in cigarette smoke and ADHD (Linnet et al., 2003). Maternal smoking during pregnancy has been linked to the emergence of more severe symptoms of the disease (Thakur et al., 2013).

# AUTISM SPECTRUM DISORDER

Leo Kanner's groundbreaking 1943 publication detailed an uncommon neurodevelopmental disorder he saw in a group of youngsters. This syndrome was dubbed "early infantile autism" by him, and it affected 594 children. This material is free and can be found at https://cnx.org/content/col11629/1.5. It was defined mostly by an inability to create intimate emotional bonds with people, speech and language problems, repetitive activities, and an intolerance of minor changes in the surroundings and usual routines (Bregman, 2005). Kanner's work is a direct extension of what is now known as autism spectrum disorder in the DSM-5.

Autism spectrum disorder is one of the most perplexing and misunderstood neurodevelopmental illnesses. Children with this disease have severe difficulties in three areas: (a) social interaction impairments, (b) communication abnormalities, and (c) repetitive patterns of behavior or interests. These disorders manifest early in infancy and produce significant functional deficits (APA, 2013). A kid with autism spectrum condition may demonstrate social interaction deficiencies such as not starting interactions with other children or turning their head aside when spoken to. These youngsters avoid making eye contact with others and appear to prefer playing alone over engaging with others. In a way, it's almost as if these people live in a secluded and insulated social world that others aren't privy to or able to enter. Communication deficits can range from a complete lack of speech to one-word responses (e.g., saying "Yes" or "No" when responding to questions or statements that require more elaboration), echoed speech (e.g., parroting what another person says, either immediately or several hours or even days later), and difficulty maintaining a conversation due to an inability to reciprocate others' comments. These deficiencies can also include difficulties interpreting and comprehending nonverbal cues (such as facial expressions, gestures, and postures) that aid in regular communication.

Repetitive patterns of behavior or interests can manifest themselves in a variety of ways. The kid may engage in stereotyped, repetitive actions (rocking, head-banging, or repeatedly dropping and picking up an object), or she may express tremendous pain at little changes in routine or environment. For example, if an object is not in its right position or if a regularly scheduled activity is rescheduled, the youngster may have a temper tantrum. In some situations, a person with autism spectrum condition may have very confined and obsessive interests that look abnormally intense. For example, the individual may learn and memorize every detail about something despite the fact that doing so provides no obvious value. Importantly, autism spectrum disorder is not the same as intellectual impairment, despite the fact that the two illnesses are frequently co-occurring. The DSM-5 states that intellectual handicap does not cause or explain the symptoms of autism spectrum disorder.

## Causes of Autism Spectrum Disorder

Early autism beliefs placed the responsibility firmly on the child's parents, particularly the mother. Bruno Bettelheim (an Austrian-born American child psychologist who was highly inspired by Sigmund Freud's views) argued that the major causes of childhood autism were a mother's conflicted sentiments and her frozen and stiff feelings toward her kid. "I declare my conviction that the triggering component in infantile autism is the parent's wish that his kid should not exist," he stated in what must surely rank as one of the most contentious declarations in psychology over the last 50 years (Bettelheim, 1967, p. 125). As you can expect, Bettelheim's viewpoint did not endear him to many people; in addition, there is no scientific proof to back up his allegations.

Despite extensive research efforts over the last two decades, the precise origins of autism spectrum illness remain unclear (Meek, Lemery-Chalfant, Jahromi, & Valiente, 2013). Autism appears to be heavily impacted by genetics, since identical twins have concordance rates of 60%–90%, but fraternal twins and siblings have concordance rates of 5%–10%. (Autism Genome Project Consortium, 2007). Autism has been linked to a variety of genes and gene mutations (Meek et al., 2013). Among the genes implicated are those required for the creation of synaptic circuits, which allow communication between different parts of the brain (Gauthier et al., 2011). A variety of environmental variables are also considered to be linked to a higher risk of autism spectrum disease, at least in part because they lead to new mutations. Exposure to contaminants such as plant emissions and mercury, urban vs rural habitation, and vitamin D insufficiency are among these causes (Kinney, Barch, Chayka, Napoleon, & Munir, 2009).

# CONCLUSION

In light of this essay, it can be concluded that a psychological disturbance is defined by aberrant thoughts, feelings, and behaviors.

Although difficult, psychologists and mental health experts must agree on what types of inner sensations and actions define the presence of a psychological condition. Inner sensations and actions that are abnormal or breach societal standards may indicate the presence of a problem; nevertheless, each of these criteria is insufficient on its own. The concept of harmful dysfunction refers to the belief that psychiatric diseases are caused by an internal mechanism's failure to execute its inherent purpose.

Many aspects of detrimental dysfunction conceptualization have been integrated into the American Psychological Association's official classification of psychological disorders. Significant disturbances in thoughts, feelings, and behaviors, according to this definition, indicate the presence of a psychological disorder; these disturbances must reflect some kind of dysfunction (biological, psychological, or developmental), must cause significant impairment in one's life, and must not reflect culturally expected reactions to certain life events.

Psychopathology is extremely complicated, with several etiological theories and views. The DSM-5 categorization system is utilized by the majority of professionals in the United States. The first version of the DSM was released in 1952. The number of diagnosable diseases included in the DSM has continuously increased throughout time. Obsession with undesirable, unpleasant thoughts and/or obsessive repetition of behaviors or mental activities Body dysmorphic disorder leads a person to be extremely self-conscious about how he appears to others.

Hoarding disorder is defined by an inability to discard or part with items, regardless of their true value. Posttraumatic stress disorder is characterized as a set of symptoms that endure for at least one month. Mood disorders are those in which a person's mood and emotions are severely disrupted. Schizophrenia is a serious condition that causes a full collapse in one's capacity to function in daily life; it frequently necessitates hospitalization. Schizophrenia patients suffer hallucinations and delusions, and they have significant trouble controlling their emotions and conduct.

The new study includes identifying people who are experiencing prodromal symptoms and studying them over time to see which indicators best predict the development of schizophrenia. Borderline personality disorder is characterized by mood, behavior, and self-image instability, as well as impulsive conduct. People with an antisocial personality lack concern for the rights of others; they are impetuous, deceptive, reckless, and guiltless. Neurodevelopmental diseases are most commonly diagnosed in childhood and are characterized by developmental deficiencies in the personal, social, academic, and intellectual arenas.

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