**Types of Mental Health Professionals:**

**Clinical Psychologist:** (What Dr. Costa is). Completes a Ph.D. in Psychology and a 1 year post-doctoral internship to be “licensed”. Specializes in the assessment (testing and evaluation) and treatment of people with chronic mental illness. Uses psychotherapy (talk therapy) to treat most conditions and cannot prescribe medications in most states (that is a special license but usually requires a medical degree).

**Psychiatrist:** A medical doctor (M.D), who prescribes medications to treat mental illness.

**Counselor: (CMH, MHT, MFT, LCSW).** A Master’s-level counselor (2 years after BS) trained to work with less severe forms of illness such as marital therapy, counseling, adjustment issues, etc…

**Defining Psychological Disorders**

Between normality and abnormality there is not a gulf but a somewhat arbitrary line. Where we draw this line depends on how atypical, disturbing, maladaptive, and unjustifiable a person’s behavior is.

**Understanding Psychological Disorders**

The medical model’s assumption that psychological disorders are mental illnesses displaced earlier views that demons and evil spirits were to blame. However, critics question the medical model’s labeling of psychological disorders as sicknesses. Most mental health workers today ***adapt a bio-psycho-social perspective***. They assume that disorders are influenced by genetic predisposition, physiological states, psychological dynamics, and social circumstances.

**Classifying Psychological Disorders- Using the DSM-5**

Many psychiatrists and psychologists use the American **Psychiatric** Association’s (medical model) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) for naming and describing psychological disorders in treatment and research. Diagnostic labels facilitate mental health professionals’ communications and research, and most health insurance policies in North America require DSM-V diagnoses before they will pay for therapy.

**Labeling Psychological Disorders**

Critics point out the price we pay for these benefits of classifying disorders: Labels also can create preconceptions that unfairly stigmatize people and bias our perceptions of their past and present behavior.

**Broad Categories of Disorders (NOTE: There’s several subtypes for each):**

**ANXIETY DISORDERS**

Anxiety is part of our everyday experience. It is classified as a psychological disorder only when it becomes distressing or persistent or is characterized by maladaptive behaviors intended to reduce it.

**Four Anxiety Disorders:**

Those who suffer **generalized anxiety disorder (GAD)** may for no clear reason feel persistently and uncontrollably tense and uneasy. Anxiety escalates into periodic episodes of intense dread for those suffering **panic disorder.** Those with **a phobic disorder** may be irrationally afraid of a specific object or situation. Persistent and repetitive thoughts and actions characterize **obsessive-compulsive disorder.**

**PTSD: Posttraumatic stress disorder (PTSD)** is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape or other violent personal assault. Symptoms last beyond 1 month, and may include intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; they may feel sadness, fear or anger; and they may feel detached or estranged from other people. People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.

**MOOD DISORDERS**

Mood disorders are characterized by emotional extremes. The two principal forms are major depressive disorder and bipolar disorder.

**Major Depressive Disorder**

In major depression, the person—without apparent reason—descends for weeks or months into deep unhappiness, lethargy, and feelings of worthlessness before rebounding to normality. Although less disabling, dysthymic disorder is marked by chronic low energy and poor self-esteem.

**Bipolar Disorder**

In the less common bipolar disorder, the person alternates between the hopelessness and lethargy of depression and the hyperactive, wildly optimistic, impulsive phase of mania.

**SAD:** Seasonal Affective Disorder (mainly up here in the Pac Northwest)

**Explaining Mood Disorders**

Current research on depression is vigorously exploring two sets of influences. The first focuses on genetic predispositions and neurotransmitter abnormalities. The second views the cycle of depression from a social-cognitive perspective, in light of cyclic self-defeating beliefs, learned helplessness, negative attributions, and aversive experiences.

**SCHIZOPHRENIA (psychosis)**

Schizophrenia typically strikes during late adolescence. It affects men and women about equally, and it seems to occur in all cultures.

**Symptoms of Schizophrenia**

Schizophrenia shows itself in disorganized thinking (nonsensical talk and delusions, which may stem from a breakdown of selective attention); disturbed perceptions (including hallucinations); and inappropriate emotions and actions. It is rarely a one-time episode.

**Subtypes of Schizophrenia**

Schizophrenia is a set of disorders that emerge either gradually from a chronic history of social inadequacy (in which case the outlook is dim) or suddenly in reaction to stress (in which case the prospects for recovery are brighter).

**Understanding Schizophrenia**

Multiple factors converge to create schizophrenia. As they have for depression, researchers have linked certain forms of schizophrenia with brain abnormalities, in this case, with enlarged, fluid-filled cerebral cavities or increased receptors for the neurotransmitter dopamine, known to be a major player in schizophrenia. Twin and adoption studies also point to a genetic predisposition that, in conjunction with environmental factors, may bring about a schizophrenia disorder.

**DISSOCIATIVE DISORDERS**

**Dissociative Disorders**

Dissociative disorders occur when, under stress, a person’s conscious awareness becomes dissociated (separated) from previous memories, thoughts, and feelings. Most mysterious of all dissociative disorders are cases of **dissociative identity** (formerly called multiple personality). The afflicted person is said to have two or more distinct personalities, with the original typically unaware of the other(s). Skeptics question whether this disorder may be a cultural phenomenon, finding it suspicious that the disorder has just recently become popular and is virtually nonexistent outside North America.

**\*\*PERSONALILTY Disorders**

Personality disorders are enduring, maladaptive patterns of behavior that impair social functioning. For society, the most troubling of these is the remorseless and fearless antisocial personality, but there are 9 other personality disorders such as Borderline, Narcissistic, Avoidant and Obsessive-Compulsive Personality Disorder (not to be confused with OCD, the anxiety disorder).

\*\*Note: The are very different than many of the other disorders in that there is no medical “treatment” to significantly change someone’s maladaptive personality, only their symptoms.

**Getting Help:**

**TCC Counseling Center: Build. 7 Phone: 253-566-5122 (Free counseling for students)**

**FOR A NON-LIFE-THREATENING BUT URGENT MENTAL HEALTH CRISIS:**

Call the Pierce County Crisis Line available 24 hours a day, 7 days a week     1-800-576-7764

**IF YOU OR SOMEONE YOU KNOW IS HAVING SUICIDAL THOUGHTS:**

Call the National Suicide Prevention Lifeline available 24 hours a day, 7 days a week  1-800-273-TALK (8255)

**Brain Injury Support Group** at TACID (TCC) Contact: [Jeff Hartson](https://www.co.pierce.wa.us/690/jffhrtsn53%40gmail.com) Ph: (253)426-5735; Meets second and fourth Thursday of each month6:30-7:30 p.m.