

Unit 12: Abnormal Behavior

I. Introduction

- A. People love to study the abnormal. By studying abnormal psychology, the hope is to gain a better understanding of normal psychology.
- B. 450 million people worldwide are estimated to have a psychological disorder.
 - 1. The disorders vary by culture.
 - 2. All cultures have depression and schizophrenia.
- C. There is a definite "gray area" between "normal" and "abnormal." Drawing a cut-off line and between the two is not always easy.

II. Defining psychological disorders

- A. **Psychological disorders** are patterns of thoughts, feelings, and behaviors that are deviant, distressful, and dysfunctional.
- B. Notice the "3D's" of psychological disorders...
 - 1. Deviant – This means the behavior strays from what is normal. The norms of a society are determined by different things...
 - a. Culture – one culture's norms may be another's deviance.
 - b. Time period – what used to be odd may now be normal, or vice versa.
 - 2. Distress – Just straying from the normal doesn't make a disorder. They must also be bothered by what they do or see it as problematic.
 - 3. Dysfunction – The abnormal behavior must also create problems in the person's life. Whereas distress is on the inside, dysfunction sees the problem carried out in real life.

III. Understanding psychological disorders

- A. "Therapies" for psychological disorders have been very crude in the past. Things were done like caging the insane, or beating/burning/mutilating them in some way.
 - 1. The normal thinking was either that the person was possessed by an evil spirit or simply acting that way for attention.
- B. Philippe Pinel was a reformer who tried to replace brutality with care and loving treatment.
- C. By the 1800s, it was learned that syphilis affects the mind. This started the movement towards hospitals and away from jail cells. It also started two new approaches to psychological disorders...
 - 1. The **medical model** is a movement that looks for biological causes of mental disorders. It believes:
 - a. Mental disorders are diagnosed based on their symptoms.
 - b. Mental disorders are cured through a therapy.
 - 2. The **biopsychosocial approach** believes ALL behavior comes from the interaction of the body/genetics and one's background/experiences as well as our thoughts.
 - a. The "bio" and the "social" parts of the name simply refer to nature and nurture.
 - b. The "psycho" part of the name is what we think about things. All three dance together.
 - c. Different cultures tend to have different disorders.

IV. Classifying psychological disorders

- A. People to classify things to define order. For instance, we can classify animals as "reptiles" or "mammals" or "birds" based on their characteristics. But, it's tricky to classify psychological disorders. We do this mainly with the "**DSM.**"
- B. The **DSM-5** is the current "disorder bible." It's the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. The DSM-5 came out in 2013 and replaced the DSM-IV-TR (which came out in 2000).
 - 1. The DSM-5 includes a diagnostic process and 16 clinical syndromes.

2. It does not try to explain causes but tries to describe the disorder.
3. The DSM-5 is structured as follows:
 - a. Axis I – Is a clinical syndrome present?
 - i. Disorders usually diagnosed in infancy, childhood, and adolescence
 - ii. Delirium, dementia, and other cognitive disorders
 - iii. Mental disorders due to general medical condition
 - iv. Substance-related disorders
 - v. Schizophrenia and other psychotic disorders
 - vi. Mood disorders
 - vii. Anxiety disorders
 - viii. Somatoform disorders
 - ix. Factitious disorders (intentionally faked)
 - x. Dissociative disorders
 - xi. Eating and sleep disorders
 - xii. Sexual disorders and gender identity disorder
 - xiii. Impulse-control disorders not classified elsewhere
 - xiv. Adjustment disorders
 - xv. Other conditions that may be a focus of clinical attention
 - b. Axis II – Is a personality disorder or mental retardation present?
 - c. Axis III – Is a general medical condition, such as diabetes, hypertension, or arthritis, also present?
 - d. Axis IV – Are psychological or environmental problems, such as school or housing issues, also present?
 - e. Axis V – What is the global assessment of this person's functioning?
4. The DSM gets good and bad marks...
 - a. The DSM has been praised for being rather reliable in diagnoses.
 - b. The DSM has been criticized for being too broad.
 - i. Almost any behavior could be stretched into being some type of "disorder."
 - ii. The number of categories has increased from 60 in the 1950s to 400 today.
 - iii. Also, the number of people diagnosed with something has increased substantially.
 1. What used to be the regular "ups and downs of life" is now "bipolar disorder."
 2. What used to be sassiness is now "oppositional defiance disorder."
 3. What used to be fidgety is now "ADHD."

V. Labeling psychological disorders

- A. Many say putting a label on a person is not right. It generates expectations for that person and puts him or her in a box.
- B. David Rosenhan did a study in 1973 on labels. He and other normal people lied and said they heard voices talking to them. They were diagnosed with disorders.
 1. The initial fact they were diagnosed might be okay. But later, the "causes" of their supposed problems were also pinpointed.
- C. In another experiment, people watched others on TV. The watchers were shown different labels for the people they were watching. Thus, the watchers drew different conclusions about the people on TV.
- D. Someone just out of prison or a mental hospital has trouble getting a job.
- E. Hollywood tends to perpetuate stereotypes too of mental disorders. A person is usually either funny, freaky, or a psychotic killer.
 1. People with mental disorders are rarely violent, but often the victims.
- F. Labels can also lead to the **self-fulfilling prophecy** where a person's expectations cause the expected result.

1. For instance, if a teacher is told a student is “gifted” the teacher may grade more forgivingly on an essay. Thus, the student gets better grades and acts as though he or she really is gifted.
2. Or if student A speaks to student B and labels a teacher as “mean”, student B might be disrespectful to the teacher, see the teacher come down hard on student B, and thus verify student B’s perception of a mean teacher.

VI. Generalized anxiety disorder

A. Introduction

1. Everyone feels **anxiety** (worrying) at some point, like being nervous before giving a speech. But, for most people, anxiety is temporary. If it’s persistent, an anxiety disorder may be present.
2. There are five basic anxieties: (1) generalized anxiety disorder, (2) panic disorder, (3) phobias, (4) obsessive-compulsive disorder, and (5) post-traumatic stress disorder.

B. **Generalized anxiety disorder** is worry that does not have a specific reason or a physical cause for the anxiety. The symptoms are things such as dizziness, sweating palms, heart palpitations, ringing in the ears, edginess, lack of sleep, and “the shakes.”

1. The focus of the worry may change. The person cannot explain why he/she is so edgy.
2. Generalized anxiety disorder often goes with depression and can lead to high blood pressure.
3. It tends to decline by about age 50.

VII. Panic disorder

A. **Panic disorder** is a sudden and paralyzing fear that something terrible is about to happen.

- B. It strikes suddenly and out-of-the blue to about 1 in 75 people. It lasts minutes.
- C. Symptoms include heart palpitations, shortness of breath, choking feelings, trembling, sweating, and dizziness.

VIII. Phobias

A. **Phobias** are irrational fears that cause a person to avoid an object, activity, or situation.

- B. There are many, many phobias. There are phobias for nearly anything you can imagine.

1. Some phobias have a natural cause, like fear of heights or snakes.
2. Other phobias have irrational causes, like fear of the number 13.

- C. Social phobias include the fears of being evaluated by others. For instance, the fear of speaking publicly or going to parties.

D. **Agoraphobia** is the fear of going into public places where a panic attack might begin.

IX. Obsessive-compulsive disorder

A. **Obsessive-compulsive disorder (OCD)** is an anxiety disorder with unwanted repetitive thoughts and/or actions. Everyone can become picky over certain things. But, with OCD, the pickiness begins to interfere with the person’s life.

- B. OCD can become paralyzing to the point that normal living becomes impossible.
- C. OCD is more common among teens and young adults.

X. Post-traumatic stress disorder

A. **Post-traumatic stress disorder (PTSD)** is an anxiety disorder with haunting memories, nightmares, social withdrawal, jumpiness, and/or insomnia that lasts weeks after a traumatic experience.

1. PTSD often hits soldiers after they return from the battlefield. It can also hit accident, disaster, or attack survivors.
2. PTSD among veterans seems to be at about 1 in 6 vets showing symptoms.

- B. A limbic system that’s sensitive can be a cause of PTSD.

- C. Identical twin studies suggest that genetics can pre-dispose a person to PTSD.
- D. Among non-soldiers who experience a tragic event, about 5-10% show signs of PTSD (90-95% do not).
 - 1. Facing a traumatic event can also make a person stronger. Or, more exactly, it can show them how strong they can be.
 - 2. **Post-traumatic growth** is a new love or appreciation for things due to an extremely challenging situation. It's like the cancer patient who says he loves his family and friends even more, whereas before, he took them for granted.

XI. Understanding anxiety disorders

- A. Modern psychologists have come up with two main theories as to causes of anxiety: (1) the learning perspective, and (2) the biological perspective.
- B. The **learning perspective** suggests that we learn to be anxious from past experiences.
 - 1. Ivan Pavlov would agree that any animal could be taught to fear anything, as long as something negative went along with it.
 - 2. It's likely that a person's anxiety has been conditioned to go along with an unpleasant (or traumatic) experience.
 - 3. Remember concepts from Pavlov and conditioning...
 - a. "Stimulus generalization" is where we broaden things. A fierce dog can be generalized to a fear of all dogs.
 - b. "Reinforcement" is where our fear gets supported. Maybe we see a movie with a mean dog—this reinforces our fear of dogs. Reinforcement works two ways to avoid our anxiety...
 - i. We may stop doing something, like going to a park where dogs might be.
 - ii. We may do something, like taking an alternate walking route to avoid a home with a dog in the yard.
 - 4. **Observational learning** can also play a part in our anxieties because we can learn worry or fear from watching others.
 - a. In one case, baby monkeys were not afraid of snakes, until they watched adult monkeys who were scared of snakes.
- C. The **biological perspective** says that our bodies may pre-dispose people to anxiety disorders.
 - 1. Natural selection holds the theory that people naturally hold onto the fears that helped our ancestors survive. Things such as a fear of heights or spiders help keep us safe.
 - 2. Genetics play a role too. Some people seem genetically prone to anxiety disorders. This has been shown in monkeys and in identical twin humans who may develop similar phobias although raised separately.
 - a. One team identified 17 genes associated with anxiety disorders.
 - b. Genes can also impact neurotransmitters that impact anxiety disorders.
 - 3. Our brains play a role too. Anxiety disorders are overly active brain areas that deal with impulse control and habitual behavior. Brain scans show an active area among people with OCD while going through certain repetitive actions.

XII. Somatoform disorders

- A. **Somatoform disorders** are symptoms that take a physical or bodily form but without a physical cause – it's like thinking yourself sick.
 - 1. Although the cause may be "in your head," the physical effects are real.
- B. **Conversion disorder** assumes that anxiety is converted into physical symptoms. This is usually associated with Freud's time and thinking. A person might have a numb hand, but no physical cause for it to be numb.

- C. **Hypochondriasis** occurs when people take small "symptoms" and imagine dreaded diseases. A person with this goes from doctor to doctor, symptom and disease to symptom and disease.
- XIII. Dissociative identity disorder
- A. The word "dissociative" means there is a break, split, or dissociation between two things. In psychology, **dissociative disorders** mean there's a break with a person's consciousness, memory, or identity. A person often can't tell what's real and what's not.
 - B. A person with **dissociative identity disorder** (DID) has two or more distinct personalities that control his or her behavior.
 - 1. The personalities are totally independent – they may have their own "flavor" and even their own accent when speaking.
 - 2. The person claims to be unaware of each one.
 - C. DID used to be called "multiple personalities" or "split personalities."
- XIV. Understanding dissociative identity disorder
- A. Some psychologists question whether DID is legit or is made up. Nicholas Spanos led this research.
 - 1. They say we all act differently in different situations. That's normal.
 - 2. They point out that the frequency of DID cases has shot up since the DSM first recognized it in the 1980s.
 - a. Diagnoses went from 2 to 20,000.
 - b. The number of personalities went from 3 to 12.
 - c. Other cultures have much less DID than America where it's a bit of a fad.
 - 3. The idea is that some psychologists actively seek out other personalities, and thus, they "find" them.
 - B. Other psychologists say DID is indeed legit. They cite...
 - 1. Distinct brain activity with different identities.
 - 2. Handedness can switch (right & left handedness).
 - 3. Visual acuity and eye muscles can change.
 - 4. Others debate the cause of DID...
 - a. Psychoanalysts say it's to combat unacceptable impulses.
 - b. Learning psychologists say it's been learned to reduce anxiety.
 - c. Some say it's a response to traumatic experiences in the past.
 - C. Overall, DID is still debated as real or fake.
- XV. Major depressive disorder
- A. There are two main mood disorders, they are (1) major depressive disorder and (2) bipolar disorder.
 - B. **Major depressive disorder** is where a person who has two or more weeks of significantly depressed moods or feelings and a lack of interest or pleasure in most activities. It's being depressed for 2+ weeks.
 - C. It's totally normal to feel down or to "have the blues" for a while. To *not* feel the blues on occasion would be the abnormal.
 - 1. 29% of high school students said they felt so down that it affected their usual activities.
 - 2. 44% of college students said about the same.
 - 3. 13% of American adults have had a depressive disorder at some point.
 - 4. 5.8% of men and 9.5% of women worldwide have depression.
 - D. Depression can be constructive. It stops us, makes us look inward, makes us assess what's important, and urges us to get back up and move forward.
 - E. **Dysthymic disorder**, or dysthymia, is a chronic depression that's less severe than major depressive disorder.
- XVI. Bipolar disorder
- A. **Bipolar disorder** is alternating between mania and depression.
 - 1. **Mania** is simply being very, very happy. It's euphoric, hyper, and very optimistic.

2. Again, it's not uncommon to feel both mania and depression, but it is unusual to feel them often and frequently and with short intervals.
 - B. Bipolar disorder, like dissociative identity, has been wildly diagnosed.
 - C. During mania, a person might...
 1. Talk a lot and not like it when interrupted.
 2. Not sleep.
 3. Be sexually promiscuous.
 4. Not want to take advice from others, though they really need it for judgment, spending, and sex. Basically, they're in a great mood, are going to "run with it", and just don't care what you say about it.
 - D. Mania does seem to produce creativity and free-flowing thoughts. Thus people in the arts seem more prone to bipolar disorder.
 - E. Bipolar is less common than major depressive disorder, but it seems more paralyzing and disruptive.
- XVII. Understanding mood disorders
- A. Peter Lewinshon summarized facts on depression...
 1. Depressed folks almost look at the negative (imagine that!). They're also more likely to abuse substances.
 2. Depression is common.
 3. Women are twice as likely as men to become depressed.
 - a. Causes for this are genes, child abuse, self-esteem, relationship issues.
 - b. Whereas women's disorders are more on the inside (depression), men's disorders are more on the outside (like alcohol abuse).
 4. Major depressive conditions usually end on their own.
 - a. It's likely to come back within two years though.
 5. Stress often comes before depression.
 - a. Things like the death of the loved one, losing a job, relationship issues, etc. can trigger depression.
 6. Depression seems to be hitting earlier with each new generation.
 - a. In North America today, teens are 3 times more likely to have depression than their parents.
 - B. There are several theories as to the causes of depression...
 1. The biological perspective of depression
 - a. Genetics causes depression.
 - i. This theory believes that some folks are genetically pre-disposed to depression.
 - ii. As always with genetics, we turn to identical twin and adoption studies.
 1. If one twin gets depression, the chances are 1 in 2 that the other will.
 2. If one twin is bipolar, the chances are 7 in 10 that the other is. This is true even for identical twins reared apart.
 3. Heritability is estimated at 35 – 40%.
 4. Adopted people with depression usually have a biological relative with depression.
 - iii. The lesson here: genetics seem to matter with mood disorders.
 - b. The brain may be pre-disposed to depression.
 - i. New technology reveals brain activity during manic and depressed moods.
 - ii. The left-front lobe seems active when in a good mood.
 - iii. The hippocampus, which deals with emotions, can be changed by stress and affect moods.
 - c. Your chemical balance can affect moods.

- i. Two neurotransmitters are in play with moods...
 - 1. Norepinephrine – boosts arousal and mood – it’s there when you’re happy, absent when you’re down.
 - 2. Serotonin – the “happy neurotransmitter” – is absent when you’re down.
 - ii. Drugs to combat depression, like Prozac, either block reuptake or prevent neurotransmitter breakdown.
 - iii. Exercise, like jogging, can also boost serotonin and help stop depression.
 - 2. The social-cognitive perspective of depression
 - a. There’s more to depression than just biology. How we feel and think about it also matters.
 - b. A depressed person always has negative feelings and thoughts.
 - i. Negative thoughts spawn more depression, which spawns more negative thoughts.
 - ii. **Learned helplessness** can play a part too. A person has effectively concluded he/she cannot do anything about the situation, so why try?
 - iii. Women are more inclined to “feel overwhelmed” than men.
 - iv. People who explain their failures outside of themselves are less likely to become depressed. Someone prone to depression usually approaches things this way...
 - 1. Stable – “The situation is stable and won’t change.”
 - 2. Global – “If affects everything.”
 - 3. Internal – “The problem is because of me.”
 - v. Optimism matters. If you’re optimistic, you’re less likely to get depressed.
 - vi. Depression is more common in Western cultures where individualism is valued (your performance or failure is your own doing).
 - vii. It’s a chicken-and-egg thing: which comes first, negative thoughts then depression, or depression which gives you negative thoughts?
 - 3. Depression makes up a vicious cycle of feeling down, acting sluggish, performing poorly, getting poor reviews, withdrawal from others, etc. which returns to feeling down again. The cycle can be labeled as...
 - a. Stressful experiences
 - b. Negative explanatory style
 - c. Depressed mood
 - d. Cognitive and behavioral changes
 - 4. The bottom line: negative thoughts make up a disease that feeds itself.
 - 5. The good news: this cycle can be broken! Some tips...
 - a. Move to a new environment (literally put yourself in a new place)
 - b. Turn your attention from inside to outside (don’t be so arrogant as to blame yourself for everything – you’re frankly not that important!).
 - c. Do something that you’re good at, no matter how small.
 - d. Remember, many very famous and very successful people suffered from depression, and overcame it.

XVIII. Symptoms of schizophrenia

- A. 1 in 100 people get schizophrenia, likely the worst of disorders.
- B. “Schizophrenia” literally means “split mind.” Most people think of it as “split personalities” but that’s wrong – “split personalities” would be dissociative identity disorder (DID). **Schizophrenia** is a split between reality and what a person thinks is real. It shows itself in 3 ways, they are...

1. Disorganized thinking
 - a. Thoughts and words come out in no logical order. Schizophrenics often speak in "**word salad**" – a jumble of words thrown together like tossed salad..
 - b. Schizophrenics cannot use "selective attention" – our normal ability to focus on the task-at-hand. Thus, they think and speak in a very scattered manner.
 2. Disturbed perceptions
 - a. Schizophrenics often **hallucinate** - sensory perception without sensory input. They can perceive with all 5 senses something that isn't there.
 - b. Usually, this comes out with them speaking out loud to no one. Often, what they say is negative, insulting, or bossy.
 - c. **Delusions of grandeur** can occur where the person thinks he or she alone knows something big, like some type of huge conspiracy that's going on and no one else realizes it.
 3. Inappropriate emotions and actions
 - a. Schizophrenics often react emotionally in a totally wrong way. For instance, they may find someone's death just hilarious.
 - b. Some schizophrenics go into a no-emotion state called the "flat affect."
 - c. Some schizophrenics go into repetitive motions like rocking.
 - d. Some schizophrenics go into "catatonia" where they remain motionless for hours, then they get agitated.
- C. Needless to say, schizophrenia causes huge problems with maintaining relationships and a job.
- XIX. The onset of schizophrenia
- A. There are some trends in schizophrenia's beginnings...
 1. Schizophrenia often begins to emerge as adulthood comes on.
 2. It hits both genders, but slightly more so to men.
 3. It can come on gradually, and often hits lower socio-economic groups hardest.
 - B. There are actually 4 subtypes of schizophrenia. They are...
 1. **Paranoid schizophrenic** – The person thinks there's some grand conspiracy going on. Often they think someone is "out to get them."
 2. **Disorganized schizophrenic** – The person's speech and behavior is disorganized, or their emotions are flat or inappropriate.
 3. **Catatonic schizophrenic** – The person remains motionless for long periods, is very negative, and speaks parrot-like.
 4. **Undifferentiated schizophrenic** – The person has many of these symptoms.
 5. **Residual schizophrenic** – The person just withdraws socially after delusions and hallucinations go away.
 - C. When schizophrenia comes on slowly, it's called either **chronic schizophrenia** or **process schizophrenia**.
 1. The chances of recovering from this type of schizophrenia are not good at all.
 - D. When schizophrenia comes on quickly, it's called **acute schizophrenia**.
 1. The chances of recovering from this type of schizophrenia are much better.
- XX. Understanding schizophrenia
- A. Psychologists look to the brain in attempt to figure out schizophrenia.
 1. Schizophrenics seem to have many more dopamine receptors in their brains.
 - a. Drugs that inhibit dopamine reception seem to help slow down schizophrenia.

- b. They don't stop the symptoms of withdrawal, however.
 - 2. Schizophrenics may have abnormal brain activity and anatomy.
 - a. Brain scans show schizophrenics brains work differently from normal folks.
 - b. While hallucinating, PET scans showed an increased action in...
 - i. The thalamus that handles incoming sensations.
 - ii. The amygdala that handles fear.
 - c. Schizophrenics' brains show signs of shrinkage in places.
 - i. The cavities between the folds of the brain become filled with fluid and thus the brain itself is smaller.
 - d. Some risk factors for schizophrenia seem to be: low birth weight, decreased oxygen at birth, and famine.
 - e. If a mother has a viral infection during pregnancy, the chances rise that the child might develop schizophrenia. Even something common like the flu ups the risk.
 - i. This is another reason pregnant women are urged to get a flu shot.
 - ii. The second trimester seems to be the especially important time period.
- B. Genetics play a role in schizophrenia.
 - 1. If you have a family member who's had schizophrenia, your odds go up considerably.
 - 2. As always when studying the impact of genetics, we look to twins and adoption studies.
 - a. The conclusions with twins are that genetics matter in a big way. If one identical twin has schizophrenia, the other has about a 1 in 2 chance of getting it.
 - b. For fraternal twins, it's much lower, at around a 15% chance. Lower, but still much higher than two random people. This also supports the impact of genetics.
 - c. Adoptions studies show that genetics are a major factor in schizophrenia, rather than the environment in which people grow up.
 - 3. The Genain quadruplets (identical DNA) all have schizophrenia. The odds of four random people getting it is 1 in 100,000,000. Genetics matter!
- C. Psychological factors or "warning signs" seem to precede schizophrenia. They are...
 - 1. A mother with serious schizophrenia.
 - 2. Complications at birth, especially oxygen deprivation and low birth weight.
 - 3. Separation from parents.
 - 4. Short attention span and poor muscle coordination.
 - 5. Disruptive or withdrawn behavior.
 - 6. Emotionally unpredictable.
 - 7. Poor interactions with others.

XXI. Antisocial personality disorder

- A. A **personality disorder** is a behavior that occurs in a continuous pattern, is disruptive, stubborn, and impairs a person's interactions with others.
 - 1. For example, a person may have **borderline personality disorder**.
 - a. Symptoms here are a lack of stable relationships, emotional outbursts, impulsiveness, fear of abandonment, and suicidal behaviors.
 - 2. Or, a person may have a **narcissistic personality disorder**.
 - a. Narcissism is exaggerating your own importance. A narcissist thinks he/she has done great things, hates any criticism, wants to be in the limelight, is very arrogant, but has no empathy for others. It's me-first and me-only.

- B. A person with **antisocial personality disorder** used to be called a “sociopath” or a “psychopath.” This person is usually a male, usually starts to show signs before age 15, and begins to lie, steal, fight, or display unrestrained sexual behavior.
 - 1. It’s a person who cannot live within the bounds of normal rules of life, and doesn’t care either.
 - 2. An antisocial person doesn’t feel sorrow or any bit of remorse or wrongdoing.
 - 3. These folks have no sense of conscience—no sense of right and wrong.
- XXII. Understanding antisocial personality disorder
- A. Both nature and nurture influence a person’s antisocial behavior.
 - B. Men who were antisocial often had these characteristics as boys: they were impulsive, uninhibited, not concerned with social rewards, and had little worries.
 - C. An antisocial person’s brain operates differently too. Their frontal lobes (which halt impulsive and aggressive behavior) show less activity on a PET scan than a normal person.
 - D. Several factors go into increasing a person’s chances for becoming a violent criminal. These support the all-encompassing biopsychosocial approach...
 - 1. Genetics
 - 2. Risk factors at birth
 - 3. Poverty
 - 4. Childhood upbringing
- XXIII. Rates of psychological disorders
- A. It’s estimated that 26% of Americans have a diagnosable mental disorder every year. The U.S. had the highest rate of mental disorders.
 - B. The American estimates are...
 - 1. Generalized anxiety disorder - 3.1%
 - 2. Social phobia% - 6.8%
 - 3. Specific phobia - 8.7%
 - 4. Mood disorder - 9.5%
 - 5. Obsessive-compulsive disorder - 1.0%
 - 6. Schizophrenia - 1.1%
 - 7. Post-traumatic stress disorder - 3.5%
 - 8. Attention-deficit hyper-activity disorder - 4.1%
 - 9. Any mental disorder - 26.2%
 - C. As far as who’s at risk of mental disorders, the poor are most at risk. Their incidence of mental disorders is double the norm.
 - D. Mental disorders usually start becoming apparent by early adulthood.