Psychological Disorders: Crash Course Psychology #28

Crash Course: Psychology
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(Intro)

Way back in 1887, a journalist named Elizabeth Cochran assumed the alias Nellie Bly and feigned a mental illness to report on the truly awful conditions inside psychiatric hospitals in the US--which were known as asylums at the time. She found rotten food, cold showers, prevalent rats, abusive nurses, and patients being tied down in her famous expose "Ten Days in a Mad House". What she documented had been pretty standard mental health treatment for centuries, but her work led the charge in mental health reform.

It's been a long battle.

Nearly a century later in 1975, American psychologist David Rosenhan published a paper called "On Being Sane in Insane Places" detailing the experiment that he conducted on psychiatric institutions themselves. The first part of his experiment involved sending pseudopatients (a group of eight totally mentally sound associates, including David himself) to knock on institution doors and falsely report that they'd been hearing voices. Once admitted, the fake patients abandoned their fake symptoms and behaved as they normally did, waiting for administrators to recognize them as mentally healthy.

Like Cochran, Rosenhan and his team learned that it's easy to get into a mental institution, but it is much, much harder to get out. The participants were kept in the institution for an average of 19 days, one of them for 52 days. They were forced to take psychotropic medication (which they sneakily spit out) and were eventually discharged with a diagnosis of paranoid schizophrenia in remission. Of course, being dubbed in remission isn't exactly the same thing as being labeled sane, and that was just one of Rosenhan's criticisms of the system. It viewed mental illness as an irreversible condition, almost like a personality trait, rather than a curable illness.

Part two of his experiment came later when Rosenhan shared his results with a teaching hospital and then told the staff that he'd be sending more pseudopatients their way in the next few months, and challenged them to detect the imposters. With that in mind, out of 193 new patients, 41 were ferreted out as likely or suspected pseudopatients. The thing is, Rosenhan never actually sent in any pseudopatients. In the end Rosenhan concluded that the way people were being diagnosed with psychiatric issues often revealed less about the patients themselves and more about their situation. Like, saying you've heard voices one time might catch a doctors attention more than weeks of normal behavior.

Naturally people criticized his methods and his findings, but his experiment raised a lot of important questions like: How do we define, diagnose, and classify mental disorders? At what point does sad become depressed? Or quirky become obsessive compulsive? Or energetic become hyperactive? What are the risks and benefits of diagnostic labeling, and how does the field keep evolving?

When people think of psychology they probably most often think about the conditions that it's been designed to understand, diagnose, and treat--namely psychological disorders. From common problems that most of us will experience at some point in our lives to the more serious dysfunctions that require intensive care. They're a big part of what psychology is here for and over the next several lessons we're going to be looking at mental illness, as well as wellness. How symptoms are diagnosed and what biological and environmental causes may be at work. But, to grasp those ideas, we first have to find out how we came to understand the idea of mental health itself and build a science around studying, discussing, and caring for it.

In 2010, the World Health Organization reported that about 450 million people worldwide suffer from some kind of mental or behavioral disorder. No society is immune from them, but when I say psychological disorder I'm guessing some of you will conjure up all sorts of dramatic images like diabolical criminals from Arkham Asylum or Hollywood stereotypes of various eccentric, scary, or tragic figures. This roll call of one-sided stock images is part of the problem our culture faces--the misconceptions and often destructive stigma associated with psychological disorders.

So, what does that term actually mean?

Mental health clinicians think of psychological disorders as deviant, distressful, and dysfunctional patterns of thoughts, feelings, or behaviors. And yeah, there are a lot of sensitive and loaded words in there, so let's talk about what we mean starting with deviant.

Sounds like I'm talking about doing things that are dicey or raunchy, but in this context it's used to describe thoughts and behavior that are different from most of the rest of your cultural context. Of course, being different is usually wonderful. Geniuses and Olympians and visionaries are all deviants from the norm so it probably goes without saying that the standards for so-called deviant behavior change a lot across cultures and in different situations. For example, in a combat situation killing people is probably to be expected, but murder is definitely deviant criminal behavior back home in times of peace. And in some contexts speaking to spirits or ancestors is A-OK, but in other settings say a bar in Iowa City at happy hour might not be quite acceptable.

To be classified as a disorder, that deviant behavior needs to cause that person or others around them distress, which just means a subjective feeling that something is really wrong. In turn, distress can lead to truly harmful dysfunction--when a person's ability to work and live is clearly, often measurable impaired.

So that's today's definition but it took a long time for the Western world to come up with a way of thinking about psychological disorders that was rooted in science and investigative inquiry. It wasn't until around the 18th and 19th centuries that we really started to put forth the notion that mental health issues might be about a sickness in the mind. For example, by the 1800s doctors finally caught on to the fact that advanced syphilis could manifest in serious neurological problems like dementia, irritability, and various mental disorders. So eventually a lot of so-called mental patients were removed from asylums to full medical hospitals where all of their symptoms could be treated.

This "a-ha" moment is just one instance of how perspectives on mental health began to shift towards what is called the medical model of psychological disorder. The medical model champions the notion that psychological disorders have physiological causes that can be diagnosed on the basis of symptoms, can be treated, and sometimes cured. That way of thinking about mental health was an important step forward, at least at first. It took us past the old days of simply locking people up when they didn't seem quite right to others.

But even if it was an improvement, the medical model was seen by some in the field as kind of narrow and outdated. Most contemporary psychologists prefer to view mental health more comprehensively through what is called the bio psychological approach. You've heard us say over and over again that everything psychological is simultaneously biological and that truism is particularly useful here. The bio psychological view takes that holistic perspective, accounting for a whole number of things clearly physiological and not in order to understand what's happening to us, what might be going wrong, and how it can be treated.

It takes into account psychological influences for sure like stress and trauma and memories, but also biological factors like genetics and brain chemistry, and social-cultural influences like all the expectations wrapped up in how a culture defines normal behavior. So by considering the whole host of nature and nurture influences, we can take a broader view of mental health, realizing that some disorders can be cured while others can be coped with, and still others may not be disorders at all once our culture accepts them.

But another important part of handling disorders with scientific rigor is attempting to standardize and measure them. How we talk about them, how we diagnose them, and how we treat them. So the field has literally come up with a manual that shows you how to do that. But it is not without it's flaws. It's called the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; or, DSM-V because it's currently in it's fifth edition. And it is used by practically everybody: clinicians obviously, but also by insurance and drug companies, policy makers, and the whole legal system.

The first edition came out in 1952, and this newest edition was released in 2013. What's particularly interesting about it is that it's designed to be a work in progress... forever. Each new edition incorporates changes based on the latest research but also how our understanding of mental health and behavior evolves over time. For example, believe it or not the first two editions actually classified homosexuality as a pathology, basically a disease. The 1973 third edition eliminated that designation, reflecting changing attitudes and a developing understanding of sexual orientation. And just by looking at the changes between the edition used today and the previous edition released in the year 2000, you can get a picture of not only how quickly things change but also how classification can affect diagnosis--for better or worse--and also what the risks are of classifying psychological disorders in the first place.

For instance, the new edition reflects our growing understanding of the symptoms of Post Traumatic Stress Disorder, and it changed the name of Childhood Bipolar Disorder to Disruptive Mood Dysregulation Disorder because kids were being over-diagnosed and over-treated for bipolar disorder when the condition that they had didn't actually fit that description. And totally new diagnoses are being explored as well, like Gambling Addiction and what's called Internet Gaming Disorder, showing that new disorders continue to arise with changing times.

But the DSM is not perfect even though we've come a long way since the Rosenhan experiment, critics still worry about how the DSM might inadvertently promote the over- or mis-diagnosis and treatment of certain behaviors. Others echo Rosenhan's concerns that by slapping patients with labels we're making them vulnerable to judgments and preconceptions that'll affect how others will perceive and treat them.

In the end, it's just important to keep in mind that definitions are powerful and things can get tricky pretty fast in the world of mental health.

Today you learned about how we define psychological disorders, and looked at medical and bio psychological perspectives on mental illness. We talked about how professionals use the DSM to diagnose disorders and how it's constantly evolving to incorporate new thinking. Thanks for watching, especially to all of you who are Subbable subscribers who make Crash Course possible. To find out how you can become a supporter, just go to subbable.com.

This episode was written by Kathleen Yale, edited by Blake de Pastino, and our consultant is Dr. Ranjit Bhagwat. Our director and editor is Nicholas Jenkins, the script supervisor is Michael Aranda, who is also our sound designer. And the graphics team is Thought Cafe.