CHAPTER PREVIEW

Mental health workers label behavior psychologically disordered when it is deviant, distressful, and dysfunctional. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) provides an authoritative classification scheme. Although diagnostic labels may facilitate communication and research, they can also bias our perception of people’s past and present behavior and unfairly stigmatize these individuals.

Those who suffer an anxiety disorder may for no reason feel uncontrollably tense (generalized anxiety disorder), may have a persistent irrational fear (phobia), or may be troubled by repetitive thoughts and actions (obsessive-compulsive disorder). Symptoms may also follow the experience of some traumatic event (post-traumatic stress disorder).

Under extreme stress, conscious awareness becomes separated from previous memories, thoughts, and feelings. Those afflicted with a dissociative disorder may even have two or more distinct personalities.

Mood disorders include major depressive disorder and bipolar disorder. Current research on depression is exploring (1) genetic and biochemical influences and (2) cyclic self-defeating beliefs, learned helplessness, negative attributions, and aversive experiences.

The symptoms of schizophrenia include disorganized thinking, disturbed perceptions, and inappropriate emotions. Researchers have linked certain forms of schizophrenia to brain abnormalities. Studies also point to a genetic predisposition that may work in conjunction with environmental factors.

Personality disorders are characterized by inflexible and enduring behavior patterns that impair social functioning. The most common is the remorseless and fearless antisocial personality.

Survey results indicate that 1 in 7 people suffers clinically significant mental disorders with most showing the first symptoms by early adulthood. Poverty is clearly a predictor of mental illness.

CHAPTER GUIDE

➤ Introductory Exercise: Fact or Falsehood?
➤ Project: Diagnosing a “Star”
➤ Feature Films and TV: Introducing Psychological Disorders
➤ Video: Discovering Psychology, Updated Edition: Psychopathology
1. Identify the criteria for judging whether behavior is psychologically disordered.

Psychological disorders consist of deviant, distressful, and dysfunctional behavior patterns. Mental health workers view psychological disorders as persistently harmful thoughts, feelings, and actions. Standards of deviant behavior vary by culture, context, and even time. For example, children once regarded as fidgety, distractable, and impulsive are now being diagnosed with attention-deficit hyperactivity disorder (ADHD).

2. Contrast the medical model of psychological disorders with the biopsychosocial approach to disordered behavior.

The medical model assumes that psychological disorders are mental illnesses that need to be diagnosed on the basis of their symptoms and cured through therapy. Critics argue that psychological disorders may not reflect a deep internal problem but instead a growth-blocking difficulty in the person’s environment, in the person’s current interpretation of events, or in the person’s bad habits and poor social skills.

Psychologists who reject the “sickness” idea typically contend that all behavior arises from the interaction of nature (genetic and physiological factors) and nurture (past and present experiences). The biopsychosocial approach assumes that disorders are influenced by genetic factors, physiological states, inner psychological dynamics, and social and cultural circumstances.

3. Describe the goals and content of the DSM-IV.

The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), nicknamed DSM-IV, is the current authoritative scheme for classifying psychological disorders. Updated in 2000 and referred to as the “text revision,” it assumes the medical model. DSM-IV defines a diagnostic process and 16 clinical syndromes. The reliability of the classification is high. Two clinicians working independently applying the guidelines are likely to reach the same diagnosis. DSM diagnoses are developed in coordination with the International Classification of Diseases (ICD). Most health insurance policies in North America require an ICD diagnosis before they will pay for therapy. As a complement to the DSM, some psychologists are offering a manual of human strengths and virtues (the “un-DSM”).

4. Discuss the potential dangers and benefits of using diagnostic labels.

Critics point out that labels can create preconceptions that bias our perceptions of people’s past and present behavior and unfairly stigmatize these individuals. Labels can also serve as self-fulfilling prophecies. Diagnostic labels help not only to describe a psychological disorder but to predict its future course, to imply appropriate treatment, and to stimulate research into its possible causes. The label of “insanity” raises moral and ethical questions about how people should treat people who have disorders and have committed crimes.

Anxiety Disorders

- Lectures: Concentration Camp Survival; Discovery Health Channel Phobia Study; Obsessive Thoughts; Psychogenic Versus Organic Amnesia; The Dissociative Disorders Interview Schedule and Multiple Personality
- Exercises: Penn State Worry Questionnaire; Taylor Manifest Anxiety Scale; The Posttraumatic Cognitions Inventory (PTCI); Fear Survey; Social Phobia; Obsessive-Compulsive Disorder; The Curious Experiences Inventory
5. Define anxiety disorders, and explain how these conditions differ from normal feelings of stress, tension, or uneasiness.

Many everyday experiences—public speaking, preparing to play in a big game, looking down from a high ledge—may elicit anxiety. In contrast, anxiety disorders are characterized by distressing, persistent anxiety or maladaptive behaviors that reduce anxiety.

6. Contrast the symptoms of generalized anxiety disorder and panic disorder.

**Generalized anxiety disorder** is an anxiety disorder in which a person is continually tense, apprehensive, and in a state of autonomic nervous system arousal. **Panic disorder** is an anxiety disorder in which the anxiety may at times suddenly escalate into a terrifying panic attack, a minutes-long episode of intense dread in which a person experiences terror and accompanying chest pain, choking, or other frightening sensations.

7. Explain how a phobia differs from the fears we all experience.

A phobia is an anxiety disorder marked by a persistent, irrational fear of a specific object, activity, or situation. In contrast to the normal fears we all experience, phobias can be so severe that they are incapacitating. For example, social phobia, an intense fear of being scrutinized by others, is shyness taken to an extreme. The anxious person may avoid speaking up, eating out, or going to parties.

8. Describe the symptoms of obsessive-compulsive disorder.

An obsessive-compulsive disorder is an anxiety disorder characterized by unwanted repetitive thoughts (obsessions) and/or actions (compulsions). The obsessions may be concerned with dirt, germs, or toxins. The compulsions may involve excessive hand washing, or checking doors, locks, or appliances. The repetitive thoughts and behaviors become so persistent that they interfere with everyday living and cause the person distress.

9. Describe the symptoms of post-traumatic stress disorder, and discuss survivor resiliency.

**Post-traumatic stress disorder (PTSD)** is characterized by haunting memories, nightmares, social withdrawal, jumpy anxiety, and/or insomnia that last for four weeks or more following a traumatic experience. Many combat veterans, accident and disaster survivors, and sexual assault victims have experienced the symptoms of PTSD. Some of us, however, are impressively resilient. About half of adults experience at least one traumatic experience in their lifetime but only about 1 in 10 women and 1 in 20 men develop PTSD symptoms. For some, suffering can lead to post-traumatic growth, including an increased appreciation of life, more meaningful relationships, changed priorities, and a richer spiritual life.

10. Discuss the contributions of the learning and biological perspectives to our understanding of the development of anxiety disorders.

The learning perspective views anxiety disorders as a product of fear conditioning, stimulus generalization, reinforcement of fearful behaviors, and observational learning of others’ fear. The biological perspective helps explain why we learn some fears more readily and why some individuals are more vulnerable. It emphasizes evolutionary, genetic, and physiological influences.
11. Describe the symptoms of dissociative disorders, and explain why some critics are skeptical about dissociative identity disorder.

In dissociative disorders, the person appears to experience a sudden loss of memory or change in identity. Dissociative identity disorder is a rare disorder in which a person exhibits two or more distinct and alternating personalities, with the original personality typically unaware of the other(s).

Psychoanalysts see these dissociative disorders as defenses against the anxiety caused by the eruption of unacceptable impulses. Learning theorists see them as behaviors reinforced by anxiety reduction. Still others view dissociative disorders as post-traumatic disorders—a natural protective response to traumatic childhood experiences. Some research suggests that those diagnosed with dissociative identity disorder have suffered physical, sexual, or emotional abuse as children. Skeptics find it suspicious that the disorder became so popular in the late twentieth century and that it is not found in many countries and is very rare in others. Some argue that the condition is either contrived by fantasy-prone, emotionally variable people or constructed out of the therapist-patient interaction.

Mood Disorders

Lectures: Bipolar Disorder; The Sadder-but-Wiser Effect; Cognitive Errors in Depression; Commitment to the Common Good
Exercises: Depression Scales; The Automatic Thoughts Questionnaire; Depression and Memory; Loneliness; Attributions for an Overdrawn Checking Account; Understanding Suicide; The Expanded Revised Facts on Suicide Quiz; The Body Investment Scale and Self-Mutilation
Videos: Program 23 of Moving Images: Exploring Psychology Through Film: Depression: Mike Wallace’s Journey; Module 28 of Psychology: The Human Experience: Mood Disorders: Major Depression and Bipolar Disorder; Modules 31 and 32 of The Mind Series, 2nd ed.: Mood Disorders: Mania and Depression and Mood Disorders: Hereditary Factors
Transparency: 155 Biopsychosocial Approach to Depression

12. Define mood disorders, and contrast major depressive disorder and bipolar disorder.

Mood disorders are psychological disorders characterized by emotional extremes. In major depressive disorder, a person—without apparent reason—descends for weeks or months into deep unhappiness, lethargy, and feelings of worthlessness before rebounding to normality. Poor appetite, insomnia, and loss of interest in family, friends, and activities are often other important symptoms. A less severe form of depression is dysthymic disorder—a down-in-the-dumps mood that fills most of the day, nearly every day, for two years or more. Bipolar disorder is a mood disorder in which a person alternates between the hopelessness and lethargy of depression and overexcited manic episodes (euphoric, hyperactive, wildly optimistic states). Major depressive disorder is much more common than is bipolar disorder.

13. Discuss the facts that an acceptable theory of depression must explain.

Peter Lewinsohn and his colleagues have suggested that any theory of depression must explain the many behavioral and cognitive changes that accompany the disorder; its widespread occurrence; women’s greater vulnerability to depression; the tendency for most major depressive episodes to self-terminate; the link between stressful events and the onset of depression; and the disorder’s increasing rate and earlier age of onset.

14. Summarize the contributions of the biological perspective to the study of depression, and discuss the link between suicide and depression.

The biological perspective emphasizes the importance of genetic and biochemical influences. Mood disorders run in families and a search for genes that put people at risk is now under way. Certain neurotransmitters, including norepinephrine and serotonin, seem to be scarce in depression. Finally, the brains of depressed people have been found to be less active. The left frontal
lobe, which is active during positive emotions, is likely to be inactive during depressed states.
Every year approximately 1 million despairing people take their own lives. Rarely does suicide
occur during the depth of depression. Rather, it most often occurs when depression begins to lift
and energy returns.

15. **Summarize the contributions of the social-cognitive perspective to the study of depression, and
describe the events in the cycle of depression.**

The social-cognitive perspective suggests that self-defeating beliefs, arising in part from learned
helplessness, and a negative explanatory style feed depression. The perspective sees the disorder
as a vicious cycle in which (1) negative, stressful events are interpreted though (2) a ruminating,
pessimistic explanatory style, creating (3) a hopeless, depressed state that (4) hampers the way a
person thinks and acts. This, in turn, fuels (1) more negative experiences.

**Schizophrenia**

- Lecture: Infantile Autism
- Exercises: Magical Ideation Scale; Virtual Hallucinations—An Audiotape
- Project: The Eden Express and Schizophrenia
- PsychSim 5: Losing Touch With Reality
- Videos: Modules 26, 27, and 29 of The Brain series, 2nd ed.: Schizophrenia: Symptoms, Schizophrenia: Etiology, and
  Autism; Module 39 of Psychology: The Human Experience: Schizophrenia; Video Clip 29 of Digital Media Archive:
  Psychology: The Schizophrenic Brain

16. **Describe the symptoms of schizophrenia, and differentiate delusions and hallucinations.**

**Schizophrenia** is a group of severe disorders characterized by disorganized and delusional think-
ing, disturbed perceptions, and inappropriate emotions and actions. Literally, schizophrenia means
“split mind” that refers to a split from reality rather than multiple personality. **Delusions** are false
beliefs, often of persecution or grandeur, that may accompany psychotic disorders. **Hallucinations**
are sensory experiences without sensory stimulation. They are usually auditory and often take the
form of voices making insulting statements or giving orders.

17. **Distinguish the five subtypes of schizophrenia, and contrast chronic and acute schizophrenia.**

Schizophrenia patients with positive symptoms are disorganized and deluded in their talk or prone
to inappropriate laughter, tears, or rage. Those with negative symptoms have toneless voices,
expressionless faces, or mute and rigid bodies. The subtypes of schizophrenia include paranoid
(preoccupation with delusions or hallucinations, often of persecution or grandiosity), disorganized
(disorganized speech or behavior, or flat affect or inappropriate emotions), catatonic (immobility,
extreme negativism, and/or parrotlike repetition of another’s speech or movements), undifferenti-
ated (varied symptoms), and residual (withdrawal following hallucinations and delusions).
**Chronic, or process,** schizophrenia develops gradually, emerging from a long history of social
inadequacy. **Acute, or reactive,** schizophrenia develops rapidly in response to particular life
stresses.

18. **Outline some abnormal brain chemistry, functions, and structures associated with schizophrenia, and
discuss the possible link between prenatal viral infections and schizophrenia.**

Researchers have linked certain forms of schizophrenia with brain abnormalities such as increased
receptors for the neurotransmitter dopamine and impaired glutamate activity. Modern brain-
scanning techniques indicate that people with chronic schizophrenia have abnormal activity in
multiple brain areas. Some appear to have abnormally low brain activity in the frontal lobes, or
enlarged, fluid-filled areas and a corresponding shrinkage of cerebral tissue. Another smaller-than-
normal area in persons with schizophrenia is the thalamus. A possible cause of these abnormalities
is a midpregnancy viral infection that impairs fetal brain development. For example, people are at
increased risk of schizophrenia, if during the middle of their fetal development, their country
experienced a flu epidemic. People born in densely populated areas, where viral diseases spread more readily, also seem at greater risk for schizophrenia.

19. **Discuss the evidence for a genetic contribution to the development of schizophrenia.**

The nearly 1-in-100 odds of any person developing schizophrenia become about 1 in 10 if a family member has it, and close to 1 in 2 if an identical twin has the disorder. Adoption studies confirm the genetic contribution to schizophrenia. An adopted child’s probability of developing the disorder is greater if the biological parents have schizophrenia, but not if the adopted parents have it.

20. **Describe some psychological factors that may be early warning signs of schizophrenia in children.**

Environmental factors may trigger schizophrenia in those genetically predisposed to it. Among the early warning signs may be a mother whose schizophrenia was severe and long-lasting; birth complications; separation from parents; short attention span and poor muscle coordination; disruptive or withdrawn behavior; emotional unpredictability; and poor peer relations and solo play.

**Personality Disorders**

- Exercises: Schizotypal Personality Questionnaire; Antisocial Personality Disorder
- Lecture: Narcissistic Personality Disorder
- Feature Film: In Cold Blood
- Videos: Module 35 of *The Mind* series, 2nd ed.: The Mind of the Psychopath; Video Clip 30 of Digital Media Archive: Psychology: The Mind of the Psychopath

21. **Contrast the three clusters of personality disorders, and describe the behaviors and brain activity associated with antisocial personality disorder.**

**Personality disorders** are psychological disorders characterized by inflexible and enduring behavior patterns that impair social functioning. One cluster expresses anxiety (e.g., avoidant), a second cluster expresses eccentric behaviors (e.g., schizoid), and a third exhibits dramatic or impulsive behaviors (e.g., histrionic). The most troubling of these disorders is the *antisocial personality disorder*, in which a person (usually a man) exhibits a lack of conscience for wrong-doing, even toward friends and family members. This person may be aggressive and ruthless or a clever con artist. Brain scans of murderers with this disorder have revealed reduced activity in the front lobes, an area of the cortex that help control impulses. A genetic predisposition may interact with environmental influences to produce this disorder.

**Rates of Psychological Disorders**

- Lecture: The Commonality of Psychological Disorders
- Transparency: 156 Risk and Protective Factors for Mental Disorders

22. **Discuss the prevalence of psychological disorders, and summarize the findings on the link between poverty and serious psychological disorders.**

Studies suggest that about 1 in 7 people has, or has had, a psychological disorder during the prior year. The three most common disorders in the United States are alcohol abuse, phobias, and mood disorders. Those who experience a psychological disorder usually do so by early adulthood, with over 75 percent showing its first symptoms by age 24. One predictor of mental disorder is poverty. Although the stresses and demoralization of poverty can precipitate disorders, especially depression in women and substance abuse in men, some disorders, such as schizophrenia, can also lead to poverty.